Critical Assessment of the Patient Protection and Affordable Care Act

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INTRODUCTION

In one important sense, those who supported the Patient Protection and Affordable Care Act (PPACA) were correct; the US needs health care reform. The reform, we received, however, fails to adequately address some of the most fundamental problems with our health care system. The PPACA won't accomplish many of its goals, it will make some problems worse, and its cost to individuals and to the federal government will greatly exceed official projections.

THE IMPETUS FOR HEALTH CARE REFORM

Many reasons can be given for why the US health care system needs to be reformed. The question is not whether it needs to be reformed, but how. It is hard to disagree with some of the arguments used by proponents of health care reform. Others are debatable and disagreements reflect different visions of the nature of human beings and what constitutes a good society.

The total amount spent and the high cost of health care in the US is, and ought to be, a major cause for concern. Health care costs have been rising faster than national income for many years. More problematic is the fact that the percentage of GDP spent on health care, which was 17.4 percent in 2009, is higher in the US than in any other high income country (Organization for Economic Cooperation and Development, 2011). In spite of the high spending, Americans are not healthier than people in other countries, and evidence suggests that the quality of health care in the US is not better and may be worse than in some other countries that spend considerably less per person than we do on health care (Furnas & Hunnicutt, 2010).

Another source of concern is the many Americans who are uninsured and cannot afford health care. The number of Americans who are uninsured has increased, reaching more than fifty

million in 2009 (DeNavas-Walt, Proctor & Smith, 2010). Those who lack health insurance must pay out-of-pocket for health care, whether preventive care or treatment for illnesses and injuries. According to Furnas & Hunnicutt (2010), the uninsured "regularly go without needed care, leading to higher medical costs down the road." (p. 12). They fail to get necessary preventive care and don't get adequate treatment for illnesses and injuries. The limited access to health care in the US of many who are uninsured contrasts with the policy of universal health care of other high income countries (Hunnicutt, 2010).

Another problem with our health care system is the growing level of government expenditures for programs like Medicaid and Medicare. As baby boomers retire, the elderly population will increase substantially. Without reform, Medicare appears to be financially unsustainable. Waste and fraud also add substantially to the cost of Medicare and Medicaid (Iglehart, New Weapons, 2010).

Proponents of reform also recognize the problem caused by the link between employment and health insurance. This link discourages workers, particularly those with pre-existing conditions, from changing jobs, while making it harder for those who lose jobs to retain health insurance coverage.

The problems described above, particularly the high cost of health care and the number of Americans who do not have access to affordable health care, played a major role in the design of the Patient Protection and Affordable Care Act.

KEY PROVISIONS OF THE AFFORDABLE CARE ACT

Below are some of the key provisions of the Affordable Care Act. The following provisions were designed to expand health insurance coverage in some way (Health Insurance Providers, 2010):

- Children must be covered by their parents' health insurance plan until they are 26.
- In 2014, health insurance companies will no longer be permitted to exclude coverage for pre-existing conditions or charge higher insurance rates based on health status or gender. They may charge older people no more than three times as much for premiums as younger people. They are permitted to charge higher premiums for tobacco users up to 50 percent higher than what they charge nonsmokers.
- Health insurance companies cannot impose annual or lifetime limits on coverage.
- New insurance plans must provide coverage for preventive care with no out-of-pocket costs.
- The minimum eligibility standard for Medicaid for all states is set at 133 percent of the Federal poverty level for those who are not considered elderly.
- All US citizens must have health insurance coverage considered acceptable by the US government or face a fine of up to 2.5% of AGI or $695 per person, whichever is smaller.
- Businesses with fifty or more employees are subject to a fine of $2000 or $3000 per employee for not offering affordable health insurance (Burkhauser, Lyons, & Kosali, 2011).
- A tax credit will be available for health insurance premiums paid by small businesses employing less than fifty people. The tax credit starts at 35% and rises to 50% in 2014.
- States must establish health care exchanges to offer insurance for those not covered by affordable employer-sponsored insurance (ESI). Subsidies will be provided to make insurance affordable for those with low household incomes.

