Chapter 20

Health Insurance for All . . . Or Maybe Not

The Affordable Care Act, sometimes referred to as Obamacare, was signed into law by President Obama in 2010. Today, most of its provisions are in effect. At the time of the law's passage, well over 40 million Americans were without healthcare insurance and prices of healthcare services had been rising rapidly. The law, it was said, would solve both problems. Now that much of the smoke has cleared, we do know that more people have indeed gained health insurance coverage since the passage of Obamacare. But we also know that the law has fallen short of its promises here and in many other dimensions.

Increased Number of Covered Individuals

The Affordable Care Act (ACA) has succeeded in increasing the number of Americans with health insurance. By 2015, perhaps between eight and eleven million adults received some form of health insurance as a result of the legislation. About half of these people purchased private insurance policies, while another half became eligible for Medicaid, the federal–state health insurance program for low-income individuals. Nevertheless, this left almost forty million adults uninsured, and most knowledgeable observers now predict that over the next decade the number of uninsured adults is unlikely to fall below thirty million.

Originally, the ACA was forecast to have a much greater impact on the number of uninsured people. After all, the law is quite specific: You are required to have health insurance, and if you don't have it, you are fined each year—about 1 percent of your income initially, but rising to

about 2.5 percent of your income within a few years. The requirement to purchase insurance is called the **individual mandate.**

The mandate was said by the president to be absolutely essential to the success of the ACA, and his administration successfully defended the mandate against legal challenges that reached the United States Supreme Court. Nonetheless, most of the uninsured will not pay the penalty. Why? Because the Obama administration has chosen to *exempt* them from the fine they were supposed to pay for not buying health insurance.

THE EFFECTS OF MANDATE EXEMPTIONS

The original purpose of the individual mandate was to ensure that younger, healthier individuals would buy medical insurance. When the insurance pool does not contain significant numbers of the young and the healthy, the high healthcare costs of older, sicker individuals can send insurance premiums skyrocketing. Moreover, because taxpayers are subsidizing the health insurance obtained under the ACA, without the young and healthy, government spending and thus the burden on taxpayers goes up as well. Due to the large number of exemptions from the mandate, the higher premiums and higher government spending on insurance were being felt within a year after the program became fully operational.

It is now expected that no more than four million Americans are likely to have to pay the fine by 2016, and some observers predict that President Obama will end up extending the exemptions to many of these people. Indeed, in referring to the president's willingness to issue exemptions from the mandate, the former Director of Congressional Budgets Office, Douglas Holtz-Eakin, has remarked, "If your pajamas don't fit well, you don't need health insurance." In other words, almost anybody can get an exemption from the supposed mandate to have health insurance. Thus, the newly insured are primarily older and sicker, because the young and the healthy have asked for and received exemptions.

YOU'RE SICK BUT HAVE NO HEALTH INSURANCE—NOT TO WORRY

The Affordable Care Act directs that you may not be turned down for health insurance due to a preexisting ailment. The purpose of this rule was to ensure that people who had serious health problems could get insurance.

But the rule has also had two other effects. First, people *without* serious problems are declining to buy insurance, knowing that when problems crop up, they are guaranteed insurance no matter how sick they are. This problem, known as **adverse selection,** drives up costs for everybody else—including both taxpayers and the relatively healthy insured population. Second, people with newly acquired insurance suddenly seem to develop health problems they never knew they had before, a phenomenon known as **moral hazard.** This, too, drives up costs for taxpayers and for others in the insured pool.

The combination of these forces began showing up quickly in the healthcare spending data. For example, during the first part of 2014, serious health problems were more than twice as prevalent among newly insured individuals, compared to those who had previously had insurance. Now, these high health costs were not totally a surprise: after all, one problem the law was designed to address was the inability of sick people to get insurance. But the *magnitude* of the high costs has exceeded all forecasts. Partly this is because exemptions from the individual mandate have created high rates of adverse selection, as healthy people are not buying. In addition, there has been more moral hazard than forecast. For example, the ACA was supposed to encourage people to obtain primary care physicians and to use them instead of emergency rooms for their health care. And while some of the newly insured are doing this, the fact is that emergency rooms visits are *up* sharply under Obamacare, the opposite of what was predicted by its backers.

NEW HEALTH-INSURANCE EXCHANGES

As part of the new law, both the federal government and numerous state governments have created health insurance exchanges. Government officials administer these, but private insurance companies sell the insurance offered on the exchanges. The goal is for insurance companies to compete against each other in the exchanges by offering more attractive and lower-cost policies. As of 2015, there is no compelling evidence that the exchanges have had much impact on competition in insurance markets. In some states, more companies are now competing for business, but in other states, consumer choices have actually declined.

