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The Unaffordable Health Care Act - A Reponse to Professors Bagley and Horwitz

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THE UNAFFORDABLE HEALTH ACT: A RESPONSE TO PROFESSORS BAGLEY AND HORWITZ

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The Patient Protection and Affordable Care Act of 2010 has stirred considerable controversy. In the public debate over the program, many of its proponents have defended it by focusing on what is sometimes called the "free-rider" problem. In a prior article, we contended that the free-rider problem has been greatly exaggerated and was not a significant factor in the congressional decision to adopt the Act.[1] We maintained that the free-rider issue is a red herring advanced to trigger an emotional attraction to the Act and distract attention from the actual issues that favor and disfavor its adoption.

In a recently published article, Professors Nicholas Bagley and Jill Horwitz responded to our article.[2] For the sake of convenience, we will sometimes refer to the two professors collectively as "the professors." In addition to addressing the free-rider issue, they also made a number of points in defense of the Act. We will concentrate on responding to those items that we discussed in our prior article and deal with only some of their broader points.

While not mentioned by the professors, one matter worth noting is the effect that the cost of implementing the Act may have on the economy. While cost is not the only potentially unfavorable feature of the medical care program that the Act creates, its economic impact should weigh heavily in evaluating its merits.

A major objection to the Act is the belief that it will impose a huge cost at a time when the government should be reducing expenditures. Proponents dispute this objection: based on a set of assumptions as to future events and behavior, the government maintains that the program will generate a surplus. We are not alone in believing that the assumptions on which that projection is made are unrealistic and that the program will greatly impair the economy. For example, the Act requires a reduction in Medicare disbursements and anticipates those savings will offset some of the Act's costs, yet there are reasons to suspect that the proposed cuts in Medicare

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1. Douglas A. Kahn & Jeffrey H. Kahn, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?,* 109 MICH. L. REV. FIRST IMPRESSIONS 78 (2011), http://www.michiganlawreview.org/assets/fi/109/kahn.pdf, [hereinafter "Kahn"].

2. Nicholas Bagley and Jill R. Horwitz, *Why It's Called the Affordable Care Act*, 110 MICH L. REV. FIRST IMPRESSIONS 1 (2011), http://www.michiganlawreview.org/assets/fi/110/bagleyhorwitz.pdf [hereinafter "Professors"].

will never materialize or will be repealed when the consequence of making them surfaces. While we also will not grapple with that issue, we are deeply skeptical of the government's contention. For this reason, we choose to refer to the Act as the "Unaffordable Health Act" (or the "Act").

I. Who Constitutes a Free Rider?

The so-called free-rider problem arises when a person who is not insured receives free medical treatment. Under the prior regime, the uninsured themselves paid for more than one-third of the medical costs they incurred,[3] and less than one-third of those costs were obtained by charging higher prices to those who paid for their care.[4] In our prior article, we posited that many of the uninsured who did not pay for their medical care were persons who could not afford insurance.[5] We contended that, in the public debate, the term "free rider" should not be used to describe such persons because the lay public's understanding of that term would make its use misleading and prejudicial.[6] The professors countered by adopting the definition of a free rider that is employed by economists: "A free rider is a person who receives the benefit of a good but avoids paying for it."[7]

The public's understanding of a term that has a special meaning within a profession may be quite different from the understanding of the profession. For example, a lawyer knows that a homicide committed in the "heat of passion" is not first degree murder; but the lay person's understanding of the crime constituting "heat of passion" homicide likely will be very different from a lawyer's. Another example is the word "gift," which not only has an artistic meaning to a tax lawyer but also has a different meaning for purposes of the income, estate, and gift taxes.

While an economist might include persons who cannot afford medical care or insurance in the term free rider, he would understand that they occupy a very different position from other free riders. He would not be misled by the use of the term. That is not true for members of the lay public. Most of them will have a different and pejorative understanding of that term. They likely will view "free riders" as parasites who could have afforded to purchase medical insurance but chose instead to pass their medical costs to the rest of society when they received free medical care.[8] It seems to us that the term was deliberately adopted to mislead the public and to slant the debate in favor of the adoption of the Act.

