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WHY IT'S CALLED THE AFFORDABLE CARE ACT

*Nicholas Bagley**
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The Patient Protection and Affordable Care Act of 2010 ("ACA") raises numerous policy and legal issues, but none have attracted as much attention from lawyers as Section 1501. This provision, titled "Maintenance of Minimum Essential Coverage," but better known as the "individual mandate," requires most Americans to obtain health insurance for themselves and their dependents by 2014.[1] We are dismayed that the narrow issue of the mandate and the narrower issue of free riding have garnered so much attention when our nation's health-care system suffers from countless problems. By improving quality, controlling costs, and extending coverage to the uninsured, the ACA means to address many of those problems. And it's about time. The United States has lower insurance coverage rates and lower life expectancy than most developed countries, and our system does poorly on several dimensions of quality. Worse still, we spend much more on health care than any other country—$2.5 trillion, or 17.6 percent of gross domestic product, in 2009.[2] These measures of total spending mask grave distributional concerns: 52 million people went without insurance during some part of 2010.[3]

Nonetheless, the individual mandate is the legal hook upon which many have hung their constitutional challenges to the ACA. In a recent essay, our colleague Professor Douglas Kahn joins with Professor Jeffrey Kahn to take issue with one of several justifications for the mandate: that it solves the free-rider problem that arises when an uninsured individual receives care without paying for it, thus forcing providers to raise costs for paying

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1. Patient Protection and Affordable Care Act, Pub. Law No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. Law No. 111-152, 124 Stat. 1029 (2010) (amending §5000A of the Internal Revenue Code of 1986) [hereinafter "ACA"].

2. *National Health Expenditures 2009 Highlights*, CENTERS FOR MEDICAID & MEDICARE SERVICES, www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf (last visited Aug. 4, 2011).

3. *Help on the Horizon*, THE COMMONWEALTH FUND, at ix (2011), www.commonwealthfund.org/Content/Surveys/2011/Mar/2010-Biennial-Health-Insurance-Survey.aspx (report accessible through hyperlink).

(typically insured) patients. Kahn and Kahn claim that the free-rider problem has been exaggerated. Even if it were a meaningful problem, they argue, the ACA only resolves it by shifting the burden of uncompensated care from insured patients to taxpayers, thus substituting one type of free riding for another. Finally, they suggest that the free-rider trope hijacked the political debate and distracted from the ACA's redistributive consequences.[4]

These claims are unconvincing. Kahn and Kahn can maintain that the free-rider problem has been exaggerated only because they define "free rider" to mean something it does not. Although their claim that the ACA substitutes provider-subsidized free riding for taxpayer-subsidized insurance is accurate, Kahn and Kahn fail to appreciate the overwhelming strength of the latter approach. And their belief that the free-rider argument somehow prevented debate about the ACA's distributional consequences is, as an empirical matter, simply false.

Notwithstanding their studied agnosticism about the policy wisdom of the ACA, Kahn and Kahn exhibit deep discomfort with the ACA's requirement that private insurers ignore beneficiary health status in setting premiums and the attendant mandate to purchase insurance. Yet they never acknowledge that achieving near-universal coverage through the private market depends on these interventions. If insurers could set premiums based on individual risk, those most in need of insurance would be unable to afford it. And if healthy people could opt out of risk pools, the resulting premium increases for those who remained would likely put insurance out of reach for millions. The ACA's redistribution is thus tied up with questions relating to the level of risk-rating that is acceptable in a decent society, the purpose of health insurance, and the moral urgency of covering the uninsured. Perhaps Kahn and Kahn prefer the status quo; their apparent unhappiness with the ACA suggests they do. But although they would have preferred the public debate to have focused more intently on redistribution, it's no surprise that debate over health-care reform has ranged more broadly.

I. A FREE RIDER BY ANY OTHER NAME

Kahn and Kahn deny that a substantial free-rider problem exists in the medical marketplace. In their view, the uninsured who cannot afford care are not really free riders because they have no meaningful choice but to go to the emergency room when they fall ill.

