CATO INSTITUTE BRIEFING PAPERS

ObamaCare
A Bad Deal for Young Adults

by Aaron Yelowitz

No. 115 **November 9, 2009**

Executive Summary

One of the most interesting questions about the health care overhaul now moving through Congress is how it would affect young adults. That legislation would force most or all Americans to purchase health insurance (an "individual mandate") and would impose price controls on health insurance ("community rating") that would limit insurers' ability to offer lower premiums to low-risk enrollees.

Those provisions would drive premiums down for 55-year-olds but would drive them up for 25-year-olds—who are then implicitly subsidizing older adults. According to the Urban Institute, many young people could see their premiums double, whereas premiums for older adults could be cut in half.

Massachusetts benefits from another type of subsidy that props up its regime of mandates and price controls: large subsidies from the federal government. In contrast, the United States as a whole has no external party it can exploit to subsidize a nationwide Massachusetts-style health care overhaul—unless Congress finances that overhaul through additional deficit spending, which is really just another way of taxing the young to subsidize the old.

The irony is that Barack Obama won the presidency with 66 percent of the vote among adults aged 18 to 29. That's a larger share than any presidential candidate has won in decades. Yet his health care overhaul could impose its greatest burdens on young adults.

Aaron Yelowitz is an associate professor of economics at the University of Kentucky and an adjunct scholar at the Cato Institute.
This paper is based on a lecture delivered to the Undergraduate Economics Society at the University of Kentucky on October 1, 2009.

Introduction

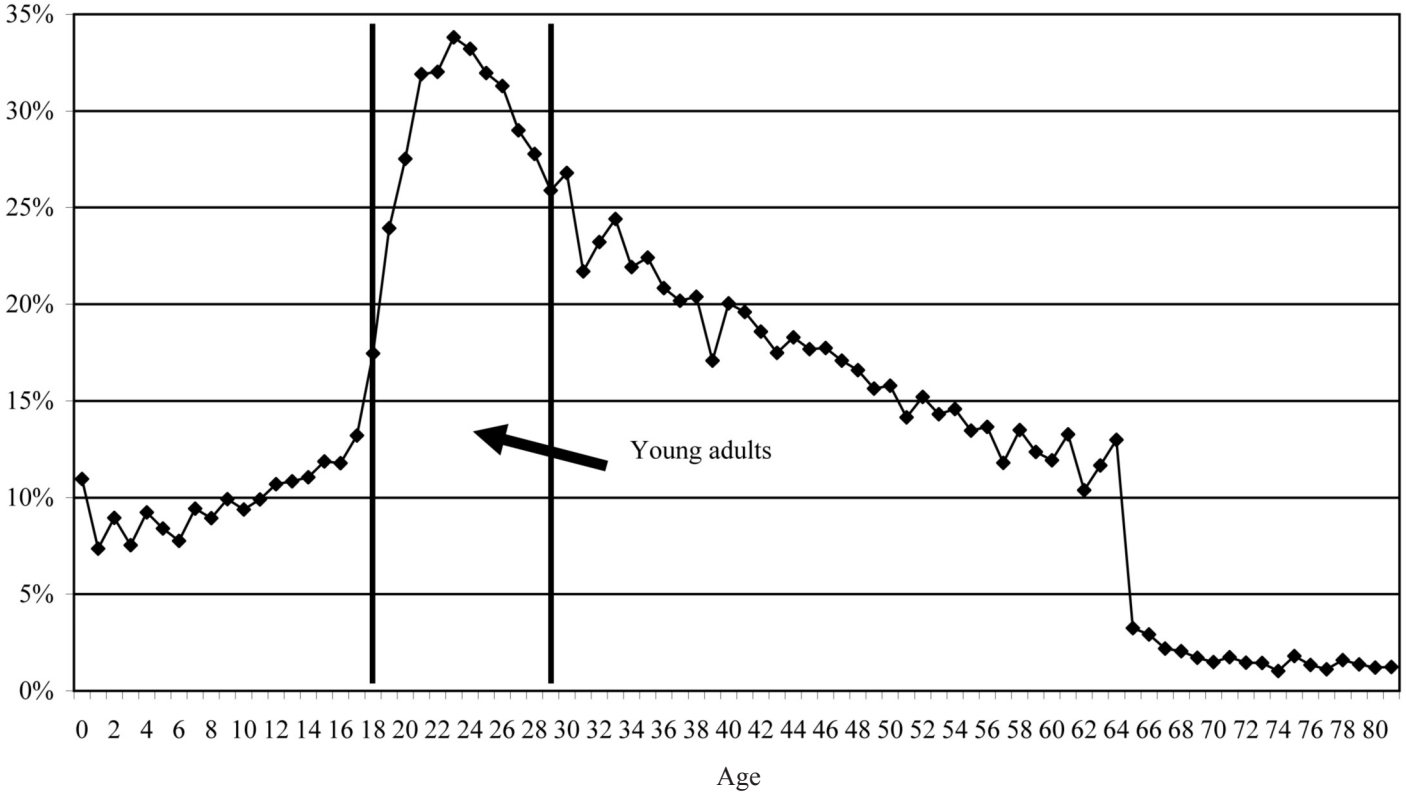
One of the most interesting dimensions of the health care overhaul now moving through Congress is how it would affect young adults. Young adults are more likely to be uninsured than either children or older adults. Related to that fact, young adults tend to need less medical care than older adults. Since all leading health overhaul bills would make health insurance compulsory for U.S. residents and would limit the ability of health insurance companies to offer discounts to low-risk enrollees, the legislation may force young adults to purchase health insurance at premiums higher than those they have already rejected.