The following provisions are designed to raise revenue to pay for the increased government spending projected as a result of the Affordable Care Act (Health Insurance Providers, 2011):

- Higher Medicare payroll tax for individuals with incomes greater than $200,000.

- Tax on the sale of some medical devices.
- Annual fees levied on all health insurance providers with total premiums greater than $25 million.
- Tax on “Cadillac” health insurance plans.

Finally, several provisions are designed to reduce health care costs (Health Insurance Providers, 2011):

- Requirements for health insurance companies to implement uniform standards for exchanging health care information.
- Providers of group insurance may spend no more than fifteen percent on administrative costs, marketing, and executive compensation, while those who sell insurance in a small group or individual market may spend no more than twenty percent.
- Creation of the Independent Payment Advisory Board (IPAB) to make recommendations that Congress must act on for holding spending within legislative limits, beginning in 2015.
- New forms of authority to “crackdown on illegal activities that plague Medicare, Medicaid, and private insurers” (Iglehart, New Weapons, 2010).

Some of the provisions of the ACA have already taken effect, while others are scheduled to become effective later (Health Insurance Providers, 2011). Most provisions will be fully effective by 2014. The provisions were designed to address perceived problems with our health care system as described below.

Relationship of Key Provisions to Problems with our Health Care System

Cost control is a major goal of health care reform. Some provisions of the ACA that expand what insurance companies must cover were also designed to reduce health care costs. One such provision is the mandate that insurance companies eliminate copayments for preventive care. If

people get more preventive care, doctors should be able to diagnose and treat chronic conditions earlier before complications develop that are more costly to treat. If preventive care is sufficiently effective, it could save insurance companies enough in future treatment costs to justify them paying its full costs.

Several other provisions of the ACA were intended to reduce government health care spending. The Independent Payment Advisory Board (IPAB) is a potentially powerful tool to reduce Medicare spending. By reducing Congressional micromanagement of Medicare policy, it is intended to impose some real discipline on Medicare. In Medicare's founding legislation, it was clearly stated that Federal officers or employees should not be permitted "to exercise any supervision or control over the practice of medicine" (Aaron, 2011). This has kept Medicare administrators from using coverage policy or financial incentives to discourage care that is too expensive or not cost effective. By contrast, not only does the IPAB recommend ways to hold spending down, but Congress must consider its proposals according to a tight timetable after which its recommendations automatically take effect if Congress fails to vote on them or come up with alternative ways to limit spending.

Provisions to reduce fraud, especially in Medicare and Medicaid, are important parts of the ACA. The ACA imposes more stringent entry requirements on those who seek approval to bill Medicare for services. It also empowers the Department of Health and Human Services to require some Medicare providers to create internal compliance programs designed to guard against fraud, and it mandates public disclosure of payments between industry and providers in order to deter kickbacks (Iglehart, New Weapons, 2010).

Several provisions of the ACA are designed to promote universal access to health care. In addition to health insurance exchanges and subsidies that get larger as income decreases, the

health insurance mandate for employers and tax credits for small businesses are all designed to reduce the number of uninsured. The requirement that insurance companies practice community rating rather than charging different premiums based on health status, will also eliminate what many perceive to be an inequity of our existing health care system. Together, these provisions should make health care affordable for all Americans.

LIKELY CONSEQUENCES OF THE AFFORDABLE CARE ACT

While many of the goals of the Affordable Care Act are laudable, it is doubtful that it will be very effective in accomplishing them. In addition, it is likely to have a number of harmful, unintended consequences.

Impact on Health Care Costs

The impact of the ACA on the overall cost of health care and its cost to the government depends partly on specific provisions intended to reduce costs, but also on its effect on incentives of consumers, providers and those who pay for health care. Its provisions may not do enough to address some causes of high health care costs such as fraud, and some of its mandates will increase health care costs.