We'll cheerfully stipulate that an uninsured, poverty-stricken person who, say, breaks her arm, will seek and receive treatment. (That's why, contrary to those bringing constitutional challenges to the individual mandate, someone who chooses not to buy health insurance will nonetheless someday participate in the interstate health-care market. She can credibly exempt her-

4. *See generally* Douglas A. Kahn & Jeffrey H. Kahn, Commentary, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?*, 109 MICH. L. REV. FIRST IMPRESSIONS 78, 81, 84-85 (2011), www.michiganlawreview.org/assets/fi/109/kahn.pdf.

self from the market for ordinary consumer goods like cars or broccoli; not so for health care.) Someone has to pay for her treatment, however. If she can't pay—and the hospital, having tried to collect, can't get her to pay—then the hospital must cover the loss. How does the hospital do this? By increasing prices for paying patients, including those with insurance (or, more worryingly, by providing profitable treatments to well-insured patients who don't need them). In other words, those who can pay for medical care also pay for those who can't. And that makes our friend with the broken arm a free rider.[5]

Kahn and Kahn resist calling her a free rider because they dislike the term's negative connotations. They think she's done nothing wrong in seeking uncompensated medical care. We agree. But the strength of her justification for seeking medical attention shouldn't obscure its economic consequences. She's still forcing someone else to foot the bill. And she can do so only because of the deeply felt social commitment, embedded in various state and federal laws, including the Emergency Medical Treatment and Active Labor Act, to provide emergency medical care even to those who can't pay. This social commitment transforms emergency medical care into a nonexcludable, quasi-public good, which allows our broken-armed patient to fob the costs of her care onto paying patients.

At bottom, Kahn and Kahn's argument rests on a semantic dispute over the term "free rider." They accept that providers shift costs from non-paying to paying patients. They don't contest the scale of this cost-shifting: $43 billion in 2008, leading to an average increase of $1,000 in a family's annual insurance premium.[6] They even acknowledge that the broken-armed patient "may be [a free rider] within the economist's use of the term."[7] Called a free-rider problem or not, this cost-shifting is still a problem—and a massive one at that.

II. ROBIN HOOD AND THE ACA

Which brings us to Kahn and Kahn's second point. They object to those politicians and advocates who, in using the term free rider, hoodwinked the public into thinking that the ACA requires citizens to accept personal responsibility for their own health expenses. In their view, this rhetoric was misleading. Shifting costs from non-paying to paying patients, they point out, is a form of wealth transfer. Of course, the ACA also transfers wealth, albeit through the tax system. It expands Medicaid to cover anyone up to 133% of the poverty line and subsidizes the purchase of private insurance for those between 133% and 400% of the poverty line. In so doing, Kahn and Kahn argue, the ACA merely institutionalizes a new kind of

5. *See* N. GREGORY MANKIW, PRINCIPLES OF MICROECONOMICS 222 (1998) ("A free rider is a person who receives the benefit of a good but avoids paying for it.").

6. ACA, § 10106(a) (amending § 1501(a)(2)(F) of the ACA).

7. Kahn & Kahn, *supra* note 4, at 82.

cost-shifting by asking taxpayers to pick up the insurance bill for lower-income Americans.

To begin with, it seems well within the bounds of fair debate to *accurately* describe those uninsured who receive uncompensated care as free riders. But more importantly, Kahn and Kahn's critique only begs the question: Which kind of distribution is better? Should we finance health care for the medically indigent through provider cost-shifting or through the tax system? On this, Kahn and Kahn decline to engage. Had they done so, they would have found at least five straightforward reasons why provider cost-shifting is much more damaging than taxpayer-driven redistribution under the ACA.