At the same time, each version of the legislation would create new taxpayer subsidies to help low-income residents afford coverage. Since young adults also tend to have lower incomes than their elders, they may be eligible for those subsidies. It may be difficult to know whether, on balance, young adults would be better or worse off after we account for those subsidies and the higher premiums and taxes they would be forced to pay.

Young Adults Are Most Likely to Be Uninsured

The Census Bureau recently published its latest statistics on health insurance for the 2008 calendar year. It estimated, for instance, that approximately 46 million individuals in the United States lacked health insurance during 2008. That translates into 15.4 percent of the population.[1]

Figure 1
Percent Uninsured by Age, 2008 Calendar Year



Source: Author's tabulation of March 2009 Current Population Survey.

I've taken those census data and broken them out by age, as shown in Figure 1. A number of things are apparent. First, for children under age 18, around 10 percent are uninsured. Medicaid—government-provided insurance for low-income individuals—serves as a safety net for many children. In fact, there is strong evidence that Medicaid coverage "crowds-out" private insurance purchases for this age range.[2] It is also important to note that among the 10 percent of children who are uninsured, many are eligible for Medicaid but are not "in the system." In a study I did a number of years ago that focused on California, I found that virtually all uninsured children appeared to be eligible for Medicaid.[3] Many of these uninsured children are "conditionally covered"—to borrow a term from health economists David Cutler and Jonathan Gruber.[4] What this means is that many of these uninsured children could quickly enroll in Medicaid health insurance if they got sick, so they are de facto insured. As a consequence, I would interpret the 10-percent figure as being too high.

You can see that the percentage that is uninsured starts a steep upward climb as children transition into adulthood. Much of that increase surely comes from being too old to qualify for Medicaid or to qualify as a dependent on a parent's policy. That increase is also related to the fact that the primary avenue for adults under 65 to get health insurance is through employer-sponsored plans, and a larger proportion of young people are likely to work for employers that do not offer coverage. Part of the steep rise, as well, might come from the decision of healthy young adults to forgo health insurance coverage because they believe their money is better spent elsewhere. In fact, young people may avoid jobs that offer health benefits because they prefer jobs that offer higher pay.

