

## Testimony



# The Affordable Care Act after Five Years: Wasted Money and Broken Promises

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\*The views expressed here are my own and not those of the American Action Forum, the Partnership for the Future of Medicare or the Center for Health & Economy. I thank Brittany La Couture for her assistance.

Chairman Hatch, Ranking Member Wyden, and members of the committee thank you for the privilege of appearing to discuss the Patient Protection and Affordable Care Act (“ACA”) on the 5<sup>th</sup> anniversary of its enactment. This milestone is the perfect time to more closely examine the law, the promises that were made to gain support for its passage, and, most importantly, how many of those promises have been kept.

The main promise that we heard repeated over and over again was that the ACA would provide universal access to affordable coverage of high-quality health care. In these remarks I will discuss (1) coverage, (2) affordability, (3) quality, and (4) access to care under the ACA.

The ACA has been riddled with wasted money and broken promises. It has proven to be poor growth policy, red-ink budget policy, flawed insurance policy, and poor health care policy. Instead of growth, it has contributed to a mediocre recovery. Instead of fiscal responsibility, it has exacerbated the red ink that plagues the government. Instead of universal coverage for the uninsured, the retention of valued policies and lower premiums, it has produced spotty, uneven coverage expansions, the forcible loss of valued policies and higher premiums for all. And instead of bending the cost curve and raising quality, it has delivered limited access to doctors and the loss of preferred providers.

## Background

The ACA was first passed in the Senate in 2009 on a partisan vote on Christmas Eve, and subsequently through the House in a similarly partisan fashion. The American public was, and remains, deeply divided over the law. Prior to passage and after enactment, President Obama and the ACA’s supporters made numerous and oft-repeated promises about all the ways in which the ACA would improve Americans’ lives by allowing for universal coverage while simultaneously lowering the cost and increasing the quality of care. Instead, the law has produced \$43.8 billion in [regulatory burden](#), 163.5 million annual paperwork hours. [1] Five years later it is clear that the law cannot deliver on those promises.

## Universal Coverage

One of the main selling points of the ACA was that all Americans, including 46.3 million uninsured individuals, would be guaranteed access to insurance coverage either through their employer or current provider, the private market health insurance exchanges created under the law, or Medicaid and CHIP. Yet five years later, over 35 million Americans are still uninsured.[ii]

Prior to passage of the ACA, most Americans had insurance plans that they liked, typically through an employer-sponsored plan. President Obama assured them on at least 37 separate occasions that “if you like your health care plan, you can keep it.”<sup>[iii]</sup> As the law went into effect in 2014, however, 4.7 million Americans lost their insurance coverage.<sup>[iv]</sup> Many were able to re-enroll in new plans, but often with higher premiums and new provider networks.

Another feature Americans were promised was an easy to use online health insurance portal. About one-third of the states established their own health care exchanges and websites with varying degrees of failure during the first year. Some states were forced to completely rebuild their exchanges, others bought software developed by more successful states, and two states gave up completely and relinquished their exchange to the Department of Health and Human Services (HHS).<sup>[v]</sup>

Speaking about the federal website operated by HHS, President Obama promised, “Now, ultimately, this website, [healthcare.gov](http://healthcare.gov), will be the easiest way to shop for and buy these new plans, because you can see all these plans right next to each other and compare prices and see what kind of coverage it provides.”<sup>[vi]</sup> This statement also turned out to be patently false—software glitches, incompatibility between Medicaid and exchange software, and miscommunication between the exchange and insurers left millions of Americans frustrated, confused, and without insurance coverage at the end of the first open enrollment period. This disaster of a website cost the American taxpayer nearly \$840 million.<sup>[vii]</sup> The second year open enrollment was slightly smoother, but has been extended to allow people to make changes once they realize how the ACA affected their tax liability in 2014.<sup>[viii]</sup> The fact that five years after the law was passed people still do not understand what it means for them is a striking indictment.