A person who could not afford insurance did not voluntarily shift his medical expenses to anyone else. Since society decrees that such persons receive medical care when needed, there will necessarily be a shifting of

3. Kahn, *supra* note 1, at 80.

4. *Id.*

5. *Id.* at 81.

6. *Id.*

7. Professors, *supra* note 2, at 3 n.5.

8. Kahn, *supra* note 1, at 81.

cost; but the uninsured's illness, rather than his action, initiated that shift. The image created in the mind of the lay public is that the Act was needed to end a widespread, parasitic practice of taking advantage of the public's benevolence. Those who cannot afford insurance simply do not belong in that category. Indeed, there likely are relatively few persons who fit that category.

The professors state that regardless of whether we call it a "free-rider" problem, the "cost shifting [that occurs] is still a problem – and a massive one at that."[9] We pointed out in our piece that the Act does not prevent cost shifting, although it does change the identity of those who bear that cost. By raising the free-rider problem as a justification for the Act, an erroneous inference was implanted that cost shifting would be eliminated by the Act. While acknowledging that the Act requires cost shifting, the professors contend that the method of shifting employed by the Act is more desirable than the method employed under the prior system. We discuss that issue in Part IV.

The professors decry that so much attention has been focused on the so-called free-rider problem when they consider so many other matters to be of greater importance.[10] We agree. Indeed, that point was a significant part of our article. Proponents of the Act are the root cause; they advanced the free-rider problem as a major justification for the Act. Their assertion of the free-rider problem and exaggeration of its significance have diverted attention from the actual goals of the Act and minimized the public debate regarding more meaningful questions. The proponents' use of the free-rider issue is akin to a magician's use of misdirection: he focuses the audience's attention on a meaningless act so that they do not notice what is actually taking place.

II. The Act's Departure From an Insurance Program

While the Act contains an insurance feature, a significant part of the Act is a social welfare program that is implemented through insurance.

A. *The Purpose of Health Insurance*

The function of any insurance program is to spread risks among a larger pool of persons so that no single person bears the full brunt of the cost of the insured event.[11] Consider life insurance, for example.

One thousand people of age *X* each have a $10,000 obligation to pay at the end of a year. Each member of the group who is alive at the end of that year will have earned enough to pay his $10,000 debt. But anyone in the group who should die before the year is over will not have had time to earn the $10,000 needed to pay his debt. Thus, all 1,000 persons want to purchase life insurance that will pay $10,000 to their estate if they should die

9. Professors, *supra* note 2, at 3.

10. *Id.* at 1.

11. *See* Helvering v. LeGierse, 312 U.S. 531 (1941).

within the year. The actuarial figures show that 1 percent of the people of age *X* will die within the next year. Consequently, it is likely that 10 of the 1,000 people will die during the year, and the aggregate amount paid to those decedent's estates will be $100,000 if everyone purchases $10,000 of insurance. To have sufficient funds to pay $100,000 to the estates of the ten decedents, each of the 1,000 persons who purchases insurance will be required to pay a premium of $100.[12]

In effect, by accepting a set amount of cost ($100), each member of the pool has shifted the risk of not being able to earn the additional $9,900 to others in the pool.

Insurance operates by charging a premium that relates to the dollar amount at risk and the likelihood that the event that is the subject of the insurance will occur. While the program adopted by the Act is partly an insurance program, the part that redistributes wealth for social welfare purposes is not insurance.

Insurers set the premiums for an age group by taking into account the health of those who comprise that group. They determine the medical expenses incurred by members of the same age group, including those with poor health. The actuarially determined cost for an age group with more unhealthy individuals will therefore be much higher.

