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Ignore the online exchange glitches

Chris Bassil | October 29, 2013

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It is by now no secret that the federal government's rollout of its online health insurance exchange market—one of the key provisions of President Obama's Affordable Care Act—has been nothing short of a total disaster. Pundits initially diagnosed the problem as high demand leading to heavy web traffic. The fact that visits to the site have dropped 88 percent and it remains inoperable, however, suggests that the problems are largely structural.

Opponents of the ACA have unsurprisingly seized on the glitches as examples of the government's ineptitude. "The very people who claim they are sufficiently competent to run health care, which constitutes about one-sixth of the nation's economy," argues Cal Thomas of FoxNews.com, "can't manage to launch a workable website, even though they had at least three years to set it up." Sen. Pat Roberts of Kansas is even calling for the resignation of Health and Human Services Secretary Kathleen Sebelius, on grounds of "gross incompetence." But people like Thomas and Sen. Roberts, who believe the glitches mark the downfall of the ACA, are likely to find themselves disappointed when such a future fails to materialize.

Now, the glitches are definitely a problem with the ACA. They are not, however, the only problem, and in the eyes of the law's opponents they are probably not even the biggest one. On top of that, they are probably going to be fixed. After all, it seems highly unlikely that President Obama will allow something like a substandard rollout to entirely undo his signature piece of legislation. In light of all that, those who oppose the ACA might consider refocusing their criticisms on areas of lasting, structural concern.

Take, for example, the effect that certain stipulations of the health care reforms are likely to have on prices within the medical environment. I've written about Comments (0) before, albeit within a different context, but in any case we should strive to understand them as more than just arbitrary sums that sellers set to fatten their wallets. They are supposed to work as signals that reflect important information concerning the state of resources as well as the nature of consumer preferences within the economy. As many citizens are well aware, however, prices within the health care system are already woefully detached from reality. Stan Liebowitz of the Cato Institute argues that this is caused by our insurance-based third-party payment system. "The major culprit," he says, "is…the removal of the patient as a major participant in the financial and

medical choices that are currently being made by others in the name of the patient." By reinforcing this structure, the ACA might further cement a mechanism that could contribute to rising costs. Furthermore, its community rating and guaranteed issue provisions, although they are noble in intent, could also have negative consequences for controlling costs and effectively allocating scarce resources.

In their 1963 "Medicine and the State," a study of the advantages and shortcomings of the socialized medical systems of the world at that time, Matthew J. Lynch and Stanley S. Raphael make a related criticism of centrally planned medical systems. "Medicine has specific problems in itself in that there can be no planning for discovery," the two explain. "A planner of 20 years ago…would have included…a large number of beds for the tuberculous, and such provision would have seemed rational and necessary. However, the discovery of chemotherapeutic agents, led by streptomycin, has virtually emptied our chest sanatoria." The point that Lynch and Raphael are making is that a planned medical system, which prepares for the future through bureaucratic forecasting rather than capital markets and the price system, may be more susceptible to certain kinds of errors than its more spontaneous capitalist counterparts.

The planned system also suffers from a consequent rigidity that could make adjusting to unforeseen developments such as medical discoveries more difficult than it might be under a decentralized system. "The chance discovery of an agent, made by anyone in scores of intellectual disciplines related or unrelated to medicine," write Lynch and Raphael in conclusion, "might well negate years of otherwise rational medical planning." The ACA itself obviously does not provide for a centrally planned medical system, but any potential to further undermine the price system within the American health care system could eventually lead us to suffer some of the same shortcomings.

A supporter of the ACA might object to the arguments presented here for political, economic or even moral reasons. They might argue that the issues with centrally planned medical systems are irrelevant to the ACA, that repealing the ACA will not solve the problems with the existing third-party payment structure or even that our moral obligations to provide health care to all Americans far outweigh any economic inefficiencies that we would accept in exchange. All of these are valid rejoinders and are open for debate. The point here, though, is simply that opponents of the ACA would do well to focus their efforts on what they perceive to be the long-lasting medical and economic implications of the reform, rather than on the ephemeral issues with the online exchange glitches.