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The Affordable Care Act and Health Care in America

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The Affordable Care Act and Health Care in America

by

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Foreword from the Author

Dear Reader,

What you are about to read is a final project meant to incorporate ideas from my undergraduate coursework with my interests in medicine and economics. Issues in health care, especially insurance, fascinate me and I chose to use my Honors Capstone Project as an opportunity to further my understanding of issues important to me as both a future physician and businessman. The purpose of this paper is to practice critical and analytical thinking skills by exploring some of the challenging issues surrounding American health insurance and the Affordable Care Act while also gaining a deeper understanding of the nuances of the health care system I will one day practice in.

I've made a conscientious effort to incorporate ideas and concepts from my economics and business coursework into this paper to create a crossover between the theoretical concepts discussed in the classroom and current real world events. The hope is that the final product will not only act as a personal writing sample, but also be informative and entertaining to the reader by conveying relevant and pertinent information. Every section of this paper is meant to tell a story: each one with an interesting history, a thorough analysis, and a forecasting of what is to come. Not all of the stories will have a neat or happy ending, but nonetheless, these are the stories that must be told.

A Brief History of Health Care and Insurance in America

Health care in the United States is one of the most controversial and complex issues facing Americans today. The advent of modern medicine has increased the average lifespan and improved the quality of life for millions of Americans, while at the same time also increasing overall costs. A little over 100 years ago, medicine was an underwhelming field with few effective treatments and a myriad of pseudoscientific and oftentimes dangerous procedures. In that day and age, medical care was often forgone and actual medical expenses would not have cost more than $100 per year in inflation adjusted dollars (Blumberg, 2009). As medicine developed, treatments became more effective and the technological advancements brought to light one of modern history's greatest debates: the issue of allocating medical goods and services amongst the American population.

Historically, medical care was distributed in a traditional free market manner with clients paying directly for the medical services rendered by the physicians. Over the course of the 20th century, the idea of insurance coverage specifically for medical expenses arose; this new concept drastically changed the way in which care was paid for. Under this new system, individuals could pay small monthly risk premiums in order to insulate themselves against unexpected and expensive medical bills in case disaster were to strike (Blumberg, 2009). Savvy entrepreneurs were quick to discover the potential for profit by providing this type of insurance and acting as a well compensated middleman between health care providers and patients.

As new insurance companies sprang into existence, individual health insurance increasingly became the new standard, gradually replacing the traditional direct payment model. In 1940, a mere 9% of people had health insurance, but by the 1960's about 70% of the population was voluntarily enrolled in a health insurance plan (Blumberg, 2009). Insurance had become ubiquitous and was not going anywhere. In fact, on July 30th 1965, the United States government introduced two programs that set in stone the health insurance model and laid the foundations for the payment system we see today: Medicare and Medicaid (CMS' Program, 2015).

Each program aimed to ensure adequate access to health insurance for specific demographics, targeting both the elderly and senior citizen population as well as America's poorest and most destitute. For the next half century, there were very few monumental changes to the American system of health care up until the passage of the Affordable Care Act in 2010 under President Barack Obama and a Democratic Party controlled congress (CMS' Program, 2015). The Affordable Care Act marked the next pronounced shift in medicine and drastically changed health care in ways that had not been seen since the introduction of Medicare and Medicaid. These changes were not just limited to health insurance as the new law produced additional effects that have rippled through many aspects of American society.

The purpose of the Affordable Care Act was to increase access to care for all American citizens, while reducing overall costs and improving treatment outcomes. When the health care law was passed, it contained no shortage of text, much of which legislated areas outside of health insurance by mandating new taxes, creating requirements for

businesses, and adding clauses that benefited special interests. The cumulative effects of the law were profound; individuals were now required by law to purchase insurance, new insurance exchanges and subsidies were created, and physicians saw changes that had a significant effect on the way they practiced medicine (ObamaCare Summary, n.d.).

The effects of the Affordable Care Act have just started to emerge over the course of the past several years as the rollout and implementation of the law has slowly come to fruition. With such a new and complex overhaul to the American health care system, many areas of study have materialized that are ripe for analysis. This paper will examine before and after snapshots in order to see what changed after the passage of the Affordable Care Act and why these changes happened. The new health care law is not simply all good or all bad, but rather has many positive and negative aspects that affect different groups in different ways; every part of the law has a profound impact on American society, creating both winners and losers. Examining the past literature as well as current events, this paper will dissect some macro issues and sections of the Affordable Care Act in order to gain a detailed understanding of who these winners and losers are, why they were affected in the way they were, and what changes could be made to create a more efficient and cost effective health care system.

The Role of True Insurance

As health insurance became increasingly popular over time, many economists sought to analyze ways to make the system as efficient as possible. This process of analysis has often been termed "the anatomy of health insurance" and is not a simple process. To complicate matters further, there is no single best solution that maximizes all areas of health insurance. Instead, health insurance is viewed as "a challenging exercise in the second best" because "on each of a variety of dimensions, goals must be traded off against each another, since first principles are in conflict" (Cutler, 2000). Many of these multifactorial issues are addressed in David Cutler's chapter, *The Anatomy of Health Insurance*, but the fundamental problem that must be discussed here is the tradeoff between risk spreading and maintaining appropriate incentives.

One of the most basic tenets of any insurance is that it must be a financially losing proposition for the average enrollee. The expected value of payouts and expenses per person for the company must be lower than the expected revenue the company receives from each enrollee. Simple math and basic economic principles show that if variable expenditures exceed revenue, a company will choose not to stay in business. Since this situation would lead to a lack of insurance providers, it is safe to say that companies would not operate if medical insurance was not profitable to the business and a losing proposition for the average consumer.

This begs the question as to why anyone would purchase any type of insurance if on average it is likely to cost more money than going uninsured. Simply put, there has to

be some sort of non-financial benefit from having insurance that is worth paying extra for. That benefit is the peace of mind and protection from disaster or catastrophe. Whether it is medical, home, life, or any other type of insurance, consumers want to purchase insurance to protect themselves from situations by which random chance could leave the customer in financial ruin or a difficult situation. In a true health insurance market, this would be the main reason to purchase insurance. However, in the convoluted health care system we have today, there are also other reasons and benefits to purchasing insurance that cannot be ignored, such as: benefitting from discounted rates (What Are, 2012), legal mandates and fines (Obamacare Individual, n.d.), and other complicated factors.

Comprehensive versus Catastrophic Insurance

The ideological goal of insurance is simply to protect against catastrophe for any one individual by pooling risk. For most people, the amount paid through premiums will far outweigh any benefits in the future. However, the additional cost provides peace of mind that the customer will be insulated in the case of a disaster. The goal of insurance should not be to pay for routine costs as such a system would lead to higher premiums and even more inefficiencies. Unfortunately, when it comes to health insurance those ends seem to be the norm. Efficient and worthwhile insurance systems have very low financial inputs and pay out only in cases of disaster or large unexpected events.

Before explaining why low cost plans are ideal for insurance optimization, it is important to first classify insurances based on premiums and coverage. I will call any insurance that has very low fixed costs, low subsidization of health care costs, and a high deductible and maximum out of pocket limit, a catastrophic plan or true insurance. The converse, a plan with high fixed costs, high subsidization of care, and a lower deductible will be called a comprehensive plan. In reality plans can and do range anywhere between the two extremes with unique and different options for premiums, coinsurance, deductibles, and other important metrics.