Low-income Americans who cannot afford to purchase individual market insurance plans were promised free access through Medicaid. However, the Medicaid program that the ACA actually created is not as targeted or complete as supporters promised it would be. In 2012, the U.S. Supreme Court ruled that the ACA’s Medicaid expansion was unconstitutional and that states cannot be forced to participate. As a result, Medicaid eligibility varies by state and in some places leaves low-income Americans with less support than higher-income individuals.<sup>[ix]</sup> The enhanced payment structure of the ACA Medicaid expansion causes counter-intuitive incentives for states to try to enroll these newly eligible individuals—those with more resources—rather than focusing on helping the neediest among us.

As a result of new coverage restrictions in the employer market, eligibility limitations in the individual market, and chaotic Medicaid eligibility standards, adults below the poverty line and children are falling through the cracks. Perverse incentives created by the ACA have caused phenomena like the [Family Glitch](#), leaving millions of individuals and families unable to enroll in affordable health insurance.<sup>[x]</sup>

## **Affordability**

During passage and implementation of the ACA, Americans heard many promises about “bending the cost curve” and “helping middle-class families” by reducing the cost of insurance thousands of dollars a year.<sup>[xi]</sup> But as it has played out, the ACA has not reduced the cost of health insurance for the federal government, states, businesses, or American families.

Before the ACA reached his desk, President Obama promised “I will not sign a plan that adds one dime to our deficits – either now or in the future.”<sup>[xii]</sup> The ACA, however, was riddled with budget gimmicks that hid the fact that it did not add up over the long term.

The Secretary of HHS promised that “[t]he state doesn’t pay” for the ACA’s Medicaid expansion, but that is simply untrue.<sup>[xiii]</sup> States are currently being held hostage by maintenance-of-effort provisions that force state Medicaid agencies to continue paying for temporary programs that have long since expired. Next year, most states will begin paying for a portion of Medicaid expansion to new populations. They will also become responsible for funding and maintaining their own exchanges if they do not use the federal platform.

In 2009, employers were told “cost savings could be as much as \$3,000 less per employer [...]”<sup>[xiv]</sup> It is unclear whether and how much employers have saved as a result of the law, but many employers generated savings by offering less generous plans with more restrictive networks. Some employers also dropped dependent coverage to lessen the burden of providing ACA-compliant coverage for their employees’ families. For some, these efforts still barely covered the new administrative costs of the law.

There is also evidence that when the employer mandate is actually enforced (it is one of a number of provisions the administration has unilaterally decided to delay), many employers will face tax penalties as well. [Employers will have to pay](#) a \$2,000 penalty per employee not offered coverage above the first thirty, and an even greater penalty will be assessed for offering non-compliant coverage.<sup>[xv]</sup>

The president promised the ACA would “cut the cost of a typical family’s health insurance premium by up to \$2,500 a year.”<sup>[xvi]</sup> In 2014, average individual market premiums increased by 50 percent, and they went up another 4 percent in 2015 with the greatest changes seen in low-cost plans.<sup>[xvii]</sup> These increases are attributable, among other things, to market uncertainty caused by the law, guaranteed issue and community rating requirements, and the mandatory inclusion of “essential health benefits.”

There are plenty of other [ways premiums could increase](#) besides the actual cost of the plan going up.<sup>[xviii]</sup> A new job, a raise, marriage, moving or being auto-enrolled in an exchange plan are all ways that the mere structure of the ACA could effectively increase the cost of private market insurance. Some of the greatest premium increases, though, hit individuals and families who did not purchase the benchmark silver plan—if the benchmark decreased, so did subsidies, and an individual or family’s share of the premium for any other plan proportionately increased. [This is what happened](#) to enrollees in non-benchmark plans in 361 of 461 rating areas where 2015 data was available, and for individuals and families in 234 of these rating areas, switching plans to the new benchmark would mean leaving their current insurance carrier and provider network, causing discontinuity of care.<sup>[xix]</sup>

Americans’ out-of-pocket expenses are also increasing. In 2014 the average deductible for a bronze plan was \$5,081—42 percent higher than in comparable group market plans.<sup>[xx]</sup> Insurers are using large increases in deductibles to offset slower premium growth caused by competition in the exchanges. Before the ACA, average annual deductible growth was about 5 percent, but it spiked to 10 percent as the ACA was implemented, though it is now beginning to settle.

