Statement before the House Committee on Energy and Commerce

Subcommittee on Health

Hearing

Texas v. U.S.: The Republican Lawsuit and Its Impacts on Americans with Pre-Existing Conditions

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Thank you Chairwoman Eschoo, Subcommittee Ranking Member Burgess, and Members of the Subcommittee for the opportunity to testify today on an unusual subject. It's one that borders on the premature, if not speculative, end of the intersection between the health law, policy, and politics spheres of influence, which have been known to collide rather unusually over the last decade when it comes to the Affordable Care Act (ACA). The particular case at issue today, more commonly referred to as *Texas v. Azar*, remains in its relatively early stages, with an ultimate fate as much as another 16 months away. The probability of a Supreme Court ruling that would overturn the entire ACA remains very low, despite last December's decision at the federal district court level reaching exactly that legal conclusion. In any case, any formal enforcement action to carry out that decision has been stayed while the case continues on appeal to the U.S. Circuit Court of Appeals for the Fifth Circuit. In the meantime, all current provisions of the original ACA as enacted in March 2010 (and then altered, to a modest degree, by subsequent legislation and far more frequently by regulatory re-interpretations and administrative actions by both the Obama and Trump administrations) will remain in full force unless and until a higher court either upholds the December ruling or modifies it in part. On the other hand, overturning that entire decision in whole would return us to the same boat, no matter how leaky it has become.

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee and health policy researcher at several other Washington-based research organizations. In addition, I do have some prior involvement in earlier litigation involving the ACA; not just as an analyst and

commentator but also more directly in a number of other areas of ACA-related litigation. I filed an amici brief with colleagues on the severability issue in *NFIB v. Sebelius* in 2012 and worked very closely with the legal strategists initiating and shaping the line of litigation that culminated in the *King v. Burwell* decision in 2015.

My testimony today aims to provide a broad, but necessarily brief, overview across the overlapping domains of health policy, health law, and health politics. Based on past history with the ACA, there are few certainties but more of a wide continuum of possibilities. However, I will suggest some upper and lower ranges of their respective probabilities.

The opening advice, or admonition, is that we've been here before. Although patience is growing thin in traveling a similar path again, it will take a while longer for the smoke to clear and overheated rhetoric to cool. Nevertheless, even our less-responsible parties in government and politics will have little to gain and far more to fear from actually harming the current and future health care of their fellow Americans. They might try, but they won't succeed. Many of us may continue to disagree over what type of public policies can best improve or at least maintain, rather than impair, the current state of U.S. health care, but those differences predominantly involve means, not ends.

Unfortunately, two longer term trends in health policy – our overreliance on outsourcing personal health care decision to third-party political intermediaries and our chronic inability to reach compromises and resolve health policy issues through legislative mechanisms – have fueled a further explosion in extending those battles to our courts. Hence, another hearing today, at least nominally starting at that point.

My testimony will be divided into the three domains I indicated above. First, it will briefly assess some of the main strengths and weakness of the *Texas v. Azar* lawsuit that was filed in early 2018 by a group of 18 Republican state attorneys general and two governors, as well as the subsequent federal district court ruling. I will also touch on the case's somewhat more speculative but ultimately determinative prospects on appeal. Although a number of important legal issues could resurface at the appellate level, such as standing and the magnitude of any injury to the U.S. Constitution, the most decisive one remains likely to involve severability. In short, even if the remaining form of the individual mandate, as a regulatory command without a tax penalty, has become unconstitutional, what happens to the rest of the ACA? And, because it could become a future factor in the legislative and executive branches' respective timelines for future policy making, I'll offer a back-of-the-envelope forecast of when the legislative clock might strike for talk to end and hard decisions to begin.

Second, I will highlight the most significant health policy problems that could be put in play eventually by various final outcomes in this litigation, and the more effective responses. Although the realm of improved health policy decision making does not have to be so closely tied to this particular case's progress, I will assume for purposes of this hearing that it will be. Acting only when absolutely necessary, at nearly the last minute, or somewhat later, is not unfamiliar territory for many current officeholders in Washington. In any case, these mixes of policy decisions would revolve primarily around both "when" it might be necessary to engage them and "what" might need to be addressed. Far too little attention has been paid to the existence of other policy options

than those simply enacting very similar provisions of the ACA all over again, minus any of their lingering legal problems.