The system we have today is heavily biased towards comprehensive plans which create economic inefficiencies by altering and distorting the demand curve for health care services. This in turn leads to overconsumption and rendering of elective services that may be unnecessary or not worth the cost. To explain why insurance, specifically those

with more comprehensive characteristics, raises costs and reduces the value to the consumer, I will use a thought experiment from the economist Johnathan Cochran who has studied the Affordable Care and health insurance in depth.

We will imagine that a patient has been suffering from lower back pain for several months. Upon going to the physician's office, the patient has the opportunity to have an MRI: a diagnostic imaging test that has the potential to reveal the etiology of the back pain. This creates the question of whether or not the patient should choose to undergo the MRI or not. The answer is not simply yes or no but instead depends on how much the individual patient values the MRI at that time. If the cost is $1000, the patient should undergo the MRI if he or she feels that the possibility of resolving the pain is worth the cost of the test. Cochran presents a litmus test in which the patient would be asked if he or she would rather consume the MRI or forgo the MRI and receive a check for $1000. If the patient would choose the money, then the decision under normal circumstances should be to not receive the MRI because the $1000 is worth more than a possible back pain diagnosis (Cochrane, 2013).

The brilliance of this example is that it shows how health care should work in an efficient market and allows for an easy means to demonstrate how insurance distorts the market. Let us pretend the patient had comprehensive insurance; the patient may now have the option of paying a partial cost of $200, or potentially no cost at all for the MRI if he or she has met the plan's deductible. The MRI still costs the health care system $1000 but the price to the consumer is now a fraction of the original cost. A situation like this is bound to affect the demand for health services.

The law of demand states that when price decreases, the quantity demanded increases (Henderson, 2008), which leads us to the conclusion that more people would undergo the MRI when enrolled in a comprehensive insurance plan than when uninsured and faced with the true cost. With catastrophic insurance, the patient is unlikely to have much if any subsidization and will be less likely to undergo the procedure unless it is truly necessary or worth the price. In a population with only catastrophic insurance, fewer MRI's will be purchased at any price than in a system with only comprehensive insurance.

The end result of a comprehensive health insurance system is that people will pay more and use more services, regardless of whether or not they are necessary or valuable. The insurance system we see now almost entirely removes traditional supply and demand when it comes to health care services. If a consumers uses little or no service, he or she will still spend a large amount each year due to expensive premiums. Those who utilize large amounts of care each year end up paying a much smaller marginal cost for the care than actual dollar amount. Once deductibles are met and maximum out of pocket limits are hit, health care services end up having a marginal cost of zero since the consumer pays no additional financial costs for any additional treatment. This creates a perilous situation where overuse becomes commonplace.

A more straightforward, but fictitious, example would be forcing every citizen to pay $100 a month for the right to buy groceries at half price from Walmart. Because all groceries are subsidized, individuals will buy many more groceries, and sometimes even more expensive ones, than they would if they went to a non-subsidized grocery store. We can extend the example further by saying that once a person buys $500 worth of groceries

each month, any additional grocery is sold free of charge. This is analogous to hitting the maximum out of pocket limit on a health insurance plan. We can see once again that this method certainly is not efficient in allocating groceries to the American population, and the same idea applies to health insurance.

Using the example of the MRI, one may mistakenly believe that the comprehensive insurance enrollee benefitted in the long run by paying a mere $200 for a $1000 procedure. However, before the visit we must remember that the consumer had paid large sums for premiums (likely several hundred dollars each month) that likely outweighed the small savings of $800, made worse by the potential that it was a service he or she may not have even needed or was worth the cost. Even if an individual was able to profit in the short run, as more and more people receive similar subsidized services the costs increase for the insurance companies and premiums increase alongside costs to keep the expected value of expenses lower than the expected value of the premiums. Put simply, the increased costs of care are shifted right back to the consumers.

At the end of the day, although a few individual cases can save money in the long run through insurance, the average consumer can never profit from holding insurance. The nature of insurance is a system in which the vast majority of individuals lose out by overpaying and a few individuals benefit from underpaying for coverage. In the end though, even the losers benefit due to the utility that comes from having the safety net. The system works because the small additional cost to most consumers is worth the benefit of the peace of mind and financial stability from protection against catastrophe. True insurance has these benefits; think of a home insurance policy that covers the cost

of the house should it be partially or completely destroyed. The insurance would not pay anything towards routine maintenance, replacing flooring, or any of the plethora of costs associated with owning a house. These normal costs are paid directly by the consumer with little distortion of value or demand and the homeowner pays a small amount in monthly premiums. The health insurance we see today saps much of the additional consumer surplus through higher than necessary costs and inefficiencies.

The Affordable Care Act and the Continuation of Past Mistakes

Looking back on the past forty to fifty years there has been a transformation from true or catastrophic insurance plans to comprehensive ones, even before the passage of the Affordable Care Act. Over that same time there has been an alarmingly high real, meaning adjusted for inflation, increase in the amount of money spent on health expenditures per person (see figures 1 and 2 in appendix). During the period from 1999 to 2013, the average premium went up by 196% while inflation only increased by 40% (see figure 3 in appendix). While the correlation between more expensive plans and total health expenditures per person may not be entirely causal, as there could be other factors contributing to increasing costs, the link between the two factors provides support for the assertion that comprehensive plans with higher fixed costs distort the demand for health care and lead to increasing amounts of both necessary and unnecessary care.

While one might assume that a law meant to minimize health care costs and reduce unnecessary services would encourage people to purchase catastrophic insurance, the Affordable Care Act actually does the exact opposite. The new health care law actually makes catastrophic plans incredibly difficult to purchase and mandates that all plans have minimum essential coverage. Under the new law, catastrophic plans are not sold by the health care exchanges, meaning there are no subsidies available for those purchasing the plans (Catastrophic Health, n.d).

In addition, individuals can only purchase these catastrophic plans if they are under 30 or qualify for a hardship exemption. This requirement adds yet another level of

effort and complexity for individuals trying to find a good plan and the extra work acts as a deterrent for catastrophic plans. To make matters worse, these plans are not even true catastrophic plans as they have maximum out of pocket costs of no more than $6,600 for a single person or $13,200 for a family per year, and the plans include other guaranteed benefits rolled into the price (Catastrophic Health, n.d.). These limits prevent additional plans with lower premiums and higher maximum out of pocket costs from existing, which could be of benefit to high income earners only looking for protection from larger medical expenses.

These changes under the Affordable Care Act have taken one the most significant issues facing health care over the past 40 years, the increasingly price insensitive health care market, and exacerbated the problem by moving American health care even further down that defunct path. Consumers by and large cannot purchase the types of plans most beneficial for themselves and instead face a mandate to purchase expensive insurance with potentially unnecessary benefits. The cancellations and removals of catastrophic plans from the market, coupled with the mandate to purchase plans with minimal essential coverage, are likely to lead to increased costs both overall and per person in America.