Because the ACA requires health insurance companies to cover everyone who applies without charging more for those with poor health, it may raise the costs of health insurance due to adverse selection, which results when people who buy insurance have poorer than average health. Insurance companies will set premiums high enough to cover the average person who is likely to buy insurance from them. Many people who are healthier than average will choose not to buy insurance because they do not expect to visit the doctor enough to justify the premiums they will have to pay. Those with poor health will perceive the premiums to be a bargain and will

buy insurance. The resulting below-average health of those who choose to buy insurance will cause premiums to rise, making buying insurance worthwhile only for those in very poor health.

The ACA was designed to eliminate adverse selection by mandating that everyone buy health insurance. Even if the individual mandate survives lawsuits challenging its constitutionality, it will not do enough to discourage healthy people from remaining uninsured because the penalty is too low. The average cost of health insurance premiums for an individual was more than $4000 in 2008 (Burkhauser, Lyons, & Kosali, 2011). With premiums higher than that now, a penalty of $695 per person will not have much impact on the decision to buy insurance.

The requirement that insurance companies pay the full cost of preventive care will likely increase the cost of health insurance. In reviewing the health economics literature, Cohen, Neumann and Weinstein (2008) find that the vast majority of preventive measures do not save money, although most result in benefits in terms of improved health and wellbeing that exceed their costs. Government decisions about what kinds of preventive care to require insurance companies to cover are influenced by political pressure from health care providers as much or more than by concerns about saving money and keeping costs low. Insurance companies who have better information about the cost effectiveness of each kind of preventive care as a function of age, health history and other patient characteristics, could make better decisions than the government about the share of the costs of preventive care that patients should be required to pay.

In spite of the claims of some proponents of health care reform, insuring the uninsured will raise, not reduce overall health spending. Many of the uninsured are relatively healthy people who prefer to pay for their own health care out of pocket as needed rather than pay

premiums to be insured against unexpected major health care expenses. It is a myth that most of the uninsured overuse emergency rooms, get less routine health care than they need, and have untreated chronic conditions. Forty-two percent of the uninsured are between 18-34 (Machlin, Cohen, & Yu, 2008). On average, the uninsured have fewer chronic health conditions than the population as a whole. Less than 36 percent of the uninsured have at least one chronic health condition, while almost 54 percent of those with insurance have at least one chronic health condition (Machlin, Cohen, & Yu, 2008).

Increasing the number of people whose health care costs are covered by private insurance companies or the government will raise the cost of health care. Perhaps the most important reason why health care costs are so high is that most health care expenses are paid for by third parties. Because they pay so little of the price, most Americans do not do research on the cost or quality of health care providers (Alexander, Casalino, & Meltzer, 2003). Newhouse and others involved in the Rand Health Insurance Experiment found that those who had to pay for the first few thousand dollars of their own medical expenses spent an average of 25 to 30 percent less than those who paid none of their own medical care costs (Cannon and Tanner, 2005, pp. 57-58).

The ACA, like health reform in Massachusetts, will lead to crowding out of private insurance by government coverage (Yelowitz & Cannon, 2010). If government pays, the cost for achieving any given quality of care will likely be higher than if private insurers pay. Unlike insurance companies, government agencies have no residual claimant whose profits depend on attracting and retaining customers by keeping costs down and providing better quality service than competitors. Thus, government agency heads have less incentive than insurance companies to limit costs and may earn a higher salary if they hire more workers than necessary.

The ACA also limits insurance company's options for controlling costs. Insurance companies are continually searching for ways to improve incentives to limit consumption of health care for those who are covered by insurance. Increasing out-of-pockets costs through higher deductibles or copayments is one of the most effective ways to discourage use of health care services that are not cost effective. By requiring all insurance plans to cover at least sixty percent of all medical costs beginning in 2014, the ACA makes it harder to do this (Herrick, 2011).

Reducing Medicare and Medicaid Fraud

Fraud is a natural outgrowth of a system where so much is paid for by third parties. The tighter the rules on what the government or an insurance company will or will not reimburse, the greater the likelihood of fraud. If a certain diagnosis is required in order for a physician to be reimbursed for a certain type of treatment, the physician has an incentive to provide that diagnosis, even if it is not accurate. Patients often benefit from health care providers deceiving insurance companies or the government in this way. In a random national sample to which 720 physicians responded, 39 percent reported that at least sometime in the past year they had exaggerated the severity of patients' conditions, changed patients' billing diagnoses, or reported signs or symptoms that patients did not have "to help the patients secure coverage for needed care." (Wynia, et al., 2000). Official estimates are "that about 10.5 percent of Medicare spending and 8.4 percent of Medicaid spending was improper in 2009" (Cannon, Entitlement Bandits, 2011).

