THE FAILURES OF OBAMACARE: HARMFUL EFFECTS AND BROKEN PROMISES

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CONTENTS

THE FAILURES OF OBAMACARE: HARMFUL EFFECTS AND BROKEN PROMISES

TUESDAY, JANUARY 24, 2017

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:00 a.m., in Room 1334, Longworth House Office Building, Hon. Diane Black [interim chair of the committee] presiding.

Present: Representatives Black, Rokita, McClintock, Woodall, Sanford, Grothman, Palmer, Westerman, Johnson, Lewis, Bergman, Faso, Smucker, Gaetz, Arrington, Ferguson, Yarmuth, Lujan Grisham, Moulton, Higgins, DelBene, Wasserman Schultz, Boyle, Khanna, Jayapal, and Carbajal.

Interim Chair BLACK. Welcome panelists. This hearing will focus on the failures of Obamacare, its harmful effects, and broken promises. We are having this hearing today to discuss the damage that Obamacare has done to patients, medicine, workers, and our economy. And after 6 years, no one can dispute that this law has been nothing but a series of broken promises. Patients have lost their doctors and their insurance plans, premiums and deductibles have skyrocketed, and small businesses have been forced to reduce their benefits and wages or put off hiring of new workers altogether.

Obamacare was sold as a solution that would tackle one of the biggest problems in our healthcare system, the rising cost of insurance. In fact, President Obama promised this law would lower premiums by $2,500 a year for an average family. In reality, the complete opposite has been true. Average family premiums have risen by $4,300 and deductibles have risen by 60 percent in the employer-sponsored market.

For working folks across the country, more money out of their paychecks just to pay for health care makes life much harder. And what are Americans getting in exchange for these higher costs? Well, not much. Twenty million Americans have said that Obamacare just is not worth the cost or the trouble, choosing to pay a fine or to file an exemption instead. And for those who do have insurance, access to care has not improved.

So, while our friends on the other side of the aisle may claim that Obamacare is increasing the number of people covered, the question we would ask is what kind of care are they receiving? For those pushed into a broken Medicaid system who are having to navigate the complicated Obamacare bureaucracy, they are not receiving the very best health care our Nation has to offer. And as a nurse for over 40 years I know that we can do better.

Now I am sure the Democrats will cite the CBO study from last week that discusses what happens to coverage numbers if we repeal Obamacare. But what the CBO study ignores is any potential Republican ideas to reform the health care and expand access. And access to quality care is what so many people in my home State of Tennessee are lacking under this law.

Let me give you an example. In our State, 28,000 people lost their coverage on a single day when Access Tennessee, which is a program that helps those that are in the risk pool, lapsed after the Obama administration decreed that it ran afoul of the Federal Government's top down requirements. Yes, in one day 28,000 people lost their insurance. This happened despite President Obama's claim that, "If you like your plan you can keep it."

Now, premiums in our State are rising by an average of 63 percent, and three-fourths of our counties only have one coverage option to choose from on the Obamacare Exchange. In five other States around the county, Alabama, Alaska, Oklahoma, South Carolina, and Wyoming patients only have one insurer in the marketplace to choose from. And if you only have one choice, then you are probably not going to find a plan that best fits the unique needs of you and your family.

And for folks not living in the city or suburbs, Obamacare has been especially harmful. Since 2010, eight rural hospitals have been forced to close, further restricting choice and access. But the good news is that it does not have to be this way. We do not have to accept Obamacare failures and broken promises. And that is why our House and Senate have worked together in this new Congress to pass a budget that begins the process to repeal Obamacare and stop the damage that it is causing.

And in the coming weeks, we will consider legislation that will roll back some of the worst aspects of this law, and begin laying a foundation for a patient-centered healthcare system. And we already have great ideas to build on. My Tennessee colleague whom I am very proud of, Congressman Phil Roe, a physician, has introduced the American Health Care Reform Act. And Congressman Tom Price has offered the Empowering Patients First Act.

And last year, our House Republicans put forward a better way, 37 pages of reform proposals that we will act on this year. So, we have got a lot of hard work ahead of us and today's hearing will be another critical step forward. And that is why I am glad that today we will welcome some witnesses and get their ideas for improving health care for the American people.

First, we have Grace-Marie Turner who is the President of the Galen Institute. Next, we have Dr. Robert Book, a Senior Director of the Health Systems Innovation Network. We also have Edmund Haislmaier, a Senior Research Fellow in Health Policy Studies at the Heritage Foundation. And finally, we have Dr. Linda Blumberg, a Senior Fellow at Urban Institute's Health Policy Center.

Thank you all for taking time out of your busy schedules today to join us for discussion. Everyone on this committee looks forward to your knowledge and insight on what we can do to improve America's healthcare system. We are committed to rolling back the damage caused by Obamacare to achieving true healthcare reform by

bringing the best minds together, which we believe we have done today. And always remembering to put patients ahead of Washington's bureaucracy we will succeed. Thank you, and with that I yield to the ranking member, Mr. Yarmuth.

[The prepared statement of Interim Chair Black follows:]

Opening Statement – Obamacare Hearing
HBC Chairman Diane Black
Tuesday, January 24, 2017

Good morning, and thank you, everyone for being here.

We're having this hearing today to discuss the damage that Obamacare has done to patients, medicine, workers, and our economy. After six years, no one can dispute that this law has been nothing but a series of broken promises. Patients have lost their doctors and their insurance plans, premiums and deductibles have skyrocketed, and small businesses have been forced to reduce benefits and wages, or put off hiring new workers altogether.

Obamacare was sold as a solution that would tackle one of the biggest problems in our health care system: the rising cost of insurance. In fact, President Obama promised this law would lower premiums by $2,500 a year for the average family. In reality, the complete opposite has been true. Average family premiums have risen by $4,300 and deductibles have risen 60 percent in the employer-sponsored market. For working folks across America, more money out of their paychecks just to pay for health care makes life that much harder.

And what are Americans getting in exchange for higher costs? Well, not much. 20 million Americans have said that Obamacare just isn't worth the cost and trouble – choosing to pay the fine or file an exemption instead. And for those who do have insurance, access to care hasn't improved. So, while our friends on the other side of the aisle may claim Obamacare is increasing the number of people covered, the question we should be asking is "what kind of care are they receiving?" For those pushed into a broken Medicaid system or having to navigate the complicated Obamacare bureaucracy, they're not receiving the very best health care our nation has to offer. As a nurse for over 40 years, I know we can do better.

Now I'm sure that Democrats will cite the CBO study from last week that discusses what happens to coverage numbers if we repeal Obamacare. But what the CBO study ignores is any potential Republican ideas to reform health care and expand access – and access to quality care is what so many people in my home state of Tennessee are lacking today under this law.

In our state, 28,000 people lost coverage on a single day when the CoverTN program lapsed after the Obama Administration decreed that it ran afoul of the federal government's top down requirements. This happened despite President Obama claiming that "if you like your plan, you can keep it." Now, premiums in our state are rising by an average of 63 percent, and three-fourths of our counties only have one coverage option to choose from on the Obamacare exchange. In five other states around the country – Alabama, Alaska, Oklahoma, South Carolina, and Wyoming – patients only have one insurer in the marketplace to choose from. If you only have one choice, then you're probably not going to find the plan that best fits the unique needs of you and your family. And for folks not living in the city or suburbs, Obamacare has been especially harmful. Since 2010, 80 rural hospitals have been forced to close, further restricting choice and access.

But the good news is that it doesn't have to be this way. We don't have to accept Obamacare's failures and broken promises. That's why the House and Senate have worked together in this new Congress to pass a budget that begins the process to repeal Obamacare and stop the damage it's causing. In the

coming weeks, we'll consider legislation that will roll back some of the worst aspects of this law and begin laying the foundation for patient-centered health care. And we already have great ideas to build on. My Tennessee colleague, Congressman Phil Roe introduced the American Health Care Reform Act and Congressman Tom Price offered the Empowering Patients First Act. And last year, House Republicans put forth "A Better Way" – 37 pages of reform proposals that we will act on this year.

So, we've got a lot of hard work ahead of us and today's hearing will be another crucial step forward. That's why I'm so glad to welcome today's witnesses and their ideas for improving health care for the American people. First, we have Grace-Marie Turner, who is president of the Galen Institute. Next, we have Dr. Robert Book, a senior director at the Health Systems Innovation Network. We also have Edmund Haislmaier, a senior research fellow in health policy studies at The Heritage Foundation. Finally, we have Dr. Linda Blumberg, a senior fellow at the Urban Institute's Health Policy Center.

Thank you all for taking time today out of your busy schedules to join our discussion. Everyone on this committee looks forward to your knowledge and insight on what we can do to improve America's health care system. We are committed to rolling back the damage caused by Obamacare to achieve true health care reform. By bringing the best minds together and always remembering to put patients ahead of the Washington bureaucracy, we will succeed.

Thank you, and with that, I yield to the ranking member, Mr. Yarmuth.

Mr. YARMUTH. Thank you, Chairman Black. I want to join the chairman in welcoming our witnesses this morning. My Democratic colleagues and I are confused why the majority did not hold this hearing before rushing through a budget to repeal the Affordable Care Act and defund Planned Parenthood. However, we will use it as an opportunity to set the record straight about a number of things.

The American people have made it clear they do not support repealing the Affordable Care Act. They rightly fear losing access to quality and affordable care, and know the consequences would be disastrous.

Over the weekend, millions of people across the Nation rallied against the dangerous policies of the new administration, including threats to our health care. I know every one of my Democratic colleagues has heard from people whose lives have been transformed or saved because of the ACA. And there are hundreds of thousands of constituents in every Congressional district across the country who have benefitted from the law.

Let me tell you about one of them, Steve Riggert, a constituent who recently wrote to me. Steve's daughter, Anna, was diagnosed with chronic pancreatitis at the age of 12 and has been hospitalized more than two-dozen times over the past 10 years for a variety of reasons. From the beginning, Steve knew that Anna's serious medical problems would make getting health insurance difficult once she transitioned out of her parents' policy.

When the ACA was enacted, he was immensely relieved that she could always get coverage even though she had a pre-existing condition. But the Republican plan to repeal the ACA has now left Steve feeling, and these are his words, "helpless," "petrified," and "literally losing sleep." At age 64 and recently diagnosed with pancreatic cancer himself, he fears that he will not be able to help his daughter. To quote his letter, "Repeal of all aspects of the Affordable Care Act would place everything I have worked for and those I care about in jeopardy."

Steve is one of many. There are a lot more. In fact, the Congressional Budget Office, as Chairman Black mentioned, estimates repealing the major coverage provisions will cause 32 million people to lose health insurance. In the individual market, eventually, three-quarters of the U.S. population will have no access to an insurer, and premiums will double. But that is just the beginning.

Under a full repeal of the law, insurance companies will once again be able to deny coverage based on pre-existing medical conditions, people with job-based insurance will face annual and lifetime limits on coverage and copays for preventive services, and seniors in Medicare will pay more for prescription drugs. Hospitals caution that repeal will increase uncompensated care costs, likely leading to service cuts, layoffs, or higher prices for everyone. Outside experts say repeal will result in 3 million lost jobs in 2019 alone. Republican governors are pleading with the Republican Congressional leadership not to go through with this repeal. Despite these warnings and despite the grave consequences, here we are.

I expect my Republican colleagues today, as Chairman Black's already done, will wave around bills and claim they have a plan to replace the ACA. They do not. The reality is that in nearly 7 years,

Republicans have yet to introduce a single bill that has the support of the majority of their conference, or comes close to matching the ACA's record of success.

We will hear a lot of ideas today from my colleagues on the other side of the aisle. And I would wager that at the end of the day, these ideas will also fail to garner the majority of their conference, or come close to a plan that matches the ACA's record of success. They will also not comprise a plan that any American citizen could infer how it will change their lives or affect their lives. I will keep an open mind. I will ask questions and I look forward to hearing more from our witnesses. And I yield back the balance of my time.

[The prepared statement of Mr. Yarmuth follows:]

Ranking Member Yarmuth's Opening Statement for Today's Budget Committee Hearing on the Affordable Care Act

Jan 24, 2017

Washington, DC – *Today, Kentucky Congressman John Yarmuth, Ranking Member of the House Budget Committee, delivered opening remarks at a hearing on the Affordable Care Act. Below are his remarks as prepared for delivery:*

Thank you Chairman Black. I want to join the Chairman in welcoming all of our witnesses this morning. My Democratic colleagues and I are confused why the Majority did not hold this hearing before rushing through a budget to repeal the Affordable Care Act and defund Planned Parenthood; however, we will use it as an opportunity to set the record straight about a number of things.

The American people have made it clear they do not support repealing the Affordable Care Act. They, rightly, fear losing access to quality and affordable health care and know the consequences would be disastrous. Over the weekend, millions of people across the nation rallied against the dangerous policies of the new Administration—including threats to our health care. I know every one of my Democratic colleagues has heard from people whose lives have been transformed or saved because of the ACA, and there are hundreds of thousands of constituents in every Congressional District across the country who have benefited from the law.

Let me tell you about one of them -- Steve Riggert, a constituent who recently wrote to me. Steve's daughter, Anna, was diagnosed with chronic pancreatitis at the age of 12 and has been hospitalized more than two dozen times over the past ten years for a variety of reasons. From the beginning, Steve knew that Anna's serious medical problems would make getting health insurance difficult. When the ACA passed, he was immensely relieved that she could always get coverage even though she had a pre-existing condition.

But the Republican plan to repeal the ACA has now left Steve feeling – and these are his words – "helpless", "petrified", and "literally losing sleep." At age 64 and recently diagnosed with pancreatic cancer himself, he fears that he won't be able to help his daughter. To quote his letter, "Repeal of all aspects of the Affordable Care Act would place everything I have worked for and those I care about in jeopardy."

Steve is one of many. There are a lot more. In fact, the Congressional Budget Office estimates repealing the major coverage provisions will cause 32 million people to lose health insurance. In the individual market, eventually three-quarters of the U.S.

population will have no access to an insurer, and premiums will double. But that is just the beginning. Under a full repeal of the law, insurance companies will once again be able to deny coverage based on pre-existing medical conditions. People with job-based insurance will face annual and lifetime limits on coverage and co-pays for preventive services, and seniors in Medicare will pay more for prescription drugs.

Hospitals caution that repeal will increase uncompensated care costs, likely leading to service cuts, layoffs, or higher prices for everyone. Outside experts say repeal will result in three million lost jobs in 2019 alone. Republican Governors are pleading with the Republican Congressional leadership not to go through with this repeal. Despite these warnings and despite the grave consequences, here we are.

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We will hear a lot of ideas today from my colleagues on the other side of the aisle. And I would wager that at the end of the day these ideas will also fail to garner the majority of their conference or come close to a plan that matches the ACA's record of success. I will keep an open mind, I will ask questions and I look forward to hearing more from our witnesses. I yield back the remainder of my time.

Interim Chair BLACK. Thank you, Mr. Yarmuth. Panelists, the committee has received your written statements and they will be made part of the formal record hearing. You will each have 5 minutes to deliver your oral remarks. And Ms. Turner, you may begin when you are ready.

STATEMENTS OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE; ROBERT A. BOOK, SENIOR DIRECTOR, HEALTH SYSTEMS INNOVATION NETWORK, LLC; LINDA J. BLUMBERG, SENIOR FELLOW, THE URBAN INSTITUTE, HEALTH POLICY CENTER; AND EDMUND F. HAISLMAIER, SENIOR RESEARCH FELLOW, HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION

STATEMENT OF GRACE-MARIE TURNER

Ms. TURNER. Thank you, Chairman Black, Ranking Member Yarmuth, and members of the committee for the opportunity to testify today on the impact of the Affordable Care Act. I plan to focus primarily on families, small businesses, and young people. While numbers of people have received health coverage through the Affordable Care Act, many more have felt personal harm.

I know that you and many members of Congress, including the leadership, have provided assurances that those currently receiving coverage through the Affordable Care Act now, will have that coverage maintained as a safety net lifeboat while you build a bridge to new coverage that will protect people that are currently being harmed by the law, but also provide new patient-centered options for care and coverage.

The cost of health care continue to be a primary concern. I rode with an Uber driver last week who said that he lives in Maryland and he has to work this second job to pay his $1,200 a month premium for himself, his wife, and his child. So, he says this is taking time away from my family, but I have to do it in order to provide them coverage. Many millions more are facing a similar fate and really are pleading for help.

Young people have been particularly disadvantaged. The law requires that insurance companies charge them only 3 times less than older people. And this 3-to-1 age rating has meant that young people are required to pay 75 percent more for their coverage than someone just pre-Medicare age. The savings for somebody on Medicare or 64 years old, so just before Medicare, are only 13 percent.

So what is happening is, young people are saying this just is not a good value. They are not purchasing from the coverage and they are not entering the pools that we need them in so that they can help balance out the risks. The ACA's employer mandate also is disadvantaging them and making it much harder to get that first real job, because it makes hiring them so much more costly.

On families, NPR's Morning Edition had a self-employed consultant from Portland, Oregon saying he is just not going to buy health insurance in 2017 because his premium had shot up to $930 a month. A broker said, "I have got clients saying the prices are nuts and I will not pay it. I will pay the penalty instead." The Congressional Budget Office had said, as you said, Madam Chairman, 21 million people would be enrolled in the exchanges as of this time

and as of June 2016, but only about 10.5 million were. Many millions of people just do not see the value in this expensive coverage, particularly in the exchanges where premiums increased an average of 25 percent last year.

In Kansas City, Warren Jones said that his coverage was $318 a month when he started under Obamacare in 2014. In 2017, his premium is going to be $716. So, it went up 46 percent. He said, "My wages have not gone up close to that." In addition, many hundreds of thousands and millions of people lost the coverage they had now. But particularly egregious, I think, is those who were on the co-ops.

The Congress provided $2.4 billion to provide the start-up funds for these cooperative health insurance plans. And all but five of them have failed, causing 800,000 people to suddenly lose their coverage because the plans were not able to, for a number of reasons, price their premiums properly. And then many millions of Americans have been impacted by the taxes; nearly two-dozen taxes, many of which go directly to the bottom line in increasing health insurance costs. Small businesses thought that they would be able to get relief, but the shop exchanges and small business tax credits that were supposed to help them were so complicated that they drew very little interest.

And then, finally, on Medicaid. Brian Blase of the Mercatus Center said that in his research, 70 percent of Medicaid enrollees in the expansion were eligible for the program in pre-ACA rules. While many unintended consequences have resulted from the law, I think one of the saddest is how it has impacted vulnerable populations.

Charles Blahous of Mercatus said that one of the results was to require the most sympathetic and vulnerable Medicaid populations, low income enrollees, pregnant women, children, et cetera to face more competition for health services from a marginally less vulnerable population—childless adults of somewhat higher income. A Louisiana Medicaid recipient told the New York Times, "My Medicaid card is useless for me right now. It is a useless piece of plastic. I cannot find an orthopedic surgeon or a pain management doctor who will take Medicaid."

President Trump's Executive Order ordered the bureaucracy to try to provide people some initial relief but, of course, only Congress can really act to change the underlying law. Thank you, Madam Chairman. I look forward to working with you, members of your committee and hopefully both sides of the aisle in coming up with options to solve these problems.

[The prepared statement of Ms. Turner follows:]

A not-for-profit health and tax policy research organization

Testimony before the
United States House of Representatives
Committee on the Budget

Rep. Diane Black, Interim Chair
Rep. John Yarmuth, Ranking Member

Hearing on

THE FAILURES OF OBAMACARE: HARMFUL EFFECTS AND BROKEN PROMISES

January 24, 2017

Testimony presented by
Grace-Marie Turner
President, Galen Institute

"THE FAILURES OF OBAMACARE: HARMFUL EFFECTS AND BROKEN PROMISES"

Committee on the Budget

January 24, 2017
Grace-Marie Turner, Galen Institute

Chairman Black, Ranking Member Yarmuth, and members of the committee, thank you for the opportunity to testify today on the consequences of the Affordable Care Act on American families, small businesses, workers, and young people.

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. I also served as an appointee to the Medicaid Commission from 2005-2006, as a member of the Advisory Board of the Agency for Healthcare Research and Quality from 2005 to 2007, and as a congressional appointee to the Long Term Care Commission in 2013.

While millions of people have received health coverage through the Affordable Care Act, many millions more have felt the personal harm it has imposed on them and their families. I know that you and many other members of this body, including Speaker Ryan, have provided assurances that repeal and replace measures will protect the people who are receiving coverage now under the health law while building a bridge to new coverage that will protect others from the damage that it has done and is doing to their pocketbooks and their access to medical care.

The costs of health insurance are crippling many families' finances, including forcing them to work extra jobs. An Uber driver who lives in Maryland told me last week that he is working this second job so he can pay for health insurance. The premium for the policy for himself, his wife, and one child is $1,200 a month. He must spend hours away from them every week to meet his obligation to provide coverage. I hear similar stories repeatedly from people across the country. While many millions are covered, millions more are pleading for relief.

The impact on young people

Young people face many daunting challenges in getting started in the workforce in our changing economy. Many of those who were fortunate enough to attend college struggle to make their student loan payments. Lackluster economic growth has made it extremely hard for them and for far too many others to find that first real job.

One of the ways that the Affordable Care Act tried to help them was by allowing adult children to stay on their parents' policies until age 26. But this provision is not free. "We find evidence that employees who were most affected by the mandate, namely employees at large firms, saw wage reductions of approximately $1,200 per year," according to Gopi Shah Goda and Jay

Bhattacharya of Stanford and Monica Farid of Harvard. As this new wave of young adults was added to their parent's existing job-based policies, the cost of coverage inevitably climbed. Companies responded by scaling back cash wages as a share of overall compensation. The study found that the costs of the 26-year-old mandate weren't "only borne by parents of eligible children or parents more generally." The costs were spread to each worker—not just the dependents' parents.[1]

This was a very popular provision, but it has been one of the factors flattening cash wages and driving up the cost of coverage for tens of millions of workers at American firms.

The ACA makes a direct hit on young people in two important ways: First, young people purchasing individual policies in or out of the exchanges are required to pay much more for their policies than their actuarially-expected costs because of the law's required 3:1 age rating band. Forcing the young to pay more drives costs up for everyone.

The average 64-year-old consumes six times as much health care, in dollar value, as the average 21-year-old.[2] Under the ACA's age-rating requirements, insurers cannot charge their oldest policyholders more than three times the price they charge their youngest customers. If every customer were to remain in the insurance market, this would have the net effect of increasing premiums for 21-year-olds by 75%, and reducing them for 64-year-olds by 13%.[3]

However, if half of the 21-year-olds drop out of the market because they don't see the insurance as a good value, this drives premiums up for everyone, including the 64-year-olds who were supposed to benefit from the rule.

In theory, the individual mandate penalty should force these younger individuals to purchase health coverage, even if that coverage is more expensive than their actual health care consumption. In reality, however, the ACA's individual mandate is relatively weak, often representing a fraction of the cost of ACA-based coverage.

Many young people are opting to pay the individual mandate penalty—or get an exemption—rather than enroll in health insurance. This has destabilized the exchange pools, which desperately need more young people to enroll to balance out the disproportionate number of older, sicker people.

The ACA's employer mandate—requiring employers with more than 50 workers to sponsor health coverage for their workers—contributes to the difficulty young people have in finding the entry-level jobs that allow them to get the experience they need to get moving with their professions and careers. Businesses are automating the jobs out of existence, hiring only part-time workers exempt from the mandate, deciding not to expand their businesses, or just doing without the help they need. Economist Ben Casselman of *FiveThirtyEight* found "the evidence suggests [the ACA] has led some employers to limit the hours of workers who were already part-time, effectively giving a pay cut to some of the most vulnerable Americans."[4] Jed Graham of *Investor's Business Daily* has an extensive catalogue of hours cut and jobs lost that employers attribute to ObamaCare employer mandate.[5]

Young people need strong economic growth to boost the economy so it can create more jobs. But they also need the federal government to lighten the regulatory burden that makes it so difficult for employers to hire entry-level lower-skilled workers.

The impact on families

The ACA imposes tax penalties on Americans who do not purchase compliant health coverage. IRS reports that for the 2015 tax year, 6.5 million people paid $3 billion in penalties.[6] Another 12.7 million claimed an exemption from the individual mandate penalty.[7] These 19 million people clearly are saying the health insurance the federal government is requiring them to purchase is too expensive or not a good value for the cost they are required to pay. Far too many of them are the younger, healthier people that we most need in the insurance pools to make them solvent.

A report in *Modern Healthcare* shows some of the problems that the ACA's attempted micro-management of health insurance have caused:[8]

> If HHS Secretary Sylvia Mathews Burwell was listening to NPR's "Morning Edition" on Tuesday, the first day of 2017 open enrollment, she must have felt sick.
>
> On the broadcast, Will Denecke, a self-employed urban planning consultant in Portland, Ore., said he planned to skip buying health insurance for 2017 because the premium had shot up to $930 a month. Instead, the 63-year-old man said if he developed a medical issue sometime during the year, he would go to the Affordable Care Act marketplace and buy a plan outside the open-enrollment window, which he's aware he's not supposed to do.
>
> He said the ACA rules sharply limiting such midyear enrollment are easy to get around. Last time he simply claimed a change of income. "I've done it before, and my broker helped me," he boasted, while admitting, "I know that undermines the economics and premise of the ACA."
>
> That's precisely the type of consumer gaming that's producing heartburn for the Obama administration. Insurers complain it's causing them serious financial losses in the ACA-regulated individual markets. Such abuses are one factor prompting widespread calls for federal policy changes to stabilize the exchanges.
>
> Meanwhile, because of the sharply rising 2017 premiums, healthier consumers increasingly are gravitating to cheaper short-term health plans that don't meet ACA rules. The growth of such plans, which as many as 1 million people have purchased, could further undercut the ACA markets.
>
> Brokers say this trend reflects the turmoil in the individual market. "I've got clients saying, 'The prices are nuts and I won't pay it, I'll pay the penalty,' " said Lisa Lettenmaier, a broker who owns the HealthSource Northwest brokerage in Portland and

who spoke during a short break in the hectic first day of open enrollment.

Enrollment in the exchanges has been far below expectations. The Congressional Budget Office originally estimated that 21 million people would be enrolled in exchange coverage by 2016. As of June 2016, only 10.5 million were enrolled.[9] That is 2.2 million fewer than had selected a plan by the end of open enrollment on February 1.[10]

For those purchasing coverage in the ACA exchanges, premiums went up an average of 25%,[11] with people in many other states experiencing much higher increases—averaging greater than 50% in Illinois, Montana, Oklahoma, and Tennessee, for example, and 116% in Arizona.

To keep premium prices from soaring further, health plans are narrowing their networks of providers and hospitals. Avalere found that networks in ACA exchange plans have 34% fewer providers compared to commercial plans.[12] A report in *Modern Healthcare* found that 70% of plans sold on the exchanges in 2014 consisted of narrow networks,[13] and the number is getting higher.[14]

According to a report in *USA Today*:[15]

> Loralea Grey, whose husband is self employed, says they are living a "middle-class nightmare" because of the law. They grew used to the necessary sacrifices to afford the premiums and out-of-pocket costs for their "catastrophic" insurance before the ACA, she says. This year they were facing a premium increase of nearly 40% with a $7,000 deductible per family member. They've decided they can't scrimp anymore to afford plans through the ACA exchange.
>
> "How is this possible or allowable?," she asks. "When I contacted the Oregon insurance commissioner, I received a response back telling me I should feel free to shop around; as if I wasn't smart enough to have already done that?"
>
> ... In North Carolina, the cheapest option with a "decent network" of doctors and hospitals for Jim Harrison's 61-year-old wife would cost $1,421 a month with a $7,150 deductible. (He is on Medicare.) Because he is retired and that isn't affordable, the family got a hardship exemption from the mandate to have insurance.
>
> "So against our better judgment, she is going to go without health insurance next year ... but we put all of our retirement assets at risk should something catastrophic happen," he says, "I never thought we would be in this situation."

Consumers faced dilemmas with rising premiums and fewer choices. *The Daily Signal* reports about the experience of Rochelle Bird, a financial adviser from Overland Park, Kansas:[16]

> Bird is one of roughly 10 million Americans who doesn't receive insurance from an employer—she's self-employed—and also doesn't qualify for a subsidy. So when insurers announced double-digit premium increases for 2017, she prepared to pay full price for coverage purchased in the individual market.

> And that wasn't it.
>
> Coventry Health Care sent Bird a notice last month saying it would cancel her policy at the end of the year.
>
> On the first day of open enrollment, the Overland Park resident selected a new plan through Blue Cross Blue Shield of Kansas City, one that is only $50 more than her old policy.
>
> But though Bird's premiums increased minimally compared to others across the country, her deductible is higher and she has less coverage than with her previous plan.
>
> "I'm paying more for less," she said.

Even with the higher premiums, insurers are facing losses on ACA policies that are driving many out of the market. One-third of all U.S. counties will have just one insurer. In 2016, a total of 225 counties in the U.S. had only one insurer offering coverage, but that number more than quadrupled to 1,022 in 2017.[17] Thirty-three states have fewer insurers offering coverage on the exchanges in 2017 than in 2016. Only one state, Virginia, gained insurers. Five states have only one insurer, while 13 have just two. This is certainly not the competitive market that creators of the ACA envisioned.

Again, *The Daily Signal* offers an example of a veterinarian whose premiums doubled over three years while the quality of his coverage eroded:[18]

> For the past 15 years, Warren Jones has had the same health insurance plan with Blue Cross and Blue Shield of Kansas City.
>
> But over the years, Jones, of Kansas City, Missouri, has watched the coverage offered in his policy "erode" over time.
>
> First, the company got rid of the dental and vision coverage he had.
>
> Then, Jones' deductible increased—to $2,500—for his plan alone.
>
> But perhaps the most significant change for Jones, a veterinarian, has been the rising cost of his monthly premiums.
>
> In 2014, the year Obamacare took effect, Jones paid $318 in monthly premiums. In 2015, the price went up to $394 per month, then to $491 for 2016.
>
> For 2017, Blue Cross and Blue Shield of Kansas estimates that Jones will pay $716 each month for his premiums—a 45.8 percent increase—according to a letter the insurer sent him.

> "You can't keep doing this because people's wages don't increase by that amount," Jones told The Daily Signal. "Nobody's wages are increasing, so it's taking a bigger chunk of the budget."

Further, more than 800,000 people who were enrolled in ACA Co-op health plans in 18 states lost their plans and were forced to find other coverage.[19] American taxpayers spent $2.4 billion[20] to finance these start-up, non-profit health plans, but they struggled from a lack of experienced management that failed to match the price of their policies with the services their enrollees were consuming. American families suffered as a result.

The law's "essential health benefits" and the extensive regulatory interpretation by the Obama administration contribute to the rising cost of insurance. Another contributor is the nearly two-dozen new and higher taxes in the ACA totaling more than $1 trillion:[21]

- **Individual mandate tax**. A mandate that people buy government-directed health coverage, with tax penalties for those who don't. *$43.3 billion in taxes.*
- **Employer mandate tax**. A mandate that employers provide government-directed health coverage, with tax penalties for those who don't. *$166.9 billion in taxes.*
- **Cadillac tax**. A 40% excise tax on generous workplace health plans. *$87.3 billion in taxes.*
- **Medical device tax.** A 2.3% tax on sales by manufacturers of medical devices and equipment that will cost jobs and make medical care more expensive. *$23.9 billion in taxes.*
- **Health savings taxes**. Tax increases on Flexible Spending Accounts and the purchase of over-the-counter medicine, and increased tax penalties on Health Savings Accounts and Archer Medical Savings Accounts. *$74.4 billion in taxes.*
- **Health insurance tax**. An annual tax on health insurers that is passed on to consumers. *$142.2 billion in taxes*
- **Pharmaceutical tax**. An annual tax on drug manufacturers that is passed on to consumers. *$29.6 billion in taxes*

The ACA has failed Americans who were promised more choices of more affordable coverage in the exchanges, but those outside the exchanges have felt the impact as well as they have been hit with these taxes.

Former President Obama promised that the average American family would see its insurance premiums fall by $2,500 a year, yet average annual family premiums in the employer-sponsored market have soared by roughly $4,300 and now total more than $18,000 annually.[22]

Some of the ACA taxes were delayed for two years as Congress saw the impact they were having on rising premiums. The Health Insurance Tax in particular is a direct sales tax on health insurance that increases the premiums people pay. The HIT was delayed for only one year, and it starts impacting small businesses as early as Feb. 1 of this year as they begin to renew their coverage. It will be fully integrated into rates shortly after as insurers start solidifying 2018 rate filings. Economist Doug Holtz-Eakin concluded this one tax will raise premiums for small businesses and households by nearly $5,000 per family over a decade.[23]

Impact on small businesses

Companies have struggled in trying to pay their workers a competitive wage while still making enough of a profit margin to stay in business. Health insurance costs for small firms have risen 56% in the last decade.[24] Worker wage increases have suffered as a result. Too much of the money that employees could have seen as wage increases has been consumed by rising health insurance costs instead. Workers also have seen their share of premium payments rising. Provider networks have narrowed. And deductibles have been rising.

The SHOP exchanges were supposed to help small businesses. Small businesses had high hopes for this program. The Obama administration's Council of Economic Advisers said in July 2009 that it would reduce the burden on small business by allowing firms to choose among more plans to provide better coverage at lower costs. That, coupled with the small business tax credit for firms with lower average wages, would help balance their higher administrative and other costs compared to larger firms.

It didn't succeed. The tax credits were so complicated and the path to obtaining them so narrow that the credits drew very limited interest and participation. The SHOP exchanges also failed to provide a broader range of affordable and attractive choices of insurance for small businesses.

Instead, small businesses face continued premium increases, administrative burdens, and ever-more-limited coverage options.

Businesses with more than 50 full-time workers that don't meet ACA health coverage criteria are subject to tax penalties of up to $3,000 per worker per year. Twenty-one percent of businesses report that they have reduced the number of employees, wages, and benefits as a result of the law.[25] The "cost of health insurance" consistently is reported as their number one problem.