The ideal solution to fix this aspect of the Affordable Care Act is to create mechanisms that incentivize companies to provide low cost plans where the cost of care is felt by consumers at the point of consumption. Assuming the rest of the law remained ceteris paribus, the exchanges and subsidies should be altered to only sell and subsidize variants of catastrophic insurance. As more consumers would purchase catastrophic

plans, the level of overall health care expenditures would likely decrease and consumers would save money on elective care they did not necessarily need. The trend of the last 40 years would be reversed and the Affordable Care Act would live up to its name and intention of providing less expensive health care.

Furthermore, the government could take steps to legislate programs that incentivize health savings. In order to effectively prepare for minor or routine expenses, individuals would need to be able to have some of the money that they saved by avoiding expensive premiums on hand. The United States already has some tax deferred pools such as flexible spending accounts (FSA) and health savings accounts (HSA). Under the revised system FSAs, HSAs, and other savings programs can be expanded to allow individuals to save more each year and be able to continuously roll over savings as desired. With these adjustments to the Affordable Care Act, the American health care system could make leaps and bounds towards providing more cost effective and efficient care.

Changes Based on Pre-existing Conditions

One of the most notable changes to the American health care system under the Affordable Care Act was the way in which insurance companies dealt with patients that had pre-existing conditions. Before the health care law was passed, insurance companies could tailor their decision on whether to provide coverage to patients by looking at the customer's past medical history. If a patient had a history of chronic or expensive illnesses, the insurance companies had the right to charge much higher premiums or even outright deny coverage to these individuals.

A congressional investigation into four of the nation's largest health care insurance companies from 2007 to 2009 found that approximately 1 in 7 individuals were denied health insurance over this time period due to having a pre-existing condition. A list of over 400 conditions or diagnoses were compiled through the congressional hearing, all of which had been used to screen clients seeking health insurance. The data uncovered by the investigation also pointed to an increasing number of health insurance rejections each year, even after accounting for growth in overall applications (Potter, 2015).

The old health care system described above has changed drastically due to the passage of the Affordable Care Act, and the winners, losers, and incentives have been altered. The Affordable Care Act specifically forbade insurance companies from denying coverage to any individual regardless of any medical condition he or she may have had in the past or was currently facing. Moreover, the law also removed the ability of insurance

companies to charge different prices for any one plan based on the health of the consumer (Obamacare Pre-existing, n.d.).

In determining the premium prices that customers will pay, insurance companies can look at no more than three risk factors: age of client, geographical location, and use of tobacco (How Health, n.d.). Before, companies could look at any number of factors and tailor a plan's cost based on these traits; now, companies are blind to many important differences and can only differentiate between customers based on the aforementioned three criteria. Due to the fact that insurance companies lack the ability to charge different prices based on the cost of individual clients, healthy and sick clients at any age level or location are charged the same amount for health insurance. This means that a 50 year old, healthy female, living in one geographical area must pay the same amount as a 50 year old male with a history of severe alcoholism, obesity, and mental health disorders in the same area if she wishes to receive the same coverage.

Winners and Losers:

Under the old system, the effect of the insurance application process had little impact on those with insurance through their employers, but was devastating to those that were laid off or needed to purchase health insurance individually from these companies. Those citizens who were employed benefitted as most group policies that employers provided did not discriminate based on health status and were also subsidized through the employer, reducing the nominal price that employees paid for premiums.

However, individuals who had lost their employer provided insurance, those wanting to switch carriers, and people trying to buy insurance for the first time all could face difficulties in finding affordable coverage or oftentimes even coverage at all (Potter, 2015).

Under the old health care system that allowed denial of coverage, healthy individuals heavily benefitted from the ability of insurance companies to deny sick individuals service. If an insurance company selectively provided coverage to a mainly healthy and low risk population, the total costs to that insurance company would be much lower overall when compared to a similar company with a sicker customer base that is more representative of the general population. These lower operating costs could in turn allow some of the savings to be passed on to existing customers in the form of lower monthly premiums and fewer out of pocket expenses. For those that were healthy when they bought insurance or lacked a history of expensive illness, this provided a relatively affordable option that would allow for coverage should an unexpected illness or medical emergency arise.

Insurance companies could also benefit under the old system by reducing the variability and risk in their customer pool by screening out those applicants with expensive pre-existing conditions. By insuring a relatively higher number of healthy individuals, these companies could minimize the threat of too many patients getting sick at the same time. The chance that too many people in an unhealthy pool get sick at the same time could negatively affect the company's ability to remain profitable in the short term, even if costs were to eventually even out in the long run.

Although healthy individuals and insurance companies benefitted from these laws, there was also a significant population that lost out. Those with chronic conditions, patients with the inability to afford health care, and those who had been laid off had very limited access to affordable insurance, and sometimes even lacked access to any coverage at all. This population was at an inherent loss under the old system, and much of the Affordable Care Act was designed in order to benefit these individuals by spreading costs onto healthier less expensive clients.

The winners and losers in the post Affordable Care Act system that disallows discrimination based on health history are almost entirely opposite that of the old system. Most notably, this means that the new premiums faced by healthy individuals will increase, while those paid by the less healthy individuals will decrease substantially. While the winners and losers for customers and patients end up reversed, the effects on the insurance companies due to these changes are far more complex and will be left ambiguous. For now, we will only surmise that healthy clients were hurt by this change, and those with pre-existing, chronic, or expensive conditions benefited.

In fact, a recent report released at the end of March 2016, found that in the past two years, those enrolled in Affordable Care Act exchanges tended to be less healthy and incurred significantly greater costs than their counterparts with employer sponsored coverage. The report showed that individuals enrolled by the exchange had increased rates of heart disease, diabetes, and depression, while also costing insurance companies 22% more on average to insure (Sun, 2016). Not only are Affordable Care Act enrollees costing the health care system more, but they are paying less in premiums due to the

subsidies, thus increasing the bill that must be picked up by other individuals. The results of this report provide a relevant real world example supporting the predictions of winners and losers discussed above.

Incentives for Work and Health:

The ban on price discrimination due to pre-existing conditions lessened two very important incentives: the incentive to maintain good health and the incentive to remain employed. The old system provided an incentive for those that were underemployed or unemployed to gain work in an environment that provided insurance, and also created an incentive for those already employed to stay at their current place of employment. The incentive to find work would be largely positive as it is likely to increase workforce participation by providing another pull factor to entering the job market. The latter incentive, the incentive to stay at one company, could have both positive and negative effects.

The positive effects would come from decreased employee turnover which would increase the efficiency of companies and reduce frictional costs associated with employers finding replacement workers. The current employees, who may have left otherwise, could also benefit by avoiding a period of joblessness and not having to go through the process of finding new work. There may also be some level of negative effect on employee satisfaction as some workers may have felt pressured to stay with their current employer despite potentially not enjoying the work or dealing with an abusive or

toxic work environment. Without further economic analysis there is no way to tell whether the positive or negative effects would dominate, however the understanding of why these effects exist is sufficient for the scope of this paper.

The pre-Affordable Care Act health care system also created a second and even more important incentive: the financial incentive to maintain good health. In medicine, costly treatments contain both preventable and random components. Figuring out the exact breakdown of preventable and random diseases is a complex issue in and of itself and is not the focus of this paper. However, it is safe to assume that both random and preventable illnesses are significant health care expenditures, meaning a reduction in either could lead to real health care savings.

