

THE ACA: POLITICS AND ECONOMICS

Debunking Myths

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Perhaps it's unwise to start with a title that mentions two dismal topics—politics and economics—in one line, but in our open system of democratic government, political decisions are influenced by their economic effects, and economic policies conform to political realities. Though this column is concerned with the economic effects of the ACA, I would first like to digress with a cautionary note: the ACA has become so politicized that we must be careful interpreting even so-called “news” reports about it. In our increasingly partisan press it's hard to find out how well the ACA is doing because the same “facts” generate widely contrasting interpretations.

Here's one example of how “news” can be manipulated. We all know that enrollment in the ACA was initially impeded by problems on its website, and that enrollment by the young was lagging. (The young are needed in any health plan, of course, because as a group they are generally healthy and thus keep down insurance premiums for everyone.) So it was newsworthy when, as the *NY Times* front page reported on February 13, 2014, “more than 1.1 million people signed up for health insurance through federal and state marketplaces in January [2014] . . . and the number of young people enrolling increased faster than that of any other group.” From October 2013 through January 2014, 25% of those who signed up were 18-34 years old. The article's headline reflected its content: “Over 1 Million Added to Rolls of Health Plan; Officials Hail Sign-Ups Among Young People.”

This might seem straightforward, but *The Wall St. Journal*—a persistent critic of the ACA and an advocate of legislation to reverse it—did not see this as encouraging news. Rather than reporting this information on its front page, a *Journal* article on page 6 described the 25% enrollment rate of 18-34 year olds as “tepid,” because they comprise 40% of “those for whom the exchanges were intended.”

“Tepid?” Really? It's not clear how they quantified “those for whom the exchanges were intended,” but even granting that the hypothetical maximum

enrollment for 18-34 year olds might be as high as 40% of those enrolling, aren't there sufficient reasons why 25% is a good response in that age group? First, the ACA permits them to be covered by their parents' health insurance up to the age of 26, so 18-26 year olds (who comprise up to half of the 18-34 cohort), may already have coverage. Many of that cohort, or even most of them, may not even be looking for insurance. Second, young people are notoriously lax about providing for their own health care because they see little need for it, so even those not covered by their parents may not be looking for insurance. Given those modifiers, is “tepid” an accurate descriptor of a 25% enrollment rate that is almost two-thirds of the hypothetical maximum of 40%? I take this as simply another indication that, now more than ever, we dare not read “news” uncritically.

The headline for *The Wall St. Journal's* article was equally slanted: “Young Remain Slow to Sign Up On New Exchanges.” (Anyone tempted to point out that the *NY Times* headline was also biased, but from an opposite and more optimistic perspective, should note that the *Times* headline did not offer its own opinion about the sign-up rates. It simply gave the number of enrollees, and reported factually—with quotes in the article—that administration officials had hailed the sign-up rate among the young.)

As a physician I am interested in the progress of the ACA, and as an editor I am particularly sensitive to tendentious reporting. So it concerns me when a report about the ACA like the one in *The Wall St. Journal* appears to cross the line from reporting news to editorializing about it within what is purportedly a “news” report. The *NY Times* and *The Wall St. Journal* articles and headlines discussed here will have different effects on public opinion. Sadly, though some coloration of the news has always been inevitable—reporters are human beings, after all—egregious and conscious distortion to manipulate public opinion for political purposes has lately become commonplace in the U.S. media.

In another example, a front page article in *The Wall St. Journal* (also on February 13, the same day as the two articles we have been discussing) was headlined: “Health Options Limited for Many; Thousands Face Few Plan Choices, High Premiums.” The article “reported” that in hundreds of counties across 15 states, only one insurer sells coverage through online marketplaces. The article implied that this was damaging new information, but though the statement is factually correct, it illustrates the adage: “Statistics are like a bikini; what they reveal is interesting, what they conceal is vital.”

The article failed to point out that in most of those predominantly rural areas there had already been only one dominant insurer, usually the local Blue. A larger picture of what has been happening in the health insurance industry is vital for context. Consolidation has already assured that in many parts of the country, one or the other of the six largest insurance companies (United Healthcare [70 million insured], WellPoint [33 million], Aetna [18 million] CIGNA, Humana, and Blue Cross Blue Shield) already has a virtual monopoly, if not an actual one. Indeed, as I have pointed out in a previous editorial,¹ the cost-containment benefits of the ACA are limited precisely because the Federal public insurance option that would have restrained premiums in the marketplace by providing an alternative insurer nationwide was gutted from the final bill to assuage Republicans in Congress and to assure passage of the bill. Instead, it has been left to the states to offer public exchanges, with spotty results. Had there been a Federal public insurance option, even dominant insurers would no longer have had a virtual monopoly anywhere, and would not have been free to raise premiums above the level charged by the Federal exchange. Since without a Federal public option the surge of new enrollees often pays high premiums, the cynics are fully justified in referring to the ACA as the “Health Insurance Industry Benefits Act.”