The federal government has not collected data on the impact of the ACA on the "opportunity cost" of small business growth, but small business owners definitely see the impact. Here is a report from *The Daily Signal* about Scott Womack, owner of about a dozen IHOP restaurants in Indiana and Ohio:[26]

> The IHOP in Terre Haute is located on South 3rd Street, just a few minutes from the Interstate 70 interchange and a short drive from the Holiday Inn where we had stayed the night before. As we sat in the back of the bustling restaurant waiting for Womack to arrive, we ordered french toast, omelets and other IHOP specialties.
>
> At the time, Womack employed about 1,000 people at his 12 restaurants. When the Affordable Care Act became law on March 23, 2010, he had big plans for his franchise. He had purchased a development agreement in 2006 that would expand the company to 14 new IHOP locations in Ohio…

> "Let me state this bluntly," Womack told lawmakers [in earlier testimony before Congress], "this law will cost my company more money than we make."
>
> The cost of Obamacare's mandates—Womack estimated it would be $7,000 to provide health care coverage for each full-time employee—left him with few options: cut costs, eliminate staff, reduce hours or convert workers to part-time status.
>
> Four years later, facing the prospect of Obamacare's employer mandate on Jan. 1, 2015, Womack opted to sell his 16 IHOP restaurants last year to Romulus Restaurant Group.

Impact on vulnerable Americans

Research from ACA architect Jonathan Gruber and his coauthors,[27] using data from the Census Bureau, estimate that Medicaid "produced 63% of the gains [in coverage] that we identified" for 2014. Gruber *et al* found that much of this gain was attributable to the enrollment in Medicaid of people who were eligible for the program under criteria that preceded the ACA's Medicaid expansion.

Mercatus Center economist Brian Blase concludes: "Dividing Gruber's estimate of the percentage gain in coverage of Medicaid enrollees who were eligible before the ACA by the percentage gain in coverage attributable to Medicaid overall means that 70% of new Medicaid enrollees in 2014 were eligible for the program under pre-ACA rules."[28]

While there are many unintended consequences of the law, perhaps the most tragic is how it is harming some of the most vulnerable on Medicaid.

Charles Blahous of the Mercatus Center concludes, based upon the latest CBO[29][30] uninsured estimate that, "although ACA substantially increased Medicaid eligibility and federal funding, it did not appreciably change the supply of health care services available through Medicaid. Accordingly, the primary effect of the ACA's Medicaid coverage expansion was to require the most sympathetic and vulnerable Medicaid population (lowest-income enrollees, pregnant women, children, etc.) to face more competition for health services from a marginally less vulnerable population (childless adults of somewhat higher income)."[31]

Too many states have enthusiastically enrolled people in Medicaid but are failing to pay providers enough to allow them to afford to see all of the Medicaid patients seeking appointments. A Louisiana Medicaid recipient told *The New York Times*: [32]

> "My Medicaid card is useless for me right now. It's a useless piece of plastic. I can't find an orthopedic surgeon or a pain management doctor who will accept Medicaid."

The next chapter in advancing health reform

President Trump's executive order of January 20[33] directed all federal agencies "to minimize the unwarranted economic and regulatory burdens" of the Affordable Care Act. While administrative actions will be able to postpone or lighten the burden of the regulations in place,

only Congress can actually change the underlying law, not only to provide relief from the existing rules but also to provide new opportunities to give people the option of more affordable coverage and more choices of coverage that people and families want and need. I look forward to working with you to develop those policies. Thank you for the opportunity to testify today, and I look forward to your questions.

ENDNOTES

[1] "ObamaCare's $1,200 Pay Cut: The cost of insuring your 26-year-old is more than you thought," The Wall Street Journal, January 12, 2016. http://www.wsj.com/articles/obamacares-1-200-pay-cut-1452643649

[2] Avik S.A. Roy, "Transcending ObamaCare. Achieving Truly Affordable, Patient-Centered, Near-Universal Coverage." Testimony before the United States Congress House Committee on Energy & Commerce Subcommittee on Health, May 11, 2016. https://www.manhattan-institute.org/html/testimony-avik-roy-house-energy-commerces-subcommittee-health-8865.html

[3] *Ibid.*

[4] Ben Casselman, "Yes, Some Companies Are Cutting Hours in Response to 'Obamacare'," FiveThirtyEight, January 13, 2015. https://fivethirtyeight.com/features/yes-some-companies-are-cutting-hours-in-response-to-obamacare/

[5] Jed Graham, "Obamacare Employer Mandate: A List of Cuts to Work Hours, Jobs," Investor's Business Daily, September 5, 2014. http://www.investors.com/politics/obamacare/obamacare-employer-mandate-a-list-of-cuts-to-work-hours-jobs/

[6] IRS Commissioner John Koskinen, letter to Members of Congress, Jan. 9, 2017. https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf

[7] The IRS also reports that an additional 4.3 million people failed to "check the box" indicating whether they had coverage. The agency is analyzing these cases to determine their status.

[8] Harris Meyer, "As enrollment opens, some consumers look for loopholes to avoid higher premiums," Modern Healthcare, November 2, 2016. http://www.modernhealthcare.com/article/20161102/BLOG/161109980/blog-as-enrollment-opens-some-consumers-look-for-loopholes-to-avoid

[9] Centers for Medicare and Medicaid Services, "First Half of 2016 Effectuated Enrollment Snapshot," October 10, 2016. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html

[10] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report for the Period: November 1, 2015 – February 1, 2016," March 11, 2016. https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf

[11] Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace, Office of the Assistant Secretary for Planning and Evaluation, 24 October 2016. https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf

[12] Avalere, *Exchange Plans Include 34 Percent Fewer Providers than the Average for Commercial Plans.* July 15, 2015: http://avalere.com/expertise/managed-care/insights/exchange-plans-include-34-percent-fewer-providers-

than-the-average-for-comm

[13] Bob Herman, *Network Squeeze: Controversies Continue Over Narrow Health Plans,* Modern Healthcare, March 28, 2015:
http://www.modernhealthcare.com/article/20150328/MAGAZINE/303289988

[14] 2017 exchange market: Plan type trends," *McKinsey & Co.*, November 2016:
http://healthcare.mckinsey.com/2017-exchange-market-emerging-plan-type-trends

[15] Jayne O'Donnell, "High health insurance costs prompt tough choices," USA Today, Nov. 20, 2016. http://www.usatoday.com/story/news/politics/2016/11/20/high-health-insurance-costs-prompt-tough-choices/93978956/

[16] Melissa Quinn, "Meet 2 Hurting Americans Who Are Ready for Congress to Repeal Obamacare," The Daily Signal, November 29, 2016. http://dailysignal.com/2016/11/29/meet-2-hurting-americans-who-are-ready-for-congress-to-repeal-obamacare/

[17] Kaiser Family Foundation, "Insurer Participation in the 2017 Individual Marketplace," December 2016. https://public.tableau.com/profile/kaiser.family.foundation#!/vizhome/InsurerParticipationinthe2017IndividualMarketplace/2017InsurerParticipation

[18] Melissa Quinn, "In 3 Years, His Insurance Premiums Double as Options Decline Under Obamacare," The Daily Signal, October 17, 2016. http://dailysignal.com/2016/10/17/in-3-years-his-insurance-premiums-double-as-options-decline-under-obamacare/

[19] Author calculations based upon report from the U.S. Government Accountability Office, "Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015," March, 2016. http://www.gao.gov/assets/680/675742.pdf

[20] The amounts awarded represent the total funding that CMS agreed to provide to the CO-OPs. *Ibid.*

[21] Andrew Lundeen, "Obamacare Tax Increases Will Impact Us All," The Tax Foundation, March 5, 2013. http://taxfoundation.org/blog/obamacare-tax-increases-will-impact-us-all

[22] Kaiser Family Foundation, 2016 Employer Health Benefits Survey, September 14, 2016. http://kff.org/report-section/ehbs- 2016-summary-of-findings/

[23] Douglas Holtz-Eakin, "Higher Costs and the Affordable Care Act: The Case of the Premium Tax," March 9, 2011, American Action Forum. https://www.americanactionforum.org/wp-content/uploads/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf

[24] National Federation of Independent Business, "Small Business Problems and Priorities," August 2016, http://www.nfib.com/assets/NFIB-Problems-and-Priorities-2016.pdf

[25] Federal Reserve Bank of New York, "Supplemental Survey Report: Firms Assess Effects of Affordable Care Act," August 2016.
https://www.newyorkfed.org/medialibrary/media/survey/business_leaders/2016/2016_08supplemental.pdf?la=en

[26] Rob Bluey, "Obamacare a Factor in IHOP Owner's Decision to Sell His 16 Restaurants," The Daily Signal, March 22, 2017. http://dailysignal.com/2015/03/22/this-longtime-ihop-owner-sold-his-restaurants-because-of-obamacare/

[27] Molly Frean, B.A., Jonathan Gruber, Ph.D., and Benjamin D. Sommers, M.D., Ph.D., "Disentangling the ACA's Coverage Effects—Lessons for Policymakers," The New England Journal of Medicine, October 27, 2016. www.nejm.org/doi/pdf/10.1056/NEJMp1609016

[28] Brian Blase, "New Gruber Study Raises Major Questions About Obamacare's Medicaid Expansion," November 27, 2016, Forbes. http://www.forbes.com/sites/theapothecary/2016/11/27/new-gruber-study-raises-major-questions-about-obamacares-medicaid-expansion/#78bfa913c936

[29] Congressional Budget Office, "How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums," January, 2017. https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf

[30] For analyses of the limitations of the CBO's estimate of the impact of partial repeal of the ACA, see:
Charles Blahous, "What CBO Analysis of Partial ACA Repeal Really Means," e21, January 17, 2017. https://www.mercatus.org/commentary/what-cbo-analysis-partial-aca-repeal-really-means;
Avik Roy, "Four Critical Problems With The CBO's Latest Obamacare Repeal Estimate," January 17, 2017, Forbes. http://www.forbes.com/sites/theapothecary/2017/01/17/four-critical-problems-with-the-cbos-latest-obamacare-repeal-estimates/#17e5ff678627; and
Chris Jacobs, "Three Points CBO Omitted from Its Report on Obamacare Repeal," January 17, 2017, Chris Jacobs on Health. http://www.chrisjacobshc.com/2017/01/17/three-points-cbo-omitted-from-its-report-on-obamacare-repeal/

[31] Charles Blahous, "What CBO Analysis of Partial ACA Repeal Really Means," e21, January 17, 2017. https://www.mercatus.org/commentary/what-cbo-analysis-partial-aca-repeal-really-means
w
[32] Robert Pear, "Cuts Leave Patients with Medicaid Cards, but No Specialist to See," April 2, 2011, The New York Times. http://www.nytimes.com/2011/04/02/health/policy/02medicaid.html

[33] Executive Order, "Minimizing The Economic Burden of The Patient Protection And Affordable Care Act Pending Repeal," The White House, January 20, 2017. http://www.cnn.com/2017/01/20/politics/trump-obamacare-executive-order/

Interim Chair BLACK. Thank you, Ms. Turner. Dr. Book, you are recognized for 5 minutes.

STATEMENT OF ROBERT A. BOOK

Dr. BOOK. Thank you, Chairman Black, Ranking Member Yarmuth, and members of the committee. Thank you for the opportunity to share my research on the failures of the Affordable Care Act to achieve its goals. As well as the harmful and presumably unintended affects it has caused some reforms that can be enacted to make health care truly affordable for all Americans who seek it.

Proponents of the ACA, both inside Congress and outside, promised that it would bring about lower health insurance premiums, better access to health care, lower healthcare costs for patients, lower total national health expenditures in part due to savings on administrative costs and non-profit co-ops, and most of all fewer Americans foregoing health care because they cannot afford to pay for it. In fact, the opposite has happened.

Health insurance premiums have increased at record rates, especially but not only, for those who have to pay for their own coverage instead of getting it at work. More health plans than ever have narrow networks of providers limiting access to care in the name of saving money. Co-payments and deductibles are at all-time highs. And according to Gallup more Americans than ever say they have avoided or delayed obtaining health care because they cannot afford the cost. Clearly, having health coverage does not mean that one can actually obtain health care.

In addition to paying record high premiums, families earning as little as $41,000 per year may have to spend as much as $14,300 out of pocket before obtaining any coverage for treatment of diseases or injuries. And even that coverage may be restricted to a very small network of providers.

Despite all these factors making it more difficult for patients to access health care, total national spending on health care has continued to increase every year, both in dollars and as a percent of GDP. Administrative costs of insurance have increased as well, as the cost of establishing and operating the government-run exchanges vastly exceeded the savings to insurers by marketing through those exchanges.

Most of the co-ops have shut down taking their taxpayer financed start-up loans with them. One reason the ACA was passed was that we were paying too much for health care and not getting enough in return. Clearly, we are paying even more and getting even less than ever before. The problems that plagued the healthcare system before the ACA are still with us, and a new layer of problems has been added.

Another reason the ACA was passed was to save lives. Proponents said that thousands of people were dying due to a lack of health coverage. If that were true mortality rates should have decreased when the full provisions of the ACA came into effect; however, this has not happened. The Centers for Disease Control and Prevention recently reported that U.S. life expectancy dropped in 2015 for the first time since 1993. While this decrease might not be the fault of the ACA, there is certainly no increase in life expectancy or decrease of mortality, for which the ACA might take credit.

Medicare beneficiaries face a separate set of new obstacles. For example, the ACA mandated a Federal program whose express purpose is to pay doctors and hospitals bonuses for providing less health care to seniors and the disabled. The canard heralded health insurance companies for decades that they are denying care to patients just to save money has now become the official policy of the Federal Government towards its own beneficiaries. And worse, they are co-opting providers of cures by paying them bonuses to deny care and say no.

In addition, the promise of health coverage for all, even just coverage not care, has still not been achieved. On September 9, 2009 then-President Obama told a joint session of Congress that, "There are now more than 30 million American citizens who cannot get coverage." The latest figures from the census bureau indicate that as of 2015 there were still 29 million uninsured. Due to a change in definitions, these numbers might not be directly comparable, but it is quite clear that the ACA's goal of achieving coverage for everyone is far from being achieved.

Last week, CBO issued an alarmist report on a possible ACA repeal predicting, based on March 2016 data, that many people would lose coverage and premiums would increase if, as the report put it, portions of the ACA would be repealed. To get this result, the CBO assumed that all the ACA provisions that made coverage expensive and difficult to obtain, would remain in place, but that subsidies to pay for insurance in the individual mandate would be repealed. This is a straw person argument because it is not anyone's idea of how to reform health care. Furthermore, this report was based on data obtained before 2017 premiums and enrollment data were available. And, in fact, most of those premium increases they predicted have already occurred, even under the ACA.

In order to make health care accessible and coverage affordable, it is necessary to eliminate those factors that artificially increase prices without improving care or benefitting patients. It is imperative to repeal provisions requiring people to purchase health plans that include costly coverage for services they do not want, will not need, or will not use. People should be permitted to purchase comprehensive coverage if they so choose, or basic coverage if they so choose. Furthermore, if subsidies are to be given, they should be structured in such a way to encourage health insurers to provide coverage for individual's pre-existing conditions by basing subsidies on health status rather than merely on income.

Thank you very much and I look forward to your questions.

[The prepared statement of Dr. Book follows:]

Statement of

Robert A. Book, Ph.D.*

Senior Research Director, Health Systems Innovation Network, LLC

Outside Healthcare and Economics Expert, American Action Forum

Before the

Committee on the Budget

United States House of Representatives

Tuesday, January 24, 2017

"Failures of the Affordable Care Act and How to Reverse Them"

*The views expressed here are my own and not those of either the Health Systems Innovation Network, LLC, or the American Action Forum.

Chairman Black, Ranking Member Yarmouth, and Members of the Committee:

Thank you for the opportunity to share my research on the failures of the Affordable Care Act to achieve its goals, the harmful – presumably unintended – effects it has caused, and some reforms that can be enacted to make health care truly affordable to all Americans who seek it.

Proponents of the Affordable Care Act, both in Congress and outside, promised that it would bring about lower health insurance premiums, better access to health care, lower health care costs for patients, lower total national health care expenditures in part due to savings on administrative costs and non-profit CO-OP health insurance, and – most of all – fewer Americans foregoing health care because they can't afford to pay for it.

In fact, the opposite has happened. Health insurance premiums have increased at record rates, especially for those who pay for their own coverage instead of getting it at work. More health plans than ever have narrow networks of providers, limiting access to care in the name of saving money. Copayments and deductibles are at all-time highs, and according to Gallup, more Americans than ever say they have avoided or delayed obtaining health care because they cannot afford the cost. Clearly, having health *coverage* does not mean that one can obtain health *care*. In addition to paying record-high premiums, families earning as little as $41,000 per year may have to spend as much as $14,300 out of pocket before obtaining *any* coverage for treatment of diseases or injuries[1] – and even that coverage may be restricted to a very small set of in-network providers.

Despite all these factors making it more difficult for patients to access health care, total national spending on health care has continued to increase every year, both in dollars and as a percent of GDP. Administrative costs have increased as well, as the cost of establishing and operating the government-run exchanges vastly exceeded the savings to insurers by marketing through those exchanges. Most of the CO-OPs have shut down, taking their taxpayer-financed start-up loans with them.

One of the reasons the ACA was passed was that we were paying too much for health care and not getting enough in return. Clearly, we are paying even more, and getting even less, than ever before. The problems that plagued the health care system before the ACA are still with us, and a new layer of problems has been added.

Another reason the ACA was passed was to save lives. Proponents said that thousands of people were dying due to a lack of health coverage. If that were true, mortality rates should have decreased when the full provisions of the ACA came into effect. However, that has not happened. The Centers for Disease Control and Prevention recently reported that U.S. life expectancy dropped in 2015[2] – for the first time since 1993. While this decrease might not be the fault of the ACA, there is certainly no increase in life expectacy for which the ACA might take credit.

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1 Centers for Medicare and Medicaid Services, "Out-of-pocket maximum/limit," at https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit.

2 Jiaquan Xu, Sherry L. Murphy, Kenneth D. Kochanek, and Elizabeth Arias, "Mortality in the United States, 2015," NCHS Data Brief No. 267, December 2016, at http://www.cdc.gov/nchs/products/databriefs/db267.htm.

Medicare beneficiaries have a separate set of new problems. The ACA mandated that the federal government implement a program whose express purpose is to pay doctors and hospitals bonuses for reducing the amount of health care delivered to seniors and the disabled. The canard hurled at health insurance companies for decades has now become the official policy of the federal government towards its beneficiaries.

In addition, the promise of health coverage for all has still not been achieved. On September 9, 2009, then-President Obama told a joint session of Congress that, "There are now more than 30 million American citizens who cannot get coverage." The latest figures from the Census Bureau, indicate that in 2015, there were still 29 million uninsured. Due to a change in definitions, these numbers might not be directly comparable, but it is clear that the ACA proponents' goal of covering everyone is far from being achieved.

Last week, the Congressional Budget Office (CBO) released an alarmist report on a possible ACA repeal, predicting that 18 million people would lose coverage and premiums would increase by 20 to 25 percent if, as the report put it, "portions" of the ACA would be repealed. They chose to assume that all the ACA provisions that make coverage expensive would remain in place, but that subsidies to pay for insurance, and the individual mandate, would be repealed. This is a "straw person" argument, because that is not anyone's idea of how to reform health care. The implementation of the ACA dismantled substantial portions of the pre-ACA health coverage system, particularly as related to the individual market, and it is well understood that simply repealing the ACA will not bring that system back. Furthermore, the old system had its problems as well. There is no alternative but to replace the ACA with an improved system that allows all Americans to access health care at reasonable and truly affordable prices.

In order to make health care accessible and health coverage affordable, it is necessary to eliminate those factors that artificially increase prices without improving care or benefitting patients. It is imperative to repeal provisions requiring people to purchase health plans that include costly coverage for services they do not want, will not need, or will not use. People should be permitted to purchase comprehensive coverage if they so choose, or basic or catastrophic coverage if they so choose. People's choices should not be limited merely to different "actuarial values," but to different collections of covered services as well.

Furthermore, if subsidies are to be given, they should be structured in such a way as to encourage health insurers to provide coverage for individuals with pre-existing conditions or adverse health status without requiring them to raise premiums for everyone. This is possible if subsidies are based on the health status of an insurer's client base, rather than merely on income.

Premiums and Deductibles Have Increased, Not Decreased

In 2008, then-candidate Obama promised that health insurance premiums would cost $2,500 less per year per family as a result of his health care plan.[3] In 2010, after the health reform law had

3 Thomas B. Edsall, "Obama's Long List Of Promises To Keep, Obligations To Meet," January 4, 2009; updated May 25, 2011, at http://www.huffingtonpost.com/2008/12/04/obamas-long-list-of-promi_n_148598.html.

passed the Senate and shortly before it passed the House, then-President Obama stated the savings for employer-sponsored covered "could be as much as $3,000" per year, per employee.[4] Instead of decreasing, annual premiums for employer-sponsored coverage have increased by an average of $4,300 by 2016,[5] and individual premiums increased 50 percent in the first year (2014) and continued to increase thereafter.[6,7,8,9]

It used to be that annual deductibles were typically $1,000 or less; consumers had to be motivated with the tax benefits of health savings accounts to enroll in "high deductible" plans with deductibles of $2,400 per family. That seems almost quaint now; the average deductible for a family silver plan in 2017 is $7,474[10] – a level unheard-of before the ACA marketplace reforms came into effect in 2014. Deductibles for employer-sponsored plans have increases as well, from an average of $978 in 2010 to $1,478 in 2016.[11]

Administrative Costs Have Increased, Not Decreased

During the debate leading up to the passage of the ACA, proponents argued that one of the benefits of establishing government-run health insurance exchanges would be the reduction in administrative costs associated with private health insurance. These arguments were based partly on assertions of superior efficiency of government operations over those of the private sector,[12,13] but primarily on the claim that having an exchange would eliminate the need for insurance companies to spend money on marketing. In addition, it was claimed that[14] requiring a minimum

4 Barack H. Obama, "Remarks by the President on Health Insurance Reform in Fairfax, Virginia," March 19, 2010, as of accessed on 1/19/2017 at https://www.whitehouse.gov/the-press-office/remarks-president-health-insurance-reform-fairfax-virginia.

5 Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, September 14, 2016, at http://kff.org/report-section/ehbs-2016-summary-of-findings

6 Douglas Holtz-Eakin, "The Affordable Care Act After Five Years: Wasted Money And Broken Promises," Testimony before the Senate Finance Committee, March 19, 2015, at https://www.americanactionforum.org/testimony/the-affordable-care-act-after-five-years-wasted-money-and-broken-promi.

7 Patrick J. Egan, "Obamacare's premiums are going up — at the same rate as everyone else's," *The Washington Post,* November 17, 2014, at https://www.washingtonpost.com/news/monkey-cage/wp/2014/11/17/obamacares-premiums-are-going-up-at-the-same-rate-as-everyone-elses.

8 Brian Blase, "Overwhelming Evidence that Obamacare Caused Premiums to Increase Substantially," *Forbes.com*, July 28, 2016, at http://www.forbes.com/sites/theapothecary/2016/07/28/overwhelming-evidence-that-obamacare-caused-premiums-to-increase-substantially.

9 "Health Plan Choice and Premiums in the 2017 Health Insurnace Markletplace," ASPE Research Brief, October 2016, at https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf.

10 "Aging Consumers without Subsidies Hit Hardest by 2017 Obamacare Premium & Deductible Spikes," *HealthPocket*, October 26, 2015, at https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles.

11 Kaiser Family Foundation, *2016 Employer Health Benefits Survey*, 14 September 2016, Exhibit 7.7, at http://kff.org/report-section/ehbs-2016-section-one-cost-of-health-insurance.

12 Paul Krugman, "The Health Care Racket," *The New York Times*, February 16, 2007.

13 Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine*, August 2003; 349:768-775, at *http://www.nejm.org/doi/full/10.1056/NEJMsa022033#t=article.*

Medical Loss Ratio (MLR) and reduction of executive pay[15] through limits on the deductibility of compensation (Section 9014) would limit the unrestrained pursuit of profit[16]. The predicted impact was that reducing administrative costs would lead to lower premiums and lower national spending on health care without having to reduce the quantity or quality of actual health care delivered.

That is not what has occurred. Instead, total administrative costs increased. While insurers indeed appear to have spent less on administrative costs, both on a per-covered-person basis and as a percentage of total premiums since the law went into effect, government spending necessary to set up and operate the exchanges vastly exceeded the amount saved by private-sector insurers, leading to an increase in total administrative costs. In fact, just the federal government's expenditures in establishing and operating the ACA exchanges – a function devoted solely to enrollment – vastly exceeds the *total* administrative costs, both for enrollment and operations – of private-sector insurers prior to the implementation of the exchanges.

In 2013, the year before the exchange provisions took effect, administrative costs averaged $414 per covered person per year in the individual market. In 2014, the first year in which exchanges operated, average costs for the entire individual market increased to an average of $893 per covered person-year. However, this obscures the full effect of the administrative cost of operating the exchanges, because these figures include both those covered in exchanges and those covered by Qualified Health Plans (QHPs) through off-exchange enrollment. For those covered in the exchange, just the federal government's administrative costs amounted to $1,539 per effectuated exchange enrollee, not including administrative costs incurred by insurers. Because insurers were instructed to report their costs for the entire individual market (both on-exchange and off-exchange) together, it is impossible to determine with certainty the relative administrative costs for both groups. Depending on what assumptions one makes, total administrative costs (both government costs and insurer costs) for exchange enrollees could range from $1,562 to $1,804 and costs for off-exchange enrollees could range from $265 to $414.[17]

Consumer Operated and Oriented Plans: A costly failure

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14 Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform," Institute for America's Future (undated but apparently completed in December 2008), p.6. *http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf*

15 Frank Clemente, "A Public Health Insurance Plan: Reducing Costs and Improving Quality," Institute for America's Future, February 5, 2009, p. 6, at *http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf.*

16 Edward M. Kennedy, "A Democratic Blueprint for America's Future," Address at the National Press Club, January 12, 2005. *http://www.commondreams.org/views05/0112-37.htm*; Pete Stark, "Medicare for All," *The Nation*, February 6, 2006. *http://www.thenation.com/doc/20060206/stark*; Max Baucus, "Call to Action Health Reform 2009," November 12, 2008, p. 77 *http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf*; Hacker (2008), p. 6-8; Clemente (2009), p. 15.

17 Robert A. Book, "The ACA Exchanges Increased Administrative Costs of Health Insurance," American Action Forum, December 21, 2016, at https://www.americanactionforum.org/wp-content/uploads/2016/12/2016-12-21-ACA-Admin-Costs.pdf

The ACA called for the establishment of non-profit "Consumer Operated and Oriented Plans" (CO-OPs) to offer health insurance at lower prices and with patient, rather than corporate, interests at heart. These plans were supposed to be an alternative to private for-profit or ordinary not-for-profit health insurers. They were supposed to take the profit motive out of health insurance, and put the interests of patients (members/owners) ahead of the interests of solvency.

To further protect CO-OPs from the supposedly evil influence of insurance past, employees and former employees of "pre-existing insurers" – that is, those in existence prior to the ACA – would not be allowed to serve on a CO-OP board of directors. And, CO-OPs would get a lot of taxpayer money (in the form of "loans") to get started and make it work.

It turns out that giving large amounts of taxpayer money to people to run a business in which they by law must have no experience was not a recipe for success, either for patients or taxpayers.[18] Twenty-three CO-OPs were established, and in less than three years, 17 of the 23 failed, either going bankrupt, shut down by state regulators for failing to maintain reserves sufficient to pay claims, or otherwise running out of money, after taking $2 billion in taxpayer financing that will never be paid back.[19] An 18th CO-OP, in Maryland, has converted to a for-profit insurance company,[20] under regulations promulgated by the Obama administration[21] but not authorized by any statute passed by Congress.[22]

Federal Government Paying Bonuses for Denying Care to Medicare Beneficiaries

One of the clearly stated goals of ACA proponents was to prevent patients from being denied health care so that others could increase their profits. As then-candidate Obama put it, one of his goals was "making sure that they are limited in the ability to extract profits and deny coverage."[23]

Now, one of the lesser-known provisions of the ACA calls for the federal government to pay physicians and hospitals bonuses if they deny health care to seniors and the disabled – and even encourages them to form local monopolies to make it harder for them to find alternative sources of care. And most patients won't even know that's the reason they are being denied care.[24]

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18 Robert A. Book, "What We Should Learn From the Health CO-OP Failures," *Forbes.com,* October 30, 2015, at http://www.forbes.com/sites/theapothecary/2015/10/30/what-we-should-learn-from-the-health-co-op-failures.

19 Tara O'Neill Hayes, "17 Co-ops Have Failed After Receiving Nearly $2 Billion in Taxpayer Financing," American Action Forum, September 16, 2016, at http://www.americanactionforum.org/weekly-checkup/17-co-ops-failed-receiving-nearly-2-billion-taxpayer-financing.

20 "Health Insurance Purchasing Cooperatives: State and Federal Roles," National Conference of State Legislatures, September 1, 2016, at http://www.ncsl.org/research/health/purchasing-coops-and-alliances-for-health.aspx.

21 Department of Health and Human Services, "Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program," 18 FR 29146–29156, at https://www.regulations.gov/contentStreamer?documentId=CMS-2016-0070-0002&disposition=attachment&contentType=pdf.

22 Robert A. Book, "The CO-OP Dream Is Over," *Forbes.com*, May 27, 2016, at http://www.forbes.com/sites/theapothecary/2016/05/27/the-co-op-dream-is-over.

23 Barack H. Obama, Remarks during the Democrats' Second 2008 Presidential Debate, June 3, 2007, transcript at http://www.nytimes.com/2007/06/03/us/politics/03demsdebate_transcript.html?_r=0.

24 Robert A. Book, "ACA 'Savings': Paying Doctors And Hospitals Bonuses To Deny Care To Patients," *Forbes.com*, February 21, 2016, at http://www.forbes.com/sites/theapothecary/2016/02/21/aca-savings-paying-

Section 3022 of the ACA establishes the Medicare Shared Savings Program (MSSP). The MSSP establishes the notion of Accountable Care Organizations (ACOs). These are groups of health care providers (hospitals, physicians, other providers) who join together for purposes of obtaining bonus payments based on their participation in the MSSP and Medicare fee-for-service incentive program.

ACOs are paid bonuses to "reduce costs" for treating their patients. Because this is part of "fee for service" Medicare, reducing costs is equivalent to reducing services delivered. Thus, the physicians and hospitals who are members of ACOs benefit from devising procedures that reduce access to care for their Medicare patients.[25] In the first year of the program, ACOs generated $128 million in "savings."[26]

Furthermore, patients have little say in the matter, and derive essentially no benefit from the program. If insurers reduce costs, patients might benefit from reduced premiums. Medicare patients have no such opportunity to derive benefit from the ACO program. Furthermore, patients don't even "enroll" in an ACO – they are assigned to an ACO ex post based on the preponderance of their utilization. That is, at the end of the year, if a patient happens to have had a plurality of care (measured by either service counts or dollars of Medicare claims), from physicians who are members of a particular ACO, then that patient is assigned to that ACO according to a methodology developed by CMS.[27] Not only do patients not enroll in ACOs; they might not even be aware of them, as assignments may take place after the fact.

ACA proponents began by accusing insurance companies of denying patients care to save money; they ended up passing a law under which the federal government enlists doctors and hospitals to do the same thing on behalf of the federal government.

Millions of Americans Still Uninsured

According to numerous opponents of further health care reform, 20 million people have gained health coverage due to the ACA.[28] According to a report by the Office of the Assistant Secretary of HHS for Planning and Evaluation, this consists of 2.3 million people between the ages of 19 and 25 covered under a parent's employer-based health plan, and 17.7 million people between the ages of 18 and 64 who enrolled in either Medicaid or Marketplace plans. This last figure nets

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doctors-and-hospitals-bonuses-to-deny-care-to-patients.

25 Robert A. Book, "Why Are Hospitals Buying Physician Practices and Forming Insurance Companies?" American Action Forum, February 11, 2016, at http://www.americanactionforum.org/research/why-are-hospitals-buying-physician-practices-and-forming-insurance-companies.

26 Tara O'Neill Hayes and Brittany La Couture, "HHS Takes Wrong Steps in the Right Direction," American Action Forum, January 27, 2015, at http://www.americanactionforum.org/insight/hhs-takes-wrong-steps-in-the-right-direction.

27 "Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications," Centers For Medicare and Medicaid Services, December 2015, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V4.pdf.

28 HHS Press Office, "20 million people have gained health insurance coverage because of the Affordable Care Act, new estimates show," March 3, 2016, at https://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates.

out people who moved from employer-sponsored coverage to Medicaid or Marketplace plans. However, it does not seem to net out people who were covered in the individual market prior to 2014. That is estimated by CMS at 12.8 million in 2013, some of whom, no doubt, switched to Medicaid or Marketplace plans – especially if their pre-2014 plan was cancelled for not meeting ACA requirements.

RAND has estimated a net increase of 16.9 million covered, consisting of 22.8 million newly insured, minus 5.9 million who had coverage before but became uninsured. Of the 22.8 million newly insured, approximately 1.5 million gained coverage through Medicare, military coverage, or other plans that were available prior to the ACA.[29] This leaves a net increase of 15.5 million more people covered, including 6.5 million newly enrolled in Medicaid.

For many years, the accepted metric for measuring changes in the level of health coverage was the Census Bureau's Current Population Survey Annual Social and Economic Supplement. While this measure, like all measures, was imperfect, for some reason the Census Bureau chose the year 2014 to implement changes in the method of data collection and the definition of "coverage," thus making it difficult to compare pre- and post-ACA coverage numbers. In 2015, at the direction of Congress, the Census Bureau conducted the survey both ways. The "old method" produced an estimate of the percent uninsured that is 0.7 percentage points higher,[30] corresponding to an additional 2.2 million people being uninsured in 2014.

The Census Bureau's estimate for the number of uninsured in 2015 is 29.0 million, which would be approximately 31.2 million under the "old" method. When addressing a joint session of Congress on September 9, 2009, then-President Obama used a figure of "30 million American citizens." It is unclear where he got that figure, since the latest Census figure available at that time would have been for 2008, when the Census estimate was 46.3 million.[31] It is possible that he meant "citizens" literally; that is, to exclude uninsured noncitizen immigrants from the figure.

Many of the newly insured are enrolled in Medicaid. Some of these are newly eligible, in states that expanded Medicaid eligibility due to the higher federal subsidies provided in the ACA for able-bodied adults with income below the poverty line. Others, however, were eligible before the ACA was passed, but for some reason did not sign up. It could be that some were unaware of their eligibility, and became aware as a results of the publicity and outreach efforts surrounding the ACA and enrolled. This is known as the "woodwork effect." It is also possible that some particular eligible individuals had no need for health care during a particular period of time (this is common), and thus had no reason to enroll – until the ACA was enacted along with an individual mandate penalty that could be avoided by simply enrolling.

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29 Katherine Grace Carman, Christine Eibner, and Susan M. Paddock, "Trends in Health Insurance Enrollment, 2013-15," *Health Affairs,* June 2015, **34**:69(1044-1048), abstract at http://www.rand.org/pubs/external_publications/EP50692.html.