First, provider cost-shifting operates as a highly regressive tax on paying patients. The reason is simple: because providers don't charge higher-income patients more for their medical care than lower-income patients, increased medical costs—usually seen in higher insurance premiums—are shared by all paying customers alike. The inflated cost of medical care occasioned by provider cost-shifting thus eats up a larger fraction of the income of a lower-income person than a higher-income person. "This regressive pattern contrasts sharply with the progressive profile of effective federal income tax rates."[8]

Second, provider cost-shifting is surreptitious. Most people have no idea that uncompensated care inflates health-insurance premiums. Even if they do, those with employer-sponsored insurance probably don't know that insurance coverage is part of compensation and that ever-rising premiums lead to reductions in take-home pay.[9] (This typically happens not through wage cuts, but rather through slower wage growth.) In contrast, subsidizing insurance for the disadvantaged through the tax system exposes the costs of the commitment to near-universal insurance and lends democratic legitimacy to the determination of how to distribute those costs.

Third, medical debts don't painlessly get wiped away. Like other creditors, health-care providers demand to get paid. Attempting to satisfy those demands not only imposes hardship on individuals and families, but it frequently sends the uninsured into a financial tailspin—which is why medical debt contributes to about half of all bankruptcies.[10] Requiring the purchase of subsidized health insurance eliminates that source of financial instability.

Fourth, uninsured patients receive worse medical care than those with insurance. Uncompensated care is typically acute care, provided in a hospital emergency room, often to address conditions that could have been prevented if detected earlier. And this kind of care is much more expensive

8. *See* Robert A. Carolina & M. Gregg Bloche, *Paying for Uncompensated Medical Care: The Regressive Profile of a "Hidden Tax"*, 2 HEALTH MATRIX 141, 158 (1992).

9. *See* Katherine Baicker & Amitabh Chandra, *The Labor Market Effects Of Rising Health Insurance Premiums*, 24 J. LABOR ECON. 609 (2006).

10. *See* David Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFFAIRS W5-63 (Feb. 2005).

than equivalent care provided on an outpatient basis. By expanding insurance coverage, the ACA encourages patients and providers to favor inexpensive primary care over expensive emergency care.

Fifth, and relatedly, the uninsured regularly defer necessary care until turning sixty-five, only to run up needlessly large medical expenses when they finally become eligible for Medicare.[11] By providing near-universal insurance coverage, the ACA discourages this wait-until-sixty-five approach and increases the likelihood that those who previously lacked insurance will secure cheap preventive care prior to entering Medicare. The ACA thus directs taxpayer dollars that would otherwise have gone to cover inefficient, late-in-the-day care toward timely and more efficient medical care.

In short, using the tax system to extend health insurance to 38 million additional people is more progressive, transparent, humane, and efficient than the redistribution caused by provider cost-shifting. We do not dispute Kahn and Kahn's observation that the ACA replaces the covert redistribution of provider cost-shifting with overt redistribution via the tax system, and that both involve redistribution. But we do dispute that minimizing uncompensated care by extending comprehensive health insurance was some sort of shell game.

III. Free Riders Hijacking the Debate

Kahn and Kahn spend the balance of their piece objecting to a different kind of redistribution they believe went unappreciated in the debate over the ACA. Here the redistribution they have in mind is a function of the ACA's imposition of community rating, under which insurers are prohibited from considering the health status of insurance applicants.[12] The annual premiums of younger and healthier members of a community-rated risk pool thus subsidize the care of the older and sicker members. In Kahn and Kahn's view, "the advancement of the free-rider justification has prevented the debate over the merits of the program from focusing on the critical question whether a redistribution of wealth from the young to the old and from the healthy to the unhealthy is an appropriate and desirable goal."[13]

This political process complaint is unpersuasive. For starters, the redistributive effects of the ACA as a whole are not as clear-cut as Kahn and Kahn suggest. Medicare already covers those sixty-five and older, so any redistribution that occurs on the exchange doesn't involve the elderly. The ACA also imposes sharp cuts on Medicare to finance the Medicaid expansion and the exchange subsidies, channeling tax dollars previously claimed by the elderly to younger individuals. To mitigate concerns about intergenerational transfers, the ACA permits exchange plans to vary premiums up to

11. See J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 357 New Eng. J. Med. 143 (2007).

12. ACA § 1201 (amending § 2701(a)(1)(A)(iii) of the Public Health Service Act).

13. Kahn & Kahn, *supra* note 4, at 80.

three times based on age. And the ACA endeavors to make health care more affordable for everyone—including the young and healthy—by eliminating medical underwriting and promoting managed competition on the exchanges.