Whether that is a well-calculated, economically rational, forward-looking choice, or a myopic decision by immature adults who think they're indestructible, is difficult to say. One's opinion on that probably is related to one's political leanings on whether the government should mandate insurance purchases. I should note, however, that many of the same older adults who disparagingly discuss the lack of health insurance coverage among young adults have, themselves, not purchased life insurance, disability insurance, or long-term care insurance—all key elements of responsible financial planning.

You can see that "uninsurance" rates peak at age 23 and 24. More than one third of all 23-year-olds were uninsured in 2008. In addition, young adults comprise 31 percent of all the uninsured but just 16.5 percent of the population. Insurance coverage steadily increases as a person ages due to marriage (and spousal coverage), finding better jobs that offer coverage, and declining health, which increases demand for insurance coverage. Insurance coverage more or less increases steadily until age 65 and then becomes nearly universal due to the Medicare program for the elderly.

What ObamaCare Means for Young Adults

I'd like to illustrate how the leading proposals before Congress might affect the insurance premiums of young adults in the individual health insurance market. The three terms to keep in mind are "community rating," "guaranteed issue," and "individual mandates."

Community rating means that you pay health insurance premiums not on the basis of your own health characteristics (e.g., smoking status, drinking behavior, weight, sex, and age) but on the average characteristics of the community. Guaranteed issue means an insurer must issue policies to all applicants whether they are healthy or unhealthy. The combination of the two essentially creates a price-control scheme where healthy 25-year-olds pay the same premiums as 55-year-old smokers if they buy insurance in the individual market. Proponents emphasize the benefits to the 55-year-olds, but 25-year-olds pay far more under this scheme and many would forgo insurance entirely.

Community rating and guaranteed issue create a price control scheme where healthy 25-year-olds pay the same premiums as 55-year-old smokers.

Young people may avoid jobs that offer health benefits because they prefer jobs that offer higher pay.

California vs. New York

To illustrate some of these effects, I did some digging on the website eHealthInsurance.com. I examined premiums and health plan offerings for 25-year-olds and 55-year-olds in California and New York. New York has community rating and guaranteed issue, whereas California has neither. Let me emphasize that I don't believe that all of the differences between the two states is due to community rating and guaranteed issue. But I suspect that a lot of what we observe here is due to those provisions.