Provisions of the ACA intended to reduce fraud, such as more stringent entry requirements on those who may bill the government for services and required internal compliance programs for some providers, could make it more difficult to commit some kinds of

fraud. Nevertheless, by increasing the share of medical costs paid by government, the ACA may increase incentives for fraud. Medicare and Medicaid fraud are common because patients are not spending their own, but other people's money.

Government Budgetary Costs

By substantially increasing government spending on health care, the ACA will almost certainly increase the deficit. Supporters of health care reform used deceptive tactics to create the illusion that the ACA would reduce the deficit. In estimating the cost of the ACA, the Congressional Budget Office (CBO) assumed that a planned 21 percent reduction in payment rates for physician's services in Medicare would be implemented beginning in 2010, offsetting some of the costs of health reform. As they have done every year since 1997, Congress subsequently canceled these planned reductions in Medicare payment rates before they took effect in 2010 rather than risking alienating seniors who would suffer the consequences if government reduced physician payments. Instead of reducing the deficit by $138 billion as estimated by the CBO, the combined effect of Congress' action to maintain physician payment rates and enact the PPACA will be an increase in the deficit of $59 billion over ten years (Cannon, Do the Math, 2010).

In addition to the growth of Medicare spending, other components of federal health care spending will also grow. One important source of increased government costs is the cost of subsidies to health care exchanges, which will likely be larger than CBO estimates. Because of the high costs involved, many large employers likely will not comply with the mandate to provide affordable coverage for all their employees. As a result the number of people who are insured by their employers may fall substantially so that the numbers who buy subsidized insurance through exchanges will be higher than the government estimates.

Government subsidies mandated by the Affordable Care Act are sufficiently generous that low and middle income workers would be better off if they purchased insurance through the exchanges and their employers paid them higher wages instead of providing employer-subsidized insurance (ESI). Firms could require those covered by ESI to pay a bigger share of health insurance premiums, while increasing wages enough to compensate them. This would likely result in the cost of ESI to lower income workers exceeding 9.5 percent of their income, which is the upper limit for insurance to be considered affordable according to the ACA (Burkhauser, Lyons, & Kosali, 2011). Holtz-Eakin and Smith show that workers earning less than $60,000 would be better off buying subsidized insurance from exchanges than being covered by ESI, even if their employers increased their wages by less than firms save in premium costs to offset the expected costs of the penalties they must pay for not offering affordable insurance to some of their employees.

Although proposed tax increases limit the impact of the ACA on projected budget deficits, those tax increases, if implemented, will have negative economic impacts. New taxes on companies that sell health insurance, pharmaceutical products and medical devices will likely contribute to higher insurance premiums (Howard, 2011). The total impact of the ACA on government expenditures is what really matters, not the effect on the deficit. The CBO estimates that federal government mandatory health care spending will increase by $401 billion over ten years (Congressional Budget Office, 2011). Because of important discretionary costs that were ignored by the CBO in its estimates, the actual cost may well exceed $500 billion (Elmendorf, 2010). This is money that is unavailable for private sector job growth and innovation.

Growth in federal health care spending is the most important contributor to projections of a long-term explosion in the federal debt. Federal health-entitlement spending, which is now 5.6

percent of GDP, is projected to be between 9 and 10 percent of GDP by 2035 (Congressional Budget Office, 2011, p. 35). This includes Medicare, Medicaid, CHIP and subsidies for proposed health care exchanges. The CBO projects that sometime in the 2050s, federal health spending will exceed all other federal non-interest spending combined (Levin, 2011).