Older individuals have larger medical expenses than young persons and have a higher incidence of illness. Accordingly, the premiums for older persons would be much greater if their age group were charged its actuarial cost, especially since the group will include unhealthy individuals. The Act, however, prohibits an insurer from charging anyone a premium that is greater than three times the lowest premium charged any adult; and so an elderly person's premium will be substantially less than the actuarial cost of his or her coverage. The insurers will make up that shortfall by charging the young a significantly larger premium than the actuarial cost of their coverage. The young will thus subsidize the coverage of their elders.

The professors note that once an individual reaches sixty-five, he is covered by Medicare, and so they conclude that he will no longer be subsidized.[13] Even if that were so, it would not eliminate the subsidy; it would merely limit it to those under the age of sixty-five. However, many individuals who are covered by Medicare purchase supplementary medical insurance and thereby will benefit from the subsidy since their premiums will be less than their actuarial cost.

The professors contend that we have overstated the subsidization of the elderly and the unhealthy. They point out that the program does permit a limited amount of variance in premiums because of age.[14] But as noted above, in light of the ceiling imposed on the amount of variance, the Act does not even come close to preventing a massive subsidy of the elderly.

12. Of course, the premium would have to be greater than $100 to cover administrative costs and allow for a profit, but $100 is the pure insurance element of the premium.

13. Professors, *supra* note 2, at 5.

14. *Id.* at 5–6.

The professors also note that the Act expands Medicaid and provides governmental subsidies for persons with lower incomes to help them purchase insurance. The professors claim that those provisions will channel tax dollars from the elderly to the young and will effectively offset the subsidy from the young to the elderly. But to what extent is that so? Income taxes are not collected exclusively from the elderly. Medicaid coverage is determined by income levels rather than by age. Moreover, Medicaid covers a relatively small percentage of the population, and many states have recently cut Medicaid payments.[15] Government subsidies for insurance premiums are given to persons with incomes that do not exceed four times the poverty level regardless of their age.

The professors contend that the Act cuts Medicare to finance subsidies to lower income individuals and that these subsidies will constitute a transfer of wealth from the elderly to the young. This claim is tainted by the widely held skepticism that those cuts will ever take place as well as by the question of whether the recipients of that largesse will predominantly be young.

While conceding that the Act will require the young to subsidize the elderly, the professors respond that this is only a temporary circumstance.[16] In time, the young will age and then be subsidized by the youth of the next era. Perhaps this argument will convince some youths: they should be pleased to subsidize the elderly because some years in the future they might be subsidized. But there are counterconsiderations. A youth may not live to become eligible for a subsidy or may not become seriously ill before attaining age sixty-five and becoming eligible for Medicare. There is a risk that the program will be discontinued or altered before the youth becomes eligible. The public opposition to the program and its potential burden on the economy raise the risk that it either will not survive or will be significantly modified. Moreover, there is the matter of time value of money. Even if a person later receives an equal amount of subsidy to what he paid, the current value of future dollars must be discounted. Also, a person's economic status affects how he values his dollars. The dollars that a youth pays may be more precious to him than dollars he *might* receive when he is older and possibly more prosperous. But all those considerations go to the question of whether the public will buy into the program; they do not alter the fact that the program rests on a subsidization of the elderly. If the facts are clearly divulged, the young can decide whether they think the Act is a good bargain.

The professors' suggestion that the young's subsidy of the old is mitigated by the likelihood that the medicines that the young will receive in their golden years will be better than today's[17] is perplexing. The quality of medicine that will be available will be the same regardless of whether the Act's program is in effect.

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15. Phil Galewitz, *Medicaid Payments Go Under the Knife*, USA TODAY, July 6, 2011, at 5A.

16. Professors, *supra* note 2, at 6–7.

17. *Id.* at 7.

B. *Variance Limitation*

The professors describe the provisions prohibiting the taking of an individual's health into account as "community rating" as contrasted with "individual risk rating."[18] In that regard, the system superficially appears similar to group medical insurance programs—that is, the rating is based on the treatment of the entire community (separated only by age) rather than on the treatment of individual applicants. But that is not all that occurs under the Act. The insurer is not permitted to use accurate actuarial figures for the medical expenses of elderly groups because of the variance limitation.