Many medical conditions such as cardiovascular diseases and obesity related illnesses can be significantly reduced by lifestyle decisions such as exercising regularly, maintaining a healthy diet, and avoiding harmful activities like smoking or using illicit drugs. For example, The Center for Disease Control and Prevention estimates that one in three deaths in America are attributable to heart disease and stroke, of which over 200,000 are estimated to be preventable by changes in lifestyle (Preventable Deaths, 2013).

As a country that already struggles with a high prevalence of preventable diseases like diabetes and obesity, removing this incentive entirely is largely detrimental. In fact, the United States currently houses roughly 13% of the world's obese individuals, despite America making up only a mere 5% of the world's population (Murray, n.d.). The

economic effects of this one issue are enormous, with estimates that the cost to treat obesity related illnesses ranges between $147 and $210 billion per year. In addition, the costs to employers that hire obese workers has been estimated at around $4.3 billion per year, mostly attributed to job absenteeism, which divides out to around $505 per obese worker per year (The Healthcare, n.d.).

These simple statistics are just a few of the many that paint a picture of the dire need to promote proper health and the avoidance of preventable diseases in America. With the goals of cutting costs and creating a healthier population, some measure needs to remain that incentivizes health maintenance if the United States hopes to reduce how much it spends on health care. The old system that allowed companies to screen health records created a real financial incentive for many people to stay healthy in order to receive less expensive coverage. Price discrimination made living an unhealthy lifestyle not just medically dangerous, but also expensive.

With the exception of one condition, tobacco use, the incentive to maintain personal health based on financial effects has been almost entirely removed under the Affordable Care Act. Besides age and location, insurance companies are currently only allowed to discriminate on price based on the client's smoking history, which provides a very real financial incentive for individuals to stop smoking. A person can face a premium penalty of up to one and a half times the going rate for smoking (How Health, n.d.), which considering the expense of health insurance, can end up being a significant extra cost.

How can the United States balance a system that guarantees the ability to purchase health insurance while still promoting healthier lifestyles? If the ban on discriminating based on health conditions was upheld, an addendum could be made allowing insurance companies to employ dynamic pricing for other lifestyle health risks, for example obesity. The exact criteria selected should be left up to committees of economists, physicians, and public health professionals, who can use their collective expertise to properly determine what factors are reasonable and effective to reduce costs.

The details and execution of such a plan would be complicated as even professionals have differing opinions on the issues. Some issues like smoking may be easy to reach consensus on, while other issues like Type II Diabetes or even driving a car may be more controversial. Although the process proposed here is less than perfect, it is a step in the right direction by placing professionals in charge of this task rather than politicians and special interest groups. By adding consideration of these additional health factors in setting prices, the financial incentive to maintain good health can once again play a role in reducing health care expenditures on preventable disease.

The solution proposed above helps mitigate many of the issues from both before and after the passage of the Affordable Care Act. The prior issue of the inability to purchase insurance is still resolved through the upheld ban on denying customers based on pre-existing conditions, while the incentive to live a healthy lifestyle, which, except for tobacco use, was removed under the Affordable Care Act, is restored by allowing more expensive premiums for individuals choosing to engage in unhealthy behaviors. All of this

is accomplished under the framework of promoting better overall health and reducing health care costs.

The Individual Mandate:

In order for the Affordable Care Act to ban price discrimination based on pre-existing conditions in a manner that allowed the insurance providers to remain solvent, the new law added two other provisions: the individual mandate and the open enrollment period. The individual mandate is a legal requirement forcing all citizens to purchase an insurance policy or face increasingly costly financial penalties (Obamacare Individual, n.d). Without the personal mandate, healthy individuals could simply not purchase insurance until absolutely necessary, and companies would primarily insure only very sick clients. Under a system like that, insurance companies could no longer stay in business as only sick individuals would enroll and both expenses for companies and premiums for consumers would increase exponentially.

The morality and ethicality of forcing individuals to carry insurance is ambiguous and highly debated. One of the most common complaints about the individual mandate is that it violates the liberty of American citizens by legally requiring them to buy a product regardless of whether they desire to do so. In fact, the Supreme Court Case *National Federation of Independent Business v. Sebelius*, challenged the individual mandate on essentially those grounds, but on June 28th 2012 the Supreme Court ruled 5-4 that the individual mandate was considered a tax and thus legal (Obamacare Individual, n.d).

While this decision allowed the Affordable Care Act to remain in effect, it did not assuage the concerns of those who opposed the mandate based on the idea of personal freedom.

One of the potential benefits that could come from having an individual mandate is that a mandate forces some level of financial responsibility on individuals for the costs of their treatments. Currently, regardless of ability to pay most hospitals must provide emergency medical treatment under the Emergency Medical Treatment and Active Labor Act (EMTALA). Although EMTALA is incredibly complex, the following quote summarizes the most important provision:

> "Any patient who 'comes to the emergency department' requesting 'examination or treatment for a medical condition' must be provided with 'an appropriate medical screening examination' to determine if he is suffering from an 'emergency medical condition'. If he is, then the hospital is obligated to either provide him with treatment until he is stable or to transfer him to another hospital in conformance with the statute's directives" (Fosmire, 2009).

Due to EMTALA many medical costs are never paid and are either expunged through bankruptcy, written off as losses, or simply never collected on. These costs end up falling on a variety of parties including the hospital, tax payers, the government, and others. In 2012, there was $45.6 billion of uncompensated care, making up approximately 6.1% of hospital expenses (Healthcare Collection, n.d.). These are enormous costs that must be made up by those who are not defaulting on health care bills.

EMTALA makes health insurance different from any other class of insurance such as collision, house, or life, because it eliminates some of the risk of going uninsured. If a

woman forgoes collision insurance on her new car and crashes it, only she is responsible for the loss of her car and no one else will be buying her a new one. Few people would make the argument that someone else should buy her a new car after she made the risky choice to drive uninsured, as she must now face the consequences of her decision.

However, in medicine if a man chooses to go uninsured and needs an emergency surgery or expensive treatment, the decisions often involve life or death outcomes. While most people would let the woman suffer the loss of her car, few would be okay with letting the man die because he made the risky choice to go uninsured. In a situation like this, America has created a society where people are given the freedom to make any decision they want, while leaving the rest of society on the hook for the costs of those poor decisions every time things go wrong.

This creates a no win situation in which a society either allows individuals to die due to their poor decision making (ex. not having some sort of insurance) or removes some of the negative financial consequences for taking the risk of going uninsured. Through EMTALA, America decided on the second option and created a loophole where individuals can consume health care services without an enforcement mechanism to collect on the costs. For someone with a low net worth, this creates an opportunity to pay out of pocket for inexpensive and routine treatments, yet still have access to care and erasable debt if disaster should strike.

Due to the fact that medical debt is dischargeable through bankruptcy, those that are uninsured actually do have protection against catastrophic medical expenses, without ever paying a premium. This situation highlights an example of what I will refer to

hereafter as pseudo insurance: which I define as any instance in which an individual gains protections similar to those of a person who is insured without actually paying the costs to be insured.