Third, we should focus more closely on the main roots of these persistent disputes over health policy that are transferred to the courts. They reflect failures of the legislative and overall political process. Poorly drafted bills, full of complex and ambiguous terms and overly ambitious but untested mechanisms that lack sufficient and sustainable political support but are pushed into law by whatever means are necessary have substantial negative spillover effects. They produce an aftermath of implementation snafus, unintended consequences, and toxic bitterness that, as is the modern American way, tends to migrate sooner rather later toward next-stage political warfare via litigation. This is particularly so when most channels of reconsideration and adjustment in Congress remain largely stalemated, if not frozen.

We could consider a more transparent and accountable approach to enacting and amending such laws, but we haven't chosen to done so for quite some time. If we want fewer ACA-like lawsuits, we might consider insisting on better-written laws that are more understandable, workable, and sustainable.

The *Texas v. Azar* Litigation

A sizable volume of pleadings, briefs, and rulings in this case at the federal district court level, as well as in recent academic and health policy commentary, already provides more than sufficiently detailed analyses of the respective arguments and contentions.[1] For purposes of this hearing, I will offer just a few observations and tentative conclusions.

"Literally" Uphill, but Far from Frivolous

The plaintiffs' case is not frivolous, but it does rely heavily on taking the actual text of the ACA literally, or at least "at its word," and thereby limiting judicial scrutiny to what the 111th Congress that enacted it appeared, on the limited record of that time, to intend by what it did. The ACA was unusual in its lack of substantially documented legislative history, its last-minute take-it-or-leave rescue via a still-unrefined Senate-passed bill in March 2010, and its underlying contradictions and political subterfuges. The plaintiffs in *Texas v. Azar* constructed their arguments to, in effect, reverse engineer and leverage the unusually contorted Supreme Court opinion of Chief Justice Roberts in *NFIB v Sebelius*. The Chief's "majority opinion of one" in the case had "saved" the ACA only by finding that the individual mandate provision could be found constitutional as a tax, rather than a regulatory penalty (despite how then-President Obama and the Congress that enacted preferred to describe it).[2] Therefore, they argue that when a subsequent Congress in 2017 reduced the maximum amount of the annual tax for failing to comply with it to "$0," beginning in 2019 (and thereby eliminating any tax liability), it also thereby made the remaining individual mandate provision in the ACA unconstitutional, in accordance with the rest of the Roberts opinion.

Some critics of this argument have insisted that the 115th Congress that zeroed out the mandate tax also expressed a clear intent to retain all of the other provisions of the ACA. This contention seems misplaced, once one recognizes the limited scope of what that Congress had power to do through the vehicle of budget reconciliation in the Tax Cut and Jobs Act of 2017. Whatever some members of that Congress may have "wanted" to do, in either further reaffirming or weakening the ACA, all that they actually *voted into*

law as a change regarding the individual mandate did not, and could not, extend to the ACA's other non-budgetary, regulatory provisions. Earlier proponents of more sweeping rollbacks of ACA regulatory provisions in the same Congress already had learned from the Senate parliamentarian that they could not do so through majority-vote, budget reconciliation mechanisms.

Such procedural inability to make possible changes in other underlying statutory law provisions is equivalent to inaction that simply leaves them in place, as originally enacted. On the other hand, enacting a specific change in a particular provision can indeed change its legal status from constitutional to unconstitutional.

Do Findings of Fact Demonstrate Legislative Intent?

Determining the legislative intent of Congress regarding the role of the individual mandate as it related to the rest of the law is at the heart of the severability component of the *Texas v. Azar* litigation. The plaintiffs contend that the Findings of Fact included in the ACA statute by the 111th Congress that passed it should be determinative on this point. That Congress essentially said that the individual mandate was essential to the functioning of several other ACA provisions, including protections against exclusions of coverage or higher premium charges for individuals with pre-existing health conditions (hereinafter more commonly referred to as "guaranteed issue" and "adjusted community rating"). Whether or not those "findings" have been borne out in practice or the economic and policy connection was quite as tight as that Congress officially assumed, the plaintiffs are not out of bounds in holding Congress to its past word, and in building on

the similar reasoning used by other Supreme Court majorities to strike ACA legal challenges in *NFIB v Sebelius* and in *King v. Burwell*.

