Problem: At present, there is a raging debate about the Affordable Care Act (Obamacare) that seems intractable, complicated, but is often just silly. It is intractable only because there are so many different (and often uninformed) opinions about the Affordable Care Act. It is complicated partly because there are so many different health care procedures and funding methods that must be considered. It is silly because politicians frequently make promises that are impossible to fulfill, e.g., to increase coverage, to improve benefits, and to lower costs, and all this by repealing and replacing the Affordable Care Act.

Many people have developed a misleading impression of the Affordable Care Act, partly because of impossible promises and misleading statements by politicians, and partly because of uninformed criticisms about Obamacare by surrogates on television news channels who are more concerned with political advantage than with improved well-being among citizens.

We grant that it is impossible for most people to understand all of the nuances and many facets of a law that is about 2700 pages long. It is also unnecessary. There are a few basic questions that should enable most people to formulate a reasonably informed opinion about future proposals and. directions in health care. Among these questions are:

Question 1. Should government (Federal, state, or local) ensure that all people have access to needed health care? Almost all people, including those in elected office, would apparently agree that government should fulfill this role. However, sometimes their actions belie their words. The first proposed replacement for the Affordable Care Act apparently would have caused up to 24 million people to lose health coverage by 2026. This was an estimate based on unclear, and for the most part, unknown assumptions, but it appears unarguable that millions would have lost coverage.

Question 2. What groups are most likely to be affected by ensuring/requiring that all people are covered by insurance? The most important are:

1. Many people with pre-existing conditions who would otherwise either be denied insurance coverage or charged an unaffordable rate.

2. Many young people, who are often in school, and whose earning are often too low to afford to pay for insurance coverage.

3. Some older Americans, who typically have higher medical care needs than younger people and in consequence, would be charged unaffordable high rates

4. Many people, often young and healthy, who are reluctant to purchase health insurance because they do not believe that they will need medical care.

Discussion for the first two questions: It is not a given that proposed replacements for the Affordable Care Act will insure that each of these groups will have access to affordable health insurance. This raises three important issues.

Issue 1: Should people be compelled to purchase health insurance (or pay a penalty) as was mandated in the Affordable Care Act? My own preference would be to require all American to purchase health insurance. One reason is that almost all people will require substantial amounts of health care during their lives. Health insurance doesn't mean that most people will pay less for health care, but these costs will be spread over their lives in affordable payments. Another reason is that the size of these health costs will vary substantially among people, and people with lower needs, as is well understood, need to be included in the insurance pool so that their premiums will help cover the costs of those with unusually high expenses

Issue 2: Should all people be charged the same insurance premium? I believe so. Let us consider different groups.

Older and Younger Americans: The Affordable Care Act allowed insurers to increase rates on a graduated scale as age increased, largely on the premise that older Americans would require more health care. The base rate was set for those aged 21 to 24, and gradually increased to a maximum amount of three times the base rate when people reach age 64. One proposed replacement for the Affordable Care Act raised the maximum premium for the oldest Americans to five times the base rate. Would this be fair? This is a very judgmental. If young and old were charged the same insurance rates, the higher costs for young people would be offset by lower costs when these individuals reach older ages and earnings are declining for many.

Pre-existing Conditions: Clearly, most people with pre-existing conditions face above average health care costs (including drugs), in some cases, astronomically high health care costs. The Affordable Health Care Act required that insurers offer people with pre-existing conditions coverage at the same premium as other people in the same age bracket. Of course, people without pre-existing conditions would have to be charged a higher rate than people with pre-existing conditions in order to cover the higher costs of the latter group. One proposed replacement to the Affordable Care Act would allow states to opt out of the requirement that insurance companies cover people with pre-existing conditions, if they established special state programs to cover the medical needs/insurance of people with pre-existing conditions. There was no requirement that they be charged the standard rate. This strikes me as folly. While we cannot predict what the effect of this provision would be, it does raises the possibility that some persons with pre-existing conditions will be charged high, even exorbitant rates for benefits that could vary widely depending up the State of residence. In fact, based on past experience with state funds for this purpose, it is a near certainty.

Young People Under Age 26: The Affordable Care Act required that they be covered under their parents policy until age 26, a provision that I hope will be incorporated into any proposed replacement of the Act.

Issue 3. How should this health care support be provided? There are three general approaches to assuring universal health care.

- A single payer system modeled after Medicare where citizens pay a premium

(tax?) into a single authority who then makes payments to private providers.

- An insurance system where individuals are covered by private insurance provided by large employers (50 or more full-time employees or the equivalent under the Affordable Care Act). In the case of persons not employed by large employers, under the ACA, they were still required to purchase private insurance. If unable to afford the premium, a subsidy is provided, presumably by the central government, either in the form of a direct payment or by coverage by a public program (medicaid).

- An insurance system without a public subsidy, but where the central government provides grants to states to partially support health care services to persons unable to afford private insurance company rates. This appears to be the model supported by many advocates for repealing and replacing the Affordable Care Act.

