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The Unaffordable Health Act – A Response to  
Professors Bagley and Horwitz

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# The Unaffordable Health Act – A Response to Professors Bagley and Horwitz

Douglas A. Kahn and Jeffrey H. Kahn

## **Abstract**

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

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

## The Unaffordable Health Act – A Response to Professors Bagley and Horwitz

*Douglas A. Kahn*<sup>\*</sup> & *Jeffrey H. Kahn*<sup>\*\*</sup>

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

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

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<sup>1</sup> Douglas A. Kahn & Jeffrey H. Kahn, *Free Rider: A Justification for Mandatory Medical Insurance Under Health Care Reform?*, 109 Mich. L. Rev. First Impressions 78 (2011), <http://www.michiganlawreview.org/assets/fi/109/kahn.pdf>, hereinafter cited as “Kahn.”

<sup>2</sup> Nicholas Bagley and Jill R. Horwitz, *Why It’s Called the Affordable Care Act*, hereinafter cited as “Professors.”

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

A major source of the objection to the Act is the belief that it will impose a huge cost at a time when the government should be taking strong measures to reduce expenditures. There is an issue as to what extent that constitutes a problem. Based on a set of assumptions as to future events and behavior, the government maintains that the program will generate a profit. We are not alone in believing that the assumptions on which that projection is made are unrealistic,<sup>3</sup> and that the program will greatly impair the economy. While we also will not grapple with that issue, we are deeply skeptical of the government's contention. For that reason, we choose to refer to the Act as the "Unaffordable Health Act" or (Act).

#### I. Who Constitutes a Free Rider?

The so-called free-rider problem arises when a person who is not insured receives free medical treatment. Under the prior regime, the uninsured themselves paid for more than one-third of the medical costs they incurred,<sup>4</sup> and less than one-third of those costs were obtained by charging higher prices to those who pay for their care.<sup>5</sup> In our prior article, we posited that many of the uninsured who did not pay for their medical care were persons who could not afford insurance.<sup>6</sup>

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<sup>3</sup> For example, the Act requires a reduction in Medicare disbursements; and it is claimed that the anticipated dollar savings will offset some of the Act's costs. However, there are reasons to suspect that the proposed cuts in Medicare will never materialize or will be repealed when the consequence of making them surfaces.

<sup>4</sup> Kahn, *supra* n. 1 at 80.

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* at 81.

We contended that, in the public debate, the term “free rider” should not be used to describe such persons because the lay public’s understanding of that term would make its use misleading and prejudicial.<sup>7</sup> The professors counter by adopting the definition of a free rider that is employed by economists – namely, “A free rider is a person who receives the benefit of a good but avoids paying for it.”<sup>8</sup>

The public’s understanding of a term that has a special artistic meaning in a profession may be quite different from the understanding of the profession. For example, a lawyer knows that a homicide committed in the “heat of passion” is not first degree murder; but the lawyer’s understanding of what constitutes “heat of passion” likely will be very different from a lay person’s. Another example is the word “gift,” which not only has an artistic meaning to a tax lawyer, but has a different meaning for purposes of the income, estate, and gift taxes.<sup>9</sup>

While an economist might include persons who cannot afford medical care or insurance in the term free rider, he would understand that they occupy a very different position from others who are included. He would not be misled by the use of the term. That is not true for members of the lay public. Most of them will have a very different and pejorative understanding of that term. They likely will view “free riders” as parasites who could afford to purchase medical insurance but chose instead to pass their medical costs to the rest of society when they receive free medical care.<sup>10</sup> It seems to us that the term was deliberately adopted to mislead the public and to slant the debate in favor of the adoption of the Act.

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<sup>7</sup> Id.

<sup>8</sup> Professors, *supra* n. 2 at f.n. 6.

<sup>9</sup> See *Commissioner v. Beck’s Estate*, 129 F.2d 243, 246 (2d Cir. 1942).

<sup>10</sup> Kahn, *supra* n. 1 at 81.

A person who cannot afford insurance did not voluntarily shift his medical expenses to anyone else. Since society decrees that such persons are to receive medical care when needed, there necessarily will be a shifting of cost; but the uninsured's illness, rather than his action, initiated that shift.

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

The professors state that regardless of whether called a "free-rider" problem or not, the "cost shifting [that occurs] is still a problem – and a massive one at that."<sup>11</sup> We pointed out in our piece that the Act does not prevent cost shifting, albeit it does change the identity of those who bear that cost. By raising the free-rider problem as a justification for the Act, an erroneous inference was implanted that cost shifting will be eliminated by the Act.