In other words, if that's the "story" for ACA defenders, they should have to stick to it, at least until a subsequent Congress actually votes to eliminate or revise those past Findings of Fact already embedded in permanent law.

Whatever the 111th Congress "may" have really intended is far more complex. At best, one might conclude that, in the final analysis, it really aimed to pass whatever surviving, though problematic version of the ACA it could, by whatever legislative and political means would work, and then try to implement it and fix it up later, as needed, as it went along. However, this gap between what was officially said with a "wink" and what actually was the political calculation is far harder to recognize in the courts as official legislative intent.

Changing Views of the Individual Mandate

The *Texas v. Azar* case indirectly highlights the changed understanding of the limits of the individual mandate since its enactment in 2010. It's somewhat ironic to find a good bit of tactical repositioning on both sides to fit the current legal moment. At least some of the mandate's past champions have begun to downplay its current and future role, while at least some ACA opponents would prefer to overstate its ongoing impact, at least for purposes of legal standing in this particular case. Even though the Congressional Budget Office, once perhaps one of the foremost advocates of the mandate's effects on health insurance coverage and costs within the ACA framework, has begun to back away from its past estimates, in incremental stages, in recent years. Nevertheless, when CBO

was advising the 111th Congress on the likely effects of the individual mandate, it placed great weight on its role as a social norm alone, even without any tax or monetary penalty effect, in incentivizing millions of Americans to obtain or retain ACA-required insurance coverage.

Hence, although the plaintiffs in *Texas v. Azar* still may face challenges to their legal standing at the appellate level, the two individuals added to the original complaint, after it was first filed early last year by state government officials, probably have pleaded just enough of a small, but plausible, injury (being compelled to follow the law) to keep the case in court.

Arguing for Maximum Nonseverability, or Even Limited Severability, Will Get Harder

Even assuming that appellate courts ahead also find some form of constitutional injury in what remains of the ACA's individual mandate as a tax-free regulatory command, the severability stage of such proceedings will become far more uphill for the plaintiffs/appellees.

Supreme Court guidance on severability doctrine has been far from totally consistent in the past. It even could be accused of being selectively results-based in certain instances. Nevertheless, the broad trend for guiding principles in this area is to focus on determining the legislative intention behind the provisions of any law coming into possible constitutional jeopardy. There also is a clear judicial bias toward retaining as much of a law as is possible, to the extent that it would not be directly affected by any constitutional infirmity. However, these tests for determining legislative intent have shades of gray, and they can be dialed somewhat up or down, as desired. Most of the

time, the primary test is functionality, in the sense of ascertaining how much of the remaining law would the Congress enacting it believe could be retained and still operate as it envisioned. An alternative "legislative bargain" test, such as whether that Congress still would have enacted the rest of the law if it knew of the constitutional problems in other related provisions, seems to have fallen into more disfavor recently as too subjective and harder to ascertain.

Critics of current severability doctrine observe that it can lead to excessive judicial rewriting of complex, interconnected statutory provisions or focus unnecessarily on providing a broad remedial tool rather than limiting courts to deciding constitutional issues only to the extent that they directly affect the parties immediately before them.

Given the murkiness of divining legislative intent in harder cases like the ACA challenges to the individual mandate, past and present, it's better to conclude that, although several different severability settings are hypothetical conceivable (see, e.g. several lower court decisions in earlier ACA cases[3]), it remains all-but-certain that an ultimate Supreme Court ruling in this case will, at a minimum, follow its previous inclinations revealed in the 2012 and 2015 ACA challenges and try to save as much of the law as possible (see, e.g., the Court's rewriting in *NFIB v. Sebelius* of the impermissibly coercive Medicaid expansion mandate into a state option).

On first glance, this still could suggest that several regulatory provisions closely tied to the individual mandate (guaranteed issue, community rating, and other pre-ex condition protections; if not the employer mandate and essential health benefits) might remain in jeopardy of being declared nonseverable from an unconstitutional individual mandate. It's a theoretically plausible viewpoint, given that even the Obama

administration's Solicitor General once adopted that legal position during briefing and oral argument in *NFIB v. Sebelius*. But that legal premise fails to account for the passage of time since the pre-implementation stage of the ACA law in 2012, the substantial embedded reliance costs of various health sector participants in adjusting to compliance with the ACA since then, and the sheer administrative and political complexity of unwinding even a handful of ACA provisions on short notice, let alone invalidating future operation of the entire law.