Reasonable people can make reasonable arguments for each of these approaches. However, I have a strong preference for using private insurers as intermediaries between health providers and individuals needing care (the second option above). My reason is simply that large insurance companies, directly competing against each other, are much more likely to create a dynamic system where they seek to keeps expenses and insurance rates as low, as possible and improve the quality of care than government bureaucracies at ***either*** the State or Federal level. Imagine, if you will, large private carriers such as Kaiser Permanente, Humana, Aetna, Blue Cross/Blue Shield ***continually*** seeking ways to cut costs and improve services in order to attract new customers.

Nothing, approaching this level of constant pressure to improve exists in any public program. Contrast the enormous progress that has been made by the private sector in computer science, automobiles, electronic appliances, and many other private endeavors with the slow pace of change in public education, road and bridge maintenance, etc. The Federal Medicare program tends to be resistant to innovative changes. Shifting responsibility to State programs (through Medicaid grants) simply creates dependence on many small bureaucracies. Although state management is often advocated on the grounds that the states are best able to design programs that meet the particular circumstances of their state, the lack of competition and past experience in the design of programs for poor and multiply disabled individuals inspires little confidence that this was be a normal feature of state programs.

Of course, if an private insurance approach is continued, provision would need to be made for:

- Much better ways of explaining to consumers the costs and benefits of their plans rather than the long, boring, and usually useless brochures;

- Assuring that there were enough insurers covering each area of the country to assure vigorous and meaningful competition, an area where the Affordable Care

Act fell short.

Question 3. What services should be covered for all citizens and to what extent?

The Affordable Care Act required that all health insurance plans cover 10 essential services, easily looked up on the internet. It can be reasonably assumed that most adults will require all of these services, some fairly frequently during their lifetimes (with the obvious nitpicking exception that males will not require maternity care). But is should be noted that many services that some people regard as important are not included. As examples:

- Dental care, except for children
- Vision care, except for children
- Cosmetic care
- Long-term care, e.g., nursing home care, institutional care

Discussion: It has been proposed that States be able to request a waiver some of the 10 essential. I cannot imagine any rationale for such a waiver. Clearly, the needs of American citizens will not differ significantly between States. But such a provision clearly has the potential to create significant gaps in coverage. To take an extreme case, suppose a state decided that kidney dialysis was not an essential service. Many people who require this procedure would be quickly faced with unaffordable insurance costs.

Almost certainly, some States would eliminate any requirement that contraceptive services be included as an essential services. Although employees are certainly not required to make use of this service, some employers apparently fear that they will be partly responsible for making it possible for their employees to avoid giving birth to unwanted children (although faithful use of the religiously approved rhythm method would accomplish the same goal). Since many birth control devices are relatively inexpensive, this would not appear to be a major issue for most people. I personally see no harm in instituting a deductible that would exceed the costs of contraception in most cases, perhaps combined with a public subsidy for persons unable to afford even these modest costs.

One might be more concerned about the lack of coverage for dental, vision, cosmetic and long term care. Dental and vision issues can have devastating effects on the ability of young people to learn and on the ability of adults to work and I believe that they should be considered essential services. Moreover, some cosmetic issues can have severely negative effects on peoples' lives, but I would be hesitant about including all such procedures as essential. I am skeptical about including tummy tucks, chin lifts, breast enhancements, e.g., as essential services, but would definitely include procedures that remove disfiguring features.

Question 4. How much should insured persons be required to pay out of pocket for health care?

The Affordable Health Care Act identified four plan levels for people to choose from. The lowest level, the bronze plan was to cover about 60% of medical care costs and the highest

level, the platinum planl was to cover ab out 90% of health care costs. However, I believe that for many people the most important limit on what they pay is the ***annual*** out of pocket limit on what insured persons will be asked to pay as deductibles or co-insurance. For 2018, the limit per family is $14,700; however, each individual family member can incur no more that $7350 in out of pocket costs. Beyond these limits, all of essential services must be paid by the insurance plan. Note that these out of pocket costs do not include services not covered as essential, nor the insurance premiums that are incurred.

I would regard the provisions of the ACA regarding annul limits on out of pocket costs as crucial. After all, it is not unreasonable for a quality family health insurance plan to cost $15,000 per year. Combine that with a near $15,000 in out of pocket cost for a total possible out of pocket cost ofof $30,000. That is almost half of the median household income of Americans in 2015. There are, of course, other approaches to setting the maximum out of pocket costs per family, but the ACA approach would appear to be the least difficult for insurance carrier to factor into their exposure level.

Question 5: Should health insurance companies be allowed to sell insurance across state lines?

To me, this is an issue of minor importance at the present time. Typically insurance carriers are incorporated (sometimes described as domiciled) in one state and then may apply to sell insurance in other states. In consequence, in many states there are far more insurance companies operating than are domiciled in that state.