30 Carla Medalia, Brett O'Hara, and Jessica C. Smith, "How did the questionnaire change in the CPS ASEC affect health insurance estimates?" How did the questionnaire change in the CPS ASEC affect health insurance estimates, U.S. Census Bureau, March 16, 2016, at http://www.census.gov/content/dam/Census/library/working-papers/2016/demo/SEHSD-WP2016-03.pdf.

31 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," Census Bureau, September 2009, at https://www.census.gov/prod/2009pubs/p60-236.pdf.

For this latter group, it's useful to note that in some sense, people eligible for Medicaid but not actually enrolled are *de facto* insured. Unlike private insurance, Medicaid coverage is retroactive. A Medicaid-eligible individual – or a health care provider treating one – can file claims for Medicaid payment for services provided up to 90 days prior to that individual's enrollment in Medicaid (provided that the individual was Medicaid-eligible at the time of service). This means that, in effect, unenrolled Medicaid-eligible individuals are covered in case they need treatment, even without being enrolled. (Hospitals are very good at getting Medicaid-eligible patients enrolled, so they can be reimbursed for services.) Therefore, those who were previously eligible for Medicaid and signed up to avoid the penalty for being uninsured, or as a result of widespread publicity, are "newly insured" only in a narrow technical sense, and should not really be considered covered due to the ACA.

How Can Health Coverage Be Fixed?

First, provisions that serve primarily to increase premiums and deductibles should be repealed. This includes broad coverage mandates for services not every patient wants, nor should every patient pay for.

Second, the ACA includes a number of taxes that merely feed back into higher premiums. Such taxes should be repealed. These include the health insurance "annual fee" tax, the medical device tax, and others.

Third, and most importantly, the problem of adverse selection, whereby healthy individuals remain uninsured, increasing premiums for those who seek to become insured, should be solved. They way to solve this without losing protection for those with pre-existing conditions is to restructure the premium subsidies to take into account health status, not just income. That is, insurance companies should be incentivized to cover "sick" people by a subsidy structure that makes them just as attractive customers as "healthy" people. The key insight, which may be learned from the Medicare Advantage Risk Adjustment algorithm, is to tie subsidy adjustments to enrollees' health relative to the pool of *eligible* potential enrollees, not to the pool of people who actually enroll.

These reforms could contribute to making health care truly affordable to all who seek it.

Interim Chair BLACK. Thank you, Dr. Book. Dr. Blumberg, you are recognized for 5 minutes.

STATEMENT OF LINDA BLUMBERG

Dr. BLUMBERG. Chairman Black, Ranking Member Yarmuth, and members of the committee thank you for inviting me to testify today. The views that I express are mine alone and do not represent the views of the Urban Institute, its funders, or its sponsors.

The ACA is an imperfect law, but it has generated substantial benefits since its full implementation in 2014. Including increasing insurance coverage by over 20 million people, improving access to care and affordability, prohibiting insurer discrimination against the sick, catalyzing insurance market price competition in many areas for the first time, lowering the growth in per capita healthcare spending, and doing all this with virtually no evidence of negative effects on employment.

Our analysis and that of the CBO indicates that repeal of the ACA through the reconciliation process without a replacement plan would leave the U.S. Healthcare System worse off than would have been the case if the ACA was never passed. It would lead to an increase of 29.8 million uninsured in 2019, nearly doubling the uninsurance rate from 11 percent under the ACA to 21 percent.

The non-group market would virtually collapse due to the loss of predominantly healthy enrollees when the individual mandate and financial assistance were eliminated, while the rules that prohibit insurer discrimination against those with health problems remained in place. Unsubsidized premiums would increase dramatically and three-fourths of the population would not have any insurer selling non-group coverage in their area.

Over 10 years, there would be an increase of $1.1 trillion in uncompensated care that would be sought from healthcare providers due to the large increase in the uninsured. But there would be no obvious source to finance this additional care. Likely, it would result in much greater financial pressures on hospitals and other healthcare providers, and much more unmet medical need for households.

This scenario is realistic since opponents of the ACA have not coalesced around a replacement policy. And doing so would require raising significant new revenues, making dramatic cuts in existing programs, or increasing the deficit while earning some Democratic votes, all of which are very politically challenging.

Contrary to some public statements, non-group insurance markets under the ACA are not in a death spiral. Market experiences vary a lot across the country. About 40 percent of the population lives in areas where low cost silver premiums decreased or increased only modestly in 2017. But about 40 percent of the population does live in areas with 2017 premium increases of 20 percent or more; in most cases though, these increases represent adjustments to underpricing by insurers in the early years of reform. In these cases, high growth rates do not mean high premiums.

In other cases though, premiums are high because of the market power of providers and/or insurers or adverse selection into the non-group market. However, policy strategies many of which have

had bipartisan support in other context could be used to address these situations. And I will come back to that shortly.

This evidence and still increasing enrollment show that it is simply not true the marketplaces are in a death spiral. However, a death spiral would occur under a repeal via reconciliation or by maintaining the ACA, but neglecting the important administrative tasks that are required for the system to continue to operate effectively.

The replacement proposals delineated by members of Congress thus far fall firmly in the philosophical camp of reducing the sharing of healthcare risk, separating expenses of people with significant healthcare needs from those who are healthy. These approaches may well reduce premiums for those who are currently very healthy, but they all would reduce access to adequate and affordable medical care for people with greater needs.

The proposals would also do much less for those with lower incomes. These strategies include such policies as expansion of health savings accounts, replacement of income-related tax credits and expanded Medicaid eligibility with age-related tax credits, sales of insurance across State lines, continuous coverage requirements, and traditional high-risk pools.

Faced with a very challenging political reality, policy makers should consider fixing the major problems they have with the ACA rather than repealing it. The following policies would address critics' concerns and also strengthen the law.

Replace the individual mandate with a modified version of the late enrollment penalties currently used in Medicare parts B and D. Eliminate the employer mandate. Replace the Cadillac tax with a cap on the tax exclusion for employer insurance with some adjustments. Improve affordability by increasing premiums and cost sharing assistance and extend an 8.5 percent of income premium cap to those with incomes above 400 percent of the poverty level.

Doing this, would allow you to loosen the 3-to-1 age rating bans. Stabilize the marketplaces by taking steps to increase enrollment, including more outreach in enrollment assistance, and allowing states to expand Medicaid up to 100 percent of poverty instead of 138 percent.

Address the effects of insurer and provider market power on non-group premiums by capping provider payment rates for non-group insurers just like the Medicare Advantage Program does. And create a permanent reinsurance program to protect non-group insurers from very high cost cases just as Medicare Part D and Medicare Advantage have. This approach would avoid the turmoil of repeal and replace for households, healthcare providers, insurers, and State governments, and would protect access to affordable adequate care for all individuals regardless of health status or income.

Thank you very much. And I look forward to your questions.

[The prepared statement of Dr. Blumberg follows:]

Statement of

LINDA BLUMBERG*

Senior Fellow, Urban Institute

before the

Committee on the Budget

United States House of Representatives

hearing titled

"The Failures of Obamacare: Harmful Effects and Broken Promises"

Tuesday, January 24, 2017

*The views expressed are my own and should not be attributed to the Urban Institute, its trustees or its funders.

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Chairman Black, Ranking Member Yarmuth, and members of the Committee, I appreciate the opportunity to testify before you on the Affordable Care Act (ACA), the implications of its repeal, and alternative policies for addressing the problems with the law. The views that I express are my own and should not be attributed to the Urban Institute, its trustees, or its funders. My testimony, submitted for the record, is based on two recent papers that I wrote with Urban Institute colleagues. I summarize them here.

The first paper, "Implications of Partial Repeal of the ACA through Reconciliation," written with Matthew Buettgens and John Holahan, compares future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The coverage effects we estimated in this December 2016 analysis are consistent with those released by the Congressional Budget Office on January 17, 2017. Our analysis finds that the key effects of passage of the anticipated reconciliation bill are as follows:

- The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103 percent). The share of nonelderly people without insurance would increase from 11 percent to 21 percent, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.
- Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. The additional 7.3 million people would become uninsured because of the near collapse of the nongroup insurance market.
- Eighty-two percent of the people becoming uninsured would be in working families, 38 percent would be ages 18 to 34, and 56 percent would be non-Hispanic whites. Eighty percent of adults becoming uninsured would not have college degrees.
- There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.
- Approximately 9.3 million people who would have received tax credits for private nongroup health coverage in 2019 would no longer receive assistance.
- Federal government spending on health care for the nonelderly would be reduced by $109 billion in 2019 and by $1.3 trillion from 2019 to 2028 because the Medicaid expansion, premium tax credits, and cost-sharing assistance would be eliminated.
- State spending on Medicaid and CHIP would fall by $76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional $1.1 trillion in uncompensated care between 2019 and 2028.

- The 2016 reconciliation bill increased funding for uncompensated care very little beyond current levels, and this additional federal funding would account for less than 4 percent of the increase in uncompensated care that would be sought. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers. The increase in services sought by the uninsured is unlikely to be fully financed, leading to even greater financial burdens on the uninsured and higher levels of unmet need for health care services.
- If Congress partially repeals the ACA with a reconciliation bill like that vetoed in January 2016 and eliminates the individual and employer mandates immediately, in the midst of an already established plan year, significant market disruption would occur. Some people would stop paying premiums, and insurers would suffer substantial financial losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.
- Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued (as related to the *House v. Burwell* case) or if some additional financial support to the insurers to offset their increased risk is not provided.

This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

The second paper, entitled, "Instead of ACA Repeal and Replace, Fix It," was written with John Holahan and was released January 16. This paper describes the challenges of replacing the ACA without reducing insurance coverage, reducing affordability, or impeding access to care for those with health care needs, while identifying new sources of revenue and creating sufficient Congressional consensus for passage. To that end, we propose a range of policies that would address critics' concerns and also strengthen the law, expand coverage, improve affordability, increase market stability, and lower the high premiums that exist in some markets. We propose the following:

- Replace the individual mandate with a modified version of the late enrollment penalties currently used in Medicare Parts B and D.
- End the employer mandate. The limited gains in coverage and the revenue it generates have not been worth the controversy it has caused.
- Replace the Cadillac tax with a cap on the tax exclusion for employer-based insurance while correcting valid concerns that apply to both approaches.
- Improve affordability by reducing premiums, deductibles, and other cost-sharing requirements for modest-income individuals, and extend to higher-income individuals a cap on premiums at 8.5 percent of income.
- With a premium cap at 8.5 percent of income applied to all, relax the 3:1 age rating rule to be more in line with actual differences in spending for younger and older individuals.
- Examine the essential health benefits package, recognizing that eliminating certain benefits would eliminate risk pooling for those services, shifting all costs to individuals needing those services. That is problematic for any service, but particularly so for prescription drugs, mental health, and substance use disorder treatment.
- Stabilize the Marketplaces by taking steps to increase enrollment. This would include investing in additional outreach and enrollment assistance and allowing states to extend Medicaid eligibility to 100 percent of the federal poverty level (FPL) rather than 138 percent of FPL. People with incomes between 100 and 138 percent of FPL would move from Medicaid to Marketplace coverage and thereby benefit from the affordability provisions mentioned above. Further, it should be made easier for working families to be eligible for income-related tax credits.
- Address the impact of insurer and provider concentration on nongroup market premiums by capping provider payments in those plans at Medicare rates or some multiple thereof—an approach currently used by the Medicare Advantage program. This would limit the use of market power by large provider systems and make it easier for insurers to enter new markets.
- Use a broad-based source of revenue (e.g., assessments on all health insurance and stop-loss coverage premiums or general revenues) to permanently protect nongroup insurers from the consequences of enrolling a disproportionate share of very high-cost enrollees, as is done in Medicare Part D and Medicare Advantage.

Most of these steps have had bipartisan support in other contexts and therefore can provide a framework for a bipartisan compromise.

URBAN INSTITUTE

Implications of Partial Repeal of the ACA through Reconciliation

Linda J. Blumberg, Matthew Buettgens, and John Holahan

December 2016

In Brief

Congress is now considering partial repeal of the Affordable Care Act (ACA) through the budget reconciliation process. Since only components of the law with federal budget implications can be changed through reconciliation, this approach would permit elimination of the Medicaid expansion, the federal financial assistance for Marketplace coverage (premium tax credits and cost-sharing reductions), and the individual and employer mandates; it would leave the insurance market reforms (including the nongroup market's guaranteed issue, prohibition on preexisting condition exclusions, modified community rating, essential health benefit requirements, and actuarial value standards) in place. There is currently no consensus around alternative health policies to enact as the ACA is repealed; consequently, partial repeal via reconciliation without replacement is possible and merits analysis.

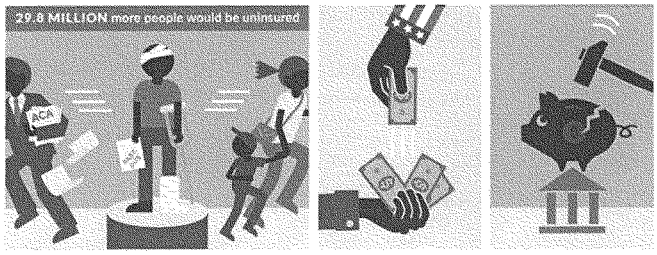
In this brief, we compare future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The key effects of passage of the anticipated reconciliation bill are as follows:

- The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103 percent). The share of nonelderly people without insurance would increase from 11 percent to 21 percent, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.
- Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. The additional 7.3 million people would become uninsured because of the near collapse of the nongroup insurance market.
- Eighty-two percent of the people becoming uninsured would be in working families, 38 percent would be ages 18 to 34, and 56 percent would be non-Hispanic whites. Eighty percent of adults becoming uninsured would not have college degrees.
- There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.
- Approximately 9.3 million people who would have received tax credits for private nongroup health coverage in 2019 would no longer receive assistance.

- Federal government spending on health care for the nonelderly would be reduced by $109 billion in 2019 and by $1.3 trillion from 2019 to 2028 because the Medicaid expansion, premium tax credits, and cost-sharing assistance would be eliminated.
- State spending on Medicaid and CHIP would fall by $76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional $1.1 trillion in uncompensated care between 2019 and 2028.
- The 2016 reconciliation bill did not increase funding for uncompensated care beyond current levels. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers. The increase in services sought by the uninsured is unlikely to be fully financed, leading to even greater financial burdens on the uninsured and higher levels of unmet need for health care services.
- If Congress partially repeals the ACA with a reconciliation bill like that vetoed in January 2016 and eliminates the individual and employer mandates immediately, in the midst of an already established plan year, significant market disruption would occur. Some people would stop paying premiums, and insurers would suffer substantial financial losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.
- Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued (as related to the *House v. Burwell* case) or if some additional financial support to the insurers to offset their increased risk is not provided.

This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

Using the Budget Reconciliation Process to Repeal the Affordable Care Act



Introduction

Congress passed a reconciliation bill repealing substantial portions of the Affordable Care Act (ACA) in January 2016; however, the bill was vetoed by President Obama.[1] Congress is now poised to pass a similar bill in early 2017.[2] The bill Congress passed did not contain policies intended to replace the ACA, presumably because a consensus did not exist on what form such an alternative should take. It is unlikely that supporters of ACA repeal will have agreed on an alternative before voting on repeal. In the absence of agreement on an alternative to the ACA, Congress is likely to delay the repeal of most, if not all, provisions in the bill for two or three years, giving members time to try developing an alternative set of policies. This was the approach taken by Congress last year.

Under Senate rules, reconciliation bills can only make legislative changes that affect the federal budget.[3] In the context of the ACA, rules permit repeal of the Medicaid expansion; the premium tax credits and cost-sharing assistance provided to people with modest income through the Marketplaces; the tax on some people who do not carry minimum creditable health insurance (a.k.a. the individual mandate); and the employer responsibility requirement (a.k.a. the employer mandate), which assesses a penalty on some employers whose workers obtain subsidized coverage through the Marketplaces. Because provisions that do not directly affect spending or revenues cannot be included in reconciliation bills, the 2016 bill did not eliminate the insurance market reforms, which include the extension of family coverage for adult children up to age 26, prohibitions on preexisting condition exclusions, and requirements for modified community rating, essential health benefits, and actuarial value standards. An attempt to repeal these provisions through normal legislative channels would be subject to a filibuster. For that reason, we assume that these provisions would remain in effect, at least in the near term.

This brief considers the effect of partial repeal of the ACA in the context of reconciliation. Since the 2016 reconciliation bill delayed its repeal of most budget-related components of the ACA for two years, we simulate the cost and coverage implications of a similar 2017 reconciliation bill in 2019. We also provide 10-year estimates for 2019 to 2028. However, even with most components delayed two years, such a reconciliation bill would substantially alter the nation's private nongroup insurance markets during 2017, with even larger effects on the 2018 plan year. Insurers could decide to stop offering insurance through the ACA-compliant nongroup insurance markets for 2018, knowing that enrollment will drop and the markets will soon be disassembled. A substantial drop in insurer participation is even more likely if Marketplace cost-sharing assistance is discontinued in 2017 or 2018 (as related to the *House v. Burwell* case) or if some additional financial support to insurers is not provided to offset their increased risk. A delay of the repeal provisions for three years instead of two would delay our estimated effects an additional year, changing the size of the estimated effects somewhat over 10 years.

The 2016 reconciliation bill would have eliminated the individual and employer mandates immediately upon passage.[4] If, under a 2017 reconciliation bill, the individual mandate penalties are not enforced beginning in 2017, people would have less incentive to pay premiums (especially people who are healthy and not eligible for premium tax credits); nongroup coverage would decline as enrollment falls almost immediately; the average health care costs of enrollees in the market would increase; and

these increased costs would create financial issues for insurers participating in 2017. As the number of uninsured people increases, providers would face increasing financial pressures because of higher demand for uncompensated care. Changes like these implemented *during a plan year* would seriously disrupt insurance markets for consumers, insurers, and providers. Thus, in addition to providing 2019 estimates for the reconciliation bill, we provide separate estimates of the immediate consequences of repealing the individual and employer mandates in 2017.

Results

We estimate insurance coverage in 2019 under the ACA and under the partial repeal expected to be included in a January 2017 reconciliation bill. We present coverage estimates for the nation as a whole and changes in the number of people uninsured for each state. We also provide detailed socioeconomic characteristics of those losing insurance coverage. We estimate the change in federal spending under each scenario in the same year, breaking out the total decrease in federal spending by Medicaid/CHIP and Marketplace financial assistance, nationally and by state. We provide estimates of the effects of elimination of the Medicaid expansion on state spending. We also show the implications of the increase in uncompensated care that would be sought as the number of uninsured increases. Finally, we estimate the financial losses of insurers if the 2017 bill, like that passed in 2016, eliminates the individual and employer mandates immediately, affecting enrollment decisions during 2017 once nongroup health insurance premiums are already fixed. Additional state-by-state detail on changes in federal and state spending in 2019 and over the 2019 to 2028 period is provided in appendix tables.

Insurance Coverage

The anticipated reconciliation bill would dramatically affect public insurance and private nongroup insurance for people covered through the Medicaid expansions, the ACA's Marketplaces, and ACA-compliant plans outside the Marketplaces. We estimate that the partial ACA repeal would increase the number of uninsured people by 29.8 million by 2019 (table 1, figure 1), raising the total number of uninsured to 58.7 million people—21 percent of the nonelderly population—compared with 28.9 million people uninsured if the ACA remains in effect. More people would be uninsured in 2019 than the 50.0 million who were uninsured in 2009, just before passage of the ACA (Holahan 2011).

The market for nongroup coverage would virtually collapse, causing 7.3 million of the additional 29.8 million people to become uninsured. Full repeal of all components of the ACA, including the insurance market reforms, would increase the number of uninsured by 22.5 million by 2019 (data not shown). The nongroup market would unravel because of three factors:

- Eliminating premium tax credits and cost-sharing assistance would make coverage unaffordable for many of the people currently enrolled, causing them to drop coverage. Those with the fewest health problems would drop their coverage fastest.

- Eliminating the individual mandate penalty would reduce the incentive to enroll for healthy people who can afford coverage.
- Insurers would remain subject to the requirement to sell coverage that meets adequacy standards to all would-be purchasers, and they would remain subject to the prohibition against charging higher premiums or offering reduced benefits to those with health care needs.

TABLE 1

Health Insurance Coverage Distribution of the Nonelderly with the ACA and an Anticipated Reconciliation Bill, 2019

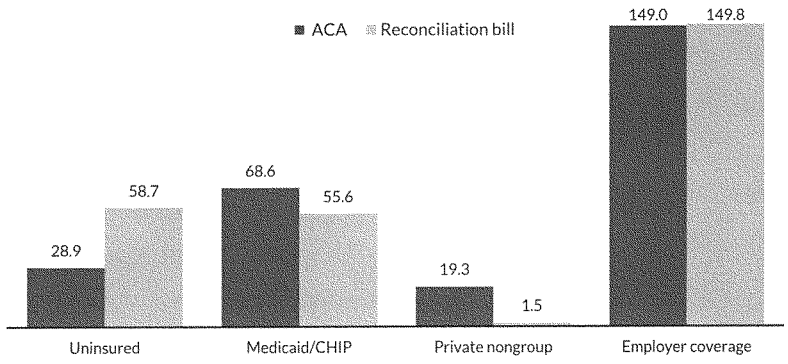
	ACA (current law)		Reconciliation Bill		
	People (thousands)	Share of US total (%)	People (thousands)	Share of US total (%)	Difference (thousands)
Insured	*245,380*	*89*	*215,598*	*79*	*-29,782*
Employer	148,974	54	149,832	55	858
Nongroup (eligible for tax credit)	9,322	3	0	0	-9,322
Nongroup (other)	9,955	4	1,560	1	-8,395
Medicaid/CHIP	68,556	25	55,632	20	-12,924
Other (including Medicare)	8,574	3	8,574	3	0
Uninsured	*28,936*	*11*	*58,718*	*21*	*29,782*
Total	**274,316**	**100**	**274,316**	**100**	**0**

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Columns may not sum to totals because of rounding.

FIGURE 1

Health Insurance of the Nonelderly in 2019, under the ACA and an Anticipated Reconciliation Bill

Millions of people



Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

As increasing numbers of people continued to drop their insurance (with healthier people leaving coverage fastest), the situation would threaten the nongroup insurers both inside and outside the Marketplaces with insupportable losses, would force insurers to raise premiums by increasingly large amounts, and would drive many insurers out of the nongroup market entirely. That is why the increase in the number of uninsured due to a reconciliation bill would exceed the gains in insurance coverage achieved under the ACA.

Table 2 gives a state-by-state breakdown of where the losses of insurance coverage would occur. The effects are uneven. The hardest hit, on average, would be states that expanded Medicaid, as those states averaged the largest coverage gains under reform. In those states, the number of people uninsured would more than double, from 14.0 to 32.5 million people, an increase of 18.5 million people. The number of uninsured would increase by 11.3 million people, from 14.9 to 26.2 million, in the states that did not expand Medicaid eligibility. In California, 4.9 million people would become uninsured; over 1 million people in Illinois and New York each would also become uninsured. Over 2 million people in Florida and 2.6 million people in Texas would become uninsured, as would over 1 million people in Georgia and North Carolina each.

TABLE 2

Uninsured under the ACA and an Anticipated Reconciliation Bill and Their Eligibility for Financial Assistance, by State and Medicaid Expansion Status, 2019

	ACA		Reconciliation Bill		Difference	
State	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
National total	**28,936**	**42%**	**58,718**	**15%**	**29,782**	**103%**
Expansion states						
Alaska	117	78%	178	12%	62	53%
Arizona	750	53%	1,459	18%	709	95%
Arkansas	211	58%	572	12%	361	171%
California	3,349	33%	8,236	14%	4,887	146%
Colorado	438	54%	1,026	13%	588	134%
Connecticut	200	47%	448	25%	248	124%
Delaware	60	58%	113	32%	52	86%
District of Columbia	31	56%	63	33%	32	103%
Hawaii	88	70%	174	12%	86	99%
Illinois	896	48%	2,046	14%	1,150	128%
Indiana	552	70%	1,119	16%	566	103%
Iowa	153	63%	383	14%	230	150%
Kentucky	244	66%	730	16%	486	200%
Louisiana	363	62%	921	12%	558	154%
Maryland	385	37%	861	10%	476	123%
Massachusetts	135	43%	504	8%	369	273%
Michigan	508	70%	1,394	13%	887	175%
Minnesota	309	67%	690	31%	380	123%
Montana	85	79%	227	15%	142	168%
Nevada	391	51%	762	18%	371	95%

State	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change in uninsured
New Hampshire	62	63%	180	9%	118	190%
New Jersey	644	37%	1,443	14%	799	124%
New Mexico	196	50%	462	15%	266	136%
New York	1,524	55%	2,662	31%	1,139	75%
North Dakota	45	69%	114	10%	69	154%
Ohio	621	71%	1,585	14%	964	155%
Oregon	256	50%	731	11%	475	186%
Pennsylvania	711	73%	1,667	13%	956	134%
Rhode Island	57	44%	153	15%	96	170%
Vermont	27	68%	62	35%	35	129%
Washington	508	51%	1,283	12%	775	153%
West Virginia	88	71%	272	13%	184	208%
Expansion states total	***14,002***	***51%***	***32,519***	***16%***	***18,516***	***132%***
Nonexpansion states						
Alabama	484	32%	841	14%	357	74%
Florida	2,482	26%	4,711	12%	2,230	90%
Georgia	1,427	31%	2,433	15%	1,006	71%
Idaho	183	36%	366	11%	184	101%
Kansas	289	39%	508	12%	219	76%
Maine	78	40%	173	12%	95	122%
Mississippi	351	40%	580	16%	229	65%
Missouri	544	38%	1,048	15%	504	93%
Nebraska	149	36%	314	12%	165	111%
North Carolina	1,140	27%	2,166	12%	1,025	90%
Oklahoma	529	43%	842	16%	313	59%
South Carolina	606	42%	959	17%	353	58%
South Dakota	81	55%	155	12%	74	92%
Tennessee	664	37%	1,190	15%	526	79%
Texas	4,377	32%	6,927	13%	2,550	58%
Utah	328	45%	601	15%	273	83%
Virginia	863	35%	1,548	9%	685	79%
Wisconsin	299	63%	731	17%	431	144%
Wyoming	61	49%	108	10%	47	76%
Nonexpansion states total	***14,933***	***33%***	***26,199***	***13%***	***11,266***	***75%***

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Financial assistance under the ACA includes Medicaid/CHIP and Marketplace premium tax credits and cost-sharing reductions. Financial assistance under the anticipated reconciliation bill consists of Medicaid/CHIP. Columns may not sum to totals because of rounding.

Overall, the elimination of the Medicaid expansion would decrease coverage through that program by 12.9 million people in 2019 as people lose eligibility for the program. The near "death spiral" in the private nongroup market described earlier is likely to occur immediately after the reconciliation bill's provisions take effect. Insurers would recognize the unsustainable financial dynamics of broad-based pooling policies (e.g., guaranteed issue, no preexisting condition exclusions, essential health benefits,

modified community rating) combined with no individual mandate and no financial assistance to spur enrollment. Similar near market collapse has occurred in the past under similar conditions. When New York's and New Jersey's state governments implemented community rating and guaranteed issue in their private nongroup markets without also providing for an individual requirement to obtain coverage or financial assistance to make coverage affordable for people with modest incomes, the nongroup markets unwound (Monheit et al. 2004).

We estimate that the number of people with nongroup insurance would drop from 19.3 million people to 1.6 million by the beginning of the 2019 plan year, concurrent with elimination of the premium tax credits. A small number of people otherwise covered by this market—fewer than 1 million—would obtain employer-sponsored insurance. Some insurers, such as Blue Cross-affiliated insurers, may continue to offer ACA-compliant plans at much higher premiums in the nongroup market, but without federal financial assistance, relatively few people—we estimate approximately 8 percent of those who have such coverage now—would enroll.

After the large increase in uninsured people that would result from a reconciliation bill, a much smaller share of the uninsured would be eligible for any financial assistance compared with the share eligible under the ACA (table 3). In the reconciliation bill scenario, only 15 percent of the 58.7 million uninsured would be eligible for any financial assistance (all under Medicaid or CHIP), given the elimination of both the Marketplace tax credits and the Medicaid eligibility expansion. As a consequence, there would be a much higher number of uninsured and very little room to significantly reduce that number absent substantial policy initiatives. In contrast, under the ACA, 42 percent of the remaining 28.9 million uninsured would be eligible for either Medicaid/CHIP or tax credits through the ACA's Marketplaces in 2019. That high rate of eligibility means that additional outreach and enrollment assistance could significantly increase the number of uninsured obtaining coverage under the ACA.

TABLE 3

Uninsured Eligible for Financial Assistance to Obtain Coverage, Nationally and by State Medicaid Expansion Status, 2019

	ACA		Reconciliation Bill		Difference	
	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Share eligible for assistance	Number of uninsured (thousands)	Percentage change
National total	**28,936**	**42%**	**58,718**	**15%**	**29,782**	**103%**
Expansion states	14,002	51%	32,519	16%	18,516	132%
Nonexpansion states	14,933	33%	26,199	13%	11,266	75%

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act. Under the ACA, assistance can take the form of Medicaid, CHIP, or Marketplace tax credits; under reconciliation, assistance can take the form of Medicaid or CHIP. Columns may not sum to totals because of rounding.

Characteristics of Those Becoming Uninsured

Table 4 provides income, age, employment, race/ethnicity, and educational attainment characteristics of the 29.8 million people becoming uninsured under the anticipated reconciliation bill. We find that approximately 53 percent of those becoming uninsured would be people with family income between 100 and 400 percent of the federal poverty level (FPL). The remaining increase in the number of uninsured would be almost evenly split between those with lower and higher incomes, 25 percent with income below 100 percent of FPL and 23 percent with income over 400 percent of FPL. These newly uninsured people would be spread broadly through the age distribution: 13 percent children under age 18, 38 percent young adults ages 18 to 34, and 49 percent adults ages 35 to 64.

The vast majority of those becoming uninsured would be members of working families (82 percent), and more than half (56 percent) would be non-Hispanic whites. The vast majority of adults becoming uninsured would lack college degrees (80 percent).

Uninsurance rates for people of all characteristics measured would increase by at least 50 percent under the reconciliation approach. For example, 10 percent of those with family income from 150 to 200 percent of the FPL are uninsured under the ACA, but that rate would increase to 26 percent under the reconciliation approach. Under the ACA, 7 percent of white, non-Hispanic people would be uninsured in 2019, but 18 percent would be uninsured under the reconciliation approach. Uninsurance rates for adults with a high school diploma would increase from 16 percent under the ACA to 30 percent.

TABLE 4

Characteristics of Those Losing Coverage under an Anticipated Reconciliation Bill and Uninsurance Rates under the ACA and an Anticipated Reconciliation Bill, 2019

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Income level				
< 100% of FPL	7,357	25%	14%	27%
100–150% of FPL	5,004	17%	8%	28%
150–200% of FPL	3,792	13%	10%	26%
200–300% of FPL	4,059	14%	10%	20%
300–400% of FPL	2,836	10%	6%	15%
> 400% of FPL	6,733	23%	11%	18%
Total	*29,782*	*100%*	*11%*	*21%*
Age group (years)				
< 18	3,998	13%	4%	9%
18–24	4,842	16%	14%	31%
25–34	6,341	21%	18%	32%
35–44	4,967	17%	14%	26%
45–54	5,103	17%	11%	23%
55–64	4,532	15%	8%	19%
Total	*29,782*	*100%*	*11%*	*21%*

	Thousands of people	Share losing coverage	Uninsurance rate under ACA	Uninsurance rate under reconciliation bill
Family employment status				
No worker	5,400	18%	16%	29%
Part-time only	4,690	16%	16%	33%
At least one full-time worker	19,692	66%	9%	18%
Total	***29,782***	***100%***	***11%***	***21%***
Race and ethnicity				
White, non-Hispanic	16,623	56%	7%	18%
Black, non-Hispanic	3,497	12%	11%	20%
Hispanic	6,501	22%	21%	32%
Asian	2,033	7%	9%	22%
American Indian/Alaska Native	654	2%	14%	26%
Other, non-Hispanic	475	2%	7%	16%
Total	***29,782***	***100%***	***11%***	***21%***
Educational attainment				
Less than high school	3,493	14%	31%	47%
High school	10,222	40%	16%	30%
Some college	6,906	27%	11%	24%
College	3,665	14%	7%	17%
Graduate school	1,497	6%	4%	12%
Total	***25,785***	***100%***	***13%***	***26%***

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; FPL = federal poverty level. Columns may not sum to totals because of rounding.

Government Spending on Health Care and Uncompensated Care

Under reconciliation, the federal government would spend $67 billion less on Medicaid/CHIP for the nonelderly and $42 billion less on Marketplace financial assistance (premium tax credits and cost-sharing reductions) in 2019.[5] This reduces spending on these programs by $109 billion that year (table 5 and figure 2) and by $1.3 trillion from 2019 to 2028 (table 5). State governments would reduce their spending on Medicaid/CHIP by $4 billion in 2019 (table 5 and figure 3) and by $76 billion from 2019 to 2028 (table 5). Total government spending on these programs would therefore be $1.4 trillion below the levels estimated under the ACA.

Table 6 shows state-specific estimates for 2019 to 2028 changes in federal spending on Medicaid/CHIP and Marketplace financial assistance. States that expanded Medicaid and enrolled larger numbers of residents in the Marketplaces would lose the most federal funding under the reconciliation bill. For example, California would lose $160 billion in federal funding over the 10 years, and New York would lose $57 billion. Although they had not expanded Medicaid eligibility, Florida and Texas would lose $87 and $62 billion in federal funding for health care, respectively, because of their large populations and high rates of Marketplace enrollment. (State-by-state 2019 federal spending estimates and 2019–28 state Medicaid/CHIP spending estimates are provided in appendix tables.)