To add insult to injury, though it was Congress’ removal of the public option from the original ACA proposal that is responsible for many of those high premiums, the same members of Congress who opposed the public option now criticize the high premiums some enrollees must pay. Meanwhile, they ignore another

reality: though many enrollees have seen their premiums rise, it is not generally because of flaws in the ACA, but rather flaws in their previous coverage. Many policies had such huge deductibles or were otherwise so inadequate they failed to meet the ACA’s minimum requirements. Now these enrollees have useful coverage with smaller deductibles. No wonder it’s more expensive.

According to eHealth, the nation’s largest private insurance exchange, average individual deductibles dropped from \$4,900 in 2013 to \$3,768 in 2014, and, for families, from \$10,568 to \$7,194.

But enough about politics! Let’s turn now to the effects of the ACA on the economy. In keeping with the theme of a new section in this *Journal* (about which more later) in which we debunk myths about health care, in this section of my column I would like to debunk some myths about the ACA and the economy.

MYTH #1. Health care consumes too large a percentage of the GDP (currently 17.2%).

This complaint is so well established and widely accepted that it undergirds every discussion of the cost of health care. And though it’s not clear what percentage would be ideal for our country and our economy, it is clear that other developed countries spend far less. The developed countries closest to our level of spending are the Netherlands, Germany, and France, all of which spend between 11-12%.

True, the cost of health care adds to the cost of every product, and if that product is for export, any added cost will potentially affect the selling price and its competitiveness internationally. But aside from that legitimate complaint by manufacturers of exported goods, is spending on health care really bad for the economy? Before we consider the matter settled and that anything we do to shrink health care expenditures is an unalloyed good, let’s dig further into that statistic.

From the standpoint of our economy, notwithstanding medical tourism,² health care is a domestic industry that is labor intensive and employs tens of millions of Americans in jobs that cannot be outsourced.* Vast numbers of health care workers are highly trained for specific roles and would not easily find other

* Though the phenomenon of medical tourism is growing, it necessarily involves only elective procedures. The total number of tourists (as many as 750,000/year, according to the McKinsey study quoted by Wikipedia) is somewhat skewed toward those seeking minor procedures because it includes a large number who cross the border to Mexico for plastic surgery and dentistry. Overall, it remains a small fraction of the totality of health care provided to Americans, and to some extent is counterbalanced by foreigners who come here for major health care (about 75,000).

employment. According to the Office of Management and Budget, 16 million people are employed in health care, or 13% of a total American work force of 145 million. This number is expected to grow by 500,000 per year over the next decade to serve an aging population, which means that one third of new jobs will be in health care. (These figures don't include employment in related industries such as pharmaceuticals, the health insurance industry, or the engineering and manufacture of specialized medical equipment, from hospital beds to heart valves.) In an era of persistently high unemployment, any shrinkage in health care employment would depress the economy, as all those laid off workers would lose spending power. Even those with translatable skills would be competing for jobs with other unemployed workers.

I am not suggesting that waste should be maintained or that we should avoid making health care more efficient and effective; surely there are many unnecessary and expensive tests, treatments, and drugs. An inefficient system is a costly jobs program. But as the *NY Times* pointed out,³ health care is a countercyclical industry that repeatedly has helped pull the economy out of recession, and the recent decline in health care spending has been an uncharacteristic drag on the economy. Health care spending peaked at 17.4% of GDP in 2009 and 2010, but declined to 17.2% in 2012. As the *NY Times* article put it, health care “grew more slowly than the economy in 2011 and 2012 and will probably be found to have done so again in 2013. Meanwhile, health care employment also expanded more slowly than overall employment last year.”

MYTH #2: The ACA will cause unemployment!

The assertion that the ACA will cause an increase in general unemployment—not merely in the health care industry—is perhaps the most illogical and therefore the most egregious of the canards about the ACA.