But let's assume Kahn and Kahn are right. As they frame the matter, debate over the ACA should have focused on the choice between individual and community risk-rating. This framing obscures the stakes of that choice, however. As it stands, and until the ACA's coverage provisions go into effect, private insurers in the individual and small-group markets may, in most states, individually risk rate. The result is that millions of Americans can't afford health insurance—especially those with preexisting conditions or ill-omened risk profiles. Because of insufficient risk-pooling, the market for those in greatest need of health insurance has unraveled. Achieving near-universal coverage through the private market thus depends on some form of community rating, meaning that the choice between community rating and individual risk-rating is tantamount to the choice between near-universal coverage and the exclusion of tens of millions from the insurance market. Against this backdrop, it's unremarkable that political debate over the ACA was more than a clinical discussion of the redistributive effects of community rating.

Or look at it another way: Kahn and Kahn have trained their attention on the dollar flows from the young and healthy to the old and unhealthy. But to gauge the overall redistributive consequences of a public welfare program, it's not enough to observe that the wealthy pay more in taxes and finance the bulk of expenditures. Among other things, you also have to tally the value of the good provided to beneficiaries via that redistribution, which in this context includes the value of insurance to those who previously couldn't secure it on the private market. Because insurance both prevents financial shocks and improves health, that value turns out to be quite large. With respect to Medicare, for example, the benefits of coverage accrue so broadly that beneficiaries at every level of income come out ahead in terms of overall welfare.[14] The distributional consequences of the ACA may or may not be as rosy. But it would have been strange for the public debate to focus on wealth transfers from young to old without considering the value of insurance to those who otherwise would go without.

Still, Kahn and Kahn are right that, taking just a one-year snapshot of premiums and outlays, the younger members of a community-rated risk pool subsidize the older. But looking at the problem this way betrays an assumption that a calendar year provides the proper frame of reference for thinking about health insurance. That's not obviously so. All of us have been young, and almost all of us will grow old. If one widens the lens to consider lifetime health risks (or, more accurately, health risks prior to qualifying for Medicare), a young person's higher premium isn't an intergenerational

14. Mark McClellan & Jonathan Skinner, *The Incidence of Medicare*, 90 J. PUB. ECON. 257, 258, 270 (2006).

transfer at all. It's an intertemporal transfer. She's putting a down payment on health insurance for her older self. And that health insurance will buy tomorrow's medicine, which likely will be better than today's. Understood from this perspective, debate over intergenerational wealth distribution becomes considerably less urgent.

Kahn and Kahn also assert that a group of prominent economists, in defending the ACA from constitutional challenge in an amicus filing, characterized the uptick in premiums that occurs when the young and healthy exit risk pools as an "externality." In discussing risk pooling, however, the economists didn't make any claim about externalities.[15] That was deliberate. When a young, healthy individual opts out of a community-rated risk pool, the resulting premium increase is a price signal that allows those remaining in the risk pool to decide whether they value insurance at more than its going price. Opting out in this way doesn't necessarily give rise to the sort of *allocational* inefficiency to which we normally attach the label "externality" (although we might still worry about the efficient distribution of health goods given how hard it is to make an adequately informed choice about the need for health insurance). To the extent insurance is an ordinary market good, opting out instead gives rise to a *pecuniary* externality—a price effect arising out of a choice to buy or not to buy a good in a competitive market. Economists do not typically worry about pecuniary externalities; they applaud them. Kahn and Kahn thus need not worry that the economists' defense of the ACA would also stand as a defense of a government mandate to purchase a car in order to keep car prices high and prop up the auto industry. And in any event, nothing turns on the externality label because—externality or not—the point stands that sustaining a health-insurance market for higher-risk populations depends on some form of community rating.