However, insurance companies face differing state standards in order to operate in different states. Apparently to encourage insurance companies to expand coverage to additional states, it has been proposed that insurance companies operating in multiple states be required to meet the standards prescribed in only one of these states. This would provide a powerful incentive to adopt the lowest standards imposed among the states that the insurance companies would operate in. This becomes a matter of great concern if revisions to health care allow States to opt out of some essential services, or allow a waiver so that persons with pre-existing conditions will not be covered at standard rates. In effect, this could result in system of health insurance in which standards are set by the least restrictive state, and result in a nationwide health insurance systems with low levels of coverage and high costs for many people, especially those with pre-existing conditions, or those who are afflicted with catastrophic health care costs.

Question 6: Should employers be required to provide insurance

Under the Affordable Care Act, employer with 50 or more full-time equivalent workers must provide health insurance to employees who work 30 hours a week or more, or pay a fee for each worker - the employer mandate. This provision has been criticized because it creates an incentive for small employers to keep their labor force below 50, or to hire part-time rather than full-time workers in order to avoid having to pay for health insurance. I cannot doubt that the Affordable Care Act has this effect, although the size of this admittedly undesirable effect is unclear.

One important advantage of requiring employers to provide health insurance is that they can shop around and obtain a group rate for all their employees.

There are, however, several important disadvantages to the employer mandate, in addition to the disincentive created for small employers to hire over 50 full-time equivalent employees. For one thing, it usually compels employees to accept whatever insurance plan their employer provides. In addition, there are many small employers who do not provide health insurance and whose employees must obtain insurance on their own or pay a penalty.

One way to deal with these disadvantages has two components:

- make employer insurance optional; and

- in the case of any employer, of any size, that does not provide health insurance, impose a payroll levy on each employee's salary at a percentage that would be sufficient to enable most employees to purchase health insurance at the bronze level. The amount withheld should be capped when it reaches a level sufficient to purchase health insurance. Instead of paying the money directly to the U.S. Treasury, the money could be put into a special account that the employee could assign to the carrier that he or she decides to purchase health care from.

I suspect that most large employers would continue to provide health insurance. If not, their employees would still be required to obtain health insurance, using the funds that are withheld as well as any additional funds that the employee wishes to add in order to upgrade to a higher level policy. If the employee declines to purchase health insurance, the withheld funds would revert to the U.S. Treasury in lieu of any additional penalty.

Question 7: Should we focus on lowering costs

There has been enormous criticism of the high and apparently rising cost of health care and of the corresponding cost of health insurance. In 2016, for example, it was estimated that the average premium for a family plan was $833 per month, or about $10,000 per year, and the average deductible paid by families was almost $8,000. In short, on average, families would pay almost $18,000 per year for health care - including both the cost of health insurance and out of pocked costs. Remember, these are averages, some families will pay considerably less, and some a great deal more and, not all medical (e.g., dental) services are covered.

It serves no purpose to blame the Affordable Care Act for these high premiums. The provision of health care is a labor intensive industry, where medical professionals undergo long training to acquire their skills and justifiably expect to be well compensated for their work. If the cost of health care (and of health insurance) is to be lowered, the major driving force will be technical change that reduces the costs of providing care. The important point is that for the foreseeable future people will have to accept that medical care will be a major part of their budget if modern and effective care is to be received.

There have been proposals to lower the costs of health insurance by removing some of the requirements of the Affordable Care Act. This is a fantasy. What this accomplishes is to lower the cost of health insurance for some people, but will often greatly increase insurance costs for others, e.g., older Americans. Or it may simply transfer the costs of medical care to uninsured private individuals who are not able to afford private health insurance, e.g., perhaps those with pre-existing conditions. Or it may shift the cost of providing medical care to other government programs, or to charitable programs. Or it may actually reduce costs by allowing the sickest among us to suffer longer and/or die off quicker.

In short, contrary to the apparent fantasies of some politicians, the cost of health care will not be lowered by reducing the cost of health insurance premiums. When making decisions about the future of health care, we need to be guided by the total social cost involved, which include health insurance premiums, out of pocket costs (co-insurance and deductibles), other costs to other public programs (state, local, and federal), private philanthropy, and finally, unpaid costs incurred by doctors, hospitals, and other medical facilities.

Concluding comments: Like it or not, the Affordable Care Act is forcing Americans to confront the issue of whether people should be entitled to appropriate health care even if this requires a public subsidy and/or compelling people to purchase health insurance. This is not a new concept. Calls for a national health insurance started may years ago; in fact, before World War II. Nor is a public requirement to compel people to provide for their own needs a new concept. After all, social security, which requires people to set aside funds to insure a pension in retirement was enacted over 80 years ago.

What is appealing about the Affordable Care Act, and *possibly* for its eventual replacement or modification, is that it uses the private sector to attain a publically mandated goal. It does this by requiring all insurance sellers to sell their plans to individuals who apply for them at the same price (with the exception of people of different ages). In consequence, insurance companies are compelled to charge some clients a rate higher than would be indicated by their actual risk of incurring medical bills in order to provide affordable insurance to other people. Privatizing the provision of health insurance in this way leaves intact the market incentives to increase profits by either lowering costs and premiums or improving services. .