TABLE 5

Government Spending on Medicaid/CHIP for the Nonelderly and Marketplace Financial Assistance, 2019 and 2019–28

Billions of dollars

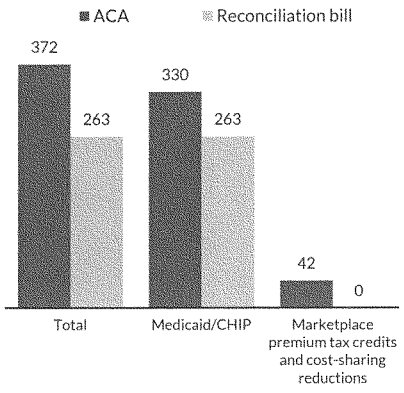
	2019			2019–28		
	ACA	Reconciliation bill	Difference	ACA	Reconciliation bill	Difference
Medicaid/CHIP spending	$525	$453	-$72	$6,643	$5,740	-$902
Federal	$330	$263	-$67	$4,153	$3,327	-$826
State	$195	$191	-$4	$2,489	$2,413	-$76
Federal Marketplace financial assistance	$42	$0	-$42	$465	$0	-$465
Total federal spending	*$372*	*$263*	*-$109*	*$4,618*	*$3,327*	*-$1,291*
Total state spending	*$195*	*$191*	*-$4*	*$2,489*	*$2,413*	*-$76*
Total federal and state spending	**$567**	**$453**	**-$114**	**$7,107**	**$5,740**	**-$1,367**

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

FIGURE 2

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019

Billions of dollars

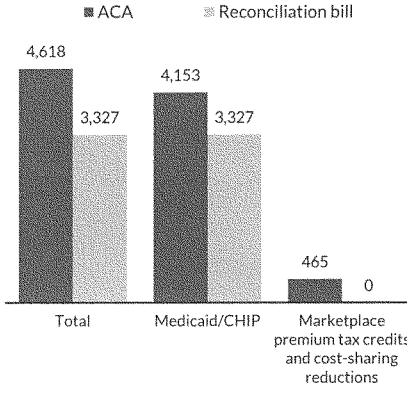


Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act.

FIGURE 3

Federal Government Spending on Medicaid/CHIP and Marketplace Assistance, 2019–28

Billions of dollars



Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act.

TABLE 6

Federal Spending on Medicaid/CHIP and Marketplace Financial Assistance under the ACA and under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Billions of dollars

	ACA			Reconciliation Bill	Difference		
State	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/ CHIP	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total
Expansion states							
Alaska	$12	$2	$13	$10	-$1	-$2	-$3
Arizona	$142	$10	$152	$110	-$32	-$10	-$42
Arkansas	$42	$2	$44	$34	-$8	-$2	-$10
California	$364	$61	$425	$265	-$99	-$61	-$160
Colorado	$74	$2	$77	$44	-$31	-$2	-$33
Connecticut	$52	$4	$56	$41	-$10	-$4	-$15
Delaware	$15	<$1	$16	$12	-$3	<-$1	-$4
District of Columbia	$18	<$1	$18	$17	-$2	<-$1	-$2
Hawaii	$15	<$1	$16	$12	-$4	<-$1	-$4
Illinois	$158	$12	$170	$120	-$37	-$12	-$50
Indiana	$81	$5	$86	$67	-$14	-$5	-$19
Iowa	$34	$2	$36	$29	-$5	-$2	-$7
Kentucky	$106	$3	$108	$59	-$47	-$3	-$50
Louisiana	$74	$4	$78	$52	-$23	-$4	-$27
Maryland	$80	$4	$84	$57	-$23	-$4	-$28
Massachusetts	$95	$5	$100	$78	-$17	-$5	-$23
Michigan	$149	$8	$157	$119	-$30	-$8	-$38
Minnesota	$82	$2	$84	$68	-$15	-$2	-$16
Montana	$23	$1	$24	$14	-$9	-$1	-$10
Nevada	$35	$4	$39	$22	-$13	-$4	-$16
New Hampshire	$14	$1	$15	$10	-$4	-$1	-$5
New Jersey	$135	$7	$142	$82	-$53	-$7	-$60
New Mexico	$72	$1	$74	$46	-$27	-$1	-$28
New York	$348	$10	$358	$301	-$47	-$10	-$57
North Dakota	$7	<$1	$8	$5	-$2	<-$1	-$3
Ohio	$177	$6	$183	$135	-$42	-$6	-$48
Oregon	$83	$3	$86	$47	-$35	-$3	-$38
Pennsylvania	$154	$13	$167	$131	-$23	-$13	-$36
Rhode Island	$21	<$1	$22	$14	-$7	<-$1	-$7
Vermont	$11	<$1	$12	$9	-$2	-$1	-$3
Washington	$90	$5	$95	$52	-$38	-$5	-$43
West Virginia	$35	$2	$37	$23	-$12	-$2	-$14
Expansion states total	*$2,799*	*$184*	*$2,983*	*$2,085*	*-$715*	*-$184*	*-$899*

State	ACA			Reconciliation Bill	Difference		
	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total	Medicaid/ CHIP	Medicaid/ CHIP	Premium tax credits and cost-sharing reductions	Total
Nonexpansion states							
Alabama	$47	$12	$59	$43	-$3	-$12	-$15
Florida	$181	$68	$249	$162	-$19	-$68	-$87
Georgia	$101	$20	$121	$88	-$12	-$20	-$33
Idaho	$26	$4	$29	$23	-$3	-$4	-$6
Kansas	$24	$4	$28	$22	-$2	-$4	-$6
Maine	$17	$4	$21	$17	<-$1	-$4	-$5
Mississippi	$44	$5	$49	$40	-$4	-$5	-$9
Missouri	$80	$13	$93	$75	-$6	-$13	-$18
Nebraska	$15	$4	$19	$15	<-$1	-$4	-$5
North Carolina	$146	$38	$184	$125	-$21	-$38	-$59
Oklahoma	$48	$8	$56	$47	-$2	-$8	-$9
South Carolina	$54	$11	$65	$53	-$1	-$11	-$12
South Dakota	$8	$1	$9	$8	<-$1	-$1	-$1
Tennessee	$98	$11	$108	$82	-$16	-$11	-$27
Texas	$323	$46	$369	$307	-$17	-$46	-$62
Utah	$33	$3	$36	$31	-$1	-$3	-$5
Virginia	$56	$15	$72	$54	-$3	-$15	-$18
Wisconsin	$49	$11	$60	$47	-$2	-$11	-$13
Wyoming	$5	$2	$6	$4	<-$1	-$2	-$2
Nonexpansion states total	*$1,354*	*$280*	*$1,634*	*$1,242*	*-$112*	*-$280*	*-$392*
National estimate	**$4,153**	**$465**	**$4,618**	**$3,327**	**-$826**	**-$465**	**-$1,291**

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program. Numbers are rounded to the nearest $1 billion, so columns might not sum precisely to totals.

As the number of uninsured increases under the reconciliation bill, the amount of uncompensated care sought would increase as well. But the source of financing this increased demand is very unclear. The uninsured use less medical care than they would if they had health insurance coverage, but they do use some care. This care is financed in different ways: some care is paid for directly by the uninsured, some is financed by the federal government (e.g., Medicare and Medicaid disproportionate share hospital [DSH] programs), some is financed by state and local governments (e.g., uncompensated care pools, Medicaid DSH, funding for public hospitals), and some is financed by providers (e.g., hospitals, physicians, pharmaceutical companies) delivering free or reduced-price care. We assume that newly uninsured people will contribute to the costs of their own care consistent with the patterns of spending by uninsured people with similar characteristics and health needs under current law.

No source of uncompensated care funding increases automatically with an increase in the number of uninsured, so it is unclear whether funding would increase to meet the demand. We estimate that under current law, the federal government would spend $23 billion on uncompensated care in 2019 and $262 billion from 2019 to 2028 (table 7). State and local governments would spend $14 billion on uncompensated care in 2019 and $164 billion over 10 years. Providers would contribute $20 billion in services for the uninsured in 2019 and $230 billion over 10 years. These amounts are consistent with total demand for uncompensated care of $57 billion in 2019, $656 billion over 10 years.

With the uninsured increasing by almost 30 million by 2019, uninsured people would seek an additional $88 billion in uncompensated care in 2019 and an additional $1.1 trillion from 2019 to 2028. However, the federal DSH programs would not increase beyond current levels without explicit federal action, and that action was not part of the January 2016 reconciliation bill.[5] Therefore, we assume federal uncompensated care funding would remain fixed. State and local governments could increase revenue to address the uncompensated care funding shortfall, providers could increase their provision of free services to the uninsured, unmet medical need could increase because the shortfall is not financed, or some combination of these possibilities could occur.

We provide two scenarios in table 7: the first assumes the uncompensated care shortfall is addressed by providers increasing their delivery of free and reduced price care, and the second assumes the shortfall is financed by state and local governments. While neither state and local governments nor providers are likely to be able to finance the extra care sought on their own, these scenarios show the large financing challenge facing the health care system under the reconciliation bill. If state and local governments were to assume all costs related to the increase in uncompensated care sought, their support for uncompensated care would have to increase more than sixfold. If providers were to assume all the increase in demand, their support for uncompensated care would have to more than quadruple. While some combination of increases from state and local governments and providers may occur, the large increase in services sought by the uninsured is unlikely to be met, and the increased burden on the uninsured will produce even greater financial burdens and more unmet need for health care services.

TABLE 7

Alternative Scenarios for Financing Uncompensated Care, 2019 and 2019–28

Billions of dollars

	2019			2019–28		
	ACA	Reconciliation bill	Difference	ACA	Reconciliation bill	Difference
Total demand for uncompensated care	$57	$145	$88	$656	$1,723	$1,067
	Scenario 1: No increase in federal or state/local uncompensated care funds; all increase in demand borne by providers					
Federal government	$23	$23	$0	$262	$262	$0
State/local government	$14	$14	$0	$164	$164	$0
Providers	$20	$108	$88	$230	$1,296	$1,067
	Scenario 2: No increase in federal uncompensated care funds or provider contributions; all increase in demand borne by states and localities					
Federal government	$23	$23	$0	$262	$262	$0
State/local government	$14	$102	$88	$164	$1,231	$1,067
Providers	$20	$20	$0	$230	$230	$0

Source: Urban Institute analysis using HIPSM 2016.
Notes: ACA = Affordable Care Act. Columns may not sum to totals because of rounding.

Elimination of the Individual and Employer Mandates in 2017

So far, our analysis has focused on the 2019 effects of the reconciliation approach. In this section, we analyze the implications of eliminating the individual and employer mandates immediately after passage in 2017. We do this because the 2016 reconciliation bill would have immediately stopped collections of these penalties.

ACA-compliant nongroup premiums for 2017 were set in 2016 before the start of the open enrollment period, following months of review by state departments of insurance and, in some cases, the federal government. Before the governmental review process, insurers assess and refine their product offerings for the coming year, and their actuaries and others prepare their proposed premiums based on last year's experiences, expected changes in the nongroup risk pool for the coming year, and other considerations. Once premiums are approved, they are locked in for the coming plan year.

Eliminating the individual mandate (and, to a much smaller degree, the employer mandate) in the middle of a plan year would change the rules of the insurance market after the year's premiums have been set. Fewer people would keep their health insurance for the remainder of the year. Once they are informed that there would no longer be a tax penalty for remaining uninsured, some people would drop their coverage after the start of the plan year. As healthier people drop coverage, premium collections across the nongroup market would be lower than the health care costs incurred by those who remain insured. This type of pricing disconnect would affect not only those insurers providing Marketplace coverage but also those selling nongroup coverage outside the Marketplaces, since the entire ACA-compliant nongroup market is treated as a single risk pool.

If the individual and employer mandates are eliminated while the ACA's Medicaid expansion, Marketplace tax credits and cost-sharing reductions, insurance market reforms, and other components are left in place in 2017, 4.3 million people would drop their ACA-compliant nongroup insurance coverage and become uninsured (table 8). Average health insurance claims for those remaining in the ACA-compliant private nongroup insurance markets would be about 10 percent higher than if the 4.3 million people stayed in the pool as they would under the ACA (data not shown); this would place financial pressure on the markets' insurers. The continuation of Marketplace financial assistance is critical to averting even higher short-run increases in average claims because the lower-priced coverage provided to many modest-income people is attractive even without a mandate in place.

TABLE 8

Nonelderly Coverage Distribution and Insurers' Premium Revenue in 2017

Thousands of people

	Current law	Elimination of individual and employer mandates early in year	Difference
Coverage			
Medicaid	67,950	67,950	0
Medicare	3,953	3,953	0
Employer-sponsored insurance	149,511	149,511	0
Other public	4,505	4,505	0
Nongroup	18,418	14,085	-4,334
Uninsured	*28,342*	*32,676*	*4,334*
Total	**272,680**	**272,680**	

Premium revenue (billions)	
Total premium revenue: current law	$46
Total premium revenue: no mandates, fixed premiums	$37
Actuarially fair premiums necessary to cover insurer costs if mandates eliminated	$40
Shortfall in insurer revenue caused by eliminating mandates mid-plan year	$3

Source: Urban Institute analysis using HIPSM 2016.
Note: Premium revenue includes direct payments by enrollees and premium tax credits financed by the federal government.

Under current law, insurers would collect an estimated $46 billion in premiums (combining those paid directly by enrollees and the premium tax credits provided by the federal government). If the individual mandate is eliminated early in 2017, insurer premium revenue would drop almost $10 billion to $37 billion, yet this revenue would fall more than $3 billion short of covering insurers' claims and administrative costs. Facing significant financial losses, insurers could request midyear premium adjustments, absorb the financial losses and remain in the markets, or exit the markets entirely. Midyear premium adjustments are likely unfeasible because the standard premium development, review, and approval processes require several months. Some larger insurers could decide to remain in the markets and internalize the losses, but others would surely leave. As a result, even if some insurers remain in some areas, more people would become uninsured in 2017, insurers would suffer financial

losses, and many consumers would be displaced from coverage and provider networks they chose during 2017 open enrollment. Financial burdens for consumers with insurers that leave the market during the year would increase because enrollees would lose credit for deductibles and cost-sharing already paid, even if they are able to enroll with a different insurer. The number of insurers leaving the nongroup market and the effect on consumers would likely be significantly larger in 2018 than in 2017. The 2016 reconciliation bill would have immediately stopped the reinsurance program as well. That would cause further financial losses to insurers than we have estimated here.

The bottom line is that eliminating the individual mandate penalties midyear would lead to a much faster unwinding of private nongroup insurance markets than would occur if the mandate were repealed in 2019. The 2019 estimates presented earlier would still hold, but the effects would begin earlier if the mandates were eliminated prior to the other changes. The effects would begin in 2017 but would likely accelerate in 2018. Any changes to the market rules, mandate, or financial assistance after premiums are set for the plan year would significantly disrupt coverage and care and would cause private financial losses for households and insurers.

Our analysis does not include the additional disruptions to insurers and consumers that would occur if the federal government immediately ceased paying cost-sharing reductions on behalf of low-income Marketplace enrollees. This is the issue under consideration in the *House v. Burwell* case. We have analyzed the potential implications of the case elsewhere (Blumberg and Buettgens 2016) but not in combination with the issues analyzed here. Eliminating the cost-sharing reductions immediately would impose greater losses on Marketplace insurers than estimated here and would force more insurers out of the Marketplaces, resulting in much broader immediate disruptions for consumers.

Discussion

We estimate that the effects of passing and implementing the reconciliation bill would be large and swift. Yet actual effects would likely be larger, for the following reasons.

- We assume that no additional states would adopt Medicaid expansions if the ACA remains in effect. If additional states expanded Medicaid, the drop in coverage relative to what would occur under current law would be greater than we estimate here.
- The ACA's individual mandate penalties increase in 2016 to their maximum level. These higher penalties, which will be felt in early 2017 when taxpayers file their returns, could lead to more people enrolling in coverage the next plan year. We do not include this possible bump in insurance coverage in our ACA estimates. Therefore, we may be underestimating the future coverage gains under the ACA as well as the decline in coverage resulting from partial repeal using a reconciliation approach.
- Many of those remaining uninsured under the ACA are eligible for Medicaid or subsidized private Marketplace coverage. Additional targeted outreach and enrollment assistance could increase health coverage further if the ACA remains in place (Blumberg et al. 2016); by ignoring

this pool of potential coverage expansion, we likely understate the decline in coverage relative to what might occur under current law.

- Repeal would mean that states that had expanded insurance coverage before the ACA using Medicaid waivers would likely need to renegotiate those waivers to keep program eligibility where it was before 2014. However, the new administration may not grant such waivers or may require substantial changes to them that would affect states' ability to provide coverage to the same number of people that they had before the ACA.

In addition, this analysis only covers the decrease in federal health care spending and does not provide a complete picture of the effect of the anticipated reconciliation bill on the federal budget. Specifically, we do not estimate the revenue consequences of eliminating the high-cost plan or "Cadillac" tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. Therefore, our estimates cannot be interpreted as federal budget effects, only decreases in spending on health care. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending estimated in this analysis. As a number of states have reported, the Medicaid expansion has led to additional state budgetary spending, and its repeal could have significant negative economic consequences for states.[7]

It is also possible that particular states would raise revenues to offset some of the coverage losses created by such a federal approach. But the state revenue required makes this response unlikely, and any state action of this sort would likely be concentrated in the highest-income states. Massachusetts was the only state that had significantly expanded coverage through its own reforms prior to the ACA, and even that state relied heavily on federal Medicaid dollars via a waiver to finance the financial assistance that was provided. Given those caveats, our central findings are that the anticipated reconciliation bill would have the following effects:

- The number of uninsured people would increase by 29.8 million by 2019.
- The number of people with Medicaid or CHIP coverage would decrease by 12.9 million, and 17.7 million fewer people would have private nongroup insurance by 2019.
- About 56 percent of those losing coverage would be non-Hispanic whites, 82 percent would be in working families, and 80 percent of adults would have less than a college degree.
- Federal spending on health care would be $109 billion lower in 2019 and $1.3 trillion lower between 2019 and 2028.
- State and local spending on Medicaid and CHIP would be $4 billion lower in 2019 and $76 billion lower between 2019 and 2028. However, uncompensated care pressures on state and local governments and on health care providers would increase significantly with the growing number of uninsured. The newly uninsured would seek an additional $1.1 trillion in uncompensated care between 2019 and 2028. Increases in uncompensated care funding would not occur automatically, and if governments or providers do not increase the funding of care for

the uninsured substantially from current levels, unmet medical need would increase even further and fiscal pressures on providers would intensify significantly.

- Eliminating the individual mandate in 2017 would lead to a significant erosion of the private nongroup insurance markets inside and outside the Marketplaces that year, with lower coverage (an additional 4.3 million uninsured), some midyear insurer exits, substantial financial losses for insurers ($3 billion), and displacement and financial losses for consumers having to change plans.

These changes in coverage and spending add up to substantial decreases in health care spending on nonelderly adults and children, with a disproportionate share of that decrease falling on middle- and low-income people, although we have not included these estimated effects here. The decrease in spending would reduce hospital admissions, visits to doctors and other health care providers, prescriptions filled, and other forms of health care, despite possible increases in public spending on uncompensated care. This scenario does not just move the country back to the situation before the ACA. Because it would lead to a near-collapse of the nongroup insurance market, it moves the country to a situation with higher uninsurance rates than before the ACA's reforms. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

Methods

Our estimates are based on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). The model has been used in a broad array of analyses of the ACA at the federal and state levels. The Supreme Court majority cited HIPSM analysis in the *King v. Burwell* case. The model has accurately forecast the stability of employer-based health insurance under the ACA. The model's estimates of the effect of the ACA on overall coverage and federal government costs compare favorably in accuracy to that of other microsimulation models, including that of the Congressional Budget Office (Glied, Arora, and Solis-Roman 2015).

Our primary source of data for the demographic and economic characteristics of Americans is the American Community Survey. Its large sample size enables state-level analysis. We use the latest available enrollment data from the Marketplaces and Medicaid to impute new coverage. As a result, our estimates of enrollees in each state match actual enrollment. After calibrating HIPSM to reproduce 2016 Medicaid and Marketplace enrollment, we estimate that 10.3 percent of the nonelderly are uninsured in that year. This estimate almost exactly matches the National Health Interview Survey's January–June 2016 estimate of 10.4 percent of the nonelderly uninsured at the time of interview (Zammitti, Cohen, and Martinez 2016, 13). HIPSM coverage estimates represent an annual average number of people in each coverage status.

Our estimates of coverage under the ACA after 2016 do not assume notably higher take-up of Medicaid or Marketplace coverage than in 2016. We recognize that participation rates could increase over time. Nonetheless, we ignore this possibility because we choose to base our estimate of ACA effects on what has already happened. We also adopt conservative assumptions for the cost of health care. Although some studies have found that the ACA contributed to the slowing growth of health care costs in recent years, there is no generally accepted estimate of how large that contribution was

(McMorrow and Holahan 2016). Accordingly, we assume that the underlying growth rate of health care costs would be the same with or without the ACA.

The methods used here are generally consistent with those described in our earlier analysis of full repeal of the ACA (Buettgens et al. 2016). Additional detail on our methods can be found in that document. We have made three changes in our methods. First, this analysis leaves the ACA components with no budgetary implications (i.e., the insurance market reforms in the nongroup insurance market and the small group insurance market) in place. As explained in the results section of this paper, this difference has substantial ramifications for the viability of the private nongroup insurance market and leads to larger coverage effects than our earlier simulations. Second, this analysis focuses on 2019 and the 10-year budget window of 2019 to 2028 instead of 2017 to 2026.

Third, we take a somewhat different approach to allocating the costs associated with increased demand for uncompensated care. We compute the demand for uncompensated care in the same way as prior analyses, but we present the implications for federal, state, and local governments and providers differently than in the last report. We calculate the demand for uncompensated care for each uninsured person based upon their characteristics and health risk. We calibrate uncompensated care costs so that the uncompensated care provided to the uninsured in 2013 matches the estimated amount spent on uncompensated care that year. We inflate the value of uncompensated care over time for each person by the projected per capita growth in medical costs. We also assume that newly uninsured people will spend money on their own care and that their levels of spending will be consistent with those of people of similar health circumstances and characteristics observed under current law. However, in the current analysis we recognize that policy changes would be required in order for federal or state/local spending on uncompensated care to increase significantly beyond current levels. In the prior analysis, we assumed all sources of uncompensated care funding would increase proportionately with the increase in demand for such care. Given that Congress did not include an increase over current levels in federal spending on uncompensated care programs in the 2016 reconciliation bill, we assume a 2017 reconciliation bill would keep federal spending at current levels as well. Therefore, we show the estimated increase in uncompensated care sought due to the increase in the uninsured and compute the relative increase in spending that it would require from states and localities or the relative increase in free care provided by doctors, hospitals, and other providers if they were to finance an increase of that magnitude.

This analysis does not include estimates of the revenue reductions of eliminating the Cadillac tax, the individual mandate penalties, the employer mandate penalties, and other tax changes. We provide decreases in federal spending on health programs, but we do not provide overall federal budget effects. The latter would be considerably smaller than the former. In addition, the anticipated reconciliation bill has implications for state budgets beyond the changes in direct Medicaid spending shown here. As a number of states have reported, the Medicaid expansion has led to additional state budgetary savings, and its repeal could have significant negative economic consequences for states; those consequences are not included in this analysis.

APPENDIX TABLE A.1

Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019

Millions of dollars

	ACA			Reconciliation Bill			Difference		
State	Federal	State	Total	Federal	State	Total	Federal	State	Total
National	**330,191**	**194,951**	**525,142**	**262,720**	**190,654**	**453,374**	**-67,471**	**-4,298**	**-71,768**
Expansion states									
Alaska	903	756	1,659	795	795	1,591	-107	40	-68
Arizona	11,138	4,594	15,732	8,567	4,176	12,743	-2,571	-418	-2,989
Arkansas	3,328	1,215	4,544	2,699	1,151	3,850	-629	-64	-693
California	29,016	23,213	52,229	20,963	20,963	41,927	-8,053	-2,250	-10,302
Colorado	5,920	3,402	9,322	3,412	3,269	6,681	-2,508	-134	-2,642
Connecticut	4,156	3,123	7,279	3,290	3,220	6,511	-866	97	-769
Delaware	1,192	687	1,879	970	765	1,735	-222	78	-144
District of Columbia	1,455	521	1,977	1,316	564	1,880	-139	43	-97
Hawaii	1,220	818	2,038	914	849	1,764	-306	31	-274
Illinois	12,618	8,954	21,572	9,543	9,051	18,594	-3,074	97	-2,978
Indiana	6,450	2,433	8,883	5,304	2,581	7,885	-1,146	148	-998
Iowa	2,726	1,513	4,239	2,280	1,594	3,874	-446	81	-365
Kentucky	8,512	2,257	10,769	4,679	1,998	6,677	-3,834	-259	-4,092
Louisiana	5,986	2,819	8,805	4,126	2,618	6,744	-1,860	-201	-2,062
Maryland	6,379	4,466	10,846	4,472	4,472	8,943	-1,908	5	-1,903
Massachusetts	7,593	6,166	13,759	6,179	5,976	12,155	-1,414	-190	-1,604
Michigan	12,023	4,525	16,548	9,510	4,785	14,295	-2,513	260	-2,253
Minnesota	6,485	4,907	11,392	5,292	5,292	10,583	-1,193	385	-808
Montana	1,797	621	2,418	1,099	535	1,634	-698	-86	-784
Nevada	2,758	1,063	3,821	1,730	995	2,725	-1,028	-68	-1,096
New Hampshire	1,144	780	1,924	815	815	1,630	-329	35	-295
New Jersey	10,906	5,916	16,822	6,544	6,265	12,809	-4,363	350	-4,013
New Mexico	5,808	1,735	7,544	3,608	1,606	5,213	-2,201	-130	-2,330
New York	27,846	21,110	48,956	23,880	23,235	47,116	-3,966	2,126	-1,840
North Dakota	559	336	895	390	386	776	-169	49	-119
Ohio	14,233	6,156	20,389	10,735	6,299	17,034	-3,498	143	-3,355
Oregon	6,624	2,115	8,739	3,747	2,115	5,861	-2,877	-1	-2,878
Pennsylvania	12,257	7,912	20,169	10,373	8,614	18,987	-1,883	702	-1,182

	ACA			Reconciliation Bill			Difference		
State	Federal	State	Total	Federal	State	Total	Federal	State	Total
Rhode Island	1,691	1,228	2,920	1,136	1,131	2,267	-556	-98	-653
Vermont	917	554	1,471	746	608	1,354	-171	54	-117
Washington	7,221	4,131	11,352	4,121	4,043	8,164	-3,100	-88	-3,188
West Virginia	2,860	782	3,642	1,849	726	2,575	-1,011	-56	-1,067
Expansion states total	*223,722*	*130,811*	*354,533*	*165,085*	*131,492*	*296,576*	*-58,638*	*681*	*-57,956*
Nonexpansion states									
Alabama	3,710	1,642	5,353	3,439	1,525	4,964	-271	-117	-388
Florida	14,230	9,728	23,958	12,719	8,732	21,452	-1,511	-996	-2,507
Georgia	7,834	3,929	11,763	6,881	3,454	10,334	-953	-475	-1,428
Idaho	2,006	777	2,784	1,798	698	2,496	-208	-79	-288
Kansas	1,877	1,363	3,240	1,734	1,258	2,992	-143	-105	-248
Maine	1,376	839	2,215	1,335	820	2,155	-41	-19	-60
Mississippi	3,498	1,263	4,761	3,185	1,150	4,335	-313	-112	-426
Missouri	6,389	3,784	10,173	5,946	3,534	9,480	-444	-250	-694
Nebraska	1,162	960	2,122	1,149	950	2,100	-12	-10	-22
North Carolina	11,436	5,817	17,254	9,803	5,009	14,811	-1,634	-808	-2,442
Oklahoma	3,810	2,141	5,951	3,675	2,065	5,740	-135	-76	-211
South Carolina	4,287	1,788	6,075	4,200	1,751	5,951	-88	-37	-124
South Dakota	645	555	1,200	624	537	1,162	-21	-18	-39
Tennessee	7,717	3,961	11,678	6,457	3,346	9,803	-1,260	-615	-1,875
Texas	25,288	17,257	42,545	23,978	16,363	40,341	-1,310	-894	-2,204
Utah	2,529	1,041	3,569	2,412	992	3,405	-116	-48	-165
Virginia	4,415	4,299	8,713	4,210	4,100	8,311	-204	-198	-403
Wisconsin	3,899	2,643	6,542	3,742	2,533	6,276	-157	-109	-266
Wyoming	360	353	713	350	343	692	-10	-10	-21
Nonexpansion states total	*106,469*	*64,141*	*170,609*	*97,636*	*59,162*	*156,798*	*-8,833*	*-4,979*	*-13,812*

Source: Urban Institute analysis using HIPSM 2016.

APPENDIX TABLE A.2

Number of People Losing Federal Financial Assistance for Marketplace Coverage, Average Assistance Forgone, and Aggregate Federal Assistance Forgone under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019

State	People who would receive tax credits under the ACA (thousands)	Average tax credit and cost-sharing assistance per recipient ($)	Premium tax credits ($ millions)	Cost-sharing reductions ($ millions)	Total federal assistance forgone ($ millions)
National	9,322	$4,480	35,338	6,427	41,765
Expansion states					
Alaska	19	$8,810	150	21	171
Arizona	126	$6,975	827	49	877
Arkansas	55	$3,516	159	35	194
California	1,403	$3,945	4,783	752	5,534
Colorado	78	$2,840	190	33	223
Connecticut	74	$5,272	348	43	391
Delaware	20	$4,025	71	10	81
District of Columbia	3	$2,368	7	0	8
Hawaii	11	$4,351	42	6	47
Illinois	258	$4,355	1,001	122	1,122
Indiana	104	$4,448	385	78	463
Iowa	42	$4,281	156	24	180
Kentucky	57	$4,547	213	46	259
Louisiana	70	$5,230	316	50	366
Maryland	129	$2,981	332	53	385
Massachusetts	126	$3,881	415	75	491
Michigan	232	$3,230	633	118	750
Minnesota	47	$3,512	163	2	165
Montana	23	$4,776	97	12	109
Nevada	63	$4,956	262	50	312
New Hampshire	29	$2,898	70	16	85
New Jersey	193	$3,152	513	94	607
New Mexico	33	$2,805	77	16	93
New York	310	$2,869	771	120	891
North Dakota	17	$3,182	47	7	54
Ohio	155	$3,446	438	97	535
Oregon	111	$2,656	255	41	296
Pennsylvania	239	$4,996	1,074	121	1,195
Rhode Island	30	$2,002	50	10	60

State	People who would receive tax credits under the ACA (thousands)	Average tax credit and cost-sharing assistance per recipient ($)	Premium tax credits ($ millions)	Cost-sharing reductions ($ millions)	Total federal assistance forgone ($ millions)
Vermont	24	$3,888	83	9	91
Washington	142	$3,005	352	73	425
West Virginia	29	$5,668	143	21	164
Expansion states total	**4,254**	**$3,908**	**14,423**	**2,203**	**16,626**
Nonexpansion states					
Alabama	151	$7,156	931	147	1,078
Florida	1,366	$4,481	5,106	1,013	6,119
Georgia	437	$4,148	1,430	381	1,811
Idaho	79	$4,178	276	56	331
Kansas	78	$4,999	329	60	389
Maine	67	$5,788	331	57	388
Mississippi	72	$6,642	390	85	475
Missouri	225	$5,216	960	212	1,172
Nebraska	70	$5,671	345	52	397
North Carolina	493	$6,943	2,947	475	3,421
Oklahoma	110	$6,260	601	87	689
South Carolina	163	$5,842	787	164	951
South Dakota	20	$5,243	90	15	105
Tennessee	173	$5,573	834	132	966
Texas	941	$4,310	3,234	822	4,057
Utah	83	$3,468	242	46	288
Virginia	326	$4,218	1,122	252	1,374
Wisconsin	197	$4,953	837	139	976
Wyoming	19	$8,190	122	30	152
Nonexpansion states total	**5,068**	**$4,961**	**20,914**	**4,225**	**25,139**

Source: Urban Institute analysis using HIPSM 2016.

Notes: Average assistance per recipient is calculated as the total of premium tax credits and cost-sharing reductions provided in each state, divided by the number of people in families receiving assistance. All those receiving Marketplace assistance receive tax credits; some receive both tax credits and cost-sharing assistance. For example, a family of four receiving a tax credit through a Marketplace would count as four people in tallies of those receiving assistance.