On their central point, Kahn and Kahn are just wrong on the facts. The fairness of compelling healthy individuals to participate in community-rated risk pools was a core feature of the political debate. For just a few examples drawn from late 2009: A former Secretary of the Department of Health and Human Services published an op-ed in the *Wall Street Journal* deploring the "massively unfair form of income redistribution" that would occur when "younger, healthier, lower-income earners would be forced to subsidize older, sicker, higher-income earners."[16] A large insurer opposed to health-care reform released a study, widely covered by the press, showing that, under the ACA, "prices would trend much higher for healthy people," particularly for younger customers, but that "[o]lder, sicker individuals would tend to

15. *See* Brief for Economic Scholars in Support of Appellees as Amici Curiae, Thomas More Law Center v. Barack Hussein Obama, at 13-14 (6th Cir. 2011) (No. 10-2388) (describing the cost escalation arising from adverse selection without calling it an externality) [hereinafter Economists' Br.].

16. Michael O. Leavitt et al., *Health "Reform" Is Income Redistribution*, WALL ST. J., Sept. 28, 2009, at A21.

see cost decreases."[17] And members of Congress hotly debated the fairness of community rating on the floor of both the House and Senate.[18] We could go on.

Nor did the public debate ignore the ACA's broader distributional consequences. At a hearing, Senator Cornyn characterized the ACA's "subsidies, fee and taxes" as "a huge income redistribution."[19] Senator Ben Nelson thought the tax-and-transfer provisions amounted to "class warfare."[20] And the day after President Obama signed the ACA, the *New York Times* ran a front-page story declaring it "the federal government's biggest attack on economic inequality since inequality began rising more than three decades ago."[21] If the ACA's distributional effects were hidden, they were not hidden well.

* * *

Although Kahn and Kahn focus on the individual mandate, the broader goals of the act—and the question of how to pay to achieve them—were subjected to lengthy, rigorous, and rancorous public debate. Indeed, the battle over the ACA was the culmination of a war over universal coverage that has raged for nearly one hundred years. Having heard exhaustive arguments about wealth distribution, the democratically elected Congress still determined that a status quo in which 52 million people lacked insurance in 2010 and millions more would lose insurance in ensuing years was unacceptable. As the economists with whom Kahn and Kahn disagree succinctly put it in their amicus filing, "This tradition of assuring the availability of some minimal level of treatment to all Americans without regard to ability to pay reflects a collective decision that we are, as a Nation, generally unwilling to see others come to great harm for lack of access to medical care."[22] Amen.

17. Avery Johnson, *WellPoint Attacks Health Legislation*, WALL ST. J., Oct. 22, 2009.

18. *Compare* 155 Cong. R. S10745-46 (daily ed. Oct. 27, 2009) (statement of Sen. Enzi); 155 Cong. R. H12450 (daily ed. Nov. 5, 2009) (statement of Rep. Gingrey), *with* 155 Cong. H6144 (daily ed. June 3, 2009) (statement of Rep. Schwartz).

19. Robert Pear & Jackie Calmes, *Senate Panel Softening Insurance Penalties*, N.Y. TIMES, Oct. 1, 2009.

20. Michael O'Brien, *Nelson: CBO Analysis 'Devastating' to Health Reform; Slams House Bill as "Class Warfare"*, THE HILL'S BLOG BRIEFING ROOM, July 17, 2009, thehill.com/blogs/blog-briefing-room/news/lawmaker-news/50657-nelson-cbo-analysis-devastating-to-health-reform-slams-house-bill-as-class-warfare.

21. David Leonhardt, *In Health Bill, Obama Attacks Wealth Inequality*, N.Y. TIMES, Mar. 23, 2010.

22. Economists' Br., *supra* note 15, at 10.