The individual mandate takes a step to close this loophole by forcing everyone to purchase insurance. If everyone has to pay in via taxes or premiums, free riders can no longer not pay into the system while still reaping services if emergencies arise. However, the individual mandate is actually incredibly ineffective in accomplishing this goal. There are numerous exemption for individuals who meet a broad set of criteria, which still allows many individuals to avoid purchasing health insurance and not pay the individual mandate tax. The CBO estimated that in 2016 roughly 90% of the approximately 30 million people without health insurance avoided paying the penalty due to the numerous exemptions (Obamacare Individual, n.d). This means that the individual mandate did little to close the pseudo insurance loophole and instead mainly functions by forcing the subsidization of the Affordable Care Act exchanges by healthy individuals.

The Open-Enrollment Period:

Now that we understand why the individual mandate was necessary for the ban on pre-existing conditions, we can discuss the other necessary clause: the open enrollment period. One major change under the Affordable Care Act, that directly ties into the mandate and the ban on price discrimination, is the creation of enrollment windows in which patients have the ability to sign up for these guaranteed coverage plans regardless of pre-existing conditions. With just the mandate, individuals could pay the

annual penalties, which oftentimes are much less expensive than insuring an entire family, and then sign up for guaranteed coverage only when sick. The open-enrollment period is the third part of Affordable Care Act along with the individual mandate and ban on price discrimination that are necessary for the law to stay afloat.

During the open-enrollment periods, individuals can purchase subsidized, nondiscriminatory health insurance from the Affordable Care Act health insurance exchanges in a window of approximately three months (Norris, 2016). This period of time is a necessity for insurance companies to be able to remain in business since they can no longer turn away any clients. Under the old system, there was an incentive for everyone to be covered at all times, even when healthy, because a single uninsured catastrophe or disease could leave an individual stranded and unable to purchase affordable insurance after the incident. The open enrollment period is necessary in order to keep this old incentive in place under the new health care law.

For an individual that does not wish to purchase continuous health insurance, a longer enrollment period makes going uninsured much less financially risky compared to a shorter enrollment period, thus providing a sort of pseudo insurance. During the enrollment period, those customers who wish to remain uninsured have the ability to purchase insurance near instantaneously, which provides a safety net should disaster strike during that time. At the far extreme of a 12 month enrollment period, there would be almost no incentive to purchase insurance in advance, as customers would have the guaranteed option to purchase insurance at any time, including immediately after a diagnosis with a chronic illness. This would create a loophole where an individual could

choose to never purchase insurance all the way up until the point that he or she needed expensive treatment, and then enroll. The length of time for the enrollment period will directly correlate with how big or small the loophole is at any point in time.

The three month window acts as a somewhat effective way to prevent this sort of abuse as it forces individuals to purchase insurance during this time span, or else face a lack of guaranteed care for the next nine months. A simple analysis, as shown above, reveals that a shorter enrollment window provides a larger incentive to purchase coverage than a longer enrollment window. The ideal length of an enrollment period may be hard to pinpoint, but the conditions under which this would happen can probably be identified.

In order to maximize the incentive to enroll, it would make sense to provide the shortest window possible in which the vast majority of individuals would have the appropriate amount of time to shop for and purchase insurance. With each day of additional time, individuals who would not normally purchase health insurance are able to have an extra period with pseudo insurance. How much exactly the current three month period should be curtailed is a matter for a more thorough economic analysis, but it is likely that this period lies on the longer end of what is optimal.

In fact, this issue is currently under review and there are plans to shorten the enrollment window in the near future. The current three month window seems to be too long and has led to increasing costs. In order to remedy this problem the open enrollment window is set to be halved to approximately six weeks beginning in 2019 (Norris, 2016).

This is most certainly a step in the right direction, and slowly starts to close a very obvious loophole created by the Affordable Care Act.

In addition to open-enrollment periods, qualifying events and unique circumstances can allow special enrollment periods in which individuals can enroll in exchanges outside of the normal window. The criteria for allowing special enrollments are also under review and measures to reform the system begin in 2016 starting with individuals needing to require proof of an eligible event in order to qualify for a special enrollment period (Norris, 2016). Why these changes are happening six years after the passage of the law is another issue entirely, but it is better that these loopholes are being closed now rather than never.

The Price Tag on the Affordable Care Act and where the Money Goes

Another consideration in the analysis of the Affordable Care Act is the mechanism by which the health care initiative is funded and how the taxes and spending cuts affect players in the market. There are many expenses that together make up the Affordable Care Act's projected price tag. Cost estimates for the law range anywhere from $1-$2.6 trillion over the next decade depending on the group publishing the study, the time-frame, which factors were included, and how the analysis was done (Cost of Obamacare, n.d.). It is also important to keep in mind that costs are constantly changing each year as new data becomes available and new expenses arise. This section will examine how the Affordable Care Act generates enough revenue to cover its approximately two trillion dollar price tag and where that money eventually ends up.

The first and most noticeable expense comes from the tiered subsidies provided by the federal government to low income families and those households making up to four hundred percent of the poverty line. Additional costs include the expansion of Medicaid and Children's Health Insurance Program (CHIP), both of which are programs aimed at providing health insurance for the destitute and families with children. The final major expenditure comes from tax credits and subsidies provided to small businesses that provide their employees with health insurance (Cost of Obamacare, n.d.). The costs of the Affordable Care Act are explained here only for reference and to give the reader an idea of where the money is going. The main focus of this section will be on the sources of revenue that are used to fund these new government expenses. Although there are many different sources of revenue for the Affordable Care Act, this paper will discuss a limited

subset containing some of the more significant and interesting sources of funding. To see the breakdown of revenue sources, please refer to figures 4 and 5 in the appendix.

Funding: The Hospital Insurance Payroll Tax

The aspect of the law that provides the largest source of revenue also happens to be one of the most straightforward: an increase of the Hospital Insurance Payroll Tax, more commonly referred to as the Medicare tax. Before the Affordable Care Act, any employed individual would pay a 2.9% tax on all earned income that went into providing funding for the Medicare program. The tax had a split legal incidence with the employer paying 1.45% and the employee matching the other half (Medicare Tax, 2016). Since 1994, the Medicare Payroll Tax has applied to all wage income and lacked any sort of ceiling.

The Affordable Care Act did not take steps to add a ceiling, but it did increase the Hospital Insurance Tax by an additional 0.9% on employees that will apply to all income over 200,000 dollars for a single individual or 250,000 for a married household (Social Security, 2014). In addition to the increase in hospital insurance tax, there are also two far less noticeable changes that will also have important effects. First, the additional tax is not adjusted for inflation, and second, the tax now applies to not only wage income but also investment income as well. Both of these changes have additional effects that go beyond the simple 0.9% nominal increase.

The fact that the tax is not indexed to inflation means that the tax will continue to affect more and more individuals each year as inflation increases and additional citizens find themselves in brackets that are subject to this additional tax. This means that the effects of the new tax are not static, but rather dynamic and susceptible to additional economic effects as time goes on.