Of course, ACA-related litigation often has defied past consensus forecasts, at least in the lower courts. The plaintiffs/appellees in *Texas v. Azar* may continue to have a "puncher's change" in future stages of court, and the Fifth Circuit is well-known as one of the most conservative appellate court circuits in the country. But they don't have much of a chance at landing a decisive haymaker at the Supreme Court, if past history is any guide to the future.

In short, some may enjoy the litigation theatrics while others either fear them or hope to leverage them to score other political points, but don't bet on more than a narrow finding that could sever whatever remains of an unconstitutional individual mandate (without much remaining practical impact) from the rest of the law.

The Appellate Timeline

We should not rule out some extended overtime ahead in playing out more fully this lingering legal dispute. The most likely timeline ahead would include a decision in the Fifth Circuit by late summer. If that appellate court finds against the plaintiffs/appellees on the merits regarding the constitutionality of the current individual

mandate, further litigation, for all practical purposes, would be over at that point. The possibility of a successful effort to get the Supreme Court to consider that decision on appeal and revive the legal issues would be extremely doubtful. One wildcard could involve en banc reconsideration of a ruling initially unfavorable to the Republican attorneys general by the entire Fifth Circuit, and a reversal then would become far more possible. On balance, I would expect the most likely scenario for the Fifth Circuit to involve changing the degree of severability and protect more, but not all, of the rest of the law. At that stage, the more closely related regulatory provisions tied to the individual mandate could still be in play as nonseverable.

If that turns out to be the case, the Supreme Court would accept the case on appeal. It's hard to envision such a matter being scheduled for oral argument before early 2020 and, in an echo of the timelines for previous major ACA legal challenges at the High Court, a final ruling would be most likely to arrive in late June of that year.

The Health Policy Context for Responses to *Texas v. Azar*

In the face of the above uncertainties and likelihoods, what lessons should health policymakers learn and what preparations can they make for the near future?

Laws Built on Faulty Premises Produce More Lawsuits

When congressional action produces a flawed legislative product, justified in large part by mistaken premises and misrepresentations, it won't work well. It will face substantial negative popular reaction for a number of years. Multiple lawsuits to overturn or modify it will grow rapidly and widely. The ACA's architects and proponents oversold the effectiveness and attractiveness of the individual mandate, touting it as an essential part

of the balancing act of subsidies and regulation that could hold the law's insurance coverage provisions together while keeping official budgetary costs within the bounds of CBO-scored budget neutrality.

The underlying theories and political beliefs of some that the individual mandate embodied in the ACA could achieve its stated goals in increasing coverage, limiting cost increases, and minimizing adverse selection turned out to miss the mark. However, they sufficed (barely) to provide the political cover to get the law enacted in 2010 and then were mostly accepted sufficiently in several Supreme Court case to get the law in business. What worked to launch the ACA and keep it viable in theory did not work as well in practice.

As I testified before a House Ways & Means subcommittee two years ago, "The ACA's individual mandate was primarily designed to help fill in the gaps between what the law's advocates could deliver politically in larger taxpayer subsidies for expanded health insurance coverage and the higher costs of coverage produced by more aggressive regulation of health insurance. It essentially aimed to require less-cost, low-risk individuals not only to obtain or retain federally-mandated minimum essential coverage, but also to pay more for it, in order to cross-subsidize lower premiums for other high-risk and/or low-income individuals. However, the individual mandate continues to face significant political limits on how large the mandate's penalties can be, how aggressively they can be enforced, and how much compliance the mandate will produce. Hence, the mandate's best future for continued survival involves operating much more as a gentle "suggestion" or nudge (with modest penalties and weak enforcement) rather than a more polarizing 'command.'"[4]

Whether an even kinder and gentler iteration of the individual mandate still amounts to an unconstitutional command beyond the powers of Congress remains to be adjudicated more fully in the *Texas v. Azar* case. But we did learn at the least that the previous Congress was eager to "cash it in" at its highest budget-score value in order to help finance, under budget scoring rules, part of the federal tax cuts it wanted to enact in late 2017 through budget reconciliation.

In a sense, one legislative fiction not only helped pass a controversial law, but ultimately begat another artificial budgetary score, which then lead to the opportunity to launch another lawsuit challenging the ACA all over again. Only in American politics?