APPENDIX TABLE A.3

Federal and State Medicaid/CHIP Spending under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

	ACA		Reconciliation Bill		Difference	
State	Federal	State	Federal	State	Federal	State
Expansion states						
Alaska	$11,516	$9,756	$10,198	$10,198	-$1,318	$442
Arizona	$142,127	$59,683	$110,043	$53,638	-$32,084	-$6,044
Arkansas	$41,909	$15,586	$34,148	$14,565	-$7,761	-$1,021
California	$363,744	$295,051	$264,676	$264,676	-$99,068	-$30,375
Colorado	$74,434	$44,204	$43,583	$41,713	-$30,851	-$2,491
Connecticut	$51,903	$39,643	$41,431	$40,547	-$10,472	$904
Delaware	$14,978	$8,821	$12,287	$9,687	-$2,690	$866
District of Columbia	$18,223	$6,671	$16,564	$7,099	-$1,659	$427
Hawaii	$15,314	$10,506	$11,586	$10,759	-$3,728	$253
Illinois	$157,567	$113,855	$120,198	$113,893	-$37,369	$38
Indiana	$81,176	$31,465	$67,268	$32,725	-$13,908	$1,260
Iowa	$34,394	$19,436	$28,998	$20,265	-$5,396	$829
Kentucky	$105,571	$29,683	$58,774	$25,098	-$46,797	-$4,585
Louisiana	$74,411	$35,939	$51,729	$32,817	-$22,682	-$3,122
Maryland	$80,069	$57,286	$56,627	$56,627	-$23,443	-$660
Massachusetts	$95,075	$78,018	$77,912	$75,343	-$17,163	-$2,675
Michigan	$148,780	$57,731	$118,792	$59,758	-$29,988	$2,026
Minnesota	$82,245	$63,400	$67,686	$67,686	-$14,559	$4,286
Montana	$22,512	$8,091	$13,945	$6,790	-$8,568	-$1,302
Nevada	$35,236	$14,091	$22,328	$12,835	-$12,908	-$1,256
New Hampshire	$14,138	$9,874	$10,172	$10,172	-$3,966	$299
New Jersey	$135,378	$76,052	$82,380	$78,785	-$52,998	$2,733
New Mexico	$72,465	$22,723	$45,594	$20,293	-$26,871	-$2,430
New York	$347,954	$267,729	$300,605	$292,248	-$47,349	$24,520
North Dakota	$7,043	$4,357	$4,980	$4,928	-$2,063	$571
Ohio	$176,730	$78,643	$134,545	$78,951	-$42,185	$308
Oregon	$82,541	$27,876	$47,423	$26,745	-$35,118	-$1,131
Pennsylvania	$154,018	$101,149	$131,365	$109,020	-$22,654	$7,871
Rhode Island	$21,045	$15,610	$14,316	$14,254	-$6,728	-$1,357

	ACA		Reconciliation Bill		Difference	
State	Federal	State	Federal	State	Federal	State
Vermont	$11,281	$6,956	$9,346	$7,612	-$1,935	$656
Washington	$90,347	$53,511	$52,283	$51,284	-$38,064	-$2,227
West Virginia	$35,274	$10,101	$23,027	$9,047	-$12,247	-$1,054
Expansion states total	*$2,799,399*	*$1,673,497*	*$2,084,808*	*$1,660,058*	*-$714,591*	*-$13,439*
Nonexpansion states						
Alabama	$46,751	$20,673	$43,341	$19,203	-$3,410	-$1,470
Florida	$180,752	$123,567	$161,626	$110,954	-$19,126	-$12,613
Georgia	$100,670	$50,498	$88,488	$44,414	-$12,182	-$6,084
Idaho	$25,670	$9,944	$23,025	$8,936	-$2,645	-$1,008
Kansas	$23,772	$17,247	$21,975	$15,922	-$1,797	-$1,325
Maine	$17,064	$10,412	$16,566	$10,179	-$498	-$233
Mississippi	$43,816	$15,814	$39,928	$14,420	-$3,888	-$1,393
Missouri	$80,482	$47,643	$74,971	$44,535	-$5,510	-$3,108
Nebraska	$14,733	$12,181	$14,581	$12,056	-$152	-$126
North Carolina	$145,642	$74,079	$124,923	$63,824	-$20,719	-$10,255
Oklahoma	$48,324	$27,159	$46,666	$26,227	-$1,659	-$932
South Carolina	$54,112	$22,566	$53,036	$22,118	-$1,075	-$448
South Dakota	$8,248	$7,103	$7,979	$6,871	-$269	-$232
Tennessee	$97,562	$50,078	$81,654	$42,303	-$15,908	-$7,775
Texas	$323,489	$220,741	$306,920	$209,439	-$16,568	-$11,303
Utah	$32,712	$13,459	$31,221	$12,842	-$1,492	-$617
Virginia	$56,263	$54,756	$53,659	$52,232	-$2,604	-$2,524
Wisconsin	$49,352	$33,442	$47,447	$32,108	-$1,905	-$1,334
Wyoming	$4,555	$4,467	$4,432	$4,343	-$123	-$124
Nonexpansion states total	*$1,353,966*	*$815,830*	*$1,242,436*	*$752,926*	*-$111,530*	*-$62,904*
National estimate	**$4,153,365**	**$2,489,327**	**$3,327,244**	**$2,412,984**	**-$826,121**	**-$76,342**

Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

APPENDIX TABLE A.4

Forgone Federal Spending on Marketplace Financial Assistance under an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

State	Federal Marketplace financial assistance	State	Federal Marketplace financial assistance
Expansion states		*Nonexpansion states*	
Alaska	1,900	Alabama	11,944
Arizona	10,017	Florida	68,139
Arkansas	2,147	Georgia	20,484
California	61,116	Idaho	3,710
Colorado	2,479	Kansas	4,316
Connecticut	4,305	Maine	4,212
Delaware	898	Mississippi	5,232
District of Columbia	85	Missouri	12,909
Hawaii	532	Nebraska	4,398
Illinois	12,483	North Carolina	38,239
Indiana	5,095	Oklahoma	7,682
Iowa	1,982	South Carolina	10,580
Kentucky	2,861	South Dakota	1,166
Louisiana	4,048	Tennessee	10,777
Maryland	4,338	Texas	45,594
Massachusetts	5,361	Utah	3,262
Michigan	8,177	Virginia	15,400
Minnesota	1,875	Wisconsin	10,722
Montana	1,205	Wyoming	1,681
Nevada	3,529	*Nonexpansion states total*	*280,449*
New Hampshire	927		
New Jersey	6,694		
New Mexico	1,027		
New York	9,853		
North Dakota	592		
Ohio	5,842		
Oregon	3,286		
Pennsylvania	13,276		
Rhode Island	653		
Vermont	989		
Washington	4,691		
West Virginia	1,794		
Expansion states total	*184,058*		
National total	**464,507**	**National total**	**464,507**

Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act.

APPENDIX TABLE A.5

Total Federal and State Spending on Medicaid/CHIP and Marketplace Assistance under the ACA and an Anticipated Reconciliation Bill, by State and Medicaid Expansion Status, 2019–28

Millions of dollars

	ACA		Reconciliation Bill		Difference	
State	Federal	State	Federal	State	Federal	State
Expansion states						
Alaska	$13,416	$9,756	$10,198	$10,198	-$3,218	$442
Arizona	$152,144	$59,683	$110,043	$53,638	-$42,101	-$6,044
Arkansas	$44,056	$15,586	$34,148	$14,565	-$9,908	-$1,021
California	$424,860	$295,051	$264,676	$264,676	-$160,184	-$30,375
Colorado	$76,913	$44,204	$43,583	$41,713	-$33,330	-$2,491
Connecticut	$56,209	$39,643	$41,431	$40,547	-$14,778	$904
Delaware	$15,876	$8,821	$12,287	$9,687	-$3,589	$866
District of Columbia	$18,308	$6,671	$16,564	$7,099	-$1,744	$427
Hawaii	$15,846	$10,506	$11,586	$10,759	-$4,261	$253
Illinois	$170,051	$113,855	$120,198	$113,893	-$49,852	$38
Indiana	$86,271	$31,465	$67,268	$32,725	-$19,003	$1,260
Iowa	$36,376	$19,436	$28,998	$20,265	-$7,378	$829
Kentucky	$108,432	$29,683	$58,774	$25,098	-$49,658	-$4,585
Louisiana	$78,459	$35,939	$51,729	$32,817	-$26,730	-$3,122
Maryland	$84,408	$57,286	$56,627	$56,627	-$27,781	-$660
Massachusetts	$100,435	$78,018	$77,912	$75,343	-$22,523	-$2,675
Michigan	$156,956	$57,731	$118,792	$59,758	-$38,164	$2,026
Minnesota	$84,119	$63,400	$67,686	$67,686	-$16,434	$4,286
Montana	$23,717	$8,091	$13,945	$6,790	-$9,773	-$1,302
Nevada	$38,765	$14,091	$22,328	$12,835	-$16,437	-$1,256
New Hampshire	$15,065	$9,874	$10,172	$10,172	-$4,893	$299
New Jersey	$142,073	$76,052	$82,380	$78,785	-$59,693	$2,733
New Mexico	$73,492	$22,723	$45,594	$20,293	-$27,899	-$2,430
New York	$357,807	$267,729	$300,605	$292,248	-$57,202	$24,520
North Dakota	$7,635	$4,357	$4,980	$4,928	-$2,655	$571
Ohio	$182,572	$78,643	$134,545	$78,951	-$48,027	$308
Oregon	$85,826	$27,876	$47,423	$26,745	-$38,403	-$1,131
Pennsylvania	$167,294	$101,149	$131,365	$109,020	-$35,930	$7,871

Rhode Island	$21,698	$15,610	$14,316	$14,254	-$7,382	-$1,357
Vermont	$12,269	$6,956	$9,346	$7,612	-$2,924	$656
Washington	$95,038	$53,511	$52,283	$51,284	-$42,755	-$2,227
West Virginia	$37,068	$10,101	$23,027	$9,047	-$14,042	-$1,054
Expansion states total	*$2,983,457*	*$1,673,497*	*$2,084,808*	*$1,660,058*	*-$898,649*	*-$13,439*
Nonexpansion states						
Alabama	$58,695	$20,673	$43,341	$19,203	-$15,353	-$1,470
Florida	$248,890	$123,567	$161,626	$110,954	-$87,265	-$12,613
Georgia	$121,154	$50,498	$88,488	$44,414	-$32,666	-$6,084
Idaho	$29,380	$9,944	$23,025	$8,936	-$6,355	-$1,008
Kansas	$28,087	$17,247	$21,975	$15,922	-$6,113	-$1,325
Maine	$21,276	$10,412	$16,566	$10,179	-$4,710	-$233
Mississippi	$49,048	$15,814	$39,928	$14,420	-$9,120	-$1,393
Missouri	$93,391	$47,643	$74,971	$44,535	-$18,420	-$3,108
Nebraska	$19,131	$12,181	$14,581	$12,056	-$4,550	-$126
North Carolina	$183,881	$74,079	$124,923	$63,824	-$58,958	-$10,255
Oklahoma	$56,006	$27,159	$46,666	$26,227	-$9,341	-$932
South Carolina	$64,691	$22,566	$53,036	$22,118	-$11,655	-$448
South Dakota	$9,414	$7,103	$7,979	$6,871	-$1,435	-$232
Tennessee	$108,339	$50,078	$81,654	$42,303	-$26,685	-$7,775
Texas	$369,083	$220,741	$306,920	$209,439	-$62,162	-$11,303
Utah	$35,975	$13,459	$31,221	$12,842	-$4,754	-$617
Virginia	$71,664	$54,756	$53,659	$52,232	-$18,004	-$2,524
Wisconsin	$60,074	$33,442	$47,447	$32,108	-$12,627	-$1,334
Wyoming	$6,236	$4,467	$4,432	$4,343	-$1,804	-$124
Nonexpansion states total	*$1,634,415*	*$815,830*	*$1,242,436*	*$752,926*	*-$391,979*	*-$62,904*
National total	**$4,617,872**	**$2,489,327**	**$3,327,244**	**$2,412,984**	**-$1,290,628**	**-$76,218**

Source: Urban Institute analysis using HIPSM 2016.
Note: ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

Notes

1. Alex Moe, "Congress Sends Obamacare Repeal to President for First Time," NBC News, January 6, 2016, http://www.nbcnews.com/news/us-news/congress-send-obamacare-repeal-president-n491316.
2. Steven T. Dennis and Billy House, "GOP Eyes Lightning Strike on Obamacare to Kick Off Trump Era," Bloomberg, November 29, 2016, http://www.bloomberg.com/politics/articles/2016-11-29/gop-eyes-lightning-strike-on-obamacare-to-kick-off-trump-era; and Lisa Mascaro, "Repeal and Replace Obamacare? It Won't Happen on Trump's First Day," *Los Angeles Times*, November 29, 2016, http://www.latimes.com/nation/politics/trailguide/la-na-trailguide-updates-1480442605-htmlstory.html.
3. "Summary of the Byrd rule," US House of Representatives Committee on Rules, accessed November 22, 2016, http://archives.democrats.rules.house.gov/archives/byrd_rule.htm.
4. A number of other provisions of the 2016 reconciliation bill that would have affected coverage would have taken effect immediately or before two years. These include the early repeal of the maintenance-of-effort requirement for eligibility of children under Medicaid/CHIP and the elimination of the tax credit reconciliation caps. These provisions are not included in the estimates presented here.
5. We assume that federal DSH payments increase very modestly over the 10-year period. The Medicare DSH cuts in the ACA were left in place in the prior reconciliation bill, as were all Medicare savings provisions. We assume that would still be the case. The ACA's Medicaid DSH cuts have never been implemented, and we assume that they are restored permanently and held constant and that there would be no congressional interest in increasing them. Medicaid supplemental payments contribute in part to funding uncompensated care, and states could increase their use of them, but there would be fewer Medicaid patients to attach them to. Other sources of federal funding for uncompensated care could increase, but these would be modest given the new administration's commitment to budget cuts.
6. The Congressional Budget Office (2016) estimates Marketplace premium tax credits in the amount of $60 billion and cost-sharing reductions in the amount of $12 billion in 2019. Those larger federal spending estimates are the result of an estimate of subsidized Marketplace enrollment of 16 million people in 2019. This level of subsidized enrollment is significantly higher than that produced by HIPSM and would represent a very large increase in enrollment relative to administrative data. According to the Department of Health and Human Services, subsidized Marketplace enrollment was 9.4 million people in March 2016 (US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "March 31, 2016 Effectuated Enrollment Snapshot," media release, June 30, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html), and Marketplace enrollment has fallen somewhat over the course of each calendar year from March levels. Our 2019 subsidized Marketplace enrollment of 9.3 million represents an average for calendar year 2019; thus, while conservative, it represents a modest increase in coverage between 2016 and 2019.
7. See, for example, Brian Fanney, Michael R. Wickline, and Spencer Williams, "Arkansas House Speaker Details Cuts if Medicaid Plan Fails," *Arkansas Online*, April 12, 2016, http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/. Medicaid expansion in Arkansas was extended on April 21, 2016; see David Ramsey, "Using Novel Line-Item Veto, Ark. Governor Extends Medicaid Expansion," Kaiser Health News, April 21, 2016, http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion; and Dorn et al. (2015).

References

Blumberg, Linda J., and Matthew Buettgens. 2016. "The Implications of a Finding for the Plaintiffs in *House v. Burwell*." Washington, DC: Urban Institute.

Blumberg, Linda J., Michael Karpman, Matthew Buettgens, and Patricia Solleveld.2016. *Who Are the Remaining Uninsured, and What Do Their Characteristics Tell Us about How to Reach Them?* Washington, DC: Urban Institute.

Buettgens, Matthew, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe. 2016. "The Cost of ACA Repeal." Washington, DC: Urban Institute.

Congressional Budget Office. 2016. *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2016 to 2026*. Washington, DC: Congressional Budget Office.

Dorn, Stan, Norton Francis, Laura Snyder, and Robin Rudowitz. 2015. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." Menlo Park, CA: Kaiser Family Foundation.

Glied, Sherry A., Anupama Arora, and Claudia Solís-Román. 2015. *The CBO's Crystal Ball: How Well Does It Forecast the Effects of the Affordable Care Act?* New York: The Commonwealth Fund.

Holahan, John. 2011. "The 2007–09 Recession and Health Insurance Coverage." *Health Affairs* 30 (1): 145–52. doi: 10.1377/hlthaff.2010.1003.

McMorrow, Stacey, and John Holahan. 2016. *The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act; An Update.* Washington, DC: Urban Institute.

Monheit, Alan C., Joel C. Cantor, Margaret Koller, and Kimberley S. Fox. 2004. "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey." *Health Affairs* 23 (4): 167–75. doi: 10.1377/hlthaff.23.4.167.

Zammitti, Emily P., Robin A. Cohen, and Michael E. Martinez. 2016. "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2016." Hyattsville, MD: National Center for Health Statistics.

About the Authors

Linda Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

Matthew Buettgens is a senior research associate in the Health Policy Center, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state by state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments, small firm self-insurance under the Affordable Care Act and its effect on the fully insured market, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the affordability of coverage under health insurance exchanges, and the implications of age rating for the affordability of coverage.

John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

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Addenda

This brief was updated at 10:00 a.m. December 8, 2016. Two additional data columns were added to appendix table A.2. No previous data were altered.

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Instead of ACA Repeal and Replace, Fix It

John Holahan and Linda J. Blumberg
January 2017

Executive Summary

Repealing the Affordable Care Act (ACA) via the budget reconciliation process without replacement policies in place risks dramatically increasing the number of uninsured people and causing chaos in the individual (nongroup) insurance markets. Replacement plans will likely be controversial and cover fewer people than the ACA. Any replacement plan will need to receive some support from Democrats in order to pass the Senate. After repeal, an ACA replacement will require new revenues because there will be a new spending and revenue baseline. This may prove to be extremely challenging.

Faced with this reality, policymakers should consider fixing the major problems they have with the ACA rather than repealing it; this would not disrupt the parts that are working effectively. To that end, we propose a range of policies that would address critics' concerns and also strengthen the law, expand coverage, improve affordability, increase market stability, and lower the high premiums that exist in some markets.

We propose the following:

1. Replace the individual mandate with a modified version of the late enrollment penalties currently used in Medicare Parts B and D.
2. End the employer mandate. The limited gains in coverage and the revenue it generates have not been worth the controversy it has caused.
3. Replace the Cadillac tax with a cap on the tax exclusion for employer-based insurance, ideally setting the cap at levels that would generate additional revenues to help finance vital enhancements.

4. Improve affordability by reducing premiums, deductibles, and other cost-sharing requirements for modest-income individuals, and extend to higher-income individuals a cap on premiums at 8.5 percent of income.
5. With a premium cap at 8.5 percent of income applied to all, relax the 3:1 age rating to be more in line with actual differences in spending for younger and older individuals.
6. Examine the essential health benefits package, recognizing that eliminating certain benefits would eliminate risk pooling for those services, shifting all costs to individuals needing those services. That is problematic for any service, but particularly so for prescription drugs, mental health, and substance use disorder treatment.
7. Stabilize the Marketplaces by taking steps to increase enrollment. This would include investing in additional outreach and enrollment assistance and allowing states to extend Medicaid eligibility to 100 percent of the federal poverty level (FPL) rather than 138 percent of FPL. People with incomes between 100 and 138 percent of FPL would move from Medicaid to Marketplace coverage and thereby benefit from the affordability provisions mentioned above. Further, it should be made easier for working families to be eligible for income-related tax credits.
8. Address the impact of insurer and provider concentration on nongroup market premiums by capping provider payments in those plans at Medicare rates or some multiple thereof—an approach currently used by the Medicare Advantage program. This would limit the use of market power by large provider systems and make it easier for insurers to enter new markets.
9. Use a broad-based source of revenue (e.g., assessments on all health insurance and stop-loss coverage premiums or general revenues) to permanently protect nongroup insurers from the consequences of enrolling a disproportionate share of very high-cost enrollees, as is done in Medicare Part D and Medicare Advantage.

Most of these steps have had bipartisan support in other contexts and therefore can provide a framework for a bipartisan compromise.

Introduction

As the new Congress contemplates partial repeal of the Affordable Care Act through the budget reconciliation process, they run the risk of increasing the number of uninsured Americans by approximately 30 million, crippling the private nongroup insurance market, causing nongroup insurance premiums to rise precipitously, and imposing significant added uncompensated care costs on state and local governments, hospitals, and other health care providers (Blumberg, Buettgens, and Holahan 2016; Buettgens, Blumberg, and Holahan 2017).

Moreover, as Congress works to craft a replacement plan that is based upon outlines of reform proposals,[1] they are likely to find it impossible to meet their stated goals of maintaining or broadening insurance coverage, making insurance more affordable, reducing government spending, improving quality of care, expanding consumer choice, and giving states and health care providers more flexibility and fewer regulations.[2] Difficult tradeoffs will have to be made, unpopular decisions will be required,

and complex and confusing rules and regulations—as onerous as those necessitated by the ACA—will prove unavoidable. In addition, replacement following repeal will require new sources of revenue to finance new policies because the revenue and spending baseline would change immediately, and a replacement plan will need some Democratic support. This constitutes a substantial political challenge.

Given the possibility of insurance market chaos during the period between repeal and effective replacement and the unavoidable challenges of implementing a new set of reforms, policymakers should ask whether correcting the flaws in the ACA might sufficiently address critics' major concerns. Fixing the existing structure could avert an increase in the uninsured population, a surge in health care costs, or another period of uncertainty during which stakeholders wonder if whatever is enacted will itself be overturned when the political landscape inevitably shifts.

The Case against Partial or Complete Repeal and the Challenges of Replacement

Simply repealing the financial assistance (premium tax credits and cost-sharing reductions for Marketplace insurance), Medicaid expansion, and individual mandate while leaving the insurance market reforms (e.g., essential health benefit requirements, prohibitions on pre-existing condition exclusions, modified community rating) in place—as is being considered as part of the 2017 budget reconciliation process[3]—would cause enormous disruption to individuals and insurers, and it would be fraught with political peril. Nearly 30 million people would lose coverage (Blumberg, Buettgens, and Holahan 2016). Hospitals and other health care providers would lose large amounts of revenue (Buettgens, Blumberg, and Holahan 2017). Private insurers selling coverage in the nongroup market would lose large numbers of covered lives. People who do not have access to employer coverage or public insurance would see such sharp spikes in premiums that the vast majority would not be able to afford coverage. If insurance market reforms were eventually repealed as well (this would have to be done through separate legislation, not budget reconciliation), many of those with health problems could be denied coverage outright or offered only limited benefit plans at high premiums.

State budgets would be adversely affected as the number of uninsured climbs and the demand for uncompensated care climbs with it. In addition, states have reaped savings by no longer funding services now provided through the Medicaid expansion and the Marketplaces; those savings would vanish (Dorn et al. 2015).[4] Providers would be faced with more patients unable to pay their bills (Buettgens, Blumberg, and Holahan 2017). Plus, the recent slowdown in health care spending would be put at risk because at least some of that slowdown is attributable to changes brought by the ACA (McMorrow and Holahan 2016).

Contrary to what some have claimed, the ACA has not been a high-cost program (Clemans-Cope, Holahan, and Garfield 2016). The Congressional Budget Office estimates that the tax exemption of contributions to employer-sponsored health insurance leads to about $250 billion in forgone revenue per year for the federal government (CBO 2013, 243–49). But we estimate that the cost of financial

assistance through the Marketplaces and the ACA's Medicaid expansion will cost the federal government only $109.3 billion in 2019 under current law (Blumberg, Buettgens, and Holahan 2016). Elsewhere, we estimated that national health expenditures for 2014 to 2019 will be $2.6 trillion lower than originally estimated, partly because of various provisions of the ACA (McMorrow and Holahan 2016). Together, the Marketplaces' use of relatively large deductibles and other cost-sharing requirements for middle-income enrollees and narrow provider networks combined with a significant coverage expansion via Medicaid for low-income enrollees have kept costs down (Blumberg and Holahan 2015a).

The central components of the current replacement proposals include expansion of health savings accounts (HSAs), replacement of income-related tax credits and expanded Medicaid eligibility with age-related tax credits, and sales of insurance across state lines. But these provisions are likely insufficient to provide affordable access to necessary care for low-income people—those most likely to become uninsured in the absence of the ACA. HSAs largely benefit higher-income people because the tax benefit increases with marginal income tax rates; low- and middle-income people benefit much less because of their lower tax rates, and they generally do not have the extra resources to contribute to the accounts anyway. In addition, HSAs are most beneficial to those not using much medical care. As a result, expanding them would have little effect on coverage.

Age-related tax credits available to all regardless of income would provide much smaller subsidies to modest- and lower-income people than income-related tax credits would, unless much more federal spending is provided to fund them. The smaller amount of assistance per eligible person would mean that affordable health insurance plans would have substantially higher cost-sharing requirements and narrower covered benefits, leaving those with health care needs facing higher costs and reduced access to care.[5] Plus, the smaller the amounts of assistance, the lower the levels of insurance coverage and the higher the number of uninsured.

Allowing insurers to sell coverage across state lines in an insurance environment largely unregulated by the federal government would permit insurers domiciled in unregulated states to effectively undermine laws in states with more regulation (Blumberg 2016). This could lead insurers to offer only high cost-sharing, limited-benefit policies nationwide in order to avoid adverse selection, in turn decreasing consumer choice and placing increased financial burdens on those with health care service needs.

Traditional high-risk pools are often proposed as a mechanism for insuring those with high health care needs separately from others, but past experiences with these pools have proven them to be unsuccessful in addressing the needs of most high-cost or high-risk people (Blumberg 2011; Pollitz 2016). Such pools either cover too few high-risk people because of inadequate government spending commitments (likely implemented through very strict eligibility requirements or enrollment limits) or, if they are designed to adequately cover the large high-risk population, would be prohibitively expensive.

These policy approaches would substantially increase segmentation of insurance risk pools, making insurance extremely expensive and often inaccessible for those with any significant health care risk.[6]

While these policies could decrease premiums for the young and healthy, they would increase premiums for many people, and out-of-pocket costs would increase markedly for virtually all those purchasing insurance in the nongroup market.

Approaches to Address the ACA's Problems and Opponents' Concerns

We recommend a number of policies that could both respond to the ACA's most serious problems and address many of the most significant complaints made by the law's opponents. Our policy recommendations would address issues with the individual and employer mandates; the excise tax on high-cost health plans, or "Cadillac" tax; the affordability of coverage; age rating; essential health benefits requirements; and high nongroup insurance premiums in some geographic areas. A package of reforms to the ACA could include the following approaches.

Replace the Individual Mandate Penalties

The income tax penalties associated with the individual mandate are by far the most unpopular feature of the ACA (Karpman, Blavin, and Zuckerman 2016; Kirzinger, Sugarman, and Brodie 2016). The mandate and penalties are intended to

1. maximize insurance coverage, short of instituting a fully financed government system into which the entire population is automatically enrolled; and
2. retain the currently insured and attract the healthiest uninsured individuals into coverage, such that health care risks of a diverse population can be shared broadly.

The reason the individual mandate is important for reaching the first objective is clear: more people enroll in insurance if they are required to do so or subject to a fine than would without these stipulations. The second objective is most critical for those without access to affordable employer-based insurance because without an individual mandate, insurers fear adverse selection, particularly in nongroup insurance markets. Enrollment rates in employer-based insurance are high, so adverse selection concerns are much lower in those markets. An individual mandate provides more robust enrollment in nongroup plans, which lowers premiums and ensures that the pre-existing condition prohibition and other consumer protections against health status discrimination can function without bankrupting insurers.

To replace the tax penalties, some proposals would introduce a continuous coverage provision, recognizing the need to encourage younger and healthier people to enroll in insurance and maintain coverage.[7] This requirement is actually an individual mandate but with much harsher and longer-lasting penalties that would fall very heavily on those with health problems, unstable employment, and limited income (Blumberg and Holahan 2015b). Under a continuous coverage requirement, those missing a one-time open enrollment period and those experiencing a period of uninsurance in the future could face medical underwriting without limits,[8] effectively locking many of those with health needs out of

coverage until they either gain access to employer-sponsored insurance or until they reach age 65 and become eligible for Medicare.[9] Middle- and lower-income people are more likely to have gaps in insurance coverage because of changing employment, life, and financial circumstances, and they are least likely to be able to pay for medically underwritten coverage that would have higher premiums, fewer covered benefits, higher cost-sharing requirements, or a combination of these. As a result, they are the most vulnerable to becoming uninsured and going without access to needed care long-term, under a continuous coverage requirement.

A better alternative, which would not differentially penalize those with health issues and would take the income of the uninsured person into account, would be to replace the ACA's tax penalties with a modified version of the premium surcharges used today in Medicare Part B and Part D. These premium surcharges have had bipartisan support under Medicare. Individuals who do not sign up for Part B upon becoming eligible pay a penalty of 10 percent of the regular Part B premium for each 12-month delay in enrolling, with the penalty assessed for the rest of their lives while enrolled, once they do ultimately enroll.[10] In Part D, a penalty for late enrollment is also imposed via the premium, equal to 1 percent per month that the individual is without qualified prescription drug coverage; again, this penalty is imposed for the rest of the person's life while enrolled.

Medicare imposes monthly or annual penalties that amount to small percentages of premiums per month uninsured, but they accumulate without end and apply to premiums paid by beneficiaries indefinitely. For a younger population, we suggest stronger penalties that apply once a person enrolls but are not long-lasting. Ideally, the premium surcharge would be designed to approximate the size of the current individual mandate penalties. This approach would set the level of the premium surcharge (e.g., 1.5 to 2.0 percent per month), a maximum period of time to "look back" for the duration of uninsurance (e.g., one or two years uninsured), and a maximum period of time for the surcharge to be applied (e.g., charged for a maximum of one or two years).

The objective of the surcharge should be to make the penalties strong enough to be effective in maximizing enrollment, yet not so punitive as to risk making coverage so expensive that the vast majority of individuals could not afford to obtain coverage after a long spell of uninsurance. Clearly, this is a challenging balance to strike. To ensure the penalties are smaller for lower-income people than for higher-income people, the surcharge should be imposed on the portion of the premium paid by the household, not the portion paid for by the federal government. It will also be necessary to set the premium surcharge percentage lower for family policies than for single policies, since the thresholds for income relative to poverty increase much more slowly with family size than do premiums.

Although they are far preferable to a continuous coverage requirement, premium surcharges may be less successful than the current ACA penalties in increasing enrollment among healthy people. Many would likely be unaware of the surcharges until they decided to enroll, whereas uninsured individuals experience the ACA penalty each year when filing their tax returns. Participation in Medicare Parts B and D is very high, yet those high enrollment rates are most likely due to the high subsidization of these programs (75 percent for most enrollees) or to a single qualifying event—namely, turning 65 years old. Consequently, high participation rates under a "stick" like a premium surcharge are most likely to be

achieved if implemented in combination with improved "carrots"—increased premium tax credits and cost-sharing assistance (discussed further below).

This new approach would need to be coupled with increased education and outreach efforts and increased enrollment assistance. In addition, an administrative mechanism to collect and compile information on previous insurance coverage would have to be developed.

It is critical to remember that merely increasing penalties without improving affordability would have little effect. Most individuals who remain uninsured under the ACA are exempt from the individual mandate penalties because they don't have access to qualifying coverage that is deemed affordable under the law's standard. If additional penalties are to have a significant effect on coverage levels, coverage would have to be made more affordable for more people.

Ending the Employer Mandate

An ACA component that is particularly unpopular with employers is the so-called employer mandate. This component was included in the law out of concern that employers would otherwise drop health insurance coverage, sending their workers into the private nongroup insurance market and increasing the costs of federal financial assistance provided there. As we and other researchers have shown, the ACA's employer mandate has little impact on insurance coverage, and eliminating it would not lead to significantly lower rates of employers offering insurance to their workers or lower rates of workers enrolling in that coverage (Blumberg, Holahan, and Buettgens 2013a, 2013b; Price and Saltzman 2013).

Employer coverage has remained stable under the ACA because contributions to employer-based health insurance are not taxable and because employers provide coverage and tailor benefits to their workers' preferences in order to attract the best workers, maintain employee loyalty, and reduce turnover (Blumberg et al. 2012). These incentives would remain strong without the employer mandate in place, just as they existed before the ACA. Therefore, eliminating the ACA's employer mandate could improve its popularity without sacrificing the law's coverage gains.

Replacing the Cadillac Tax

A third unpopular component of the ACA is the high-cost plan, or "Cadillac," tax. This excise tax on employer-sponsored insurance plans whose costs exceed a certain threshold was intended as a cost containment strategy, meant to discourage employers from purchasing overly generous policies that might encourage enrollees to over-use medical care. It was also intended to raise revenue to help finance the financial assistance the ACA provides to low- and middle-income populations. Critics of the tax have raised several concerns, arguing that the tax does not sufficiently allow for variation in employer health insurance costs, imposes overly tight indexing rules, and has the potential to increase cost-sharing requirements that would have adverse effects on those with health problems and modest incomes (Aaron et al. 2017).

Capping or eliminating the exclusion has been a staple of proposed health policy changes for many years and has enjoyed bipartisan support among health economists. As we have shown, a cap on the

exclusion would have the same distributional effects as the Cadillac tax in most circumstances, and the same criticisms levied against the former could be levied against the latter (Blumberg, Holahan, and Mermin 2015). But carefully designed policy strategies can address much of this criticism, and under certain circumstances, a tax cap is more progressive than the Cadillac tax. Potential fixes include pegging growth in the tax thresholds to GDP instead of CPI; adjusting thresholds based on employer size, geographic differences, and health status variability across employers; and using some of the revenue to offset high out-of-pocket spending requirements for modest-income families.[11]

Thus, the Cadillac tax could be replaced with a cap on the tax exclusion of employer contributions to health insurance, if this is indeed more politically palatable. The thresholds to which the cap would apply could be set at levels that would help finance some of the proposed reforms below. However, the lower the cap on the tax exclusion, the weaker the incentives for employers to provide work-based insurance and for workers to take it up; as a result, employer-based insurance risk pools could be disrupted.

Improving Affordability

A major criticism of the ACA—from both supporters and opponents—is the continued presence of high nongroup cost-sharing requirements (e.g., high deductibles, high out-of-pocket maximums) and high nongroup premiums for some enrollees. Addressing this would require increasing federal financial assistance to make coverage for low- and moderate-income Americans less costly. As we have written elsewhere, such assistance should include increasing both premium tax credits and cost-sharing assistance for Marketplace coverage (Blumberg and Holahan 2015a). While the ACA has made substantial strides in increasing the affordability of coverage, many people still face very steep costs to obtain insurance (Blumberg, Holahan, and Buettgens 2015).

Additional assistance should be income-related as under current law. Tax credits that vary with age but not income, which are part of several replacement plans, would either be too small to make adequate coverage affordable for middle- and low-income people or would require extraordinary increases in federal resources. Setting levels of financial assistance to make adequate coverage affordable to all, regardless of their income, requires not only affordable premiums but also affordable cost-sharing requirements (e.g., deductibles, coinsurance, copayments, out-of-pocket maximums) to ensure that people can use their insurance to effectively access medical care when they need it.

Elsewhere we have proposed a tax credit and cost-sharing assistance schedule for nongroup insurance that would reduce premiums and lower cost-sharing requirements at every level of income below 400 percent of FPL (Blumberg and Holahan 2015a). We also proposed a cap of 8.5 percent of income on benchmark insurance premiums, rather than the 9.69 percent cap set by the ACA for 2017.[12] The 8.5 percent cap would apply to all enrollees, including those with incomes above 400 percent of FPL (ACA assistance with Marketplace premiums stops at 400 percent of FPL today). Unlike the flat dollar-amount tax credits, the 8.5 percent cap for the higher-income group would not affect most of the higher-income individuals potentially eligible for it because premiums do not increase as incomes increase. However, it would provide additional protection particularly for those older adults, between 400 and 500 percent of the federal poverty level, who face the full effect of age rating under the ACA—

premiums up to three times the amount charged to a young adult—but whose income is not high and who are not eligible for financial assistance to help defray the cost. Our approach would also peg premium tax credits to the gold level (80 percent actuarial value) of insurance premiums instead of to the silver level (70 percent actuarial value) premiums used under current law, which would have the effect of reducing deductibles, coinsurance, and out-of-pocket maximums.[13]

Making Marketplace coverage more valuable and affordable would increase enrollment in nongroup markets, improve the nongroup insurance risk pools, reduce deductibles and overall financial burdens, and improve access to care for those with modest incomes.

Age Rating of Nongroup Insurance Premiums

ACA critics routinely cite age rating as a significant concern. Many insurers have complained that the ACA's 3:1 age rating bands for nongroup insurance do not reflect the true cost differences between their oldest and youngest adult customers (Blumberg, Buettgens, and Garrett 2009). The ACA's age bands were intended to make coverage more affordable for older adults, spreading a portion of their higher costs more broadly across the age distribution than was the case prior to 2014. The narrower the age bands, the more health care costs are shared across the age distribution.

We suggest that the additional health care risk of older adults be redistributed by income rather than by age. With the enhanced set of premium tax credits and cost-sharing reductions outlined above, especially the cap at 8.5 percent of income for benchmark premiums, age rating bands could be changed from 3:1 to 5:1 without making coverage unaffordable for older adults. With enhanced financial assistance in place, older nonelderly adults would have limits on their financial exposure, and loosening the age rating regulations would reduce the extent to which their health insurance costs are shared through the premiums of younger adults (Blumberg and Buettgens 2013).