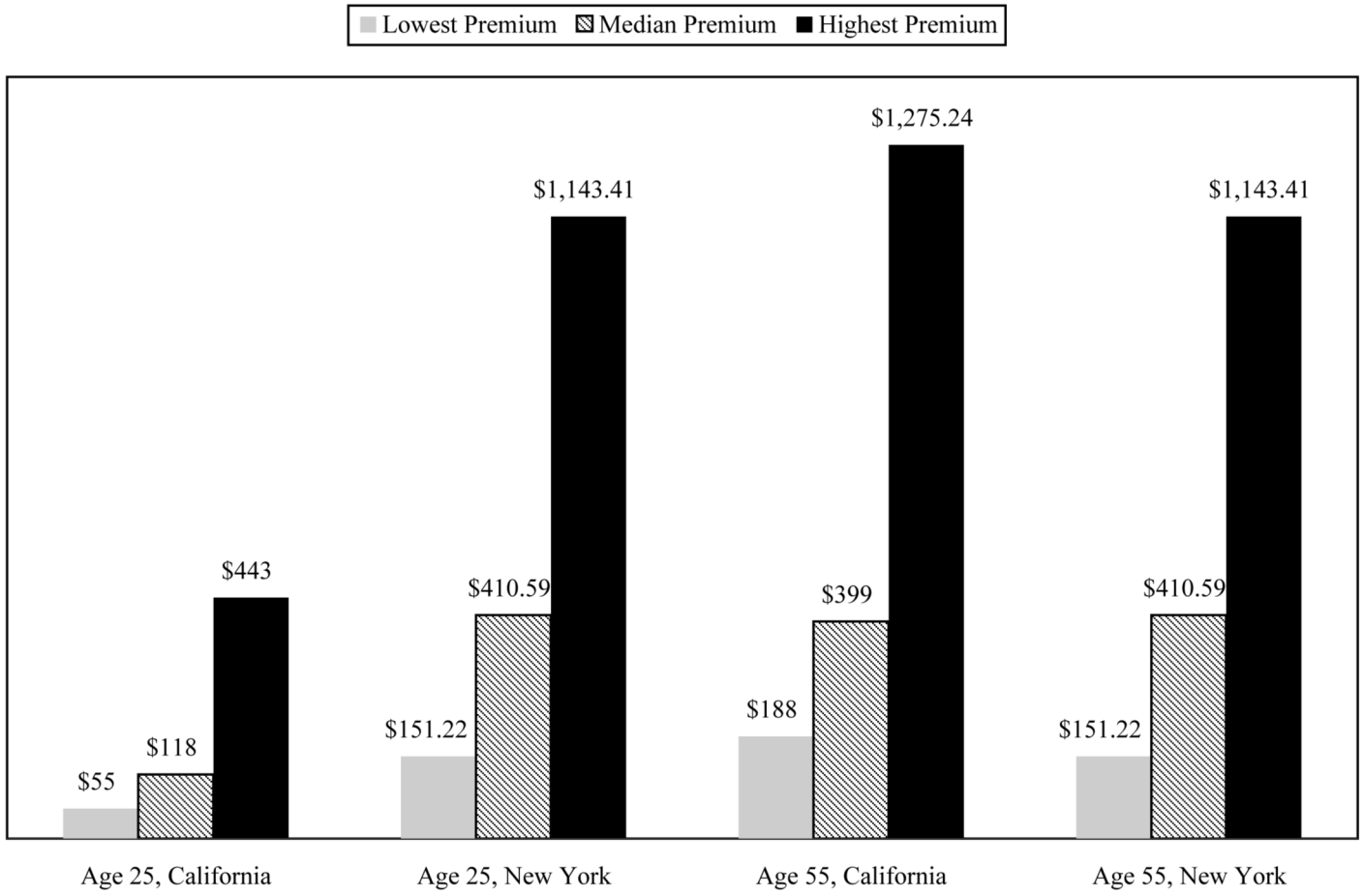
In Table 1 and Figure 2, you can see that in New York, regardless of whether you are young or old, a smoker or nonsmoker, or male or

Table 1
Individual Plan Premiums and Plan Choices, California vs. New York

	California No Community Rating or Guaranteed Issue (Zip Code 90201, Bell Gardens, Population 105,275)	**New York** Community Rating and Guaranteed Issue (Zip Code 11226, Brooklyn, Population 106,154)
	Age 25 (born September 28, 1984)	
Male, nonsmoker	107 plans offered Premiums: $55–$433/mo Median premium: $118/mo	12 plans offered Premiums: $151.22–$1143.41/mo
Female, nonsmoker	107 plans offered Premiums: $56–$433/mo Median premium: $133/mo	Median premium: $410.59/mo
Male, smoker	107 plans offered Premiums: $55–$433/mo Median premium: $123.19/mo	
Female, smoker	107 plans offered Premiums: $56–$461.75/mo Median premium: $133.91/mo	
	Age 55 (born September 28, 1954)	
Male, nonsmoker	112 plans offered Premiums: $188–$1275.24/mo Median premium: $399/mo	12 plans offered Premiums: $151.22–$1143.41/mo
Female, nonsmoker	112 plans offered Premiums: $204–$1267.61/mo Median premium: $399/mo	Median premium: $410.59/mo
Male, smoker	112 plans offered Premiums: $188–$1466.52/mo Median premium: $404/mo	
Female, smoker	112 plans offered Premiums: $204–$1457.75/mo Median premium: $411/mo	

Source: eHealthInsurance.com, September 28, 2009.