This criticism is based on a recent estimate from the Congressional Budget Office that the ACA would reduce employment by the equivalent of 2.5 million full-time jobs. Opponents seized on this as evidence that Obamacare is a “job killer.”⁴ But as the *NY Times* pointed out, “that’s not what the C.B.O. meant.” The estimated reduction stems almost entirely from the fact that workers are no longer imprisoned by “job lock,” in which they dare not leave even a dead-end job they hate because their health insurance is tied to their job.

This phenomenon of “job unlock” is actually a good thing from an economics perspective, because it increases job mobility and the efficient allocation of labor. When people stop working at jobs they don't need or want, unemployment doesn't actually increase. The need for their labor remains and others will be hired to fill their place. People with entrepreneurial dreams will be freed to pursue them if they have the ideas, initiative, time, and resources. They may eventually employ others, providing further benefit to the economy. Unemployment may decrease in the long run.

These mechanisms for efficient utilization of labor are fundamental to free markets and would ordinarily be lauded by conservatives. It is ironic that in their frenzy to fault the ACA, they have overthrown their own economic principles. It is not the ACA that is causing unemployment; the major culprit is the advance of technology, which allows more work to be done by fewer workers. In that regard, health care is—in one sense—a savior, because it is such a labor intensive industry. There are a vast number of jobs such as nursing, which can be made somewhat more efficient by technological advances, but nurses cannot be replaced. (There are 2.6 million licensed nurses employed in nursing in the U.S.)

MYTH #3: The ACA extends government control over another sector of the economy.

Many feel that “Medicare for all” would be a more workable and efficient solution to the problems of our health care system. If nothing else, it would eliminate the 20% that the health insurance industry extracts from every health care dollar and facilitate control of health care spending.

Instead, the ACA rejects that extension of government control and preserves the central role of the health insurance industry. By requiring that every individual obtain health insurance and that all employers of more than 50 workers provide it, the ACA has preserved the role of the private sector and virtually assured that it will be hard to make major reductions in health care spending.

CONCLUSIONS:

Though the ACA is riddled with problems, many are merely organizational and will be swiftly ironed out. Those who take an optimistic view see the ACA as a step forward, but only as a starting point for reform of our health care system. I do

not think it can solve our systemic problems in its present format, though it will reduce the number of uninsured. Nor do I advocate single payer health care, or “Medicare for all” as proposed by Drs. Gates and Fogleman in their article. Such a vast expansion of government control would bring with it a host of problems, including a marked reduction in physician autonomy. I discussed some of the advantages and disadvantages of various alternatives in previous issues of the *Journal*.^{1,5} As with all my columns, the purpose of the current one is simply to point out aspects of health care that may be counterintuitive or at least not obvious.

In my personal opinion, expressed in a previous editorial,⁵ a vertically integrated system such as the Kaiser-Permanente system (in its full iteration on the West Coast, where Kaiser owns its own hospitals and the Permanente physicians’ group is separately administered but contractually related) is the best system that is compatible with high quality, controlled costs, and an American culture that favors non-government solutions.

IN THIS ISSUE

As mentioned earlier, this issue inaugurates a new section in which we debunk various medical myths. My editorial attempts to demonstrate that concept. In the remainder of the *Journal* we include an article by Fred Rogers, Medical Director of the Trauma Program, which critiques the myth of a Golden Hour for rapid treatment of trauma. Also, Alan Peterson offers a comprehensive refutation of common myths about vaccines.

The remainder of the issue is full of important articles. Drs. Gates and Fogleman provide the third and final chapter of their comprehensive overview of health care delivery, which includes some firm recommendations for change and improvement; Dr. Alexandra Gibas offers an encyclopedic review of the current treatment of Hepatitis C, which has recently undergone some radical and exciting advances; Dr. Ketan Kulkarni offers a comprehensive summary of the current alternatives for managing Barrett’s Esophagus, a precancerous lesion; and Dr. Alan Peterson concludes the issue, as always, with an article on his Top Tips.

REFERENCES

1. Bonchek, LI. When it comes to health care, can’t we get anything right? *J Lanc Gen Hosp*. 2013; 8: 97-99.
2. en.wikipedia.org/wiki/Medical_tourism#cite_note-Hansen08-79. Accessed Feb. 28, 2014
3. Binyamin Appelbaum. Will saving on health care hurt the economy? *The NY Times*, Feb. 9, 2014
4. Shaila Dewan. How Obamacare creates job opportunities. *The NY Times*, Feb. 20, 2014
5. Bonchek, LI. A modest proposal for health care reform. *J Lanc Gen Hosp*. 2012; 7: 65-67.