O

ctober is the first time the public will see the Affordable Care Act (ACA) in action. At least that is what the schedule says.

On October 1, 17 state-run exchanges and 34 federal exchanges have begun accepting applications for health insurance. Things may not go well that day—or that month—but any bad news will be drowned out by a congressional uproar over the budget, the debt limit, and the war in the Middle East.

Despite repeated claims that the ACA is on track, the Obama Administration has missed deadlines and delayed implementing major provisions of the law. The most significant admission that all is not proceeding smoothly was the July announcement that the employer mandate would be delayed 1 year. This action undermines the logic of the ACA and sets up the precedence for additional delays of this and other requirements in the coming years. This is not simply a matter of needing more time to solve technical problems. These issues drive the core of healthcare reform and the lack of public support for the President’s signature accomplishment.

Opponents of the ACA see a train wreck around every bend. Supporters see victory—in the 2014 elections and in the healthcare sector. Both will be disappointed.

Delaying the Employer Mandate: Promise of Things to Come

The ACA’s employer mandate requires midsize and large firms to offer coverage to all of their employees or to pay thousands of dollars in penalties. An employer with 50 or more employees that does not offer insurance that meets federal standards will pay $2000 in fines per full-time employee, excluding the first 30 employees. A company with 50 employees would pay $40,000 in fines; a company with 100 employees would pay $140,000. An employer who offers coverage would be subject to a fine of $3000 for every employee who opted instead for subsidized coverage through the exchange.

Although the 40-hour workweek remains the norm in most industries, the ACA says that a full-time employee is someone who works 30 hours or more weekly. This was meant to ensure that most workers in larger firms would be covered by their employer’s plan.

Employers can minimize the amount of the fine by reducing work hours to below 30 and by cutting back on hiring to remain having less than 50 employees. Conversely, the brunt of those changes will be borne by the low-wage workers, who were supposed to have been helped by the mandate. Rather than making it possible for those workers to be covered by what is often a generous health plan, the mandate will result in lost wages and will send more people into the exchanges, for insurance.

The recent decision by the Obama Administration to delay the employer mandate by 1 year does not change the incentive that some firms have to cut back on their workforces. In fact, it gives firms more time to map out a strategy to avoid the steep penalty that will be levied if even 1 of the company’s employees receives an exchange subsidy.

The penalty is a real threat for many companies. Even with the employer paying a substantial part of the premium, low-income workers often cannot afford to buy into the company plan. ADP Research Institute’s 2012 survey of companies with more than 1000 employees found that 63% of workers earning $15,000 to $20,000 annually declined their employer’s health coverage compared with 20% or less of workers earning at least $35,000. Many of these workers would be eligible for heavily subsidized insurance through the exchange, which triggers the employer penalty.

There is growing evidence that employers are shifting to part-time workers and shorter hours where they can. In October 2012, Darden Restaurants, one of the 30 largest employers in the United States, with brands that include Olive Garden and Red Lobster restaurants, stopped offering full-time schedules to its hourly employees in some locations. In February 2013, thousands of part-time state workers in Virginia were told that their hours would be cut to no more than 29 hours weekly. In March 2013, Regal Entertainment Group, which operates more than 500 theaters in 38 states, rolled back the hours of its nonsalaried workers to 30 hours weekly.

The White House insists that these are merely anecdotes, but some of the biggest supporters of healthcare reform are beginning to worry.
ternational Union, which has 1.2 million members, says that the problem is real. “Wait a year. You’ll see tremendous impact as workers have their hours reduced and their incomes reduced.”9

Indeed, wait a year. The administration will no longer be able to deny that the problems caused by the employer mandate are serious. An additional year will not make the politics any easier for the President, and will not make it easier for many firms to report accurately to each employee whether the plan they can get through their job is affordable. An additional 1-year delay is virtually certain next fall, just before the midterm congressional election.

What about the individual mandate? If business gets a break, why not consumers? From an insurer’s standpoint, the argument is simple. Unless you force healthy young people to buy coverage, the cost of insuring those who need health services will skyrocket. But this is an argument for protecting insurers, who have been in the Democrats’ crosshairs for some time. Perhaps next fall’s announcement of a suspension of any penalties on individuals will be justified by the newness of the program and the (political) need to give people more time to do the “right” thing.