Figure 2
The Effect of Health-Insurance Price Controls: Premiums for Male Non-Smokers in California vs. New York



Source: eHealthInsurance.com, September 28, 2009.

female, you can find only 12 policies on eHealthInsurance, ranging from a plan that costs $151 per month and doesn't even cover hospitalizations to a plan that costs $1,143 per month. The median monthly premium for an individual plan in New York is more than $400 per month for a single person.

In California, more than 100 plans are available. You can see that the lowest premiums for 25-year-olds are under $60 per month. The $56-per-month Anthem Basic PPO 2500 plan, for example, is a high deductible plan offering an annual deductible of $2,500, a coinsurance rate of 20 percent, an annual out-of-pocket maximum of $5,000 (including the deductible) and a lifetime maximum spending limit of $5,000,000. Such a plan offers bona-fide insurance against low-probability, high-cost events (by covering all annual medical expenses that exceed $15,000), but creates strong incentives for the young adult to shop around for cost-effective medical treatment at lower levels of medical expenditure.

The median premium for young adults in California is around $120 per month— more than 70 percent lower than the median premium in New York. And you can see slight differences for 25-year-olds based on smoking status and sex. I suspect that the premiums for smokers aren't much higher because the adverse consequences of smoking don't catch up with you until you are much older than 25, so

the health of smokers at that age isn't much different than that of nonsmokers, and because private insurers expect you'll be covered by some employer by then, anyway.

Premiums increase considerably as a person ages. A 55-year-old in California faces a median premium of around $400 per month—which is eerily similar to the median premium in New York. It looks a whole lot like the plans in New York—which are unable to adjust premiums on the basis of a person's age—are pricing as if the typical applicant is a 55-year-old. There are likely many 25-year-olds in New York who would purchase insurance if it were priced appropriately based on their health risk, but who decide to go uninsured rather than to buy policies priced for a 55-year-old. Health economist Victor Fuchs writes that "unless accompanied by a strict mandate, these shifts may lead to an increase in the uninsured because some healthy individuals will discontinue their health insurance coverage in responses to higher premiums."[5] A study by the Manhattan Institute suggests these effects are important. Prior to community rating and guaranteed issue, 4.7 percent of non-elderly New Yorkers bought insurance in the private market; now that percentage is 0.2 percent, falling from around 752,000 enrollees to 34,000 enrollees.[6]

The Individual Mandate

Finally, how do "individual mandates," which attracted a lot of attention in George Stephanopoulos's interview with President Obama on ABC a few Sundays ago,[7] matter for the California/New York illustration?

The compulsory purchase of health insurance would drive up the premiums for 25-year-olds—who are then implicitly subsidizing older individuals.

An individual mandate forces young people to purchase insurance whether they want to or not. It was a centerpiece of Republican Mitt Romney's overhaul of health insurance in Massachusetts in 2006.[8] In many respects, the individual mandate is similar to the concept of the military draft, where young adults are forced to supply their labor to the military at a specified wage, even if that wage would be insufficient for them to volunteer. Indeed, the nonpartisan Congressional Budget Office has likened an individual mandate to the draft: "Federal mandates that apply to individuals as members of society are extremely rare. One example is the requirement that draft-age men register with the Selective Service System. The Congressional Budget Office is not aware of any others imposed by current federal law."[9]

Some have argued, like President Obama in that ABC interview, that mandating health insurance coverage is just like mandating car insurance. In my view, that analogy with current health care proposals falls flat, because one can choose to avoid the auto-insurance mandate by not owning a car—as many people do in large cities like New York, Boston, and Washington, D.C. It also falls flat because in most places, auto-insurance premiums are intimately related to accident risk—a 16-year male with a speeding ticket rightfully pays a lot more for the same insurance coverage than a 55-year female. The analogy would be a lot closer if nondrivers were forced to buy insurance and pay the exact same premiums as a 16-year-old.[10]