In addition to being 7.8 percent of the Federal budget, Medicaid consumes about 22 percent of state government budgets (National Governors Association, 2011). It will become more expensive as the Affordable Care Act increases the percentage of the population eligible for coverage. Another sixteen million are expected to become eligible for Medicaid under the ACA (Iglehart, Medicaid, 2011). Given the fiscal crisis faced by so many states, even a small increase in Medicaid spending may be more than they can handle.

The ACA does include a plan for reducing the growth of Medicare spending. The plan makes "record-breaking cuts in payments to hospitals, nursing homes, home health-care agencies, Medicare Advantage plans and even hospice programs" that could yield an estimated $575 billion of savings over ten years (Moffit, 2011). The Independent Payment Advisory Board is to play an important role in making recommendations about how to achieve these cuts. It is highly unlikely, however, that Congress will let the IPAB have enough power for its recommendations to be politically sustainable. If the government were to enforce cuts in payments in response to IPAB recommendations, it would also have to come up with a method for rationing health care since reduced payments will reduce the quantity of health care supplied.

Distributional impact of the ACA

A major source of health care inequity is the difference in the after-tax cost of insurance for those who buy their insurance in the individual market versus those who get employer-sponsored insurance (ESI). Because of its high cost, 74 percent of the population eligible to purchase

individual health insurance does not do so (Pauly and Herring, 2007). Reducing the cost of insurance policies available in the individual market is an important reason why health insurance exchanges were included as part of the PPACA. Massachusetts has implemented a health insurance exchange, the Commonwealth Health Insurance Connector Authority, which appears to have worked well in presenting information about alternative health plans in a format that is beneficial to consumers (Kingsdale, 2010). Using a web-based system to distribute coverage to individuals and small employers, the Health Connector has an administrative budget of three percent of total premiums. By contrast, private sector firms that distribute individual and small-group insurance through conventional channels have administrative costs of ten to twenty percent of premiums (Kingsdale, 2010).

Although some provisions of the ACA, such as Health insurance exchanges, may enhance equity, other provisions create new inequities. It forces those with a low risk of health problems to subsidize those with high risk. While it might make sense for well off, low risk people to subsidize the poor with high risks, it does not make sense for a middle income person with low risk to subsidize a high income person with high risk. Many people have a high risk for health problems because of lifestyle choices they made. A person who chose to consume too much food or alcohol, or not exercise enough may experience poor health as a result. Why should those who take care of their bodies be forced to bear the costs of others' poor choices through the premiums they pay?

Just like differences in income, many differences in health status are not the result of choices but of circumstances beyond the control of the individual. Nevertheless, the size of the reduction in cost for those with high risks of health problems if the ACA enforces community rating may be smaller than many proponents expect. A recent study found that even without

required community rating of risk, the difference in premiums paid between higher risk and lower risk patients in the individual insurance market is considerably less than the difference in expected health care costs. Based on panel data of medical expenditures, expected expenses for the higher risk half of the population were about four times as high, but insurance premiums were only 1.6 times as high (Pauly and Herring, 2007). In states without regulations that require community rating, those in the 95th percentile of coverage were only about ten percent less likely to get coverage than those with average risk. Although community rating results in more of those with high health risks being covered by insurance, it discourages those with low risks from purchasing insurance because of higher average premium costs and may reduce the overall percent of the population covered by insurance (Pauly and Herring, 2007).

Besides their impact on healthy people, the rules prohibiting rate differences based on health status might make some people with health problems worse off. Companies that sell individual policies will try to limit costs by making it harder for such people to obtain coverage or providing them with inferior service.

By expanding health care entitlements, the ACA may harm low income people by reducing economic growth and employment. The uncertainty associated with how it will be implemented, particularly uncertainty about tax increases and mandates, has likely discouraged firms from expanding their operations and hiring more workers. Although some provisions of the ACA, such as the subsidies to households with lower incomes and the tax credits for small firms, may encourage hiring, other provisions are likely to reduce employment in the long run. The effects of higher taxes and higher government deficits needed to pay for health reform will almost certainly discourage hiring and private capital investment. According to the CBO, the biggest effects on employment will come from the substantial expansion of Medicaid and the

fact that subsidies provided through insurance exchanges decline with income. Like any government transfer program, these changes brought about by the ACA will reduce people's incentive to work so that some work fewer hours and others drop out of the labor force. The net effect will be a reduction of employment of about half of a percent (Congressional Budget Office, 2011).