The true competitive impact of the exchanges may be masked by the uncertainties created by the ACA. The large numbers of exemptions from the individual mandate have driven costs up relative to what the insurance companies expected when the law was passed. Moreover, because

the insurers cannot turn anyone down, it has proven difficult for them to predict whether their newly insured customers would be sick, sicker, or sickest. The highly volatile, uncertain costs that insurance companies have faced are likely to continue for some time. Until the companies have a better idea of how to operate in the new environment, competition on the exchanges is likely to be unpredictable at best, as firms enter and exit the market in various states.

One key element of the exchanges may have produced considerable political fireworks even before you read this. Under the terms of the ACA, federal subsidies are available to people earning up to 400 percent of the federal poverty level (about $100,000 per year for a family of four). The government has granted subsidies based on what people *said* their incomes were when they applied for insurance on the exchanges. But these claims must be substantiated by rigorous documentation in the year after the insurance is sold. Some knowledgeable observers are predicting that in any given year, many people will be unable to document their eligibility. If so, they will have to repay the subsidies, in addition to facing much higher premiums than they expected. This will induce some individuals to drop their insurance, adding to turmoil in these markets, and increasing the number of uninsured people.

MANY HOSPITALS HAVE HIT THE JACKPOT

Thus far, there is little doubt that the ACA has caused an increase in the demand for health care. Partly this is because many previously uninsurable people now have coverage. Plus, there are people who are now buying policies simply because they are eligible for subsidies. Both groups are consuming more health care: more emergency room visits, more elective surgeries, more prescription drugs. And this additional health care has no doubt had substantial benefits for these consumers—which was, after all, the point of the law.

But there is another group of beneficiaries: the suppliers of healthcare services, most notably hospitals and pharmaceutical makers. *Uninsured* in-patient admissions have fallen at most hospitals throughout the United States, at the same time that *insured* admissions have risen even more, yielding a substantial net increase. Hospitals, therefore, benefit in two ways. They have more patients, and the revenue they collect per patient is higher than before. Pharmaceutical makers have also seen a sharp rise in demand for their products as new enrollees are taking advantage of their insurance coverage. During 2014, the first full year of Obamacare in action, the stock prices of healthcare companies rose by

roughly 25 percent compared to the average of all stock prices, due to the upsurge in healthcare profits.

THE CONTINUATION OF A TWO-TIER HEALTHCARE SYSTEM

One thing the ACA will not do is eliminate the two-tier healthcare system in the United States. Newly insured individuals fall into these broad groups: those who have purchased their own insurance policies on the exchanges and those who the law has made newly eligible for Medicaid (the federal–state healthcare program for the poor). Although there are a variety of insurance plans available in the exchanges, their typical provisions are much more modest than employer-offered plans or even individual plans offered outside the exchanges. The amounts that people have to pay out of their own pocket for services are thus higher with exchange policies, and enrollees have sharply limited choices of doctors and especially hospitals. In short, none of these plans come close to the "Cadillac" plans commonly available to unionized employees, or even to the "Chevrolet" plans purchased outside the exchanges.

The situation is even worse for Medicaid enrollees. The federal and state governments place significant restrictions on what types of care Medicaid can provide and how much doctors and hospitals will be paid for this care. As a result, heathcare outcomes tend to be worse for Medicaid patients than for persons with their own health insurance. Moreover, because of the low reimbursement rates under Medicaid, about one-third of primary-care physicians and one-fourth of specialists have completely closed their practices to new Medicaid patients. The bottom line is that the newly insured are better off than they were, but the care they are getting is still significantly below average.

THE IMPACT ON THE PREVIOUSLY INSURED

Written into the ACA were a variety of items that Congress and the president thought should be covered by all insurance plans, regardless of whether those plans were purchased through the exchanges. Thus, the law mandated that all policies offer maternity care, contraceptives, annual checkups, and so forth.

Almost 80 percent of individual plans in place when Obamacare became effective at the end of 2013 did not contain one or more of these provisions. Hence, insurers were required to *cancel* tens of millions of policies, which were no longer in compliance with federal law. This

caused an enormous political uproar, which forced the Obama administration to back down on the cancellations. By the time it did so, however, the damage was done, and millions of people had to scramble for new policies, often costing much more than their previous policies. In pushing for the law's passage back in 2010, the president had promised that "if you like your insurance, you can keep it." It was a promise not kept for many Americans.

THE RISE OF THE 49ERS

No, we are not talking about the football team. Rather, we are talking about companies that refuse to hire their fiftieth employee. Businesses with fewer than fifty employees are exempt from the most costly Obamacare requirements that larger employers incur under the healthcare law. Indeed, firms with fewer than fifty employees may lawfully offer no health insurance at all and avoid paying the penalties that apply to large companies that don't offer insurance. Thus, some firms have been reorganizing themselves, or simply firing employees, to get down to forty-nine or fewer employees. Others are shelving their growth plans that have now become uneconomical in light of the law's costly insurance requirements.