The Slow Death of a Sales Job

To be blunt, one of the primary ways that the Obama administration "sold" its proposals for health policy overhaul was to exaggerate the size, scope, and nature of the potential population facing coverage problems due to pre-existing health conditions[5] ACA advocates then argued that the only way to address those problems was with a heavy dose of (adjusted) community rated premiums and income-related tax subsidies, complemented by an individual mandate. Unfortunately, this combination also made the coverage offered in ACA exchanges less attractive to younger and healthier individuals, who were asked to pay more for insurance that they valued less. We ended up with the worst of both worlds, a mandate despised by many (low-risk) individuals that largely failed to accomplish its intended goals. To the extent that net insurance coverage gains still were achieved under the ACA, they were due overwhelmingly to the combination of generous insurance subsidies for lower income ACA exchange enrollees, plus an

aggressive expansion of relatively less-expensive (but even more generously taxpayer-subsidized) Medicaid coverage in many states.

Right-Sizing Estimates of Serious, but Smaller, Problems

It's important to remember that the problem of pre-existing condition coverage, before the ACA was enacted and implemented, was limited almost entirely to the individual market. A host of semi-specialized risk pools and other pre-ACA legal provisions already offered various types of such insurance protection to many otherwise-vulnerable Americans.[6] Of course, public policy to address remaining problems *could* and *should* be improved in other less prescriptive and more transparent ways than the ACA's tangled web of less-visible regulatory cross-subsidies and income-related premium tax credits (for example, extending HIPAA's continuous-coverage provisions and risk protections to the individual market).[7] However, the price of maintaining and extending more choice and freedom, with accompanying responsibilities, within the sphere of competitive private insurance markets must include ensuring that our safety net protections for the most vulnerable Americans are sufficient, robust, and realistic. Various policy options such as better targeted subsidies, more sustainably funded high-risk pools, well-structured reinsurance mechanisms, more effective investments in the early determinants of improved lifetime health, and delivery system reforms that actually work all should play far larger roles than the ACA's more narrow focus on using broad regulatory commands alone to police remaining problems of excessive and unfair risk-based insurance coverage and pricing at the individual level.

Better Alternatives Are Available

Hence, if the ACA's current, overbroad regulatory provisions involving guaranteed issue, adjusted community rating, and prohibition of coverage exclusions for pre-existing conditions were stricken down in court in the near future as inextricably tied to an unconstitutional individual mandate, there are better policy alternatives available to lawmakers. Whether they would choose to adopt them, of course, would remain to be seen. The biggest near-term hurdles, not surprisingly, would involve time, money, and political willpower.

Other Potential Responses to Defuse Legal Problems

Some less-wise, but otherwise politically viable policy alternatives in the other direction – to head off future legal liabilities -- might include either doubling down on the ACA's premises or moving away from them. The first move might restore an individual mandate with at least some monetary penalties, if not even larger ones than before. Or individual states could adopt and implement ACA-style insurance regulations on their own. Other humbler legislative actions that could save the ACA from additional legal jeopardy might include adopting new congressional findings of fact that, in essence, would revise or eliminate the aforementioned findings by the 111th Congress when it enacted the original ACA. Perhaps even a simple admission on the record along the lines of "We were wrong. Sorry," might be a good start. Of course, if further disruption and political division is desired, some members of the current Congress could always accelerate action on their future plans for Medicare for All, or at least Many More.

The Most Powerful Factor in Washington Policymaking Is the Political One

Sadly, we are here today primarily to score talking points or deflect them. Meanwhile, the many shortcomings of the ACA as enacted and implemented persist, and the path to better alternatives remains obstructed, if not increasingly abandoned. When the going gets tough through regular legislative channels, more zealous advocates in health policy are particularly prone to seek other forms of redress through the courts and regulatory workarounds. We experienced a great deal of that during the Obama administration's years, and the last two years of the Trump administration have provided somewhat of a mirror image response in reverse through newer litigation and regulation. Revising portions of complex health care legislation, let alone installing a more comprehensive alternative is not only politically difficult; it poses immense structural and transitional challenges. The exhaustion of most substantial repeal and replace efforts through legislation in the last Congress has left a host of lesser ACA-opposition efforts flickering at a lower ember, while onetime legal defenders of ACA rules and regulations are initiating lawsuits of their own to overturn the Trump administration's proposed and implemented changes to them.