The other factor mentioned that exacerbates the effects of the tax is the provision that income investments are now subject to the additional tax. Before, an individual would pay no Hospital Insurance Taxes on any form of investment income as the tax was only a payroll tax. The new provision makes it so that all individuals with investment income over the new 200,000/250,000 threshold will now pay an additional 3.8% tax (2.9% normal Hospital Insurance Tax plus additional 0.9% Affordable Care Act tax) on their investment income. This means the 0.9% increase is actually about four times more expensive on investment income than the nominal increase may imply. Both of these factors should be kept in mind as they will amplify whatever effects the new tax has on American citizens.

Moving onto the analysis of the tax itself shows several different effects. The simplest level of analysis shows that this is a tax largely levied on high income earners as anyone making less than the threshold will not see any direct loss of income. Since the tax affects only high income earners and many of its funds go directly to the subsidization of low income earners, there is a clear effect of redistribution of wealth. Whether this is ethically correct is subjective and depends entirely on the perspectives and personal values of an individual, and as such, the morality will not be discussed here.

For the high income earners, upon which the extra burden would be placed, the tax will likely lead to the typical array of economic effects that any tax usually creates. One of the effects will be an additional deadweight loss that consumers of labor (employers) and suppliers of labor (employees) will both lose out on. Although the legal incidence of the new tax falls entirely on the suppliers of labor, classical economics shows that the economic incidence of the tax will actually be divided across both parties, with the incidence mainly determined by the slope or elasticity of the demand curve for labor (Prante, 2006). In this instance, employers lose out on some of the surplus from paying employees less than their reservation wage and employees lose out as their true wage is closer to their reservation wage than it was before.

This loss of satisfaction will also be accompanied by some level of cutback in the supply of labor as a substitution effect makes leisure time more desirable for those affected by the tax. It may even be fair to assume that because the tax only falls on high income earners, the percentage decrease in labor supplied will be greater than a similar tax on low income earners because wealthier individuals are more easily able to substitute labor and leisure than a person living at or near the poverty level. The exact reduction of the labor supplied as well as the exact loss of consumer and producer surpluses are not as important as the understanding that these effects exist, and will have an impact on the economy. To summarize, we can say that the additional Hospital Insurance Tax will have a negative effect on consumer and producer surpluses, shrink the labor supplied, and will have increasingly harmful effects over time as inflation makes more individuals subject to the tax.

Funding: The Individual Mandate Penalty

One of the other sources of revenue, quite ironically, comes from a penalty for those who choose not to purchase health insurance. Any individual that is not enrolled in a qualifying insurance program is set to face the larger of either a flat fee or a certain percentage of his or her income. The additional tax is set to increase gradually each year to provide an even larger incentive to purchase insurance (Obamacare Individual, n.d.). The mechanism of the law that spells this out is known as the individual mandate and is meant to incentivize individuals to purchase health coverage through a financial penalty. While the individual mandate remains hotly contested in society, the effectiveness of such a tax is pretty straightforward. The estimated income over the ten year period from 2013 – 2023 is roughly $55 billion (Kliff, 2012), which is no small amount in balancing the spending from the Affordable Care act over that time period.

While this revenue source may hit expectations for the next decade, there seems to be a serious flaw in the way this particular tax is designed. Simply put, the tax's effectiveness is directly antagonistic to the effectiveness of the Affordable Care Act in signing individuals up onto health care plans. As more and more people sign up for plans, the costs of the Affordable Care Act increase, due to more subsidies being paid out, and the revenue from this particular provision decreases, as fewer individuals are liable to pay the individual mandate fee. The longer the Affordable Care Act remains in place, the more expensive the overall program becomes, while the money flowing in to cover these expenses shrinks, making the overall funding gap larger. Simply put, this is not a sustainable tax for the purposes of properly funding the Affordable Care Act. As was the

case with many issues addressed before, there are several philosophical objections that arise with mandating health coverage, however, from a solely financial standpoint, the individual mandate is not a proper long term funding mechanism for the Affordable Care Act due to its decreasing effectiveness over time.

Funding: The Cuts to Medicare

Despite the myriad of taxes, including larger ones like those discussed above and other smaller ones like a 10% tax on indoor tanning services (Obamacare's Funding, n.d.) the federal government still was not able to receive enough funding to cover the large expenditures under the new health care law. In order to close this funding gap, the law enacted spending cuts in other areas so that the money could be redirected into the Affordable Care Act. Approximately 741 billion dollars is appropriated through this manner, with the vast majority of those cuts coming via a decline in Medicare funding (Kliff, 2012). The direct effect of the decreased funding for the Medicare program is a smaller Medicare budget, in which some areas must be cut in order for the program to remain solvent. There are several mechanisms that Medicare can use to compensate for this loss, but all of them negatively affect those insured by the program.

The first solution is that Medicare beneficiaries can simply pay more into the system for the same care. This means that seniors will see increased costs through co-payments, deductibles, and other out of pocket expenses for the same services. Through this method, seniors are directly paying for the brunt of the funds that have been lost

under the Affordable Care Act. The other way to cover this reduction is by reducing the payouts that Medicare gives to physicians and hospitals for their services. On the surface this seems like a zero-sum condition in which hospitals and doctors are the ones who now face the loss from the Obamacare cuts rather than seniors, but this just is not the case. In reality, the patients are the ones who suffer due to such an outcome through adverse effects on their health.

Both Medicaid and Medicare already reimburse for medical treatment at pennies on the dollar compared to private insurances, only paying about 50% and 80% of the costs respectively. Pat Howry, an administrator at an otolaryngology clinic in Colorado, stated that for a standard office visit the clinic would be reimbursed $119 for patients with private insurance, $73 for patients with Medicare, and $53 for patients with Medicaid, despite each patient receiving the same treatment. Because of this, the clinic began limiting each doctor to no more than two Medicaid patients per day, a trend which is becoming all too common as only about 46% of physicians accept Medicaid patients (Tozzi, 2014).

The most serious result of the already low payment rates is that they create an incentive for many health care providers to refuse to treat Medicaid and Medicare patients, or even more common, to limit the number of patients with these insurances that are treated. See Figure 6 in the appendix to see the increasing number of doctors opting out of Medicare each year. The effects of decreasing Medicare reimbursements below their already low levels would only serve to exacerbate this issue and reduce the ability of Medicare patients to find a doctor of their choice or potentially any doctor at all

in a timely manner. A combination of both decreasing reimbursements and forcing Medicare patients to pay more out of pocket will be direct effects of the Affordable Care Act's Medicare cuts. This funding source only serves to exacerbate the current issues facing the health care system, and without adjustment will only worsen the situation as expenses increase along with the aging population.

Crony Capitalism in Political Legislation and the Affordable Care Act

As one would expect based on the negative results from the cuts to Medicare, the senior citizen population overwhelmingly took issue with the reforms presented in the Affordable Care Act. In fact, the oldest members of society were among one of the groups with the most unfavorable opinions of the health care law (Roy, 2012). Surprisingly, the American Association of Retired Persons (AARP), which represents the interests of the majority of people enrolled in Medicare, actually endorsed the Affordable Care Act which went against the desires and beliefs of their constituents. All of these pieces of information lead to a fascinating question: "Why did the AARP go against the interests of the people it represented and endorse the Affordable Care Act?" This example provides an interesting case study of how incentives in businesses matter and why people and organizations sometimes act in ways contrary to the best interests of those they represent.