Essential Health Benefits

Some critics blame high premiums on the ACA's essential health benefits requirements for nongroup insurance. Ten categories of benefits are required in all ACA-compliant nongroup insurance plans,[14] and states were provided with a number of options for defining how those requirements would be implemented (Corlette, Lucia, and Levin 2013). Some definition of required benefits is necessary to ensure that guaranteed issue of policies, prohibitions on pre-existing condition exclusions, and other strategies to eliminate insurer discrimination against the sick are meaningful. In most states, the essential health benefits benchmark plan was based on the small group insurance plan in that state with the most enrollment or the largest HMO plan, both reflecting a broadly accepted range of covered benefits. Additional benefits were added if necessary to meet federal standards.

Policymakers can re-examine the essential health benefits requirements under the law, but this is risky territory. Most of the health care claims costs associated with essential health benefits are attributable to services such as hospital inpatient and outpatient care, emergency room care, physician

and clinic services, laboratory and imaging services, and prescription drugs; these are the core of any insurance plan most Americans would consider adequate.

Cutting a benefit from the rest of the package puts the cost of that type of care wholly on those families who have a health care need for it. In many circumstances, such cuts would make obtaining that type of care unaffordable for those needing it. Eliminating a benefit eliminates the sharing of risk for that type of care. For example, men do not use maternity care and women do not use prostate care, but everyone's contributions to all types of care, regardless of individual needs, allow the costs of everyone's care to be spread over a large population (all those in the insurance pool). Cutting mental health and substance abuse disorder services from the benefit package would eliminate risk pooling for these services, and access to and use of these services would drop precipitously. Given the recent focus on mental health services as a mechanism to address gun violence and rising concerns over opioid addiction and other substance use disorders, restricting coverage for these services would contradict those expressed concerns and could require the development of a costly new government program to address these issues.

Finally, eliminating benefits for certain types of care could lead to increased costs within the set of insured benefits as well. For example, removing maternity care from the benefits package could lead to more medical complications among newborns and mothers later on. Eliminating prescription drug coverage would make it difficult for many people to treat their conditions with medications—an approach that is often substantially more cost-effective than hospitalization and other more expensive interventions.

Stabilizing Nongroup Insurance Markets

The ACA's nongroup insurance reforms, including the Marketplaces, were designed to increase the sharing of health care risk. Increasing nongroup insurance enrollment, both inside and outside the Marketplaces, could go a long way toward stabilizing the subset of markets that have experienced high premiums and reduced insurer participation. We suggest three policies (in addition to the increased financial assistance and modified individual mandate penalty structure presented earlier) that could increase nongroup enrollment significantly, with much of that enrollment among healthy new enrollees (Blumberg and Holahan 2017). In addition, we provide two policy strategies that would address the sources of high premiums and low insurer participation in some nongroup insurance markets.

MEASURES TO INCREASE ENROLLMENT

Three strategies that would increase enrollment in the nongroup Marketplaces are (1) increased funding for education, outreach, and enrollment assistance; (2) fixing the so-called family glitch; and (3) allowing Medicaid expansion up to 100 percent of FPL, instead of requiring it up to 138 percent of FPL. Additional federal funds are needed for education, outreach, and enrollment assistance to increase awareness of coverage options, available financial assistance, and premium surcharges for late enrollment, and to make it easier for individuals to sign up for coverage. This is essential and not expensive.

The "family glitch" denies Marketplace financial assistance to families facing high-cost employer insurance when one family member has access to affordable worker-only (but not necessarily family) coverage. This inequity, which results from a regulatory interpretation of the law, should be eliminated. Doing so would substantially improve the affordability of coverage for significant numbers of low- and moderate-income families and would create a strong incentive for these generally healthy families to enroll in nongroup Marketplace insurance plans, boosting overall enrollment in the nongroup insurance market (Blumberg and Holahan 2015a; Buettgens, Dubay, and Kenney 2016).

Allowing states to receive the ACA's enhanced federal matching rate if they expand Medicaid eligibility up to 100 percent of FPL, instead of 138 percent as required by current law, would likely encourage some of the states that have not yet chosen to do so to expand Medicaid. This is critical to making adequate coverage affordable for this very low-income population. In addition, if states that have already expanded Medicaid move their eligibility rules down from 138 to 100 percent of FPL, nongroup enrollment would increase in those states. The proposed increase in premium and cost-sharing assistance (discussed above) would apply to those moving from Medicaid into private coverage. Most of this increased nongroup market enrollment should come from relatively healthy people, and they would be likely to improve the nongroup market risk pool once enrolled.[15]

REDUCING PREMIUMS

Two additional policy strategies would address other sources of high premiums in some nongroup insurance markets: (1) limits on provider payment rates paid by nongroup insurers and (2) government funding for high-risk people, allowing them to be fully integrated into the array of private insurance plans offered through the nongroup market (Blumberg and Holahan 2017). First, many nongroup insurance markets (both inside and outside Marketplaces) have significant insurer and/or provider concentration. This problem existed before the ACA and would persist even if the ACA was repealed. Consolidation of providers and insurers drives insurance premiums upward because insurers have little incentive to operate efficiently in the case of insurer concentration or, in the case of provider consolidation, because insurers have little to no leverage to negotiate payment rates with providers (Roberts, Chernew, and McWilliams 2017).

The most realistic proposal for addressing both types of concentration is to rely upon the precedent set by Medicare Advantage, a program for which there has been bipartisan support (Blumberg and Holahan 2017). This approach would place a cap on provider payment rates for nongroup insurers and their enrollees. The payment caps could be set at Medicare levels or some percentage above Medicare levels, or they could use some other metric. The cap would apply to in- and out-of-network services. Insurers could negotiate with providers for payment rates lower than the cap, but they would not pay more than the cap. Some providers may choose not to participate, even at rates significantly above Medicare payment levels, but most likely would participate because participation at Medicare rates is high and because the nongroup market represents a small share of the population. This approach would allow more insurers to enter markets where few insurers currently participate. Some insurers currently cannot participate in markets they want to enter because they cannot negotiate competitive payment

rates with providers there; with a payment rate cap, they would be able to enter new markets and pay lower payment rates to local providers than they could have negotiated on their own.

Second, renewed attention must be paid to the importance of additional sharing of health care risks for those purchasing coverage as individuals. Not all ACA-compliant nongroup insurance markets are enrolling a disproportionately high-cost population of enrollees, compared with the employer-sponsored insurance market, but some are (Blumberg, Holahan, and Wengle 2016). The three-year limit on the reinsurance program included in the ACA was insufficient for some markets, particularly those with low enrollment. Thus, implementing a mechanism for adjusting risk between the nongroup insurance market and the broader population (either the employer-sponsored insurance market or the larger taxpayer population) would correct for long-term differences in health care risk that may persist in some areas. The approach should be designed to redistribute funds to the nongroup market from the much larger employer-based insurance markets or from general revenues, when that nongroup market is experiencing significant adverse selection. In essence, this would be akin to raising high-risk pool revenues from a large population base that would be distributed to nongroup insurers enrolling a disproportionate share of high-cost individuals. Another way to think about the approach is as a risk adjustment mechanism between nongroup insurers and employer insurers or between nongroup insurers and the population at large.

Medicare Advantage and Medicare Part D offer precedents for permanent programs like this. For example, some percentage of each claim against a nongroup insurer exceeding $1,000,000 could be reimbursed from general revenues or from a broad-based dedicated revenue source beyond nongroup insurance enrollees and their insurers (e.g., all those with employer-based or nongroup insurance). Extremely high claims can be devastating for an insurer, and risk adjustment within the nongroup market alone cannot sufficiently limit exposure if the incidence of such large claims is higher than in the wider population. Such a broadly financed program would reduce risk for insurers, making it more attractive for them to participate in and out of the Marketplaces, lowering premiums, and increasing the markets' stability year to year.

Conclusion

Congress is seriously considering repeal of the coverage and tax provisions of the ACA, with the expectation that replace legislation will follow. This will not be a straightforward process. If the ACA is partially repealed, there will be a new spending and revenue baseline. The replace proposal will need bipartisan agreement on the design, and it will need new sources of revenue. The Congressional Budget Office (and others) will weigh in on coverage and cost impacts. Developing a plan that could garner the support needed in the House of Representatives and the Senate will be challenging.

With this in mind, we have delineated a package of health care reforms that could short-circuit this process. The proposals outlined here, many of which have had broad bipartisan support in other contexts, would address many of the problems raised by ACA critics and acknowledged by ACA supporters. Pursuing these policies would permit the new administration and Congress to put its own

stamp on health care reform while avoiding the consequences of repeal, which include increasing the number of uninsured by approximately 30 million people (Blumberg, Buettgens, and Holahan 2016), creating adverse financial impacts for hospitals and other providers, leading to turmoil in the insurance industry, and negatively impacting state and local budgets. If a new framework like this is agreed upon and enacted through legislation with bipartisan support, robust implementation efforts must follow in order for it to succeed.

Notes

1. "A Better Way to Fix Health Care: Snapshot," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-Snapshot.pdf; and "Empowering Patients First Act: Section-by-Section Overview," Office of Congressman Tom Price, May 13, 2016, http://tomprice.house.gov/sites/tomprice.house.gov/files/Section%20by%20Section%20of%20HR%202300%20Empowering%20Patients%20First%20Act%202015.pdf.
2. Joseph Antos and James Capretta, "The Problems with 'Repeal and Delay,'" *Health Affairs Blog*, January 3, 2017, http://healthaffairs.org/blog/2017/01/03/the-problems-with-repeal-and-delay/; and Ezra Klein, "There Is No 'Terrific' Replacement for Obamacare," *Vox*, January 9, 2017, http://www.vox.com/policy-and-politics/2017/1/9/14206052/obamacare-replacement-mcconnell-trump.
3. Steven T. Dennis and Billy House, "GOP Eyes Lightning Strike on Obamacare to Kick Off Trump Era," *Bloomberg*, November 29, 2016, https://www.bloomberg.com/politics/articles/2016-11-29/gop-eyes-lightning-strike-on-obamacare-to-kick-off-trump-era; and Lisa Mascaro, "Repeal and Replace Obamacare? It Won't Happen on Trump's First Day, GOP Leader Says," *Los Angeles Times*, November 29, 2016, http://www.latimes.com/nation/politics/trailguide/la-na-trailguide-updates-1480442605-htmlstory.html.
4. See Brian Fanney, Michael R. Wickline, and Spencer Willems, "Arkansas House Speaker Details Cuts If Medicaid Plan Fails," *ArkansasOnline*, April 12, 2016, http://www.arkansasonline.com/news/2016/apr/12/plan-wields-ax-to-anticipate-a-medicaid/; and David Ramsey, "Using Novel Line-Item Veto, Ark. Governor Extends Medicaid Expansion," *Kaiser Health News*, April 21, 2016, http://khn.org/news/using-novel-line-item-veto-ark-governor-extends-medicaid-expansion/. Medicaid expansion in Arkansas was extended on April 21, 2016.
5. In addition, current proposals would offer larger tax credits to older adults, but none would provide tax credits large enough to compensate for the higher premiums older adults would face if 3:1 age rating limits were replaced with 5:1 or 6:1 limits—another change from the ACA envisioned under these approaches. Consequently, affordability of coverage and, ultimately, access to medical care would be increasingly compromised with age. Age rating bands limit the extent to which insurers can vary premiums with age. For example, 3:1 age bands under the ACA prohibit nongroup and fully insured small group insurers from charging premiums for 64-year-olds that are more than three times the premium charged for the youngest adult for the same plan.
6. Linda Blumberg and John Holahan, "Don't Let the Talking Points Fool You: It's All about the Risk Pool," *Health Affairs Blog*, March 15, 2016, http://healthaffairs.org/blog/2016/03/15/dont-let-the-talking-points-fool-you-its-all-about-the-risk-pool/.
7. "A Better Way: Health Care," Office of the Speaker of the House, June 22, 2016, http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf; and "Patient Choice, Affordability, Responsibility, and Empowerment Act," US House Committee on Energy and Commerce, February 5, 2015, https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf.
8. Much depends upon how the rule would ultimately be drafted; no specifics have yet been provided in any of the public proposals. Still, it is hard to see how a time limit on this type of requirement could be implemented. If the person seeks coverage after a period of uninsurance and is denied or charged a premium that they cannot afford, they would remain uninsured. When would a "time clock" on such a requirement begin, and when would

it end? Would it start at the beginning of a spell of uninsurance? When someone shopped for insurance and found it unavailable or unaffordable? How would that be documented? Would it end after a defined period of uninsurance? Could that time be differentiated in terms of whether the individual sought coverage and was refused, could not afford to enroll at higher rates, or simply remained uninsured without shopping? Limits could be imposed on how much more someone could be charged relative to "standard" rates, but there has been no mention of such limits in the proposals released. Even if limits were put in place, the coverage would likely remain unaffordable for most of those who would be charged the higher premium, so the limit may not provide any practical protection compared with a no-limit scenario.

9. Medical underwriting is prohibited in the nongroup and fully insured small group insurance markets under the ACA. Underwriting is the process that insurers undertake to assess the health care risk of potential enrollees, and that information was used to determine whether coverage was to be offered at all in the nongroup market (federal law prohibited coverage denials in the small group market beginning in 1996), the premium to be charged if coverage was offered to an applicant, and the benefit and cost-sharing packages offered to applicants (in states that permitted such differentiation based on health risk).

10. "Part B Late Enrollment Penalty," Centers for Medicare and Medicaid Services, https://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html; and "Part D Late Enrollment Penalty," Centers for Medicare and Medicaid Services, https://www.medicare.gov/part-d/costs/penalty/part-d-late-enrollment-penalty.html. Special enrollment periods are available for those not taking Part B due to enrollment in a group health insurance plan. No penalty is assessed for those enrolling late under these provisions.

11. Aaron and colleagues (2017) provide a detailed discussion of policy approaches to address the criticisms of the Cadillac tax or a cap on the employer-based insurance tax exclusion.

12. The benchmark, or second-lowest-cost silver premium offered in the enrollee's rating region, is used to determine the amount of premium tax credit for which an applicant is eligible under the ACA. The percent-of-income caps used to determine premium tax credit amounts increase somewhat for every year that health care costs grow faster than general inflation. In addition to proposing lower percent-of-income caps to improve affordability, we suggest eliminating the indexing of the caps.

13. Under current law, individuals choosing the second-lowest-cost silver Marketplace plan available in their area cannot be charged a premium that exceeds the percent-of-income cap applicable for the applicant's income level. If the individual picks a more expensive option, they must pay the full difference in cost; if they choose a less expensive option, they will get the savings. If the premium tax credits were instead tied to the second-lowest-cost *gold* plan available in the area, individuals could much more easily afford higher actuarial value coverage, with lower deductibles, coinsurance, copayments, and out-of-pocket maximums.

14. "What Marketplace Health Insurance Plans Cover," Centers for Medicare and Medicaid Services, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.

15. Under current law, Medicaid-eligible people can enroll in the program even if their employer offers insurance deemed affordable to them; however, Marketplace tax credit–eligible individuals are prohibited from getting financial assistance if their employer offers them affordable coverage. In states that move eligibility to 100 percent of FPL, the law should allow those with incomes between 100 and 138 percent of FPL access to Marketplace premium tax credits and cost-sharing assistance, even if they have an employer offer of insurance. The enhanced premium tax credit and cost-sharing assistance schedules we propose would reduce the negative financial impact of a transition from Medicaid to Marketplace coverage for people in states that had already expanded to 138 percent of FPL and made a decision to change their Medicaid eligibility threshold to 100 percent of FPL.

References

Aaron, Henry J., Linda J. Blumberg, Paul Ginsburg, and Stephen Zuckerman. 2017. *Building a Better "Cadillac."* Washington, DC: Urban Institute.

Blumberg, Linda J. 2011. "High-Risk Pools — Merely a Stopgap Reform." *New England Journal of Medicine* 364:e39.

———. 2016. "Sales of Insurance across State Lines: ACA Protections and the Substantial Risks of Eliminating Them." Washington, DC: Urban Institute.

Blumberg, Linda J., and Matthew Buettgens. 2013. "Why the ACA's Limits on Age-Rating Will Not Cause 'Rate Shock': Distributional Implications of Limited Age Bands in Nongroup Health Insurance." Washington, DC: Urban Institute.

Blumberg, Linda J., Matthew Buettgens, Judith Feder, and John Holahan. 2012. "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act." *Inquiry* 49: 116–26.

Blumberg, Linda J., Matthew Buettgens, and Bowen Garrett. 2009. "Age Rating under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens." Washington, DC: Urban Institute.

Blumberg, Linda J., Matthew Buettgens, and John Holahan. 2016. "Implications of Partial Repeal of the ACA through Reconciliation." Washington, DC: Urban Institute.

Blumberg, Linda J., and John Holahan. 2015a. *After* King v. Burwell: *Next Steps for the Affordable Care Act*. Washington, DC: Urban Institute.

———. 2015b. "The New Bipartisan Consensus for an Individual Mandate." Washington, DC: Urban Institute.

———. 2017. *High Premiums in Nongroup Insurance Markets: Identifying Causes and Possible Remedies*. Washington, DC: Urban Institute.

Blumberg, Linda J., John Holahan, and Matthew Buettgens. 2013a. "Employer versus Individual Responsibility Requirements under the ACA." *New England Journal of Medicine*.

———. 2013b. "It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs than the Individual Mandate." Washington, DC: Urban Institute.

———. 2015. "How Much Do Marketplace and Other Nongroup Enrollees Spend on Health Care Relative to Their Incomes?" Washington, DC: Urban Institute.

Blumberg, Linda J., John Holahan, and Gordon B. Mermin. 2015. "The ACA's 'Cadillac' Tax versus a Cap on the Tax Exclusion of Employer-Based Health Benefits: Is This a Battle Worth Fighting?" Washington, DC: Urban Institute.

Blumberg, Linda J., John Holahan, and Erik Wengle. 2016. "Are Nongroup Marketplace Premiums Really High? Not in Comparison with Employer Insurance." Washington, DC: Urban Institute.

Buettgens, Matthew, Linda J. Blumberg, and John Holahan. 2017. "The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation." Washington, DC: Urban Institute.

Buettgens, Matthew, Lisa Dubay, and Genevieve M. Kenney. 2016. "Marketplace Subsidies: Changing the 'Family Glitch' Reduces Family Health Spending But Increases Government Costs." *Health Affairs* 35 (7): 1167–75.

CBO (Congressional Budget Office). 2013. *Options for Reducing the Deficit: 2014 to 2023*. Washington, DC: CBO.

Clemans-Cope, Lisa, John Holahan, and Rachel Garfield. 2016. "Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence." Washington, DC: Kaiser Family Foundation.

Corlette, Sabrina, Kevin W. Lucia, and Max Levin. 2013. "Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan." New York: Commonwealth Fund.

Dorn, Stan, Norton Francis, Laura Snyder, and Robin Rudowitz. 2015. "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States." Menlo Park, CA: Kaiser Family Foundation.

Karpman, Michael, Fredric Blavin, and Stephen Zuckerman. 2016. "QuickTake: Individual Mandate Is Increasingly Important to Adults with Nongroup Coverage." Washington, DC: Urban Institute.

Kirzinger, Ashley, Elise Sugarman, and Mollyann Brodie. 2016. "Kaiser Health Tracking Poll: November 2016." Menlo Park, CA: Kaiser Family Foundation.

McMorrow, Stacey, and John Holahan. 2016. *The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act: An Update*. Washington, DC: Urban Institute.

Pollitz, Karen. 2016. "High-Risk Pools for Uninsurable Individuals." Washington, DC: Kaiser Family Foundation.

Price, Carter C., and Evan Saltzman. 2013. *Delaying the Employer Mandate: Small Change in the Short Term, Big Cost in the Long Run.* Santa Monica, CA: RAND.

Roberts, Eric T., Michael E. Chernew, and J. Michael McWilliams. 2017. "Market Share Matters: Evidence of Insurer and Provider Bargaining over Prices." *Health Affairs* 36 (1): 141–48.

About the Authors

John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

Linda J. Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of particular policies. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a "Roadmap to Universal Coverage" in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.

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February 2, 2017

Congressman John Yarmuth
131 Cannon House Office Building
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Washington, DC 20515

Congressman Yarmuth,

Thank you for the opportunity to testify before the House Budget Committee last week. I am writing to you now in order to correct some clear misstatements of fact by one of the other witnesses at the end of the hearing. I feel strongly that these errors should not be the last word in the official record of the hearing.

As part of the last set of questions posed in the hearing, witness Robert Book stated that the Congressional Budget Office (CBO) had substantially under-estimated the costs that would be associated with the Affordable Care Act (ACA) and substantially over-estimated the effect the law would have on the uninsured. These statements are incorrect. As John Holahan and Stacey McMorrow painstakingly documented in two separate analyses, both CBO and the Centers for Medicare and Medicaid Services (CMS) have repeatedly adjusted their estimates of health expenditures under the ACA downward as evidence accumulated that spending under the law was substantially *lower* than their original estimates.[1] Quoting directly from their most recent analysis (pages 8-10, with bold added here):

> "In 2010, after the passage of the ACA, CBO estimated that exchange subsidies would amount to $464 billion from 2014 to 2019. In its most recent forecast, CBO projects $313 billion, a reduction of 32.5 percent. In its 2010 forecast, CBO projected federal Medicaid and CHIP outlays for the expansion population would be $434 billion from 2014 to 2019 compared with $366 billion in its current forecast, a reduction of 15.7 percent. Small-employer tax credits are also 85

> percent smaller than originally projected because of limited use. Consequently, CBO's projected gross cost of all ACA coverage provisions for 2014 to 2019 has fallen from $983 billion in the 2010 forecast to $686 billion in the 2015 forecast, a reduction of 26.9 percent.
>
> CBO also currently forecasts a reduction of $528 billion in Medicare mandatory outlays from 2014 to 2019, or 11.2 percent relative to their 2010 forecast. Finally, federal Medicaid outlays for 2014 to 2019 for those not newly eligible under the ACA Medicaid expansion are now projected to be $287 billion lower than in their 2010 forecast, a reduction of 13.1 percent. ... **That is, current CBO projections are far below those made when the ACA was enacted in 2010. Altogether, federal spending for Medicare, Medicaid, and ACA coverage provisions for 2014 to 2019 are now projected to be $1.1 trillion, or 14.7 percent, below CBO's 2010 ACA forecasts."**

A separate analysis by economist Sherry Glied and colleagues confirms that the CBO originally *over*-estimated the costs associated with marketplace subsidies and shows that CBO's estimates of the change in the number of people uninsured under the ACA was very close to the realized change.[2] If CBO made an error, it was to over-estimate the number of workers who would lose their employer based insurance under the ACA, and, as a result, they over-estimated enrollment in the marketplaces. As I stated during the hearing, employer-based insurance has remained essentially level since implementation of the ACA, consistent with the Urban Institute's projections. This issue, however, did not affect CBO's estimates of the uninsured.

Based on the witnesses misstatements of the evidence, Mr. Book then agreed with the Congressman questioning him that it would be appropriate for Congress to launch an investigation of CBO as to potential bias that may have led to such substantial under-estimates of costs and over-estimates of reductions in the uninsured. Such a suggestion based upon a completely erroneous understanding of the

facts at hand was terribly irresponsible from my perspective, and, thus, I felt compelled to try to correct the record.

Sincerely,

Linda J. Blumberg

Linda J. Blumberg

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[1] John Holahan and Stacey McMorrow. April 2015. "The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act." ACA Implementation – Monitoring and Tracking Report. http://www.urban.org/sites/default/files/publication/48991/2000176-The-Widespread-Slowdown-in-Health-Spending-Growth-Implications-for-Future-Spending-Projections-and-the-Cost-of-the-Affordable-Care-Act-ACA-Implementation-1.pdf; John Holahan and Stacey McMorrow. June 2016. "The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act, An Update." ACA Implementation – Monitoring and Tracking Report. http://www.urban.org/sites/default/files/publication/81636/2000824-The%20Widespread-Slowdown-in-Health-Spending-Growth-Implications-for-Future-Spending-Projections-and-the-Cost-of-the-Affordable-Care-Act-an-Update.pdf

[2] Sherry Glied, Anupama Arora, and Claudia Solis-Roman. December 2015."The CBO's Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?" Commonwealth Fund Publication 1851, vol. 35. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/dec/1851_glied_cbo_crystal_ball_forecast_aca_rb_v2.pdf

Interim Chair BLACK. Thank you, Dr. Blumberg. Mr. Haislmaier, you are recognized for 5 minutes.

STATEMENT OF EDMUND HAISLMAIER

Mr. HAISLMAIER. Thank you, Madam Chairman and Mr. Yarmuth, ranking member. I have submitted, of course, testimony which I will briefly summarize. I am a senior research fellow in Health Policy at the Heritage Foundation and the testimony is my own and is not, and should not, be construed as an official position of the Heritage Foundation or anyone else.

I am testifying in response to the committee's request to present the analysis of health insurance enrollment data that I have been conducting; basically looking at the areas that have been most affected by the key provisions of the Affordable Care Act. That would be the expansion of Medicaid and the introduction of subsidized coverage through the exchanges for the individual market and the related rules governing the individual and employer market, particularly the small employer market.

I should note, very briefly, that this is data that I am using that is drawn from regulatory filings that insurers make in the case of the private market with State regulators. In the case of Medicaid, this is data reported by the states to the Centers for Medicare and Medicaid Services, which publishes it. That data is done periodically though in the case of the private market, quarterly in the case of the Medicaid data monthly though the best and most comprehensive is on an annual basis.

When you look at the experience that we have seen in the first 2 years, 2014 and 2015, we saw a growth in the individual market from a base of 11.8 million people at the end of 2013, that was pre-ACA. We saw a growth to 17.7 million people in that market. In the employer coverage market, we saw two things fully insured, that is plans where the employer buys the coverage as a group policy from an insurer. Fully insured employer coverage declined from 60 million to 53 million. At the same time, self-insured employer coverage, and those tend to be larger employers, grew by 4 million.

The net of those three interactions on the private market was a net increase over 2 years of 2.3 million people with private market coverage. In comparison, over the period, you saw an increase from 60.9 million to 72.7 million in total Medicaid enrollment. So what that leaves us with is a net growth of enrollment in those 2 years of 14 million of which almost 84 percent was in Medicaid.

Now, when we turn to 2016, we do not have full year data yet for either of these programs. But we do have some initial data for the first three quarters. And what we see is a growth of a further 842,000 people in the individual market, a further decline of 1.1 million in the fully insured employer group market, a further increase of 776,000 roughly in the employer self-insured market, and a further 2 million increase in Medicaid enrollment.

Again, these are preliminary figures. But it looks like by the end of 2015 we, 2016 sorry, we can reasonably project that over the course of the 3-year period, health insurance enrollment will have expanded by about 16.5 million individuals. Of which 13.8 million would be attributable to public coverage, Medicaid and CHIP, and the other 2.7 million to private coverage.

What does all of this mean? In general, what it means is that the experience of the ACA appears to have had three significant effects. It has increased the number of people covered by individual market insurance. But a lot of that has been offset by a decline in employer provided insurance. And it has principally produced enrollment increases through an expansion of public programs, particularly Medicaid, and particularly in those states that adopted the ACA expansion to able-bodied adults.

I will be happy, Madam Chairman, to answer any questions the committee may have. Thank you.

[The prepared statement of Mr. Haislmaier follows:]

The Heritage Foundation

The Real Changes in Health Insurance Enrollment Under the Affordable Care Act

Testimony before Committee on the Budget

United States House of Representatives

January 24, 2017

Edmund F. Haislmaier
Senior Research Fellow
The Heritage Foundation

Mr. Chairman and members of the committee, thank you for inviting me to testify. My name is Edmund F. Haislmaier. I am a Senior Research Fellow at The Heritage Foundation. The views I express in this testimony are my own and should not be construed as representing any official position of The Heritage Foundation.

In response to the Committee's request, my testimony today presents my analysis of health insurance enrollment data and trends since the major components of the Affordable Care Act (ACA) took effect at the beginning of 2014.

Various analyses have attempted to measure the effects of the ACA on health insurance coverage. However, almost all of those analyses report estimates derived from government or private surveys. Yet, even well-constructed surveys have their limitations and, at best, can offer only approximate answers. The data I am presenting today are "administrative data," meaning the enrollment figures reported by public programs and private insurers.

The principal coverage provisions of the ACA consist of offering income-related subsidies for individual-market coverage purchase through the new exchanges and the expansion of Medicaid eligibility. Consequently, my analysis focuses on the data from the sectors affected by those provisions. Those sectors are the private coverage markets for: 1) individual (or, non-group) health insurance; 2) fully insured employer-group health insurance; 3) self-insured employer-roup health insurance, and; 4) Medicaid and the Children's Health Insurance Program (CHIP) coverage.[1]

For all four sectors, the data are for individuals enrolled in "comprehensive" or "full benefit" coverage. Private market data are from annual and quarterly reports that insurers are required to file

[1] In a "fully insured" plan, the employer purchases a group coverage policy from an insurer. In a "self-insured" plan the employer retains the risk but contracts with an insurer, or other third party, to perform administrative tasks, such as enrollment, provider contracting, claims adjudication, and claims payment.

with state insurance regulators, while Medicaid and CHIP data are from reports published by the Centers for Medicare and Medicaid Services (CMS), based on program reporting by states to CMS.[2]

2014 and 2015 Experience

For the two year period 2014 and 2015, enrollment in individual-market policies increased by 5.9 million individuals, from 11.8 million individuals at the end of 2013 to almost 17.7 million at the end of 2015.

For the employer-group coverage market, enrollment in fully insured plans dropped by 7.6 million individuals, from 60.6 million individuals at the end of 2013 to 53 million as of the end of 2015. During the same two years, enrollment in self-insured employer plans increased by 4 million individuals, from 100.6 million in 2013 to 104.6 million in 2015.

The combined effect of the changes in individual-market and employer-group coverage resulted in a net increase in private sector coverage of 2.3 million individuals during the two-year period.

Net Medicaid and CHIP enrollment over the two years grew by almost 12 million individuals, from 60.9 million at the end of 2013 to 72.7 million at the end of 2015. In those states that adopted the ACA Medicaid expansion enrollment increased by 10.4 million, while in the states that did not adopt the expansion enrollment increased by 1.4 million individuals.

Thus, for the two-year period the combined enrollment increase in both private and public coverage was just over 14 million individuals—with 84 percent of that increase attributable to the ACA Medicaid expansion.

Diminishing ACA Effects

Three coverage segments experienced significant change in 2014, but in all three the rate of change considerably diminished in 2015. Enrollment in the individual market grew by 40 percent in 2014 and by an additional 7 percent in 2015. Enrollment in fully insured employer-group plans declined by 11 percent in 2014 and by a further 2 percent in 2015. For the states that adopted the ACA Medicaid expansion, Medicaid and CHIP enrollment increased by 23 percent in 2014 and by 4 percent in 2015. Three states (Alaska, Indiana and Pennsylvania) implemented the Medicaid expansion in 2015, and Medicaid enrollment growth in those states accounted for 28 percent of all expansion state Medicaid enrollment growth in 2015 (or just over 1 percentage point of the 4 percentage point growth in expansion states).

In contrast, the number of individuals covered by self-insured employer plans grew by two percent in both years. Similarly, Medicaid enrollment grew by three percent in both years in those states not implementing the Medicaid expansion.

Changes in 2016

Complete data are not yet available for 2016, though preliminary data are available for the first three-quarters of the year. The preliminary data show that during that period, enrollment in the individual-market grew by a 842,028 individuals, enrollment in fully insured employer plans declined by 1,128,597 individuals, enrollment in self-insured employer plans increased by 776,780 individuals, and Medicaid and CHIP enrollment increased by 2,044,809 individuals.

Thus, the preliminary data indicate that net total enrollment increased by a further 2,535,020 individuals in the first three-quarters of 2016. Of that 2.5 million increase, the net increase in private coverage was 490,211 individuals. Medicaid accounted for 81 percent of the incremental growth in enrollment in 2016—a ratio consistent with the experience during the previous two year's of ACA implementation.

ACA subsidized coverage

[2] For a more detailed discussion of data sources see the Appendix to: Haislmaier and Gonshorowski, "2015 Health Insurance Enrollment: Net Increase of 4.8 Million, Trends Slowing," Heritage Foundation *Issue Brief* No. 4620, October 31, 2016, http://www.heritage.org/research/reports/2016/10/2015-health-insurance-enrollment-net-increase-of-48-million-trends-slowing

CMS reported that, as of the end of 2015, there were 8,780,545 people covered by individual-market plans purchased through ACA exchanges, of which 7,375,489 received subsidies that offset the cost of their coverage.[3] The most recent available CMS data on exchange enrollment is for only the first half of 2016.[4] CMS reports that as of the end of June 2016 total effectuated exchange enrollment was 10.5 million, of which 8.8 million were receiving coverage subsidies. That indicates that subsidized enrollees account for about 45 percent of the total individual market, with about 10 million people enrolled in unsubsidized individual-market coverage.

Conclusions

While the final figures will be somewhat different once the more complete end of year data is available, at this point it is reasonable to expect that for the three year period 2014 through 2016, the net increase in health insurance enrollment was 16.5 million individuals. Of that figure, 13.8 million were added to Medicaid and 2.7 million were the net increase in private sector coverage enrollment.

In general, enrollment data indicate that the implementation of the ACA appears to have had three effects on health insurance coverage: (1) a substantial increase in individual-market enrollment; (2) an offsetting decline in fully insured employer-group plan enrollment; and (3) a significant increase in Medicaid enrollment in states that adopted the ACA Medicaid expansion.

Mr. Chairman, this concludes my prepared testimony. I thank you for inviting me to testify today. I will be happy to answer any questions that you or the other members may have.

[3] Centers for Medicare and Medicaid Services, "December 31, 2015 Effectuated Enrollment Snapshot," March 11, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html

[4] Centers for Medicare and Medicaid Services, "First Half of 2016 Effectuated Enrollment Snapshot," October 19, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html?DLPage=3&DLEntries=10&DLSort=0&DLSortDir=descending

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Interim Chair BLACK. Thank you, Mr. Haislmaier, excuse me. We will now begin our question and answer session. I will start by, first of all, again thanking all the witnesses for being here and asking some questions.