Groundhog Day may have been last Saturday, but it often seems to repeat every day when it comes to legal battles over the ACA. It would help to recheck and change the dates on our calendars. On Capitol Hill, we are far better at defending or attacking the ACA in more of a continuous loop than we are at fixing it constructively. Some closing observations follow

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The ACA Has Losers, as Well as Winners

I don't want to neglect pointing out the disappointing results and collateral damage caused by the ACA's execution of its stated objectives. Yes, U.S. taxpayers spent more money, or we borrowed it, and millions more Americans were covered with insurance than before while others had their coverage upgraded and subsidized more generously. At the same time, less-visible victims of the ACA lost the coverage they had preferred to keep or had to pay much more for it if they fell outside of the law's more generously subsidized cohorts. Insurance and health care markets were substantially destabilized for years, although, with enough premium hikes and Silver-loaded subsidy alchemy in the last two years, that's begun to change. Nevertheless, the overall size of the individual market actually have grown smaller than its pre-ACA levels.

Perhaps most of all, our political discourse and civility has suffered deeply. All political actors need to be more sensitive to the risks of unleashing less-predictable and manageable drastic changes on this front without far better transition and implementation plans.

Time Shifts in Law & Politics

The possible policy options noted further above, for dealing with pre-existing condition protections and related insurance issues differently, remain largely moot at the moment, unless and until a highly unlikely future court ruling in *Texas v. Azar* unscrambles the current ACA eggs and necessitates at least somewhat more immediate responses. Under the current status quo, the political center of gravity on most of the ACA has shifted, as evidenced by changes in public opinion polls and last November's

election returns. Mounting a theoretical case for a turn elsewhere in the more market-friendly policy direction suggested above still would need to develop much more of a change in public perceptions, political support, and realistic transitional timelines in order to become more viable. We are not back in 2010, or 2012, or even 2017 anymore. Changes in popular expectations, health industry practices, and sunk-cost financial commitments since 2010 are substantial brakes on even well-structured proposals for serious reform. Moving from where we are stuck at the moment in health policy, like it or not, will continue to be a heavy lift

We Could Buy A Little More Time, but Should Not Waste It

If a need for short-term transitional adjustments, if not complete emergency action, arises after an unexpected development in the *Texas v. Azar* litigation, we should expect the ultimate court decision itself then to provide some transition time before it goes into effect. Although that time may still be squandered in procrastination, indecision, and finger pointing, we do ultimately have to take some deep breaths and remember that voters eventually will insist on a more representative and accountable performance by their elected officials. We certainly need a better-functioning Congress that writes, enacts, and monitors more effective laws, in order to fail less and succeed more in health policy. Sooner or later, we will get one.

Notes

[1] For one particularly noteworthy contribution ahead that captures most of the reasoning behind the initial *Texas v. Azar* ruling, see Josh Blackman, "Undone: The New Constitutional Challenge to Obamacare," 23 Texas Review of Law & Politics __ (Forthcoming 2019).

[2] Although four dissenting justices would have declared the entire ACA nonseverable from its unconstitutional individual mandate and therefore unenforceable as well, the Court never had to reach a final decision on possible severability, given the ruling opinion's finding that the mandate still could be found constitutional after all.

[3] During the two years before the Supreme Court ruling in *NFIB v. Sebelius*, the three different federal district courts delivering rulings on the severability issue after finding the individual mandate unconstitutional were evenly divided. Their decisions ranged from complete nonseverability (Florida, 2011) to partial severability including guaranteed issue and pre-existing condition coverage provisions (Pennsylvania 2011) and to full severability that struck down only the individual mandate provisions (Virginia 2010).

[4] Thomas P. Miller, Testimony before the House Ways and Means Subcommittee on Oversight hearing on "Examining the Effectiveness of the Individual Mandate under the Affordable Care Act." January 24, 2017.

[5] Mark V. Pauly and Thomas P. Miller, "A Better (but Modest) Case for High-Risk Pools," American Enterprise Institute, March 2017.

[6] Tom Miller, "The Concentration and Persistence of Health Care Spending," 40 *Regulation* 4: 28-34.

[7] Thomas P. Miller, Testimony before the House Energy and Commerce Subcommittee on Health hearing on "Protecting America's Sick and Chronically Ill," April 3, 2013.