Impact of the ACA on Health Care Quality

A major problem in health care is the underuse of treatments that could produce favorable outcomes in patients because physicians lack adequate information on what works and what does not work in specific situations. The enormous increase in medical knowledge about efficacy and effectiveness poses both a challenge and opportunity for the medical profession (Chassin, 1998, pp. 575-76). By promoting the adoption of sophisticated information systems by health care providers, the ACA could contribute to greater use of the most effective treatments for each patient. Without appropriate incentives, sophisticated information systems may not be enough to motivate physicians and other providers to use the information in a way that efficiently enhances the quality of care patients receive.

Competition is an important source of incentives for improving the quality of health care while simultaneously keeping costs down. The current structure of the health care market does not encourage enough competition to provide quality care. The existing system promotes competition to reduce costs, but not enough competition to improve quality (Porter & Teisburg, 2004). Competition to improve quality depends on each patient having the opportunity to choose from as wide a universe of providers as possible. Requiring people to pay more for using health care providers outside of a limited network of preferred providers reduces quality competition by reducing the options of each patient. Allowing the patient the freedom to choose any provider

without restriction, subject to whatever price that provider offers to all comparable patients, combined with a copayment that rises with price would give patients a greater incentive to seek the best value for the price.

It is hard to get third-party payers to invest the time and effort required to develop innovative ways of managing health information and delivering health care that would enhance quality. They want to avoid complaining clients so are likely to emphasize minimum care standards, but won't be motivated to reward superior care unless it saves money. This problem is even more serious when the third party is the government, which because of its power to tax is effectively a monopoly supplier of health care subsidies.

A growing percentage of the population using health insurance exchanges could enhance quality competition. The question is whether exchanges will devote enough resources to providing information that consumers need to choose cost-effective health insurance. Because the ACA has so many subsidies and mandates that apply to any company selling insurance, administrators of exchanges will likely devote much of their time to managing subsidies and enforcing mandates. To facilitate household decisions about what insurance coverage to purchase, exchanges must estimate tax credits in advance, which will require them to find a way to collect accurate information from each participant so they can predict changes in household income and in the number of dependent family members (Short, et al., 2011). This will be a demanding and complicated administrative task, which will raise administrative costs while limiting the time available to provide good information to consumers.

Access to Care

"Universal" access to health care does not mean that everyone has access to whatever health care he or she might want or need. Like health care systems in other countries, the ACA seeks

universal access by providing subsidies so that almost no one is denied basic health care because he or she cannot afford to pay for it. Although, the ACA will increase access to health care for some low income people who are currently uninsured, it may reduce it for many others. This is a direct consequence of scarcity, which applies to all goods and services. Because of scarcity, goods must be rationed according to some criterion. Health care reform intends to eliminate or reduce rationing according to ability to pay as happens in a free market.

The Affordable Care Act, by making low or zero cost health care services available for more consumers than before, will increase the demand for health care. In order to attract enough new physicians and other health care workers to satisfy the increase in demand, prices the provider charges would need to rise substantially, especially in the short run. As a result government subsidies would exceed CBO projections and sustainable levels of spending. Thus, government will likely have to implement price controls, and rules for rationing care, or both.

The expansion of health coverage will likely exacerbate existing shortages. Shortages and non-price rationing are already a problem with the Medicaid program, which will likely get worse because of the increase in the number covered by Medicaid. The AAMC Center for Workforce Studies estimated a shortage of 91,500 physicians by 2020 (Kaiser Commission, 2011, p. 3). This problem is evident in Massachusetts, where health reform reduced the number of uninsured by half. Since the expansion of coverage, the wait to see a new doctor has increased and is twice as long in Boston "as in any other US City." (Goodman, Emergency Room, 2010).