Just as the cost of insurance has increased under the ACA, the cost of not having comprehensive insurance has increased. Individuals who choose not to be insured or purchase only catastrophic coverage are now subject to an [individual mandate penalty](#) that will increase annually as a percentage of the individual’s income.<sup>[xxi]</sup> There is hardly anything less “affordable” than paying for something you don’t have.

## Quality

One of the first promises made by President Obama in his rush to get health reform passed was “I will protect Medicare.”<sup>[xxii]</sup> Yet the ACA makes substantial cuts to the Medicare program and uses Medicare money to

fund the law's subsidies for non-seniors, while simultaneously being used on paper to delay the Medicare trust fund's insolvency.

Cuts to Medicare mean seniors will have less access to the doctors and care they need, yet the law does [next to nothing](#) to improve the quality or efficiency of the Medicare program.[\[xxiii\]](#) Voters were also told that “the law prohibits IPAB [the Independent Payment and Advisory Board] from rationing health care.” Since that statement was made some supporters of the law have acknowledged that some rationing in Medicare is inevitable, while then-Secretary Sebelius suggested that CMS will avoid this limitation through its ability to define “rationing.”[\[xxiv\]](#)

“The final bill [...will] make sure that people are getting the care they need and the checkups they need and the screenings they need before they get sick—which will save all of us money and reduce pressures on emergency rooms.”[\[xxv\]](#) We were told that the Medicaid expansion would work by using preventive care to increase overall health and decrease utilization of emergency rooms. Yet there is evidence from studies done in Oregon and the RAND Health Insurance Survey that show that Medicaid coverage does not increase overall health or reduce [emergency room use](#).[\[xxvi\]](#) In fact, Medicaid coverage arguably leads to the worst health outcomes because reimbursement rates for providers are so low that it makes non-emergency room care virtually inaccessible. Yet the expansion of Medicaid will cost American taxpayers around \$33.5 billion between 2014 and 2020, \$12 billion of which will be paid by the states for administrative costs.[\[xxvii\]](#)

## Access to Care

Medicare and Medicaid enrollees are not the only ones whose access to quality health care has been impeded by the ACA. Individuals and families in individual and group market plans have seen networks constrict to keep premiums low.

“If you like your doctor, you will be able to keep your doctor” is another promise that has not been kept. The ACA restricts insurance plans' ability to control costs in a number of ways, leaving narrow provider networks as one of the few cost control mechanisms still available to insurers. As a result insurers are creating [narrow networks](#) where only a few providers are covered, and those providers are sent high volumes of patients at lower reimbursement rates.[\[xxviii\]](#) While having the choice of narrow network plan options is not a bad thing for consumers, the ACA incentivizes this type of plan structure to the exclusion of more robust provider options. Other studies indicate that many providers and hospitals have decided not to participate in one or more ACA exchange plans because of the extremely low reimbursement rates. Many sole practitioners and small physician groups have similarly indicated an intention to switch to cash-only practices or even enter early retirement to avoid the burdensome new mandates and financial obligations imposed on them by the ACA, further limiting patients' choice of providers and driving up wait times in the offices where enrollees are being accepted.

As a result of these incentives, individuals may find that while they have insurance coverage and access to doctors and hospitals, they may have access to an in-network hospital but not have coverage for the doctors inside it. Likewise, individuals may have access to an in-network doctor, but none of the hospitals in which he or she operates.[\[xxix\]](#) This is hardly access to care.

## Conclusion

The past five years have revealed how the promises made by President Obama and the ACA's supporters, however well-intentioned, do not match the reality of the law. The number and scope of broken promises around the ACA show that the current law is not what Americans wanted and is not the kind of reform American health

care needed. With this clearer understanding of the past, perhaps we can make the most of lessons learned and start moving towards more effective refo

<http://americanactionforum.org/week-in-regulation/30-billion-in-regulatory-costs>