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Argument for One-Year Delay of Health Reform Riddled with Flaws

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In the latest effort by health reform's opponents to defund, unravel, or delay the law, House Republicans announced today that they will attach, to a Senate-passed bill to fund the government in fiscal year 2014, a one-year delay in health reform. To support the defund, unravel, or delay efforts, health reform's opponents over many months have produced a long list of exaggerated claims, misleading complaints, glaring omissions, and blatantly false arguments. Unfortunately, syndicated columnist Kathleen Parker echoed many of them in a recent *Washington Post* op-ed, and we should expect to hear more of them as part of the government funding fight. Not only are most of Parker's points inaccurate, but some of them are wrapped in heated rhetoric that's more likely to inflame rather than inform the public debate.

Parker's bottom line is that, as House Republicans now propose, health reform should be delayed a year. But no one should think the result of such an action would simply be a one-year postponement. A year from now, opponents would demand another delay and then another or outright repeal. Indeed, House Republicans have said they are designing their new debt-limit bill so that we hit the debt limit again at the end of 2014 at the same time that the one-year health reform delay would end — so they can be tied together again a year from now. A one-year delay would be a mortal blow to health reform, with tens of millions of Americans who otherwise would gain coverage instead remaining uninsured, possibly for many years.

Parker, herself, may not share that more sweeping goal. But we should see the push for a one-year delay, buttressed by misleading and inaccurate arguments and the selective use or omission of relevant data, for what it is: a core element of an effort to impede and ultimately dismember health reform so that it never comes to pass.

Here's where Parker and various other health reform detractors err and misrepresent important health reform issues.

- **Health reform has not spurred a big jump in part-time work.** Employment data don't support the claim, which Parker repeats, that health reform's requirement for employers to offer coverage is prompting widespread cutbacks in workers' hours to below the 30-hour threshold at which this requirement applies. Although some employers have said they are cutting certain employees' hours, the data show they are the exception. The number of people who want to work full time but can only find part-time employment has declined, as a share of

all workers, over the last couple of years.[1] And analysis conducted by economists at the Federal Reserve Bank of San Francisco finds that "the ultimate increase in the incidence of part-time work when the ACA [the Affordable Care Act, the health reform law] provisions are fully implemented is likely to be very small, on the order of a 1 to 2 percentage point increase or less."[2]

- **Health reform is not causing big layoffs.** The data also fail to support another of Parker's assertions — that employers are eliminating employees altogether as a result of health reform. She cites only one example — the Cleveland Clinic. And there she misrepresents the situation, as the very article to which she links reveals.[3] Like other health care systems, the Cleveland Clinic is taking steps to operate more efficiently — a desirable trend that predates health reform and that health reform will encourage. But the Clinic reports that it's still growing and still hiring.

- **Young adults won't have to pay unaffordable premiums for their health insurance**. Parker says that health reform will require young people who are unemployed or earn little to buy coverage that many of them will have difficulty affording. In fact, the large majority of young adults aged 19 to 29 who either are uninsured or now purchase individual coverage — and *nearly all* young adults who have low incomes because they're unemployed or earn low wages — will be eligible for premium tax credits to help them buy coverage through the new health insurance exchanges or for Medicaid (if they are poor and live in states that adopt health reform's Medicaid expansion). Parker's claim here is far off base. A young adult earning $17,200 a year, for example, will have to pay a premium of no more than $57 a month for a mid-level "Silver" plan in the exchange thanks to the tax credits, according to the Kaiser Family Foundation.[4] He or she also will be eligible for substantial help with deductibles and co-payments.

- **Most young adults won't be subject to tax penalties**. Parker uses heated rhetoric about large numbers of young adults "falling under the thumb of the IRS" because they will elect to remain uninsured and be subject to a penalty. But the relatively small number of young adults who don't already have coverage, cannot stay on their parents' health insurance plans because they are over age 26, *and* have incomes too high for premium tax credits will be able to purchase cheaper "Bronze" plans or special, low-cost plans that provide only catastrophic coverage. If they still can't afford the premiums because the plans would cost more than 8 percent of their income (or they are poor and their state won't expand Medicaid at this time), they will *not* have to pay any penalty for not having health insurance.