Exchange Coverage Is No Bargain

Consumers going to the exchanges looking for insurance will find out the hard way that the plan they want will not be cheap. That is likely to be true even for a person who is eligible for a big subsidy.

The subsidies are substantial. Based on the Kaiser Family Foundation’s subsidy calculator, an individual with an annual income of $17,000 will pay approximately $55 monthly, or $660 annually, for “silver” plan coverage. A person with a $20,000 income will pay $85 monthly, or $1,020 annually.10

But this is not just any silver plan. The advocates and online premium calculators that back them up overlook an important fact: a more expensive plan will cost more, regardless of whether one receives an exchange subsidy.10

The exchange subsidy is tied to the silver plan offering the second-lowest premium. If your doctor is not in 1 of the 2 lowest-cost silver plans, which cover 70% of the health costs for an average person, you may want to buy a more expensive plan.

In New York State, for example, state regulators report that the unsubsidized premium for the second lowest-cost silver plan is $349.14 monthly.11 An individual with an annual income of $17,000 will pay approximately $55 monthly, or $660 annually, for silver coverage.10,12 The remaining $294.14 will be paid by the exchange subsidy.

The New York State plan that falls in the middle of the range of costs has a premium of $466.81 monthly.11 The premium paid by the same person with a $17,000 income is the subsidized $55 monthly plus the full difference between the 2 unsubsidized rates, which comes to $172.67 monthly, or $2,072 annually—not the $660 promised by state officials.13 For most people with low incomes, higher-cost plans that offer better access will be out of reach financially, despite the exchange subsidy. If consumers cannot afford the plan they want, they may buy a plan they do not want just because it is cheaper.

That is the reason for the individual mandate. But the penalty is far less than the cost of insurance, even with the subsidy. Next year, scofflaws are liable for a $95 penalty, or 1% of their income. In later years, the penalty grows to 2.5% of income, which will still look like a bargain compared with insurance premiums that will be higher in the future.

Buying health insurance on a wait-and-see basis will be a good strategy for many people. Insurers cannot turn people down if they skip a year, and the premiums cannot be increased either. The exchange subsidy is tied to one’s income, not whether a person has followed the rules. And there is a good chance that the Internal Revenue Service will not be able to collect the penalty, because it is limited to taking the money out of a person’s tax refund.13 American households that do not file federal income tax returns are not subject to the penalty, and the rest can adjust their withholding to avoid the penalty.

The individual mandate will cause some people to buy exchange coverage who otherwise would not have done so, but not because of the penalty. The mandate is an attempt to establish a new social norm that remaining uninsured is unacceptable. Will it work? We will have some idea in a few months.

Can Republicans Exploit the ACA’s Unpopularity?

The ACA is remarkable for remaining consistently unpopular with the public. A recent NBC News-Wall Street Journal poll taken in July 2013 shows that 47% of those polled think that the new law is a bad idea compared with 34% who support it.14 According to a June 2013 survey, only 19% of respondents think their families will be better off under the reform,15 which is the worst showing for the President’s program since it was enacted.

The problem is not that the public does not know how good the ACA will be.10 The problem, if we can call it a problem, is that 85% of Americans already have health insurance, most through their employers.17 Few of them will be eligible for lower premiums or for larger subsidies in the exchanges.

Offering the status quo—“if you like your healthcare plan, you can keep your healthcare plan”18—will not make the majority of the public “fall in love” with one of the most complex pieces of US legislation in modern times, especially if that promise cannot be kept.
The coverage that employees have today will soon be a thing of the past. Employers have already begun to change their health plans and restructure their workforces to avoid some of the higher health costs arising from the ACA. As a result, workers will pay more for a less generous employer coverage.

The prospect of new taxes and higher costs has caused many employers to take a second look at the way they manage their employee benefits. The “Cadillac tax” penalizes employer health plans whose total premiums exceed $10,200 for an individual or $27,500 for families. Although that tax does not start until 2018, companies are beginning to take steps to lower the cost of their plans.

The United Parcel Service (UPS) hit the headlines with its decision to exclude 15,000 working spouses from its health plan beginning in January 2014. Those spouses have access to insurance at their own jobs, but having to buy a separate policy increases the family’s cost to maintain the same level of coverage. This action lowers UPS’s benefit costs and reduces the average insurance premium that determines whether the plan is liable for the Cadillac tax.