(Mal)Redistribution

The compulsory purchase of health insurance would drive premiums down for the 55-year-olds, because the community-rated price would be a weighted average of the expected claims of the 55-year-olds and the 25-year-olds. But it would drive up the premiums for 25-year-olds—who are then implicitly subsidizing older individuals. Fuchs recently made the same point: "This obviously reduces premiums for the sick, but, not so obviously, also increases premiums for the healthy."[11]

The eHealthInsurance example shows that this is far more than an abstract concern. Those provisions that purport to "level the playing field" through community rating, guaranteed issue, and individual mandates essentially redistribute income from young to old. The redistribution would be greatest if the price control scheme required old and young to pay the same premiums. But such redistribution would occur even if the ratio of "old" to "young" premiums were not one-to-one but some other ratio like 2-to-1 or 5-to-1. According to the Urban Institute, moving from a 5:1 age-rating band to a 1:1 ratio would essentially double the

premiums for those aged 18 to 24, from $1,884 to $3,744 annually, so that premiums for those aged 55 to 64 could fall by 60 percent (nearly $5,700).[12] The consulting firm Oliver Wyman finds that moving from a 5:1 ratio to a 3:1 ratio would increase premiums for the "youngest-healthiest third of individuals" by 35 percent. A 2:1 ratio would increase those premiums by 69 percent.[13] Any premium increases would be even higher for young adults who currently face no price controls.

The legislation would also create subsidies to help low- and moderate-income people comply with the mandate. According to the Urban Institute, more than 90 percent of adults aged 18 to 24, and more than 80 percent of those aged 24 to 34, would receive subsidies if they purchase health insurance through the new "exchanges."[14] The money for those subsidies has to come from somewhere, though. Presumably, some of it would come from young adults themselves in the form of higher taxes or the tax penalties imposed on those who do not purchase insurance. Fuchs explains:

> When eligibility for a subsidy includes those individuals and families with incomes up to 500 percent of the poverty level (approximately $110,000 for a family of 4) as in one Senate proposal, even the shifting of costs is an illusion. It is impossible to collect enough taxes from those with incomes of more than $110,000 to subsidize the poor and the sick and also help the numerous middle and upper middle income households. The latter will have to pay for their own health care one way or another.[15]

So the presence of subsidies does not necessarily mean that young adults would come out winners. Ironically, all the complexity may actually help the legislation pass Congress precisely because it obscures whom the legislation would tax.

Massachusetts benefits from another type of subsidy that props up its regime of mandates and price controls: large subsidies from the federal government. That creates a different kind of redistribution—from the other 49 states to the Commonwealth of Massachusetts. In fact, taxpayers in other states contribute as much to the cost of the recent reforms as Massachusetts' own government does.[16] In contrast, the United States as a whole has no external party it can exploit to subsidize a nationwide Massachusetts-style health care overhaul—unless Congress finances that overhaul through additional deficit spending, which is really just another way of taxing the young to subsidize the old.

Conclusion

It is ironic that Barack Obama won the presidency with 66 percent of the vote among voters age 18 to 29.[17] That's a larger share than any presidential candidate has won in decades. Yet his health care overhaul could impose its greatest burdens on the young.

Moving from a 5:1 age-rating band to a 1:1 ratio would essentially double the premiums for those aged 18 to 24 so that premiums for those aged 55 to 64 could fall by 60 percent.

Notes

1. See Carmen DeNavas-Walt et al., "Income, Poverty, and Health Insurance Coverage in the United States: 2008," U.S. Bureau of the Census, September 2009, p. 20, http://www.census.gov/prod/2009pubs/p60-236.pdf.

2. See Jonathan Gruber and Kosali Simon, "Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" *Journal of Health Economics* 27, no. 2 (March 2008): 201–17, http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8K-4R7NPWM-2&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&_docanchor=&view=c&_searchStrId=1033390560&_rerunOrigin=google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=df7db06db8bcb63d957a722fc992abc2.