Although Medicare is funded heavily by the federal government through taxes that all citizens pay in order to provide health care coverage to the elderly, there are still costs that individuals on Medicare are forced to pay for the treatment they receive. Oftentimes these costs can be rather high, encouraging seniors to purchase a product known as gap insurance. Commonly referred to as Medigap, this private insurance is used to pay for the additional costs that patients are still responsible for after Medicare has paid its portion (Roy, 2012). Interestingly enough, the AARP generates significant revenues by selling its members gap insurance through a slew of private companies that in turn give the AARP a hefty commission. This creates a very strong incentive for the

AARP to not only ignore the issue of the Medicare gap, but also places the AARP in a position where it would directly benefit from an increase in the gap.

The Affordable Care Act did not take any measures to improve the issues surrounding Medigap insurance. This lack of action was incredibly beneficial to the AARP because any measures to curtail the need for supplemental insurance would cost the AARP billions in lost commissions. However, the funding scheme from the health care law went further than just maintaining the status quo; it directly cut funds from Medicare forcing patients to pick up additional costs that Medicare no longer covered. This phenomenon acted as a driver of demand by encouraging more people to purchase Medigap insurance.

As seniors sought to buy more supplemental insurance, the AARP would benefit through the additional money it levied on commissions. Over the course of 10 years, with an estimated commission of around 4.95%, the AARP is anticipated to gain $1 billion through the increase in Medigap sales and avoid a $1.8 billion loss that would have been realized had the AARP not lobbied against including gap reform measures in the health care law (Roy, 2012). These incentives provide a convincing explanation for why the AARP was willing to go against the will of its members through its endorsement of the Affordable Care Act.

At over 900 pages, the Affordable Care Act contains many examples of ways in which palms were greased, deals were made, and special interests were appeased in order to get the law passed. These examples are numerous in not just the Affordable Care

Act, but also many other pieces of legislation and the examples could provide topics for many more research papers. The important lesson to be learned is that crony capitalism is a serious issue in American Society today and its prevalence was furthered through the passage of the Affordable Care Act.

In order to have a properly functioning health care system, economy, and business environment, the corruption and favor trading that exists must be absent from any future bills. The Affordable Care Act failed to rise above the dishonesty that seems to be all too common in politics, and instead perpetuated the defunct system by which American laws are made. The passage of the law played a part in incentivizing the continuation of crony capitalism by acting as one of the most noteworthy examples of the effectiveness of dishonest politics.

Conclusion:

We have now seen first-hand a sampling of the challenges that came along with the passage and implementation of the Affordable Care Act. Although the law was able to accomplish its goal of increasing access to health insurance for millions of people, it did not address the serious issues of the American health care system that are leading to ballooning costs and poor health outcomes. In order to accomplish the massive insurance expansion, there were large redistributive effects that take revenue from high income earners and healthy individuals in order to fund insurance for those who are less wealthy and in poorer health. The law does this by banning insurance companies from charging different prices for different patients and then requiring all Americans to purchase insurance in order to subsidize the costs of the system. Whether this is right or wrong is ultimately up to you, the reader, to decide, but the effects listed above are the simple reality that Americans find themselves living in.

Regardless of redistributive effects, there are serious holes in the funding mechanisms proposed under the Affordable Care Act. Taking from Medicare to pay for Obamacare is a major disservice to the elderly and the deal was made in a corrupt manner that went against the wishes of senior citizens. Perhaps most devastating of all are the continually increasing costs of health care as the Affordable Care Act encourages and subsidizes expensive and comprehensive plans that distort the demand for health care services. The Affordable Care Act had the opportunity to address this issue, but instead did the opposite and many Americans have now lost the low cost plans they once had. In

the system we have today, health insurance is barely recognizable as any sort of true insurance.

Working within the framework of the Affordable Care Act, there are simple changes that could be made to increase health and reduce costs. By allowing insurance companies to raise prices for individuals engaging in unhealthy behaviors, Americans would be further incentivized to maintain a healthy lifestyle. By offering low cost plans with high out of pocket expenses, Americans could reduce the number of unnecessary procedures and keep more of their hard earned income. Finally, by shortening the open-enrollment period and not exempting the majority of Americans from paying the individual mandate tax, the few remaining loopholes for pseudo insurance could be removed.

The analysis conducted in this paper simply scratches the surface of how the Affordable Care Act has changed America. The complications discussed here are a minor subset of the many problems surrounding the Affordable Care Act and hopefully provide insight into some small steps that could slowly start to improve some of the issues facing the American health care system. There are still many more matters to be discussed and stories to be told involving the Affordable Care Act, but those will have to be saved for another analysis. I sincerely hope this paper has been informative in summarizing some of the major problems relating to insurance and the economics behind health care.

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Appendix

Figure 1:

Graphic showing a real increase in health care spending per person from 1980-2009.

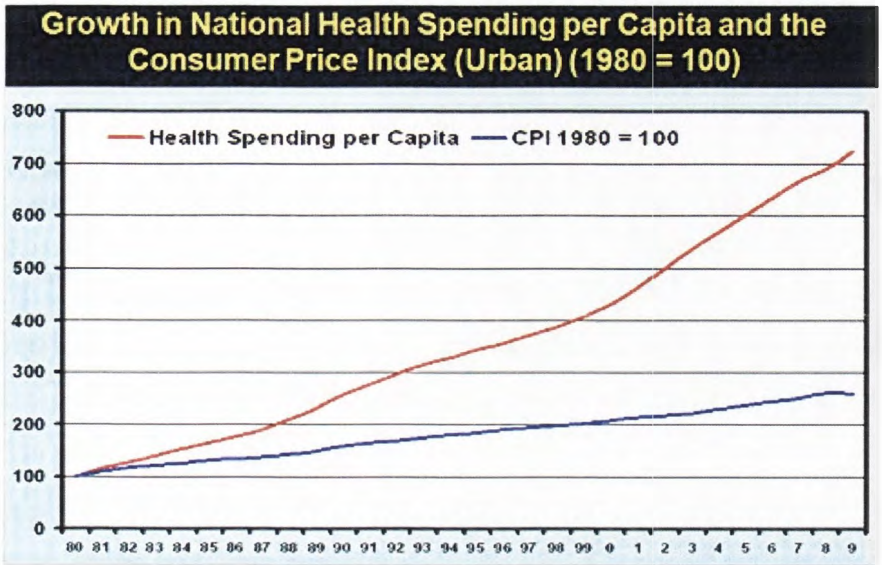

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Figure 2:

Graphic showing a large increase in health care expenditures per person for both private insurance and Medicare enrolled patients from 1969-2009.