While acknowledging that the Act requires cost shifting, the professors contend that the method of shifting employed by the Act is more desirable than the method employed under the prior system. We discuss that issue in Part IV.

The professors decry that so much attention has been focused on the so-called free-rider problem when they consider so many other matters to be of greater importance.<sup>12</sup> We agree. Indeed, that point was a significant part of our article. Proponents of the Act have caused that focus by advancing the free-rider problem as a major justification for it. The assertion of the free-rider problem and the exaggeration of its significance has diverted attention from the actual goals of the

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<sup>11</sup> Professors, *supra* n. 2 at \_\_\_.

<sup>12</sup> *Id.* at \_\_\_.

Act and resulted in minimizing the public debate on more meaningful questions. The proponents use of the free-rider issue is akin to a magician's use of misdirection when he focuses the audience's attention on a meaningless act so that they do not notice what is actually taking place.

## II. The Act's Departure From an Insurance Program

While the Act contains an insurance feature, a significant element of the program has no connection to insurance.

### *A. Purpose of Health Insurance.*

The function of any insurance program is to spread risks among a larger pool of persons so that no single person bears the full brunt of the cost of the insured event.<sup>13</sup> Take life insurance for example.

One thousand people of age X each have a \$10,000 obligation to pay at the end of a year. Each member of the group who is alive at the end of that year will have earned enough to pay his \$10,000 debt. But anyone in the group who should die before the year is over will not have had time to earn the \$10,000 needed to pay his debt. So, all 1,000 persons want to purchase life insurance that will pay \$10,000 to their estate if they should die within the year. The actuarial figures show that 1% of the people of X age will die within the next year. Consequently, it is likely that 10 of the 1,000 people will die during the year, and the aggregate amount paid to those decedent's estates would be \$100,000 if everyone purchased \$10,000 of insurance. To have sufficient funds to pay \$100,000 to the estates of the ten decedents, each of the 1,000 persons who purchases insurance will be required to pay a premium of \$100.<sup>14</sup>

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<sup>13</sup> See *Helvering v. LeGierse*, 312 U.S. 531 (1941).

<sup>14</sup> Of course, the premium would have to be greater than \$100 to cover administrative costs and allow for a profit, but \$100 is the pure insurance element of the premium.

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

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

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

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

The professors note that once an individual reaches 65, he is covered by Medicare, and so they conclude that he will no longer be subsidized.<sup>15</sup> Even if that were so, it would not eliminate the subsidy; it would merely limit it to those under the age of 65. However, many individuals who are covered by Medicare purchase supplementary medical insurance and thereby will benefit from

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<sup>15</sup> Professors, *supra* n. 2 at \_\_\_\_.

the subsidy since their premiums will be less than their actuarial cost.

The professors contend that we have overstated the subsidization of the elderly and the unhealthy. They point out that the program does permit a limited amount of variance in premiums because of age.<sup>16</sup> But, as noted above, in light of the ceiling imposed on the amount of variance, the Act does not even come close to preventing a massive subsidy of the elderly.

The professors also note that the Act expands Medicaid and provides governmental subsidies for persons with lower incomes to help them purchase insurance. The professors claim that those provisions will channel tax dollars from the elderly to the young and so offset the subsidy from the young to the elderly. But to what extent is that so? Income taxes are not collected exclusively from the elderly. Medicaid is provided according to income levels rather than by age. Moreover, Medicaid covers a relatively small percentage of the population, and many states have recently cut Medicaid payments.<sup>17</sup> The subsidies given by the government for insurance premiums are to persons having income that does not exceed 4 times the poverty level regardless of their age.

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

While conceding that the Act will require the young to subsidize the elderly, the professors respond that that is only a temporary circumstance.<sup>18</sup> In time, the young will age and then be subsidized by the youth of that era. Perhaps, it will convince some youths that they should be

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<sup>16</sup> Id. at \_\_\_.

<sup>17</sup> USA Today, July 6, 2011, at p. 5A.