3. Aaron Yelowitz, "The Cost of California's Health Insurance Act of 2003," Employment Policies Institute, October 2003, p. 7, http://www.epionline.org/studies/epi_Yelowitz_10-2003.pdf.

4. David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics* 111, no. 2 (May 1996): 392, http://www.economics.harvard.edu/faculty/

cutler/files/Does%20Public%20Insurance%20Crowd%20out%20Private%20Insurance.pdf.

5. Victor Fuchs, "Cost Shifting Does Not Reduce the Cost of Health Care," *Journal of the American Medical Association* 302, no. 9 (September 2, 2009): 999-1000, http://jama.ama-assn.org/cgi/content/short/302/9/999.

6. See Stephen T. Parente and Tarren Bragdon, "Healthier Choice: An Examination of Market-Based Reforms for New York's Uninsured," Manhattan Institute, September 2009, http://www.manhattan-institute.org/html/mpr_10.htm. For a more general overview of state experiences, see Peter Suderman, "The Lesson of State Health-Care Reforms," *Wall Street Journal*, October 7, 2009, http://online.wsj.com/article/SB20001424052748703298004574455560453947646.html.

7. See George Stephanopoulos, "Obama: Mandate Is Not a Tax," George's Bottom Line (blog), September 20, 2009, http://blogs.abcnews.com/george/2009/09/obama-mandate-is-not-a-tax .html.

8. See Michael F. Cannon, "All the President's Mandates: Compulsory Health Insurance *Is* a Government Takeover," Cato Institute Briefing Paper no. 114, September 23, 2009, http://www.cato.org/pubs/bp/bp114.pdf.

9. U.S. Congressional Budget Office, "The Budgetary Treatment of an Individual Mandate to Buy Health Insurance," CBO Memorandum, August 1994, p. 1, http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf.

10. For more on the analogy between health-insurance mandates and auto-insurance mandates, see David A. Hyman, "The Massachusetts Health Plan: The Good, the Bad, and the Ugly," Cato Institute Policy Analysis no. 595, June 28, 2007, http://www.cato.org/pubs/pas/pa-595.pdf.

11. Fuchs, pp. 999–1000.

12. Linda Blumberg et al., "Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs and Household Financial Burdens," Urban Institute/Robert Wood Johnson Foundation, October 07, 2009, http://www.rwjf.org/files/research/49470.pdf.

13. Oliver Wyman, "Impact of Changing Age Rating Bands in 'America's Healthy Future Act of 2009,'" September 28, 2009, p. 1, http://www.oliverwyman.com/ow/pdf_files/OW_En_HLS_PUBL_2009_AgeRatingAnalysisFinal.pdf.

14. Blumberg et al., p. 8.

15. Fuchs, pp. 999–1000.

16. See Alan G. Raymond, "Massachusetts Health Reform: The Myth of Uncontrolled Costs," Massachusetts Taxpayers Foundation, May 2009, http://www.masstaxpayers.org/files/Healthcare-NT.pdf.

17. Scott Keeter et al., "Young Voters in the 2008 Election, Pew Research Center for the People and the Press, November 12, 2008, http://pewresearch.org/pubs/1031/young-voters-in-the-2008-election.

Published by the Cato Institute, Cato Briefing Papers is a regular series evaluating government policies and offering proposals for reform. Nothing in Cato Briefing Papers should be construed as necessarily reflecting the views of the Cato Institute or as an attempt to aid or hinder the passage of any bill before Congress.

CATO INSTITUTE

Contact the Cato Institute for reprint permission. Additional copies of Cato Briefing Papers are $2.00 each ($1.00 in bulk). To order, or for a complete listing of available studies, write the Cato Institute, 1000 Massachusetts Avenue, N.W., Washington, D.C. 20001. (202) 842-0200 FAX (202) 842-3490.