Firms with fifty or more employees do have options to avoid the law, however. They can make sure that many more of their employees are "29ers." That is, they can limit their employees to working twenty-nine or fewer hours a week because thirty hours or more per week is Obamacare's definition of full-time employment. Employers are not required to offer health insurance to part-time employees, so firms can save thousands of dollars per employee by utilizing this tactic. There are now about twenty-eight million part-time workers in America. Most would be working reduced hours even without the ACA, but observers generally agree that the health insurance law is contributing to the numbers.

THE BOTTOM LINE

The ACA has conferred substantial benefits on a narrow segment of the American population. Indeed, for people at the bottom of the income spectrum, it has been estimated that the law has added about 6 percent to their real income, by improving their health care or reducing their out-of-pocket healthcare costs. And for some of those people who were previously uninsurable, the law literally has been a lifesaver.

For many more individuals, the ACA has raised the cost of insurance and compelled some of them to pay for items of insurance coverage against their will. Some have had their policies cancelled and found the replacement policies offered them to be too expensive. Taxpayers can also expect their bill to go up: to pay for the expansion in Medicaid and to pay the subsidies on those policies sold on the insurance exchanges.

Overall, the law has contributed to an increase in the demand for health care, which can be expected to increase prices for healthcare services. The law has a number of provisions that are supposed to reduce healthcare costs by encouraging people to seek routine treatment before their health deteriorates. So far there is little evidence of this, but matters may change as people become more comfortable with the new system. Of course, Medicare and Medicaid (both enacted in the 1960s) were supposed to reduce costs in some of the same ways, but actually ended up drastically *raising* healthcare costs because of the sharp increase in demand for health care that they induced.

Not all of the uncertainties that have developed under the Affordable Care Act have resolved themselves and may not for quite some time. One thing does seem certain, however. Given the importance of health care to everyone and the high costs of consuming it, this is an issue that will not go away.

DISCUSSION QUESTIONS

1. Under what circumstances would you try to avoid purchasing health insurance?
2. Do increased physician and hospital treatments for serious illnesses among those who are newly insured tell you anything about the price elasticity of demand for medical care? If so, what?
3. When an employer chooses to reduce the hours worked by many of its employees to fewer than thirty per week, what might be some of the negative consequences to the business? What damages might the affected employees suffer?
4. People over the age of sixty-five are eligible for Medicare, which offers subsidized health care—as long as the doctor involved agrees to accept the relatively lower fees paid by Medicare. Some people over sixty-five choose instead to pay out-of-pocket for so-called "concierge" physicians, who provide medical services on a cash or credit card only basis. Can you explain why patients would turn their backs on Medicare and instead pay out of their own pockets?

5. In Britain, everyone has the right to health care provided by the National Health Service, paid for out of tax revenues. Nevertheless, two-thirds of British citizens earning more than $80,000 per year currently purchase private health insurance. Why would these people opt to "pay twice" for healthcare services? (HINT: Think of Americans who pay for sending their children to private schools.)
6. Under what circumstances would an employer be willing to pay an annual fine for not providing legally required employee health insurance?

CHAPTER 21

The Deception of Green Energy

If good intentions were all that were necessary to create "green" power, we would have so much of it today that we would not need to use coal, oil, natural gas, or nuclear power. Of course, it is also true that if wishes were horses, beggars would ride.

In the last decade or so, the federal government has poured tens of billions of dollars into "green" energy projects. The results have neither noticeably reduced our dependence on foreign oil nor cleaned our air and water of pollutants. They have not even made a dent in the atmospheric buildup of greenhouse gases. What we *have* accomplished by using up all of these scarce resources on solar, wind, and battery power is a convincing demonstration that while green energy may make for great politics, it also makes for lousy environmental and economic policy.

GREAT GOALS, BUT NOT MUCH SCIENCE OR ECONOMICS

Anyone who is worried about the environment—meaning each of us—is concerned about potential global warming as well as pollution that occurs with many sources of energy. Environmental quality is a valuable resource, and it is important that both environmental and economic policy treat it as such.

Enter the era of **green energy,** which refers to processes that can be harnessed to meet our energy needs with little pollution. Most observers would include in green energy, at a minimum, wind power, solar power, tidal and wave power, and geothermal power. Others might add hydroelectric and nuclear power to this list, although plenty of people would exclude these two on the grounds that (i) hydropower threatens the long-term survival of some fish species and (ii) nuclear power yields