Again, by saying as a nurse for over 40 years, what I am really concerned about and as folks in my district call me and tell me the stories that are just so disheartening to me about their access to quality care and affordability. It really just bothers me terribly to know that there are some folks, as I said in my opening statements, that liked what they had and were not able to keep it. In particular, the high-risk patients in our State who were on a plan that the State had set up themselves and people were happy about it. And in one day, 28,000 people, with some pretty serious conditions, were out of care.

But let me also go to some statistics. Let me first of all talk about the cost, the rising cost, because we hear this every day in our office; 25 percent average increase in premiums this year for millions of Americans that are trapped on the exchanges. There was a lady in Tennessee who runs a daycare center, and she was on the exchanges, and her deductible went from $2,000 to $9,000 this last year. There is no way someone running a daycare business can afford that.

One trillion dollars in new taxes mostly falling on families and job creators have really hurt people in what they are able to do in their life besides just their health care. It really has hurt them.

How about choice? Nearly one-third of the U.S. counties have only one insurer offering the exchange plans. In our State three-fourths of our State only has one option. That is not choice—that is a monopoly. We also see 4.7 million Americans kicked off of their healthcare plans by Obamacare.

And finally, I think you mentioned it, Ms. Turner, is the fact of the failed Obamacare co-ops. We had a co-op in our State that went belly up and this is a cost to the taxpayers of $1.9 billion, billion dollars not million, forcing many of these patients to try to find new insurance. And if I could have the staff pull up slide number 5, this is particularly disturbing to me because, let's go back to the one with the hospitals, yeah there.

Hospitals who have been forced to close under the Obamacare, these are rural hospitals; 50 percent of my district is rural. If you can look at Tennessee, you will see a number of Hs, hospitals who have closed in my district. Now, when that happens if someone has an emergency, such as a heart attack, they are about 40 minutes from the closest hospital because their small rural hospital has closed.

This is devastating to communities not just for care that is provided, but also for recruiting businesses, because one of the things that new businesses will ask is, "Where is your health care?" They want to know that there is health care in that community. This has really been devastating and I think that we cannot discount these real stories that come to our office and just break my heart that that is what is occurring.

So, let me ask you, Mr. Haislmaier, Obamacare really focused almost exclusively on coverage—we saw that as they were pushing people into the computer to sign up for that—while neglecting the

cost and the access of care. It was just, "Let's get as many people signed up as we can so we can say that this program was successful." If health insurance does not cover the care you need, or if you cannot afford the deductibles that come with your plan, or you do not have access, then is not the number of people that are covered really meaningless?

Mr. HAISLMAIER. Sorry, it is true that the authors of the legislation prioritized enrollment over cost control, which I think is one of the reasons the public was never sold on the bill, because most of the public wanted the reverse; they wanted cost control prioritized.

In terms of the deductibles and the coverage, the argument had been made, indeed, by advocates of this law that insurance with high deductibles was of less value; some even called it junk insurance. The interesting thing is that that is what this law has produced. The reason for that is pretty straightforward. We saw that in other states that had adopted, in the 1990s, similar measures, and that is when the law limits what dials the insurers can turn, they reach for the only dials that are left. In this case, the only dials really left are to raise the deductibles as much as you can and/or to limit the networks, and that is what we have seen progressing in the last several years in plan design in the exchanges, yes.

Interim Chair BLACK. Ms. Turner, you talked about some of young folks. I know that there are about 20 million Americans who have said that Obamacare just is not worth the cost; they have either paid the fine—which really is just almost funny to me where the whole idea of this is to make sure everybody has coverage, and what is more important is now you are paying fines for something you are not even going to get coverage on, and then there are another group of people that filed an exemption.

So, we have got 20 million people out there who maybe would have had access to health care, potentially, insurance, but now the cost of it is so high that they neither have the access to the health care, nor do they have a dollar in their pocket because they are paying a fine. Could you talk a little bit about that?

Ms. TURNER. Well, as you say, Madam Chairman, it does really go against the purpose of the law and I know that many of the policy proposals that you and others have advocated would provide incentives for people to buy the coverage, and of course, the most important incentive is to make it more affordable.

One of the reasons that the coverage is so expensive is not only because of the 3-to-1 age rating ban that is so disadvantageous as young people, but also because of the benefit requirements that are so much more generous than most people could afford. I think those are two specific things to look at in addition to the taxes that really go the underlying cost mechanism of the law. Getting the costs down would provide the incentive for people to purchase coverage.

Interim Chair BLACK. I think it is interesting, when we talk about 20 million—and that number moves all over the place, but let's just use 20 million—that 20 million people have received insurance. We look at the other side; there are 20 million people who have not received it but either are exempt or who have paid the

penalty. I do not know that we need to hurt one group to help the other. I think that we probably can get to the place where we have a true patient-centered care, and that we are helping everyone. I know, Dr. Book, I am going to just leave you about two and one-half minutes. But as we prepare legislation in this area that truly is patient-centered reform, what is the biggest lesson from the Obamacare experience that we can learn? And then, if you have a second to tell us if there is anything that you think we ought to take from it that would also help us to make sure that we take out what is good.

Mr. BOOK. Thank you. I think the biggest thing to learn is that when Washington tells people what they need to buy, that does not necessarily make those people better off. The main reform I would suggest, though, one thing that we all want, is not to exclude people, make it impossible for people with preexisting conditions to get coverage.

I myself had multiple preexisting conditions when I left my previous employer and had to go and buy my own insurance, and this was before the ACA reforms took effect. I had no problem getting insurance. I did have to pay for it, more than the average person, but I had no problem getting it, and that was under a law that was passed at least a decade before.

On the other hand, now that Obamacare is in effect, I am paying two and one-half times as much for my premium and my deductible has gone from $2,400 to $7,000; my out-of-pocket is $13,000; and I am one of those people that was supposed to be helped by the bill as a self-employed person who pays for his own insurance and has preexisting conditions. I think we need to adjust the way we do subsidies.

Right now, we subsidize insurance companies for covering people who have low incomes. There is nothing necessarily wrong with that, but people with low incomes are not necessarily the same as people with health problems. Obviously, there is overlap, but they are not all that well correlated. I think we need to incentivize companies to cover people who actually have adverse health status. We do that in the Medicare Advantage program using something called risk adjustment.

There is a risk adjustment provision in the ACA, but it is completely different; it just moves money around between insurance companies without any reference to the health status compared to the underlying eligible population. If we did a risk adjustment that was based on the eligible population, I think we could solve the preexisting condition problem without forcing insurers to charge more to everybody else. That would be my primary suggestion.

Interim Chair BLACK. Thank you very much. I now recognize the ranking member from Kentucky, Mr. Yarmuth, for any questions.

Mr. YARMUTH. Thank you, Madam Chairman. Thank you all for your testimony. It occurs to me that what we have basically just heard, in the aggregate, is our biggest complaint and observation about this debate in recent weeks and months, and that is, we spent a lot of time hearing about the problems with the ACA and very little hearing about the alternatives, if I am going to characterize all the testimony.

Now, Dr. Blumberg gave a number of suggestions; by the way, I would say, Dr. Blumberg, every one of those could be implemented by this Congress acting. And eliminating the employer mandate, for instance, could be done by this Congress. There has been no suggestion from the Republican side of doing that, and that is kind of where we have been over the last 6 or 7 years, is that while we have seen problems arise, Republicans have been unwilling to address problems.

Instead, they have just said, "Let's repeal it," and they have done that 65 times in the House. Anyway, Ms. Turner, in your testimony, I guess you could infer that you would recommend doing away with the employer mandate since you said that was a problem, but beyond that, you really do not offer any solutions.

Dr. Book had seven pages of criticism of the ACA and identifying problems and then three paragraphs of solutions, one of which is two provisions to be repealed and then mentioning the question of the high-risk population which, I do not know, I would characterize it as just another form of a high-risk pool; you just change the mechanism for government financing of high-risk patients. And Mr. Haislmaier had no particular recommendations which probably makes sense since the Heritage Foundation was the originator of the idea of the Affordable Care Act, much of it. This is why we are so frustrated, because this Congress and this President have said, "We are going to repeal it; that is first priority" and really there are no ideas for replacing it.

Now, I have my opinion about that and I have said it many times: There are only, in my opinion, two alternatives to the Affordable Care Act. One is to go back to where we were, where insurance companies decided who lived and died, and single-payer, Medicare for everyone. The other solutions that have all been proposed are just tweaks of the Affordable Care Act and that is why we keep saying there is no plan. There are ideas. Health savings accounts; that is an idea. Selling insurance across State lines is an idea. It is also allowed under the Affordable Care Act, but this is not a plan.

That is, again, a lot of my frustration, but I am also frustrated about the way we talk about this and debate it, because we all have anecdotes. I mentioned an anecdote in my opening statement; the chairman has mentioned anecdotes. In my State, which has probably done the best job of expanding Medicaid of any State in the country, we have reduced the uninsured population by 60 percent; 440,000 people signed up for Medicaid as part of the expansion, and yes, some of them probably would have qualified before, but not all of them, by any stretch. We do not have any complaints about access to providers.

As a matter of fact, if you look at virtually every category of care—preventive health, screenings, dental visits, vision visits, just about every one you can mention, we have had a more than 100 percent increase in that activity in our State, so our State is getting a lot healthier.

It is also kind of frustrating—here where we tend to get in the weeds a lot—we hear the statistic all the time "one-third of the counties in the United States have one provider." I would say one-third of the counties in the United States do not have enough peo-

ple to support more than one provider. I mean, that has to be a factor in that statistic. But again, it sounds pretty doom-and-gloom. The Chairman mentioned 80 rural hospitals closing since 2010. We passed the Affordable Care Act in 2010; I would be interested in knowing how many of those hospitals have closed in the last 2 or 3 years because in my State of Kentucky, what we have heard is that rural hospitals have been saved by the ACA.

As a matter of fact, we had a hospital in Morehead, Kentucky—not in my district—which was on the verge of bankruptcy. Because of the ACA and because the population that that hospital serviced was largely a very, very poor and unhealthy population, now they are getting compensated for the care they were not getting compensated for, and they have now built a big professional office building, the hospital is doing fine, and we hear that story time after time. So, again, we can all cite anecdotal situations that support our point of view, but we need to be balanced in that.

I have a question, Dr. Blumberg. Several of the replacement plans that we have heard about—Dr. Price's and several others—seem to be at least focused on certain common elements, and one of them is a tax credit. In Dr. Price's plan, for instance, you can go out and buy insurance that provides tax credits that vary only by age, and it goes from $900 to $3,000 per person. Do you have any idea what kind of coverage in today's market you could buy for $900 to $3,000 a person?

Ms. BLUMBERG. Well, we have recently done some estimates. What the goal was, was to construct a package; we assumed five-to-one age rating, as many of those looking for replacements are leaning that direction with the age rating. We tried to construct a package that would allow an individual of any age—so, any adult from 18 to 64—to buy a particular package with the tax credit that was offered under the Price plan by the different age categories.

The most generous plan that we were able to construct that brought in everybody of those ages with that amount of money was a plan that would require the individuals to spend the first $25,000 in health expenses, so a $25,000 deductible for a single; $50,000 for a family. We found that we had to take out coverage for drugs that were not generic, so only generic is covered. That excludes chemotherapy drugs; it excludes insulin—those are not generics—a number of other expensive drugs for chronic illnesses.

We had to exclude coverage for outpatient mental health and substance use disorder treatment. We had to exclude physical therapy, occupational therapy, speech therapy, and rehabilitation care. Now, you could structure this somewhat differently, but you are bound and constrained by the math. So, you could provide some coverage up front and then far less at the back end. You could fill a little bit with which of the benefits that we included or excluded, but you are quite constrained by the amount of money.

Mr. YARMUTH. So, let me get you to repeat that. We would be talking about $25,000 per insured in deductibles, $50,000 for a family, and elimination of a substantial amount of the coverage that a policy under the Affordable Care Act would provide?

Ms. BLUMBERG. That is correct.

Mr. YARMUTH. I appreciate that. One thing, while we are on the subject of costs, that I think we need to mention is that while costs

have gone up—and by the way, the year before we passed the Affordable Care Act, I think insurance policies across the country, rates were going up 38 percent; I know they were in California, they were in Kentucky, they were in Connecticut; that was a strange number, but that 38 percent seemed to occur in a lot of places.

After the Affordable Care Act has now been in effect for 5 or 6 years, we have seen the lowest rate of growth in insurance costs and in Medicare expenditures and in Medicaid that we have seen in modern history. Medicare, I think, is down to about 2 percent annual growth. Private insurance is around the 2 percent level. So, while, yes, costs are still going up in the system, the improvement has been rather dramatic. Is that your assessment as well, Dr. Blumberg?

Ms. BLUMBERG. Yes, what we know is that per capita spending in national health expenditures has grown much more slowly than had been anticipated prior to implementation of the Affordable Care Act. Certainly, some of that is attributable to the Act itself and some of it is from other economic and structural changes, but that certainly is the case.

Mr. YARMUTH. And finally, I think it is interesting that several of you said the ACA focused largely on coverage, which was certainly one of our goals, but the changes that were made, again, with protections for people who already have insurance, the changes in annual and lifetime limits, the removal of those limits, allowing young people to stay on their parents' insurance policy until 26, these had nothing to do with people who did not have coverage. This was people who already had coverage, and also the improvements we made in Medicare, reducing the costs of prescription drugs in Medicare, getting free preventive care, annual wellness visits.

There were a lot of improvements that have been made for patients who already had care one way or another. Unfortunately, we did not talk about them, and that is the main reason, I think, that the Affordable Care Act has not been as popular over the last few years as it otherwise would be. Thank you very much, Madam Chairman. I yield back.

Interim Chair BLACK. I thank the ranking member. I do feel that I do need to make a statement here. When we talk about these scenarios that we talk about, anecdotal scenarios, these are real people; 28,000 people in my State, who were sick people that were in a risk pool that liked it, lost their insurance in one day because it did not meet all the criteria that Washington said it needed to meet. I want to tell you, before I came here last week I got a call from one of my constituents who has lupus. She had lost her insurance when that day occurred. She is now on the exchanges.

She is unable to use the doctor that she has used for years to control her lupus. There is only one provider of the insurance company in her area. So, now she lost her doctor; she cannot take the same medication that she was taking previously that helped control her condition for years; and now her costs have gone up to the point where she said, "I have got to pay it; I cannot do anything else or I am not going to be able to function."

These are very real faces that we are talking about. These are not stories that are made up. These are very real lives, and we have got to change that so that people can have their lives. With that, Mr. McClintock from California, you are recognized for 5 minutes.

Mr. MCCLINTOCK. Thank you, Madam Chairman. The thing about Obamacare is you really cannot spin one way or the other. To a greater or lesser extent, every family in America has had an up-close and personal experience with it. I think any politician that tries to convince them that their experience is different than what they know is going to look downright foolish.

The polls tell us most Americans do not like it. This was a prominent issue in the last three congressional elections in which the Democrats lost a net of 67 U.S. House seats. This Congress has a mandate to deal with it to relieve families of its burdens, to fix the underlying issues that spawned it, and restore what was once the finest healthcare system in the world.

There are basically two options that we have. One is to repeal it in its entirety and immediately replace it with the patient-centered free market reforms that the Chairman referenced earlier; restore to people the freedom to choose a plan that best meets their own family's needs from a vast market that is competing with each other to provide better services at lower prices and to, through the tax system, assure that every family has at least a basic plan within their financial reach. That is one option.

There is another option that we seem to be pursuing, and this is what I want to drill down on in my questions, and that is to repeal parts of Obamacare with reconciliation and through administrative action, and then rely on follow-up legislation to finish the job. Reconciliation would bypass the 60-vote closure rule in the Senate; the follow-up legislation cannot, and that leads me to wonder, what is the market going to look like if Senate Democrats decide not to cooperate on the post-reconciliation fix? I would like to ask a series of yes/no questions of Dr. Blumberg and Mr. Haislmaier to see where the two sides agree and where they do not.

Can reconciliation end the Obamacare subsidies and replace them with tax credits? Dr. Blumberg, yes or no?

Ms. BLUMBERG. I know it can repeal the subsidies. I am not clear on the—replacing it.

Mr. MCCLINTOCK. Okay, Mr. Haislmaier.

Mr. HAISLMAIER. I believe so.

Mr. MCCLINTOCK. Okay, so we generally agree on that. Can it zero out the taxes and the tax penalties that are used to enforce the individual mandate?

Ms. BLUMBERG. That is my understanding, yes.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. Mine as well.

Mr. MCCLINTOCK. Can it end the noncompliance penalties on businesses, return Medicaid to its pre-Obamacare condition?

Ms. BLUMBERG. I believe that is the case, yes.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. I believe so, yes.

Mr. MCCLINTOCK. Okay, now, HHS does have some latitude in redefining the mandates, does it not? Dr. Blumberg.

Ms. BLUMBERG. There is some latitude, yes.

Mr. MCCLINTOCK. Right. Mr. Haislmaier.

Mr. HAISLMAIER. HHS does have latitude, yes.

Mr. MCCLINTOCK. Okay. Is the HHS, though, still required to provide guidance consistent with benefits found in a typical policy? Dr. Blumberg.

Ms. BLUMBERG. I am not sure I understand the question. Can you ask again?

Mr. MCCLINTOCK. Does not the underlying bill, or underlying law, require that the essential benefits match those found in a "typical" policy?

Ms. BLUMBERG. That is right. There is some State flexibility on that.

Mr. MCCLINTOCK. Okay. Mr. Haislmaier.

Mr. HAISLMAIER. They have such categories of benefits and within that HHS would have to work.

Mr. MCCLINTOCK. Is HHS still bound by the Administrator Procedures Act that forbids actions that are arbitrary or capricious?

Ms. BLUMBERG. I am not familiar with that, so I cannot answer.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. Yes.

Mr. MCCLINTOCK. Can reconciliation repeal the underlying law? Dr. Blumberg.

Ms. BLUMBERG. I do not think reconciliation can repeal all the components of the law, no.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. That is my understanding of Senate procedure as well.

Mr. MCCLINTOCK. Okay. Will noncompliant policies then still be illegal? Whether it is being enforced or not, will they still be illegal?

Ms. BLUMBERG. Noncompliant plans are not illegal today, sir. There are many of them being sold. That is one of the problems in the State of Arizona, and why their premiums have gone up so much, because there are lots of noncompliant plans being sold.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. Yes, there are noncompliant plans that are legal and will remain so.

Mr. MCCLINTOCK. Okay, now, is this because state governments are still the principal enforcement mechanism for Obamacare?

Ms. BLUMBERG. It is because the Affordable Care Act regulated a certain category of non-group insurance coverage, but not those that remained outside. So, plans that do not cover you for an entire year are noncompliant plans and are out there.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. Yes, there are certain underlying types of coverage that are exempt from the ACA.

Mr. MCCLINTOCK. In a post-reconciliation world, do state governments still have to approve any new plans? Dr. Blumberg.

Ms. BLUMBERG. Right. The Department of Insurance and the State regulates what is offered there.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. That is a matter of state law, yes.

Mr. MCCLINTOCK. Okay, now, final question, and this you can elaborate on, but you have about 5 seconds each to do it, and that is, in this post-reconciliation market then, do we run the risk of adverse selection being accelerated and States refusing to approve noncompliant plans or insurance companies refusing to issue them?

Ms. BLUMBERG. There is a definite risk that non-group markets in general, for comprehensive coverage and other types of coverage most people like to purchase in the non-group market, would utterly collapse.

Mr. MCCLINTOCK. Mr. Haislmaier.

Mr. HAISLMAIER. There is a slight risk of making the current adverse selection in the market marginally worse. There are things that HHS administratively can do to marginally decrease the adverse selection that is already occurring, so, on balance, it may be about where we are right now.

Interim Chair BLACK. The gentleman's time is expired. The gentleman from New York, Mr. Higgins, is recognized for 5 minutes.

Mr. HIGGINS. Thank you, Madam Chair. Now that the Affordable Care Act has been taken out of a political context, at least in terms of the calendar, it needs to be dealt with in a legislative context, and facts are very important in that regard.

Medicare is where 55 million Americans get their health care. It costs $600 billion a year; it is 15 percent of the Federal budget. Before the enactment of Medicare in 1965, more than half of the senior citizens in this country did not have health insurance, the reason being is that for-profit insurance companies did not want to write a policy for people that were sick and therefore costly, so the American government had responded by establishing a Medicare program. We went from 56 percent of American seniors without health care to, today, 97 percent do have health care because of that program.

But the cost of that program was not sustainable because between 1970 and 2010, Medicare per-person costs grew at an annual rate of 7.5 percent, about four times the rate of inflation. It was breaking businesses, it was breaking individuals, and the number of individuals that were filing for bankruptcy protection soared because of this. Today, because of the Affordable Care Act, annual per-person growth is at 1.4 percent, fully 6 percent less than it was prior to the enactment of the Affordable Care Act, and Medicare costs are lower per person today by over $1,300 per person than they were in 2010.

When we set out to do healthcare reform, there were two objectives. One was to increase the number of people that did not have insurance. Individual mandate; why? Because the insurance model only works in health care if you have healthy payers who are paying for the cost of those that need it later in life, analogous, some people say, to car insurance. Twenty million more people have health insurance today, so that is a success.

The other objective was bending the cost curve, as economists would call it, basically trying to reduce the annual growth of health care so that it does not exceed the rate of inflation. Because if it does, eventually, businesses go broke and individuals go broke. That is just how it works. I think on those two counts the Afford-

able Care Act has been a very positive thing. Before we consider repealing it or obliterating it, we ought to have an alternative that is constructive and based on fact.

The individual mandate; again, a hallmark of healthcare reform. The idea, again, is to ensure that you have healthy payers that are paying into the system to pay for the cost of those who are older and need health care. Mr. Haislmaier, how long have you been at Heritage?

Mr. HAISLMAIER. That is a trick question, because I left and came back, but I have been associated with it for about 30 years, of which I have been there about 15.

Mr. HIGGINS. Thirty years? So, you were there in 1989?

Mr. HAISLMAIER. Yes.

Mr. HIGGINS. Did you contribute to a report that was sponsored by Heritage called "A National Health System for America?"

Mr. HAISLMAIER. Yes.

Mr. HIGGINS. And you collaborated with Stewart Butler?

Mr. HAISLMAIER. Yes.

Mr. HIGGINS. In that report, Mr. Butler said that, "Many States now require passengers in automobiles to wear seatbelts for their own protection; many others require anybody driving a car to have liability insurance. But neither the Federal Government nor state requires all households to protect themselves from the potentially catastrophic costs of serious illness. Under the Heritage plan there would be such a requirement."

That was the basis for the individual mandate. Do you still believe that the individual mandate should be a part of the healthcare system in America?

Mr. HAISLMAIER. Well, it depends on how you define an individual mandate.

Mr. HIGGINS. I think it is pretty clear here, sir.

Mr. HAISLMAIER. Well, no, it is not, because you are assuming that it is a pay-or-play mandate. When we actually helped draft legislation, which we did in 1993 with the Nickles-Stearns bill, we said, look, if you did not have health insurance, you would lose your personal exemption on the tax code. Now, one might be able to characterize that as a mandate, but that is very different than the design in the ACA, which says, "Buy a plan or we fine you."

Mr. HIGGINS. Claiming back my time, because my time is expired, I would just say for the record that it is pretty clear here the origins of the individual mandate, and the sound reasoning behind it. That was embraced as a major piece of the Affordable Care Act.

Interim Chair BLACK. The gentleman's time has expired.

Mr. HIGGINS. I yield back.

Interim Chair BLACK. The gentleman from Georgia, Mr. Woodall, is recognized for 5 minutes.

Mr. WOODALL. Thank you, Madam Chair. I am pleased to be back on the Budget Committee with you this cycle, but I will tell you, if we reclaim time that has already expired, then we see what the problems are we are going to face.

Interim Chair BLACK. That is right.

Mr. WOODALL. So, I am going to try to balance this budget going forward. I am glad you all are here. Dr. Blumberg, I particularly

appreciate the solutions that you added to the end of your testimony because I do think there is so much that we can do together.

Mr. Haislmaier, they asked you how long you had been associated; here I was a staffer on the Hill when it was led by the great bipartisan Newt Gingrich from the State of Georgia, and of course, in those good bipartisan times, we passed healthcare reform. We abolished preexisting conditions for every single healthcare plan that the Federal Government had jurisdiction over. Every single one.

You may think that that got jammed through with reconciliation. I happen to have those conference report numbers here. There was a conference report with that bill at that time, abolishing preexisting conditions. The vote in the Senate was 98–0 and the vote in the House was 421–2, with one of those great opponents of healthcare reform, Pete Stark, voting no at that time. Of course, Pete voted no because it did not go far enough, not because it got that done. I contrast that with what is going on right here.

You suggested, Dr. Blumberg, that if we repealed the ACA today that we would be worse off than if the ACA had never passed. I want to stipulate that I believe that to be true. I think we have wasted so much time fighting about this that we could have dedicated to real, fundamental reform. You know how much time we have spent arguing about repealing preexisting conditions in the Federal healthcare market since 1996? Zero. Zero, and people are benefiting from it. We are wasting time and money here, and a repeal would not get that back.

I think we have also threatened some of the underlying economics of the plan. I want to point to Mr. Haislmaier's testimony; he says this—reading glasses have come about since we have been fighting about the Affordable Care Act, too—he says, "In general, enrollment that indicates that implementation of the ACA appears to have had three effects on health insurance coverage: an increase in individual market enrollment, an offset and decline in the fully ensured employer group plan enrollment, and a significant increase in Medicaid enrollment." Does anyone dispute the—Dr. Blumberg?

Ms. BLUMBERG. Yes, I dispute his findings of his study.

Mr. WOODALL. You believe that we have not seen an increase in Medicaid?

Ms. BLUMBERG. No, I know we have had an increase in Medicaid.

Mr. WOODALL. Do you believe we have not seen a decrease in employer coverage?

Ms. BLUMBERG. Absolutely not. We have not seen any measurable decrease in employer-sponsored insurance, and we see that in multiple nationally representative surveys, both of employers and of households. Employer-sponsored insurance has remained incredibly stable since the implementation of the Act.

Mr. WOODALL. But the truth is, if you are going to spend $1 trillion on a program, it is really not surprising that we can tell stories of folks who have benefited, and I am glad. I say that sincerely; I am glad for folks who have found a benefit out of $1 trillion out of taxpayer money. What is shocking, is that we can spend $1 trillion and find folks who are worse off today than they would have been today before.

The small groups that I experience in my district, those small family businesses that went out of their way to buy a more expensive plan because one secretary in that office had a special needs child and the entire office wanted to collaborate in order to get that child the plan that they needed, the care that they needed, and those days are behind us now. Those plans have gone away. That employer cannot afford to do that anymore because he has lost the choice in that marketplace.

I think about the work that Ms. Turner has done. Yes, 75 percent higher rates for young people for a corresponding 12 percent decrease for 64-year-olds. And when those young people act based on their own economic self-interest—shocking that people still do that, but they do—then we see those elderly folks, those 64-and-under folks, disadvantaged in ways that they would not have been pre-the Affordable Care Act.

It encourages me that I can read Ms. Turner's testimony and I can read Dr. Blumberg's testimony and I can see that we all agree that those three bands have failed. We all agree that that pricing structure has failed, and it can be on the short list of things that we begin to collaborate on. 421 to 2, 98 to 0, Republicans in the House, Republicans in the Senate, Democrats in the Senate, and Bill Clinton in the White House got this done, and shame on us for having started down this road. I hope we can do better in fixing it. I yield back.

Interim Chair BLACK. The gentleman's time has expired. The gentlelady from Washington, Ms. DelBene, is recognized for 5 minutes.

Ms. DELBENE. Thank you, Chairman Black and thanks to all our witnesses for being here with us today. If you knew nothing else about the Affordable Care Act all you would need to do is read the title of today's hearing to understand that it's brazenly partisan. The majority wants to talk about the effects of the ACA, so let's talk about them.

One effect is that people do not go bankrupt when they get sick anymore. That sounds like a pretty good outcome to me. More than 120 million Americans with pre-existing conditions are no longer denied coverage. Young adults can stay on their parents' plans until they are 26, and over 10 million seniors have received help with their prescription drug payments. And all insurance plans are required to cover preventative services at no cost.

This is especially critical for women. Each year, this helps 55 million women save more than $1.4 billion on birth control. Many of my friends from across the aisle have said they want to keep the good parts and just get rid of the bad.

So, what are we really doing here? For years, my colleagues and I have offered proposals to strengthen the ACA and were turned away each time. I have a bill to make it easier for small businesses to provide coverage for their workers, for instance, and yet folks do not want to talk about that. They just want to talk about repeal.

So, now we know the effects of the ACA, which is the purpose of the hearing today. So, let's talk about the effects of repeal. You are going to hear a lot of numbers thrown around today, and it is easy to get lost in the statistics and forget that this is about people.

What is important to remember is, repealing the ACA hurts real people across the country in profound ways. It means taking away health coverage for 30 million Americans, it means seniors will have to pay more for critical prescription drugs, and it means women will once again be denied coverage simply for being a woman.

It also means a great deal to people like Sue Black. Sue is a public school teacher from my district who was diagnosed with stage four ovarian Cancer at the age of 47. Five years later, she received a short, but terrifying letter from her insurance company. In four sentences, it said she had exhausted three-quarters of her lifetime benefit limit. Thankfully, the Affordable Care Act banned lifetime caps on coverage. And she is not the only one.

In the past few weeks, my office has been flooded with stories from constituents describing how the Affordable Care Act saved their life or the lives of their loved ones. And meanwhile, the Republican plan for health care in America is repeal the Affordable Care Act and then just trust us. I think our constituents deserve better than to have their health coverage taken away with no plan for what comes next.

Ms. Blumberg, I wondered in your opinion, is there a segment of the population that would benefit from repealing the Affordable Care Act without a replacement plan in place?

Ms. BLUMBERG. You know, folks who do not want to purchase health insurance coverage and are subject to a mandate penalty as a consequence of the Act—under that sort of repeal through reconciliation, they would have less penalty to pay. The problem is that there would be such a huge loss of insurance coverage for a much larger percentage of the population, the uncompensated care burdens would increase so much on healthcare providers and on state governments that I think that would be far outweighed. Otherwise, I cannot really come up with people who are going to be benefiting as a consequence.

Ms. DELBENE. And can you describe the effects on children if the Affordable Care Act were repealed?

Ms. BLUMBERG. By our estimates, roughly 4 million children would lose health insurance coverage. Some of these children are covered with their families through the marketplaces with financial assistance. Others will lose their coverage, because what we know from a lot of experience with the Medicaid system and with the ACA is that when adults know that they can have assistance in getting coverage, they find out when they go to enroll that their children are eligible for CHIP as well. And so, if the parents know they cannot get coverage and they do not go seeking it, then their children will not end up getting insured as well.

Ms. DELBENE. Thank you. And we keep hearing from my colleagues on the other side of the aisle how the Affordable Care Act is going to collapse, but has not enrollment been growing, especially right now, and is not the real threat, right now, the promise of repeal?

Ms. BLUMBERG. Absolutely. The repeal without replacement is a recipe for a death spiral. And right now, the Affordable Care Act, as I said, has some areas in which there have been high premiums and that we have some policy strategies that should be put in place

to address them. But, by and large, it is being successful at increasing coverage, increasing access, and improving affordability.

Ms. DELBENE. Thank you. I yield back, Madam Chair.

Interim Chair BLACK. The gentlelady's time is expired. The gentleman from Alabama, Mr. Palmer, is recognized for 5 minutes.

Ms. PALMER. Thank you, Madam Chairman. I just want to share some information that I have gotten from some of my constituents. A doctor sent me some information that he saw a patient last week whose deductible was $9,000. Essentially, her insurance is basically catastrophic insurance. She probably has two patients a month who cannot schedule surgery, or they schedule and then cancel the surgery.

And basically, because people cannot afford the deductibles they are not getting the health care that they need. It is impacting the quality of life, impacting their health. Here is another family that has gone through three or four different plans. Their premiums went from about $1,400 for a family of four to $2,100. When they take the out of network, their deductible is $13,700. Madam Chairman, the Affordable Care Act is an oxymoron.

There is still over 28 million people who do not have health insurance, and most of them, according to the Kaiser Foundation, say it is because they cannot afford it. So, you have basically put one group into the Affordable Care Act, most of them are Medicaid. You have displaced people who had employer-provided plans, I think there are about 8 million of those. You have caused companies to not expand. I have information here from companies where they would not hire that 50th employee; as a matter of fact, one of these had 45 employees, they have cut back to 32 because of the premiums that they have to pay to provide health insurance for their employees.

And Madam Chairman, it has had a terrible impact on employment. I do not know if our friends across the aisle are aware of this, but there is over 94 million able-bodied Americans who are out of the workforce, the highest number, I think, ever for the country. Prior to 2008, there were 100,000 more businesses starting up than were closing. These are mostly small businesses.

According to a report from Gallup as of 2014, there are now 70,000 more businesses closing than starting up. You have people who had full-time jobs with good wages and health benefits that have been cut back to part-time. They are now having to work two part-time jobs at lower wages with no health insurance.

You know, the best thing that I can say about the Affordable Care Act is that we now know what does not work. And I am confident that we can move forward with plans to replace it. Ms. Turner, you have worked in this area for years. We know, I think goes all the way back to the 1990s, that you have been involved in health care reform, are you confident that we can repeal this and replace it with something that we do not put millions of people out of the insurance market, we allow people to actually choose their doctor, choose their health insurance. Do you think we can do that?

Ms. TURNER. Absolutely. I agree with you, Mr. Palmer, that we have learned a lot about what does not work with this law, and I think that is a good foundation to figure out what we can do. And I know that many members actually have real legislation on both

sides of the aisle and, certainly, the House spent a great deal of time developing the better-way plan that the chairman talked about. There are good ideas out there. They involve putting patients at the center, returning power to the states, to add resources to the States, to better organize their health insurance markets to be more responsive. But, yes, I am highly confident. Everybody talks about repeal and replace, not just repeal.

Mr. PALMER. Dr. Book, you brought up the fact that life expectancy declined this past year for the first time in over two decades. I think, what was it, 12 or 13 million people were put into Medicaid, that gets counted among the number of people who received health insurance. Are you aware of the studies that show that people who are on Medicaid have poor health treatment outcomes than if they had no insurance at all? Can you comment on that?

Mr. BOOK. Yes, I am familiar with that. There are multiple studies showing that people on Medicaid have worse health outcomes than people who are uninsured. It is hard to argue that Medicaid actually makes people sicker, but it is possible that people who are uninsured are either able to pay their own bills, able to obtain charity care, or perhaps, are simply healthier to begin with. But, certainly Medicaid does not have a very good record in terms of restoring people to health, making people live longer. People with Medicaid use emergency rooms more than the uninsured and more than people with insurance, and they have worse health outcomes than any other group.