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[1] Jared Bernstein and Paul Van de Water, "Obamacare isn't destroying jobs," POLITICO, August 6, 2013, http://www.politico.com/story/2013/08/obamacare-isnt-destroying-jobs-95239.html.

[2] Rob Valetta and Leila Bengali, "What's Behind the Increase in Part-Time Work?," *Federal Reserve Bank of San Francisco Economic Letter*, August 26, 2013, http://www.frbsf.org/economic-research/publications/economic-letter/2013/august/part-time-work-employment-increase-recession/.

[3] David A. Graham, "Obamacare Isn't Really Taking Away Jobs: Cleveland Clinic Edition, *The Atlantic*, September 20, 2013, http://www.theatlantic.com/politics/archive/2013/09/obamacare-isnt-really-taking-away-jobs-cleveland-clinic-edition/279834/.

[4] Kaiser Family Foundation Subsidy Calculator, http://kff.org/interactive/subsidy-calculator/.

- **Health reform will be of substantial benefit to the near-elderly — precisely the opposite of what Parker asserts**. Today, large numbers of people aged 55 to 64 who don't have employer-provided coverage either cannot afford coverage on their own or can't find an insurer willing to sell them a policy at any price. As a result, many of these people don't get treatment for their medical conditions.

  Today, insurance companies that are willing to sell policies to near-retirees charge them a great deal more because of their age. Health reform addresses this affordability problem. Nearly four of every five uninsured people in this age bracket — 78 percent of them — have incomes that, under health reform, will make them eligible for either premium credits or Medicaid. And more than half of the 55- to 64-year-olds who already purchase coverage in the individual market will also qualify for premium credits or Medicaid, which will lower their costs. While insurers will be able to charge the near-elderly higher premiums than they charge young adults, the degree to which they will be permitted to do so will be *less* than it is today in most states. Moreover, near-elderly people will get larger premium subsidies to make coverage affordable.

- **The health plan from the Republican Study Committee (RSC) isn't a serious alternative to health reform.** Parker cites the RSC plan as a better alternative to the ACA. In fact, the RSC plan would *not* prohibit insurers from refusing to cover anyone with pre-existing medical conditions, as the Affordable Care Act does starting in 2014. The RSC plan would only bar insurers from denying coverage to people with pre-existing conditions who *already* have continuous health coverage, whether through an employer or in the individual market; that's only a slight improvement over the deeply flawed situation before health reform. Under the RSC plan, someone without job-based coverage who has been denied coverage in the individual market because of cancer or diabetes would likely remain uninsured.

  Moreover, even if someone had continuous coverage, if it was in the individual market, they would be eligible under the RSC plan only for coverage through a high-risk pool. Relying on such pools to provide coverage would be "extremely expensive and likely unsustainable," as the Commonwealth Fund has explained.[5] That's because high-risk pools don't pool sick individuals with healthy individuals, but rather pool sick people with even sicker individuals who cost more to insure. Indeed, experience with state high-risk pools, as well as with the temporary high-risk pools created by health reform (until the major coverage expansions take effect), shows that unless the government increases its financial support for such pools, they eventually have to sharply restrict enrollment, set premiums at high levels that exceed what many families can afford, and/or scale back the scope of the coverage that can be purchased, in order to keep their costs from spiraling out of control. The RSC plan, however, provides no federal high-risk pool funding (other than an authorization for appropriations that might never be acted on, especially if sequestration remains in effect, severely constraining the funding available for appropriated programs).

  Moreover, the RSC plan terminates the tax exclusion for employer-based coverage and replaces it with a tax *deduction* for health insurance that can be used by people who buy on their own or through their employer. That would likely cause employer-based health coverage to seriously erode by encouraging employers to discontinue their coverage. And insurance companies in the

[5] Jean Hall and Janice Moore, "Realizing Health Reform's Potential," Commonwealth Fund, September 2012, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Sep/1627_Hall_PCIP_enrollment_costs_lessons_rb.pdf.

individual market would be able to deny coverage to workers in poorer health, whose only options would then be a high risk pool or becoming uninsured.