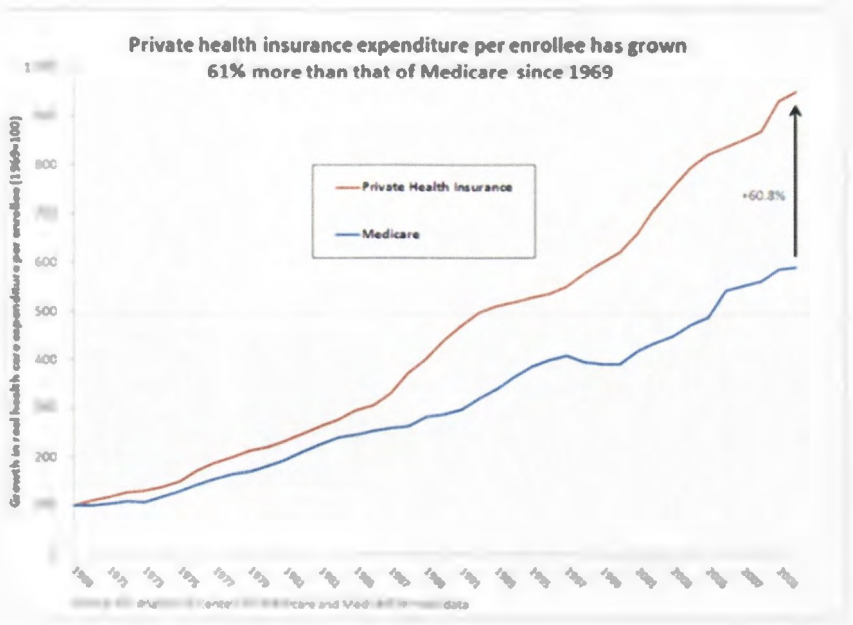
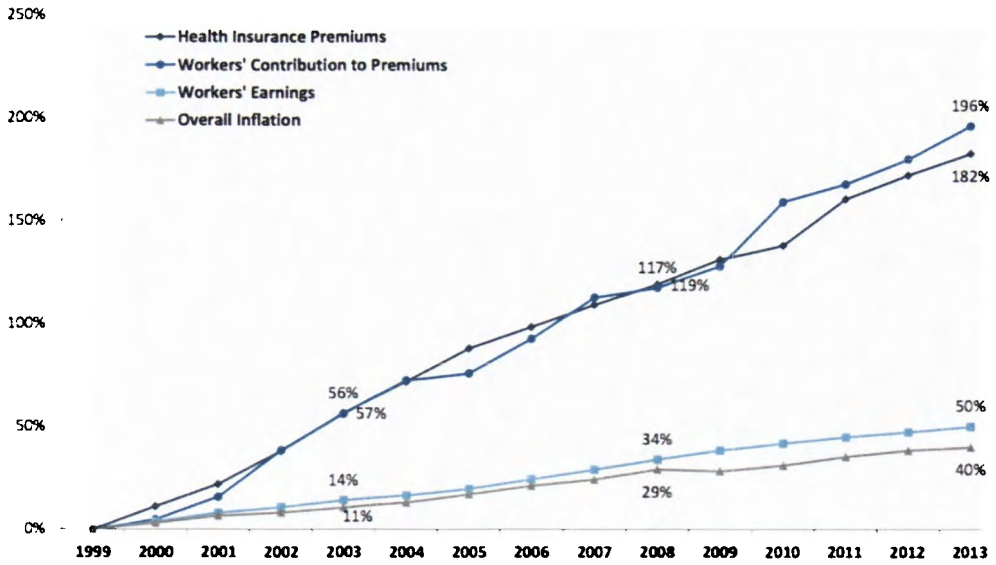


Figure 3:

Graphic showing the rapid real increases in premium prices each year after inflation.



SOURCE. Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2013. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2013; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2013 (April to April).

Figure 4:

Graphic indicating where spending cuts are being made to funnel money into the Affordable Care Act. Note that the majority of cuts are to Medicare.

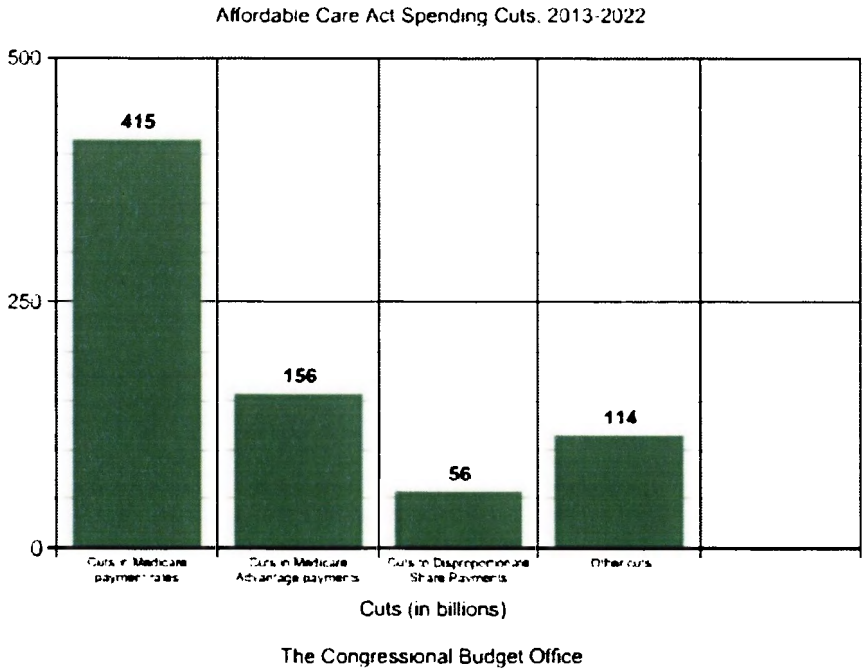


Figure 5:

Graphic detailing the new revenue sources and taxes needed to fund the Affordable Care Act and the health insurance exchanges.

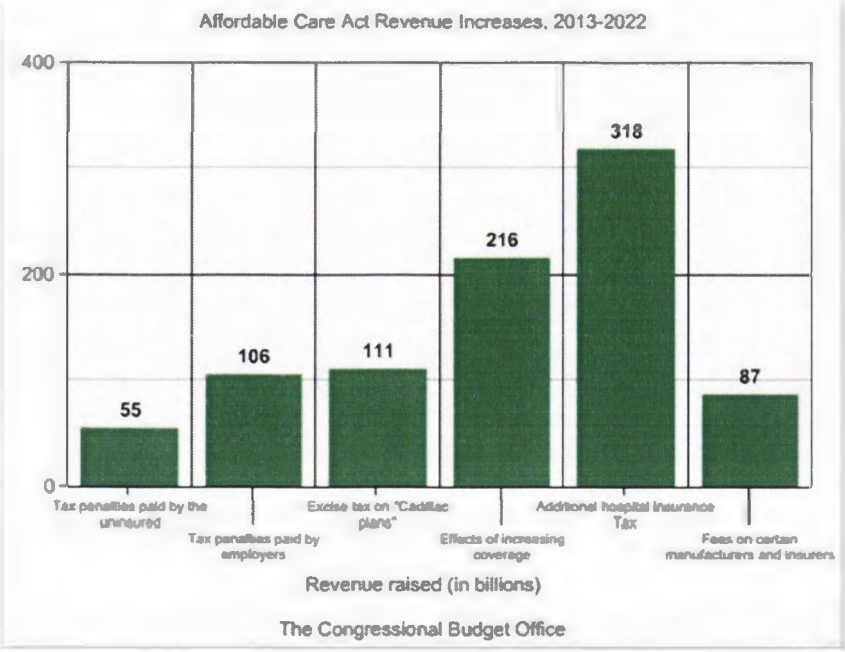


Figure 6:

Graphic demonstrating a rapidly increasing number of providers choosing to opt out of Medicare each year.