If government enforces the right to health care for those who cannot otherwise afford it, government must necessarily set limits on that right, which means rationing. One of the more common ways to ration health care is by requiring people to wait for treatments that are in short supply. If they have to wait for treatment, some patients may die or no longer be able to benefit

from a treatment before it is their turn to get the treatment. For example, because of delays for colon cancer treatment in Britain, twenty percent of the cases considered curable at the time of diagnosis became incurable by the time of treatment (Goodman, Health Care, 2005, p. 3).

Alternative Approaches to Health Care Reform

Although some provisions of the ACA may improve access to affordable, quality health care, other provisions may reduce access to quality care, while the overall impact on health care costs, the government budget, and employment are likely to be negative. Trying to eliminate the likely negative consequences of the ACA by changing individual provisions will make things worse. For example, the cost of subsidizing the purchase of insurance through exchanges could be reduced substantially by raising the penalty to employers for not providing insurance to their employees. Raising the penalty to employers so that it equals the full cost of providing health insurance would make it unaffordable to continue to employ many workers whose wages are close to the minimum, resulting in job losses for more than 200,000 workers, according to one estimate (Levy & Baicker, 2007).

The inequities of our health care system could be corrected without the expansion in federal government coercion to redistribute income. Extending the same tax deductions that apply to group insurance provided by employers to those who buy insurance in the individual market would reduce the horizontal inequity between those two markets. For the sake of equity, it would be even better to eliminate tax deductions for health insurance premiums. This is because, with a progressive tax system, tax deductions reduce the cost of health insurance more to high income households whose marginal tax rate is higher. The many American households whose incomes are too low to owe much federal income tax gain little benefit from tax deductions for health insurance.

The tax deductibility of health insurance premiums results in many Americans having too much health insurance. When insurance companies pay most of the costs of routine treatment, the total cost of that treatment rises. This happens for two reasons. First the insurance company, as middleman between the consumer and the health care provider, has costs that must come out of what the consumer pays. Second, insurance that pays for routine care lowers the cost of each doctor visit to the consumer, thus increasing demand and leading to higher prices. If the tax deduction for health insurance premiums were eliminated, most workers would be better off paying for routine care and treatment for preventable conditions out of pocket. This would reduce premium costs to employers, who could then pass the savings on to their workers as higher wages, which would more than offset the higher medical bills the typical worker would have to pay.

An alternative approach to health care reform should also address the problem of pre-existing conditions, making health insurance unaffordable for some. One promising free-market approach is the option to buy health status insurance when young to cover the risk of developing a condition that would raise future health insurance premiums. Firms selling this insurance would agree to pay a lump sum to those whose health deteriorates so that they could afford to pay for new insurance without an additional financial burden (Schansberg, 2011, pp. 33-35). If health status insurance were available, all insurance companies could freely adjust individual premiums to reflect changing risk without creating a financial hardship for those whose health unexpectedly deteriorated. This would eliminate or reduce the problem of workers staying with a job they did not like in order to maintain affordable health insurance coverage.

CONCLUSION

The ACA is fundamentally flawed because it increases the role of the federal government in health care financing and decision-making, while reducing the role of households. It assumes that experts can make the best decisions about what health care Americans are entitled to. It also assumes that those experts can devise and manage a system where key decision-makers will have adequate incentives to provide quality care that people need in a cost-effective way.

Medicare, Medicaid and the new entitlements created by health care reform are on a collision course with economic and fiscal reality. The more government is involved in health care, the less people have an incentive to economize on their use of it. By increasing the role of government and expanding insurance coverage, the ACA contributes to the continued escalation of health care costs, which neither the government nor employers can afford to pay.

The Affordable Care Act reflects a particular vision of the economy. It is a vision which is fundamentally in conflict with traditional American understanding of freedom. Too many Americans value their freedom to accept the rationing of care that would be necessary to sustain the existing system of entitlements combined with those added by the ACA. Rather than accept the dictates of a government bureaucracy, Americans will continue to demand the health care we think we deserve. Unfortunately, we cannot have our freedom and the kind of massive health care entitlements that we now have, even without the added entitlements of the ACA. Thus, in the name of freedom and future prosperity, we need a different kind of health care reform than what the Obama administration gave us.

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