The deduction would also do very little to help uninsured people gain coverage. That's because the subsidy that the deduction would provide would primarily benefit people in higher tax brackets and be worth little (or nothing) to the vast majority of uninsured; most of the uninsured don't earn enough to owe income tax or are in the 10 percent or 15 percent tax brackets. The deduction's primary benefit would go to high income people, who least need help in affording insurance and are the most likely already to have coverage.

- **Health reform won't be a drag on the economy.** Claims that health reform will seriously damage the economy and cause the loss of many jobs, which Parker echoes, are sharply inconsistent with the assessments of leading non-partisan economists. Recent statistics show no sign that health reform is negatively affecting hiring, notes Mark Zandi, chief economist for Moody's Analytics. And the Congressional Budget Office (CBO) has found that health reform would not seriously damage the economy or cause big layoffs. CBO foresees only a small reduction in labor supply — and only because some people who now work mainly to get health insurance would choose to retire earlier or work somewhat less, *not* because employers will eliminate jobs. Health reform will also increase labor market flexibility and productivity since the need for health coverage will no longer lock workers into a job.

- **The Administration did not provide a special break for lawmakers and their staffs.** Parker also echoes the claim that because the federal government will make an employer contribution to the cost of coverage for members of Congress and their staffs, Congress is getting favored special treatment. She portrays the federal employment contribution as a "break other Americans won't get." This is mistaken. Under health reform, small employers are eligible to purchase coverage for their employees through the new health insurance exchanges *and* to make a contribution toward the premium costs. The treatment of members of Congress and their staffs is similar. Moreover, it is the result of a Republican amendment to the health reform law (added during its Senate consideration); the amendment requires that members of Congress and their staffs enroll in plans offered through the exchanges, rather than continuing to enroll in plans available to all other federal employees through the Federal Employees Health Benefit Program. And the amendment's author, Sen. Charles Grassley (R-IA), has said he intended for the federal government to continue its employer contributions.

  In short, members and their staffs will be treated like the employees of the small businesses that use the exchanges — they will buy coverage through the exchanges, their employer will make a contribution toward the premium, and they will be *ineligible* for the premium subsidies that people buying coverage through the exchanges on their own (rather than through their employer) can get if their incomes are low enough. This isn't special treatment. There is no additional federal contribution here. In contrast, barring the federal government from making an employer contribution for coverage for members of Congress and their staffs, as Parker and other critics suggest or imply should be done, would single them out for special, but less favorable, treatment than all other employees. They would be the only individuals in the country whose employer is barred by law from making an employer contribution toward their health care costs.

- **A one-year delay in health reform's individual mandate would have serious adverse consequences.** Such a delay, which Parker joins health reform's opponents in calling for,

would add millions to the ranks of the uninsured and raise health insurance premiums. CBO estimates that it would increase the number of Americans who are uninsured by about 11 million in 2014, relative to current law, and would reduce health reform's coverage gains in 2014 by nearly 85 percent. CBO also finds that it would lead to higher insurance premiums in the individual market.[6] And it would create severe problems for the health insurance exchanges just as the open enrollment season is about to begin; insurance companies have said that the prices at which they have pledged to offer coverage through the exchanges would have to be withdrawn — and new, higher prices imposed instead — if the individual mandate is delayed.[7]

[6] Edwin Park, "Delaying the Individual Mandate Would Result in Millions More Uninsured and Higher Premiums," Center on Budget and Policy Priorities, September 12, 2013, http://www.cbpp.org/cms/index.cfm?fa=view&id=4012.

[7] Sarah Kliff, "Here's Why Obama Won't Delay the Individual Mandate," *Wonkblog*, September 24, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/09/24/heres-why-obama-wont-delay-the-individual-mandate/.