The variance limitation and resulting wealth redistribution are not elements of an insurance program. They represent a social welfare program to secure proper medical care for everyone. The additional cost borne by the young is a kind of tax that the government has imposed to provide universal access to health care. Much of the professors' reply makes a case for the need for such a social welfare program. Like any social welfare program, it should have to pass a cost-benefit analysis. The professors spell out the benefits of the program, but give little attention to its costs.

III. Disclosure of Redistribution

The professors reject our complaint that the redistributive aspect of the Act has received too little publicity. They believe that it has been discussed at length in Congress and in the public domain. We do not claim that the redistributive purposes of the Act were ignored entirely or were hidden. We do say that the free-rider issue has dominated the public discussion of the Act and has distracted attention form the real issues. To their credit, the professors have fleshed out many of the real issues and have made their case for them.

IV. Surreptitious Cost Shifting and Progressivity

The professors criticize the hidden aspect of the prior system's shifting of the cost of unpaid medical services to those who paid for their own care. Much of the payment for medical care is made by insurance provided by employers. Most employees do not realize that they bear the burden of paying for that insurance through lower wages.

The professors claim that the Act's shifting of the burden of some of the medical costs to the government (through the subsidization of premiums for low-income individuals) will make it more transparent because taxpayers will understand that the funds come from tax collections.[19] There is reason to doubt that taxpayers take notice of the extent to which their tax dollars participate in specific governmental expenditures, but even apart from that question, the Act's cost shifting is just as surreptitious. Much of the Act's redistribution is to shift the elderly's cost to the young. Many of the young

18. *Id.* at 6.

19. *Id.* at 5.

are employed, and their medical insurance is provided by their employers. Consequently, the cost shifted to the young will be paid by the employers, who will pass it on to employees in the same surreptitious manner that occurred under the prior regime.

The professors note that many who paid for their medical care under the current system were unaware that they were bearing the cost of those who did not pay. Under the Act's program, many of the young will be unaware that they are subsidizing the elderly, and so the Act does nothing to cure that problem.

The professors contend that the prior system's shifting of costs to paying patients was regressive because the amounts charged were not dependent on the patients' income levels. They claim that shifting costs to the government will be progressive because of the graduated income tax rates.[20] Much of the Act's redistribution is to shift costs from the elderly to the young, and there is no progressivity in that significant part of the Act. As to the prior regime, it is plausible that paying patients with higher incomes would choose more expensive care and would thereby incur a higher percentage of the indigents' costs. It is doubtful that the Act does much to improve progressivity; but even if it does, that likely played no part in the motivation for adopting the program.

V. Reduction of Health Costs

The most disappointing feature of the Act is that it does so little to reduce the costs of health care.[21] Costs are skyrocketing, and that makes health care unaffordable to many. Moreover, it is strangling the economy.[22] Increasing the number of persons insured is likely to cause an increase in the demand for medical services, which will cause an increase in the cost of those services. Not only does the Act fail to deal with rising costs, it compounds the problem. There is reason to fear that the health care system in this country is in crisis; but the Act does not adequately address the core problems. Rather, it deals with only one aspect (albeit an important aspect) of the problem and, in doing so, exacerbates the national deficit problem that looms so ominously at this time.

Conclusion

The professors have described the meritorious benefits of the Act. There also are negative considerations, and we lack the space to discuss some of those. The question of the retention of the program rests heavily on a cost-benefit analysis. In that regard, there are three important questions: whether the economy can bear the cost; whether the benefits are worth that cost; and

20. *Id.* at 4–5.

21. The Act does take steps to reduce insurance costs by eliminating underwriting and promoting an exchange program. But neither of those provisions reduces the costs of providing medical care.

22. *See* David Brooks, *Death and Budgets*, N.Y. Times, July 15, 2011, at A23.

whether the cost will be borne by appropriate persons. Time will tell how those questions are answered.