<sup>18</sup> Professors, supra n. 2 at \_\_\_.

pleased to subsidize the elderly because some years in the future they might be subsidized. But there are counter considerations. A youth may not live to become eligible for a subsidy or may not become seriously ill before attaining age 65 and becoming eligible for Medicare. There is a risk that the program will be discontinued or altered before the youth becomes eligible. The public opposition to the program and its potential burden on the economy raise the risk that it either will not survive or will be significantly modified. Moreover, there is the little matter of time value of money. Even if a person later receives an equal amount of subsidy to what he paid, the current value of future dollars must be discounted. Also, a person's economic status affects how he values his dollars. The dollars that a youth pays may be more precious to him than dollars he *might* receive when he is older and possibly more prosperous. But all those considerations go to the question of whether the public will buy into the program; they do not alter the fact that the program rests on a subsidization of the elderly. If the facts are clearly divulged, the young can decide whether they think the Act is a good bargain.

The professors suggestion that the young's subsidy of the old is mitigated by the likelihood that the medicines that the young will receive in their golden years will be better than today's<sup>19</sup> is perplexing. The quality of medicine that will be available will be the same regardless of whether the Act's program is in effect.

*B. Variance Limitation.*

The professors describe the provisions prohibiting the taking of an individual's health into account as "community rating" as contrasted to "individual risk rating."<sup>20</sup> In that regard, the system superficially appears similar to group medical insurance programs – that is the rating is

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<sup>19</sup> Id. at \_\_\_.

<sup>20</sup> Id at \_\_\_.

based on the entire community (separated only by age) rather than by treating each applicant individually. But that is not all that occurs under the Act. The insurer is not permitted to use accurate actuarial figures for the medical expenses of elderly groups because of the variance limitation.

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

### III. Disclosure of Redistribution

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

### IV. Surreptitious Cost Shifting and Progressivity

The professors criticize the hidden aspect of the prior system's shifting of the cost of unpaid medical services to those who paid for their own care. Much of the payment for medical care is made by insurance provided for employees. Most employees do not realize that they bear the burden of paying for that insurance in that the amounts paid by an employer are passed on to

the employees through lower wages.

The professors claim<sup>21</sup> that the Act's shifting of the burden of some of the medical costs to the government<sup>22</sup> will make it more transparent because taxpayers will understand that the funds come from tax collections. There is reason to doubt that taxpayers take notice of the extent of their tax dollars participation in specific governmental expenditures; but, even apart from that question, the Act's cost shifting is just as surreptitious. Much of the Act's redistribution is to shift the elderly's cost to the young. Many of the young are employed, and their medical insurance is provided by their employers. Consequently, the cost shifted to the young will be paid by the employers who will pass it on to employees in the same surreptitious manner that occurred under the prior regime.

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

The professors contend that the prior system's shifting of costs to paying patients was regressive because the amounts charged were not dependent on the patients' income levels. They claim that shifting costs to the government will be progressive because of the graduated income tax rates.<sup>23</sup>

Much of the Act's redistribution is to shift costs from the elderly to the young, and there is

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<sup>21</sup> Id. at \_\_\_.

<sup>22</sup> The professors are referring to the government's subsidizing the premiums paid by low income individuals.

<sup>23</sup> Professors, *supra* n. 2 at \_\_\_.

no progressivity in that significant part of the Act. As to the prior regime, it is plausible that higher income paying patients would choose more expensive care and so would thereby incur a higher percentage of the indigent's costs. It is doubtful that the Act does much to improve progressivity; but even if it does, that likely played no part in the motivation for adopting the program.

## V. Reduction of Health Costs

The most disappointing feature of the Act is that it does so little to reduce the costs of health care<sup>24</sup>. Costs are skyrocketing, and that makes health care unaffordable to many. Moreover, it is strangling the economy<sup>25</sup>. Increasing the number of persons insured is likely to cause an increase in the demand for medical services, which will cause an increase in the cost of those services. Not only does the Act do little to deal with rising costs, it may exacerbate the problem. There is reason to fear that the health care system in this country is in crises; but the Act does not adequately address the core problems. Rather, it deals with only one aspect (albeit an important aspect) of the problem, and, in doing so exacerbates the national deficit problem that looms so ominously at this time.

## VI. Conclusion

The professors have described the meritorious benefits of the Act. There also are negative considerations, and we lack the space to discuss some of those. The question of the retention of the program rests heavily on a cost benefit analysis. In that regard, there are three important questions – namely, whether the economy can bear the cost, whether the benefits are worth that cost, and whether the cost will be borne by appropriate persons. Time will tell how

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<sup>24</sup> The Act does take steps to reduce insurance costs by eliminating underwriting and promoting an exchange program. But, neither of those provisions reduces the costs of providing medical care.

<sup>25</sup> See, David Brooks, "Death and Budgets," N.Y. Times, July 15, 2011, p. A21.

those questions are answered.



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