This is not an isolated incident. In its recent survey of midsize and large employers, benefits consulting firm Towers Watson found that nearly 40% of firms are changing their employee health plans for 2014, in part prompted by the ACA. Even more employers will adopt new strategies to cut costs in 2015 and 2016 to avoid having to pay the Cadillac tax.

If the ACA is as unpopular as surveys show, and if employers are citing the ACA as the reason for aggressively cutting back benefits, why are Republicans having such little luck rallying the public to their side? The problem, at least in part, is the apparent lack of empathy in Republican policy positions. “Repeal and replace” sounds like “repeal without resolving the real problems.” The Democratic message of universal coverage (which translates into an implicit promise of security, regardless of the cost) has a greater surface appeal. The details, as Representative Nancy Pelosi (D-CA) said, can be sorted out later.

Republicans have an opportunity to regain the high ground in this debate, but only if they offer a positive vision for healthcare reform as well as a practical way to get there.

Beyond October

Experts on both sides agree that the ACA has substantial flaws. A host of new problems will be uncovered as the exchange process gets under way over the next year. Some of those problems arise from a poorly constructed law; others, from poorly thought-out changes that are promulgated by subsequent regulations and administrative actions.

Under less contentious political circumstances than we find with the healthcare reform, many of those problems would have been taken care of through a House–Senate conference committee before the final vote in Congress. That did not happen, because of the surprise election of Scott Brown (R-MA) to replace the late Senator Ted Kennedy (D-MA), giving Republicans 41 Senate seats. Democratic leaders feared that Senate Republicans could filibuster a conference report and prevent enactment.

The legacy of that decision is gridlock on Capitol Hill. Small technical issues remain unresolved that under other circumstances would have been addressed through an uncontroversial corrections bill. Larger issues that could have been the subject of public debate remain outstanding.

The administration has not let political gridlock get in the way of shaping the law to fit political needs and business realities. Regulations and informal guidance have been used to make changes that in normal times would have been acted on by Congress. Deadlines have been changed when the administration needed more time to get the results it wants. The mandate on employers to offer coverage was delayed in response to opposition from the business community, even though the ACA does not allow for such an action.

It now appears that the Obama Administration wants to extend to union members insurance subsidies that were intended to help the uninsured buy coverage. Those workers already have employer-sponsored insurance that is subsidized through the US tax system. Such a proposal would prompt a bitter political fight if it were introduced in Congress, something the White House can avoid by implementing the policy through regulation.

Except in the unlikely event that Republicans gain a sizable Senate majority in the 2014 midterm election, this aggressive regulatory process, which is controlled by the Executive Branch, will continue to play out for the next 3 years. That will solidify the federal government’s dominant role in the healthcare sector, which, thanks to the ACA, now extends well beyond Medicare and Medicaid. That does not mean everything will go smoothly. Perhaps the biggest danger to the President’s agenda comes from the overzealous actions of its strongest supporters. Premium rates that have been approved thus far in several major states are substantially below the levels that health plans requested. In many cases, those rates can be expected to rise sharply in future years. Insurers have an incentive to underprice their products initially to attract market share, and they are well aware of the prevailing political climate that demands low premium increases in the exchanges. But at some point they have to make a profit or drop out of the market.

That is the reason that Aetna, the third largest insur-
er in the country, has pulled out of the exchange markets in Maryland, Connecticut, Ohio, Georgia, and New York. Other large national health insurers have planned limited entries into the new exchanges, giving them a chance to see whether they operate smoothly and whether enough healthy people sign on to offset the costs of sicker new members. If healthy people fail to enroll, that will drive up costs that will not be reflected in already-approved rates for next year.

The ACA will not be the success its supporters want it to be. It will also not be the disaster its opponents think it will be. It will cause permanent changes—some good, some bad—in the way health insurance is purchased in this country.

There will be a shakeout of the insurance industry over the coming years, as more experience is gained about exchange operations and regulators face business reality. Consequently, the ACA will not be the success its supporters want it to be. It will also not be the disaster its opponents think it will be. It will cause permanent changes—some good, some bad—in the way health insurance is purchased in this country. It will also add to the growing fiscal burden that threatens to damage the health of the economy. Congress and the President will not be able to ignore those facts indefinitely.

Author Disclosure Statement
Dr Anton reported no conflicts of interest.

References