Interim Chair BLACK. The gentleman's time is expired.

Mr. PALMER. Thank you, Madam Chairman.

Interim Chair BLACK. The gentleman from California, Mr. Khanna, is now recognized for 5 minutes.

Mr. KHANNA. Thank you, Madam Chair, and thank you, Ranking Member Yarmuth for your leadership. It is an honor to be on this committee. Ms. Turner, on April 8, 2016, you were quoted in the New York Times as describing President Trump's proposals as "sketchy and inadequate." You went on to say and I quote, "He has to flesh out his proposals with much more detail if he hopes to persuade voters that he has a credible plan to replace Obamacare." Do you remember saying that?

Ms. TURNER. Yes, sir.

Mr. KHANNA. Do you still believe that?

Ms. TURNER. That was a very early preliminary list of seven points that he issued during the primary season.

Mr. KHANNA. Do you believe he has now articulated a comprehensive plan?

Ms. TURNER. He is working with members of Congress as, I think, is really a very appropriate and looking forward to——

Mr. KHANNA. Can you point to any specific changes that he has offered, now different from your statement in April?

Ms. TURNER. Yes, he gave a major speech in Pennsylvania on November 1st, and outlined a very different and visionary kind of approach to health reform that would return much more power to the states, deregulate the market, give people many more choices of coverage than before——

Mr. KHANNA. I thought he has been saying that since he announced. Was there any specific changes he has offered since your statement in April?

Ms. TURNER. He is working with members of Congress. He does not do, as I think, the Obama administration——

Mr. KHANNA. Okay. If I can move on, President Trump also had called for removing barriers to imported drugs from other countries, same as, by the way, Senator Sanders. Now, you are opposed to the President's policy on that, correct?

Ms. TURNER. I believe that there is a great risk to the American people of imported drugs that we do not know the origin——

Mr. KHANNA. So, you disagree with President Trump when it comes to imported drugs?

Ms. TURNER. Yes.

Mr. KHANNA. And you disagree with Bernie Sanders, and you are on the opposite end of what President Trump is proposing on that? Is that correct?

Ms. TURNER. I think that there are legitimate safety concerns that the Federal Government, including former FDA Commissioner Mark McClellan—cannot provide safe terms.

Mr. KHANNA. I picture that I am—I just want to be clear that you are on the—you disagree with President Trump when it comes to that?

Ms. TURNER. Yes.

Mr. KHANNA. And your op-eds consistently, as you disclosed to your credit, say that your organization is funded by the pharmaceutical industry—is that correct?

Ms. TURNER. No, that is not correct. We received some funding from the pharmaceutical industry, but we have brought broad funding from individuals inside and outside the health sector.

Mr. KHANNA. I respect that, but on all the op-eds it says you're partly funded from pharmaceutical industries. In your own McClatchy editorials.

Ms. TURNER. And so as—virtually every person in the think tank has some funding from pharmaceutical companies because they believe in innovation, as we do.

Mr. KHANNA. Can you disclose to this committee which pharmaceutical companies fund your organization and how much money you receive from them?

Ms. TURNER. Those—that list is really a proprietary information, it is basically how we—how we have special relationships with all of our donors inside and outside the health sector.

Mr. KHANNA. Ms. Turner, with due respect, when I have to disclose every financial interest, I have, my spouse has, because if I am going to articulate a viewpoint on something, the public has a right to know what financial interests I have. I would suggest, if you are giving testimony to the United States Congress, the public should have a right to know what financial interests your organization has.

Ms. TURNER. We disclosed those on an I–90 Form that we file with the Internal Revenue Service every year. The Congress has seen fit to allow the list of donors to remain private as proprietary information because it is basically our intellectual property. How do we get our funding?

Mr. KHANNA. So, you are unwilling to disclose which pharmaceutical companies are funding your organization or how much money you received from them?

Ms. TURNER. It would be unfair to them, because they are—we receive funding from many other organizations, a great majority outside the pharmaceutical industry.

Mr. KHANNA. So the pharmaceutical funding is less than the majority?

Ms. TURNER. Oh, absolutely.

Interim Chair BLACK. Mr. Khanna, that really is not the purpose of this hearing. I think the witness has already answered that she is following the law, if you would like to ask another question. I think we ought to stay on the topic of what we came here to do.

Mr. KHANNA. Well, Madam Chair, I think that the issue with the President has said that he is for the importation of drugs and that is an important point in this debate on health care. The witness is offering an opinion that is in opposition to the President of the United States. And I am trying to understand why she believes what she believes and if there are financial interests that may be coloring her opinion.

Interim Chair BLACK. Mr. Khanna, I think the witness has, again, answered that she is following the law. Now, if there is a part of this that you would like to change the law, you certainly have the authority to be able to offer a bill.

Mr. KHANNA. And I think my time has expired.

Interim Chair BLACK. Thank you. The gentleman from South Carolina, Mr. Sanford is recognized for 5 minutes.

Mr. SANFORD. Yeah, and given the last interchange, I think we should all be careful about judging each other's intent. I could list a long list of left-leaning organizations that do not disclose their funding sources, there are groups on the right. I think we need to be careful about that. And in that regard, I would give credit to my Democratic colleagues for what they have tried to do with Obamacare. I think that if you look at the actual intent of Obamacare, it was good. The idea was to help people with preexisting conditions, to look at how you deal with this. I remember there was a great movie years ago, Helen Hunt was in it and I cannot remember the name of the movie to save the life of me, but there was a great tag-line. This is back at the time that insurance companies were declining people, and she said something to the fact of, "Well, my insurance company declined me." And the audience in the movie theater that I was in, I mean, they went nuts; I mean, the people literally started clapping spontaneously.

So, I think that the intent of Obamacare was good, it was, "How do we get our arms around this problem?" The question has been in implementation. I think that that is was a lot of us struggled with from the Republican side, and I suspect many independents and Democrats, as well. And with that said, I guess I would say a couple of different things, you know, I think fundamentally we all recognize the fact that the marketplace likes a product that somebody else pays for. That in the history of mankind, there is almost unlimited demand for a product, in fact, that somebody else is paying for.

And it has, to a degree, part of that fatal flaw built into it. I think that we have to recognize—the math certainly shows it—that sick people cost more than healthy people. And, you know, the fundamental problem of health care in general is, it is almost an 80/20 phenomenon; that wherein 20 percent of the folks are costing about 80 percent of what we deal with in health care. That is from the right or from the left.

And as we age, we cost more. I mean, my sons are immortal, or pretty closely so. And as you look at large pools of population, those trends hold true, notwithstanding horrible illnesses that happen to young people. And what we have come up with in construct with Obamacare, is we are going to stick the young people with the bill. In essence, it is fundamentally flawed. This 3-to-1 ratio is mathematically incorrect. And there is some math built into this equation that just does not work. And so, a number of us are saying, "Okay, the intent was good, but practically speaking, where do we go from here given the fatal flaws that are built into it mathematically?"

To my colleague, Mr. Palmer's, point, if you look at some of the outcomes, and I dealt with this for 8 years when I was governor as we were dealing with Medicaid, that, you know, there is just some fundamental flaws. We have a disease-treatment program, but we do not have much in the way of prevention.

And so, I think we are all struggling with, "Where do we go from here?" Is there a different way of dealing with preexisting condition and high risk pools, and all the things that are talked about that perhaps you have seen at a different country, or something that really has worked well with an individual county or State? I just in a minute and 35 seconds that are left, I would be curious to hear any of your thoughts in terms of best practices that we can borrow as we all collectively struggle with this debate before us. Yes, ma'am.

Ms. TURNER. I would say that, you know, almost all industrialized countries have a single payer type system where—I agree with you. The fundamental problem with doing reform is this skewness of the distribution of health expenses. And so how do you share those expenses? And I think, you know, obviously, all the foreign single payer plans spread those costs broadly through the tax payer system.

And, you know, here we are not in that place to be doing that, but I think, you know, we do not want to criticize the 3-to-1 age rating without recognizing that without a different mechanism, the people who are older adults who have more health problems would not be able to afford their coverage if we went to—I mean, I used to see 11-to-1 rating from some insurers in the old says. So, yeah.

Mr. SANFORD. See, I have 30 seconds.

Ms. TURNER. Okay.

Mr. SANFORD. I am going to reclaim it. It just seems to me on that very point that you raise—it is a legitimate point in terms of industrialized countries around the globe—that you have got three variables within health care though. You have got access, you have got costs, and you have got quality. And in as much as many of those countries have been able to spread access, it has been to the detriment of quality and cost. And so people do not go to Britain to do certain procedures. You are literally on a death list in Brit-

ain. And I think that those kind of societal questions are part of what we are struggling with. I am going to hand off to your colleague—go in the second you have got.

Mr. BOOK. In 5 seconds, a lot of those single-payer countries have annual and lifetime limits on the services they can provide to a person and they have much higher death rates from serious disease like cancer, because they just do not treat them.

Mr. SANFORD. Thank you.

Interim Chair BLACK. The gentlelady from Washington, Ms. Jayapal is recognized for 5 minutes.

Ms. JAYAPAL. Thank you, Madam Chair. As this is my first hearing on the House Budget Committee, I just wanted to express my great appreciation to you and to our ranking member, Mr. Yarmuth, for your leadership and guidance. And I am looking forward to working with everyone on the committee.

Madam Chair, last week over 2,000 people joined me in Seattle in support of the Affordable Care Act and demanded that it not be repealed without a replacement and that we in fact focus on expansion. I have heard from many who are seriously terrified that their health care will not only be stripped away, but that there is no replacement.

Sally is a single, 80-year-old woman who told me that she would be severely affected if her Medicare benefits were cut. She worked for 30 years, was healthy until 3 years ago when she was diagnosed with a serious cancer. Medicare benefits covered much of her hospital and treatment costs which she could not have paid for on her own.

She said, if Medicare is cut or reduced, "I will be struggling to keep up with healthcare costs." Madam Chair, I agree with you that this is about real people. And this is just one story, I have heard hundreds.

I would like us to consider the big picture in the State of Washington, my home State, a repeal of the ACA would mean three-quarters of a million people would lose their health care, almost 3 million people in Washington State with preexisting conditions would not be guaranteed coverage anymore. And speaking of preexisting conditions, being a woman, would once again be one of those preexisting conditions as we would have to pay out-of-pocket for cancer screening, PAP tests, and birth control.

Our State benefited greatly from Medicaid expansion, 605,000 people gained coverage and would once again be without health care. And 55,000 young people in Washington State who are barely getting by, would once again be kicked off of their parents' health insurance. There are no winners with an Affordable Care Act repeal, Madam Chair. And that is why I hope, that forums like this can be focused on what we can do to make it better, but a replacement plan, which has not been offered, instead of nothing.

I wanted to say, I come from the State Senate where—which is controlled by Republicans and the chair of the Healthcare Committee in the Washington State Senate, Senator Randi Becker recently said, "This is not a partisan issue, this is a bi-partisan issue." She believes that any replacement should build or improve the reach of Medicaid expansion funds. In Washington, this rep-

resents about $3 billion and the majority of the funding received under the ACA.

So, Dr. Blumberg, can you speak to specifically Medicaid expansion and the states across the country who have benefited from Medicaid expansion?

Ms. BLUMBERG. Sure, there has been a big infusion of Federal dollars into the states that expanded Medicaid allowing them to make all individuals, regardless of their family situations, eligible up to 138 percent of the poverty level for the first time. This has done a lot to improve the financial situations of hospitals in those states relative to the states that did not expand, as my colleague Fred Blavin has shown in a recent JAMA article. This is big financial benefits. In addition, these are comprehensive benefits with no cost sharing, so it makes coverage and access to care incredibly affordable for the low-income population.

Ms. JAYAPAL. Thank you. I appreciated the concern for fairness throughout everybody's statements and so—but I am trying to understand exactly what you do believe should be covered and some of the provisions of the Affordable Care Act. So, just yes or no answers, if you would for all of our testifiers. Do you believe that young adults should be able to stay on their parents' plan until they are 26?

Ms. TURNER. As long as the $1,200 costs——

Ms. JAYAPAL. Just a yes or no, Ms. Turner, thank you.

Ms. TURNER [continuing]. Is visible.

Ms. JAYAPAL. Was that a yes?

Ms. TURNER. If they want to pay for it?

Ms. JAYAPAL. So, that is a yes?

Ms. TURNER. If they want to pay for it, I guess.

Ms. JAYAPAL. Dr. Book.

Mr. BOOK. I think if employers want to offer that, it should be perfectly legal.

Ms. JAYAPAL. Dr. Blumberg.

Ms. BLUMBERG. I agree, it should stay.

Ms. JAYAPAL. Dr. Haislmaier.

Mr. HAISLMAIER. Irrelevant.

Ms. JAYAPAL. Is that a——

Mr. HAISLMAIER. It is irrelevant under either ACA or the replacement, because they will be treated as their own household, anyway.

Ms. JAYAPAL. Let me ask about seniors on Medicare, a critical part of the Affordable Care Act. Do you believe seniors on Medicare should be able to afford their medications and not fall into a prescription drug gap? Ms. Turner.

Ms. TURNER. Yes, but there are creative ways to do that.

Ms. JAYAPAL. Dr. Book. Dr. Book.

Mr. BOOK. Could you repeat the question?

Ms. JAYAPAL. Do you believe that seniors on Medicare should be able to afford their medications?

Mr. BOOK. I think everybody should be able to afford everything.

Ms. JAYAPAL. Great, thank you. Dr. Blumberg.

Ms. BLUMBERG. I agree.

Ms. JAYAPAL. Dr. Haislmaier.

Mr. HAISLMAIER. I mean, comprehensive——

Ms. JAYAPAL. Yes or no, Dr. Haislmaier.

Mr. HAISLMAIER [continuing]. Drugs is fine, I mean that is——

Ms. JAYAPAL. Thank you. How about making sure that insurance companies cannot deny coverage because of a person's medical history? Ms. Turner.

Ms. TURNER. That was the case before, and will continue to be the case moving forward.

Ms. JAYAPAL. So, that is a yes. Dr. Book.

Mr. BOOK. That was the case since 1996 and the ACA should never be able to——

Ms. JAYAPAL. Dr. Blumberg.

Ms. BLUMBERG. Yes, I agree, but that has not been the case, universally, by a long shot.

Ms. JAYAPAL. Thank you. Can you say more about that, Dr. Blumberg?

Ms. BLUMBERG. Yes.

Interim Chair BLACK. Sorry, the gentlelady's time has expired.

Ms. JAYAPAL. I yield back.

Interim Chair BLACK. I apologize, but we have so many other members. So, I hate to cut you off, it is great conversation and thank you very much. Now, the gentleman from Arkansas, Mr. Westerman is recognized for 5 minutes.

Mr. WESTERMAN. Thank you Madam Chair and thank you to the panel for being here today. You know, it was mentioned that a lot of people want to keep the Affordable Care Act in place, they are fearful that it might go away, but I will remind the committee that millions of Americans were fearful that they might lose their doctor or their premiums would go up, but they were promised they could keep their doctor.

They were told their premiums would go down by $2,500, but from the testimony here today, we have heard that there has been increased premium costs, there has been increased taxpayer costs, people indeed are seeing higher deductibles, they are seeing fewer benefits, they are seeing reduced access.

There has been talk about Medicare and what might happen to Medicare, but I would also remind the committee that when the ACA was passed, that there were cuts to Medicare reimbursements in the Affordable Care Act to pay for Medicaid expansion and the exchange policies as much as or over $700 billion in those cuts to Medicare.

I was visiting with a neurosurgeon from my State who has been affected by the cuts to Medicare. He explained it like this, certain surgery might take five steps to the surgery and Medicare pays for two of them. And he assured me that if there is anything he knows about how the Affordable Care Act was that whoever wrote it knew absolutely nothing about medical care.

We have heard about the number of people who have benefited from the Affordable Care Act, there is really no consensus on that number from the panel. I believe there is consensus that most of the people that have benefited from the Affordable Care Act are in the Medicaid population. I know that was definitely true in my State. There is arguments about how many people could have already received Medicaid who have qualified for it, the woodwork effect, that actually signed up for Medicaid because of the expansion.

And, you know, if we just take Dr. Blumberg's number of 20 million people who benefited from the Affordable Care Act, if we look at the population of our country that is 6.2 percent of our country. So, we could say 6.2 percent possibly got more because of the Affordable Care Act, but I think we failed to remember that 93.8 percent of Americans are getting less for more because of the Affordable Care Act.

As a State legislator in Arkansas, I lived through the debate on Medicaid expansion, and our State did expand Medicaid. It was supposedly an innovative plan that did not expand a traditional Medicaid, but used Medicaid dollars that come from an apparently bottomless pit of money in D.C. to buy private health insurance. So, the 320,000 Arkansans that are now on Medicaid that were not before, have a very nice health insurance plan. They have got a Blue Cross plan that they pay nothing for, they do not have a deductible, and it pays the providers very well, but it comes at a tremendous cost. And now over a third of my State is receiving benefits through the Medicaid program.

So, Mr. Haislmaier, I want to ask you a question on the Medicaid part, was the traditional Medicaid system for the aged, the blind, the disabled, was it having any problems before the Affordable Care Act?

Mr. HAISLMAIER. Well, it depends on the State, but, yes, I mean, there were clearly problems in the program.

Mr. WESTERMAN. Yeah, I know from my experience there were huge problems in the Medicaid program. And the follow-up to that is, did the ACA do anything to address the underlying problems with Medicaid, or did it simply add a new layer of——

Mr. HAISLMAIER. It was mainly an expansion to it; it expanded to a new population. They did make some other changes to the program, but they were largely around the areas of eligibility.

Mr. WESTERMAN. So the 324,000 in my State, take away about 7 percent of that for the woodwork, were all able-bodied, working age adults that are not even part of the traditional Medicaid system, the aged, blind, the disabled. Do you believe the traditional Medicaid population across the country has suffered any damage because of the expansion for the able-bodied adults?

Mr. HAISLMAIER. The problem with it is not just so much the expansion, that increases the caseload, but the problem is that there is a sort of inequity in basically the Federal Government paying the states more for people who need the program less, and paying them less for people who need the program more. I mean, my classic example with this——

Mr. WESTERMAN. Do you think States need more flexibility to design their own Medicaid plans?

Mr. HAISLMAIER. Well, in general, but I think also in particular with this population. I mean, one of the things we have learned both in terms of the Medicaid expansion and the subsidies for the very low income in the ACA is that these are people who will show up when they need medical care, but they are not going to stick with it afterwards. And you have to really direct them away from the emergency room. And Medicaid is not set up to do that.

Interim Chair BLACK. The gentleman's time has expired. The gentlelady from Florida, Ms. Wasserman Schultz is recognized for 5 minutes.

Ms. WASSERMAN SCHULTZ. Thank you, Madam Chair, and congratulations to you, as well as to our ranking member. The chair noted that I served on the Budget Committee in the 112th Congress, but it appears that I have returned to the alternate facts committee, because that is what we have been subjected to throughout this hearing.

Madam Chair, I respectfully want to share with you in case you are not aware, that I know you referenced 28,000 people in Tennessee supposedly, you know, losing coverage from TennCare which existed before the Affordable Care Act, but I wonder if it would surprise you to learn that 28 percent more Tennesseans gained coverage under the Affordable Care Act, that is 266,000 people in Tennessee who now have coverage which is a far sight better than the 28,000 you referenced who supposedly lost it.

I am also confident, if you checked, you would probably see that most of those 28,000, if not all of them, were able to gain more affordable coverage under that Affordable Care Act.

In my State, 1.3 million Floridians gained the coverage who did not have it before, the most in the country and I will note, something that we have not really talked about here—let's focus for a moment on the fact that people with employer-based insurance would be gravely harmed from the significant benefits that they gained under the Affordable Care Act. The return of annual and lifetime coverage gaps, coverage limits, preventative care without a co-pay or a deductible like mammograms, colonoscopies, well-woman care, all of which made health care more affordable.

By the way, the availability of birth control for free without a co-pay or deductible has contributed to a precipitous drop in the unwanted pregnancy rate. So, the majority of people who already had coverage before the Affordable Care Act will be significantly harmed by repeal.

I want to note, also, that Dr. Book clearly referenced in one of his responses that he supports returning to "health underwriting" which was extremely dangerous and harmful and expensive, and contributed to death spirals when we had a purely private market-based system. Ms. Turner is clearly advocating returning to strict private market practices that were unaffordable and harmed millions of people.

So, let's be very clear here, there has not been a replacement plan proposed and, respectfully, my colleagues on the aisle had 7 years to do that and still have not done it. We have millions of people who gained access to health care who did not have it before; millions of people who had healthcare coverage and got better coverage; millions of seniors who can have more affordable prescription drugs and, frankly, also have benefits like being able to go and get a check-up every year without a co-pay or deductible. Representing a State who has the largest percentage of seniors in the entire country, I can tell you that most of those folks were only able to go to the doctor when they were sick because they could not afford copays and deductibles on a well care visit for them, so we are keeping them healthier as a result.

In my last—under 2 minutes, I want to ask Mr. Haislmaier, do you believe—and I would like, in the interest of time, just a yes or no answer—do you believe all Americans should have access to quality, affordable health care—all? Yes or no. Given the time constraints, again, please answer with a yes or no and can we agree that health care is a right and not a privilege?

Mr. HAISLMAIER. That is the wrong question because——

Ms. WASSERMAN SCHULTZ. Yes or no. You do not get to dictate——

Mr. HAISLMAIER. No, I am not going to answer yes or no on that because you are——

Ms. WASSERMAN SCHULTZ. Clearly, because you probably do not think it is.

Mr. HAISLMAIER [continuing]. Because you are—because all health care is not——

Ms. WASSERMAN SCHULTZ. And before the ACA—if you will not answer my question, I do not——

Mr. HAISLMAIER. You know, facelifts are not a right.

Ms. WASSERMAN SCHULTZ. I guess, add. See, my name is on the door, so I get to ask the questions and decide which ones are right.

Mr. HAISLMAIER. Okay, but you do not——

Ms. WASSERMAN SCHULTZ. You clearly do not believe that health care is a right, not a privilege. None of the majority witnesses do. And before the ACA, there was no all-out band prohibiting discrimination against individuals with pre-existing conditions until age 26, correct?

Mr. HAISLMAIER. No, that is not true.

Ms. WASSERMAN SCHULTZ. No, it is true.

Mr. HAISLMAIER. No, the——

Ms. WASSERMAN SCHULTZ. There is no question that you were—an insurance company could drop people or deny them coverage——

Mr. HAISLMAIER. No, that is not true.

Ms. WASSERMAN SCHULTZ. Before the——

Mr. HAISLMAIER. The 19—Congresswoman, if you actually read the 1996 HIPAA Law, you would understand that, that is not true.

Ms. WASSERMAN SCHULTZ. That would be news to the thousands of people that I know in my district who were dropped or denied coverage. As a breast cancer survivor, I can tell you that I have spoken to many of my sister survivors who were dropped in the middle of their treatment by their insurance company and had to choose to——

Mr. HAISLMAIER. And that was illegal and they had recourse.

Ms. WASSERMAN SCHULTZ [continuing]. Between—excuse me, no, it was not illegal. It happened every day.

Mr. HAISLMAIER. It was.

Ms. WASSERMAN SCHULTZ. And they had to choose between either the chemo or the radiation because they could not afford the copays or deductibles on both. That is the nightmare that the majority——

Mr. BOOK. The ACA does not require coverage for either.

Ms. WASSERMAN SCHULTZ. Excuse me, I have not asked you a question, Dr. Book. Madam Chair, if you could return a few sec-

onds of my time because I keep getting interrupted, I would appreciate it.

Interim Chair BLACK. I am proffering you 5 seconds.

Ms. WASSERMAN SCHULTZ. Thank you so much. At the end of the day, the majority is clearly proposing to repeal the Affordable Care Act without assuring us that we would have universal access to quality affordable coverage. That is unconscionable, unacceptable and we will not allow you to do it without a fight.

Interim Chair BLACK. The lady's time is expired. I do want to recommend to my colleagues that keep saying there are not plans out there, there is a Ryan, Price, Sessions, Roe, and then there is the Better Way with Guiding Principles. With that, the gentleman from Ohio, Mr. Johnson is recognized for 5 minutes.

Mr. JOHNSON. Thank you. Madam Chairman, I appreciate the opportunity and I appreciate our panel being here with us today. You know, we are holding this hearing today for one simple reason. Obamacare has failed and it has caused a series of very serious problems for the American people. I think we all remember the Democrat Minority Leader famously stating, "We have to pass Obamacare to find out what is in it." Well, we have done that, or they did that and it is full of broken promises that are harming American individuals, families and businesses.

Instead of reducing healthcare costs, Obamacare has driven up premiums and deductibles and millions of Americans have lost affordable quality healthcare plans and their choice of doctors in many cases. The average annual family premium in the employer-sponsored market has soared, totaling more than 18,000 annually, while deductibles for individual plans are up an average of 60 percent since 2010.

At its core, the law did nothing to drive down the healthcare costs for the American people. During a time of economic recession and hardship, Obamacare employer mandate makes full-time workers more costly to hire, resulting in many cases in job reductions, lower wages, and reduced benefits. And these are just a few of Obamacare's harmful effects that we are exploring here during this hearing. And I have listened to some of the questions and comments by some of my colleagues on the other side of the aisle and I want to agree with one of the things they say.

It is not about statistics, it is about people, but yet they cite statistics about coverage without acknowledging the fact that coverage does not necessarily mean affordable. Because I can tell you that in Appalachia, Ohio—along the Ohio River, there are thousands of people who, because of the high premiums and the high deductibles, they do not bother going to the doctor even though they might have coverage in the theoretical sense, or the technical sense, it is not affordable and it does not give them quality health care.

So, Ms. Turner, under Obamacare, out-of-pocket costs, as I just mentioned for families and individuals, including the deductibles, are simply unaffordable and it constrains their budgets, so why in your view are costs so high?

Ms. TURNER. They are high primarily because the Federal Government decided it knew better than the American families to what needs to be covered in their health insurance policies. In addition,

the Affordable Care Act included a trillion dollars in new and higher taxes, many of which get booked and built into the premiums, as well as rules and regulations that have discouraged the young people from entering. So, we, therefore, have many more young, older sick people in the pools not offset by the younger people who would otherwise be there to help lower premiums.

Mr. JOHNSON. So, basically, you have got bureaucrats running our healthcare system instead of physicians and patients.

Ms. TURNER. Right, correct.

Mr. JOHNSON. Dr. Book, what are the areas of spending in Obamacare with the greatest unforeseen cost overruns? Do you have some examples you can share with us quickly?

Mr. BOOK. I would say the most unexpected thing from the standpoint of the proponents was the huge increases and deductibles and that was the result of a system that encourages sick people to sign up. It discourages healthy people to sign up especially if you are under 26. You know, why buy and exchange plan when you can get on your parents' plan. And then regulators try to crack down on premiums and they cannot cut covered services because there is a whole bunch of required covered services, so the only thing they have to do is increase deductibles.

And what used to be a high deductible plan that qualified you for a tax break, if it was $2,400, it is now lower than any deductible you can find. Now, people are paying $9,000 for a deductible, which by the way, is double the statutory limit because the previous Administration issued a waiver allowing deductibles at the double the level the text of the ACA actually allows.

Mr. JOHNSON. So, just one quick final question because I am out of time. So, has Obamacare successfully bent down the cost curve in healthcare spending?

Mr. BOOK. No. In fact, during the last year that stat is available, costs went up 5 percent per capita. The 5-year average before was 2.9 percent.

Mr. JOHNSON. Okay. Thank you, Madam Chair, I yield back.

Interim Chair BLACK. Your time is expired. The gentleman from California, Mr. Carbajal, 5 minutes.

Mr. CARBAJAL. Thank you, Chairman Black and thank you, Ranking Member Yarmuth and all my colleagues. I would like to thank all the witnesses that are here today, and I want to start by saying that, you know, the Affordable Care Act never purported to be perfect. So, it is important to recognize that as the baseline by which we are debating and discussing this. It did a lot of good. It continues to have some challenges, but it did a lot of good in attempting to fix a broken healthcare system that we all know we had and continue to have. We need to build on that.

It has been three weeks since I was sworn in as a member of Congress. In this short time, I have seen the Republican majority take concrete action to begin dismantling the Affordable Care Act and I am deeply concerned about where we are headed. We have no substantive plans from the Republican majority to replace the ACA with a proposal that would match the benefits provided by the ACA. I would love any plans that have been proposed to become available so that I could see them first hand.

Now, I want to be clear. I do not believe the Affordable Care Act is perfect. There are changes that can be made to make it better. I have heard from constituents who have greatly benefitted from the healthcare law and that is the reason I am here. I asked my constituents to share with me their stories about how a repeal would impact their lives. And I would like to share some of those stories with you, not statistics, but some of those stories.

Jerry, a business owner in Los Osos in my district, lived without health insurance for years until the Affordable Care Act, hoping that their young son would not get sick or break a bone. Brian, in Santa Barbara, was uninsured for nearly 20 years because he could not afford health care coverage. The Medicaid expansion under the ACA allowed him to get covered. Just last year, Brian was diagnosed with a degenerative disc disease and without surgery covered by this medical expansion, he would have been left severely disabled. He told me the ACA quite literally saved his life.

Elle Donna in Balboa Beach, donated her kidney the same year the Affordable Care Act was signed into law, in 2010. If not for the Affordable Care Act, her life-saving act would have prevented her from obtaining health insurance due to a new pre-existing health condition as a living donor.

These are just a few of the stories that I have heard about tangible life-saving impacts the Affordable Care Act has had. I see I am running out of time. Dr. Blumberg, can you elaborate more on how repealing the Affordable Care Act would impact my home State, California?

Ms. BLUMBERG. I do not have my California specific figures in front of me, Congressman, but as the largest State——

Mr. CARBAJAL. Let me ask you a second question then. What do the people losing coverage look like to you? Are they working families? Are they mostly poor or not?

Ms. BLUMBERG. So, about over 80 percent of those who would lose coverage are in working families and the vast majority of those have at least one full-time worker in the household; 53 percent have incomes between 100 percent and 400 percent of the Federal poverty level. That is about $24,300 for a family of four as poverty. It has spread very broadly across the age distribution, contrary to some of the things we have heard. There has been—the biggest uptake in coverage that has been among young adults and 80 percent are people who have not obtained a college degree.

Mr. CARBAJAL. Thank you. I come from a working family. My dad was a farm worker. I have seen people back home struggle to pay their medical bills when a family gets sick. It is imperative that we continue to work together providing affordable health care coverage for all, especially these working families that stand to lose the most from repeal. I yield back.

Interim Chair BLACK. The gentleman yields back. The gentleman from Minnesota, Mr. Lewis, is recognized for 5 minutes.

Mr. LEWIS. Thank you, Madam Chair. For the record, anyone on the Panel can answer this, the HIPAA Law of 1996 does not allow or does cover by law, pre-existing conditions, employer-to-employer?

Mr. HAISLMAIER. That is correct.

Mr. LEWIS. Oh, I just wanted to get that in for the record then. I do want to talk a little bit about what the ACA has done in Min-

nesota. Now, there is a lot of talk from the other side about how repeal would impact certain groups, but we know what the law has already done. In my home State of Minnesota, which is really at the epicenter of all this, the commerce commissioner there called it an emergency situation. Two years of back-to-back premium increases, 50 percent and 67 percent. A hundred thousand people being shoved into a default option.

The governor, Governor Mark Dayton, whom we are all wishing well today, called the Affordable Care Act is, "no longer affordable." It is an existential crisis in the State of Minnesota. So, we can talk all day long about what repeal and replace is going to look like, but we know what the current law looks like and it has been a disaster. One thousand counties in the United States have one insured to choose from.

Now, I am going to focus a little bit about—on two things, one, employer coverage as well as what we call the age rating or the community rating in some circles. First of all, I believe Grace-Marie Turner has commented on the Affordable Act not just hitting the individual market, what we are hearing from the other side is, "Well, gosh, you are just talking about 5 percent of the people in the individual market being hurt by all of this. It is no big deal, 95 percent of the people have coverage and their very healthy employer pool, but, in fact, the Affordable Care Act has really impacted employer coverage too, has it not?

Ms. TURNER. Absolutely, and as we heard earlier, the requirements of the law have significantly driven up costs and deductibles to the cost of the average family policy for employer is now $18,000 a year, more than the $4,000 higher than it was before, not the $2,500 savings that they were promised.

Mr. LEWIS. And Dr. Book, to your point, an acquaintance of mine was recently offered a plan, at work, again not the individual market, employer-based coverage, his deductible was $13,000. The family plan was well over $1,500 a month. This is living proof that health insurance is no longer health care.

Mr. BOOK. Right, well, yes and that kind of deductible was unheard of before the ACA. Nobody had a $13,000 deductible before that.

Mr. LEWIS. It used to be in the market-based economy, it would work a little bit like the bond, 10-year bond. The interest rates go up, the bond goes down. Premiums go up, your co-pays and deductibles go down. Now, we are getting a massive hike in premiums along with massive hikes and co-pays, stricter drug formularies all sorts of things that were unheard of just a few years ago.

Mr. BOOK. That is absolutely right.

Mr. LEWIS. Anybody else want to comment on that?

Ms. BLUMBERG. I would like to comment. There was some turmoil in the early years of the ACA in Minnesota because of the problems with underpricing by the co-op and then the removal of the risk core where payments that were intended to pay and that was a congressional decision and that really financially harmed the market in Minnesota tremendously and I get that, but 380,000 people have gained insurance coverage through or at risk of losing

their health insurance coverage through repeal. In Minnesota alone——

Mr. LEWIS. I can tell you the insurance companies are more than making up for that underpricing early on.

Ms. BLUMBERG. No, and I understand that.

Mr. LEWIS. I mean, it is 50 percent, 67 percent the last 2 years.

Ms. BLUMBERG. And there are some strategies that we can discuss for stabilizing the market there and increasing competition within the framework of the Affordable Care Act.

Mr. LEWIS. I think it is just going to be, soon, one insurer left in MNsure, the State exchange. They are fleeing the State.

Ms. BLUMBERG. But if you want to discuss it, I can give you some ideas of how you might increase competition.

Mr. LEWIS. I want to get one more question in for Mr. Haislmaier and that is, do you know of any economic model where freely floating prices are not a requirement for the proper allocation of assets?

Mr. HAISLMAIER. No.

Mr. LEWIS. So, why are we putting price controls on the health insurance market that basically says, "Well, gosh, the price has to be within a band for everybody," which is effectively jacked up premiums so high that we price young people out of the healthcare market.

Mr. HAISLMAIER. Well, basically, that is a pricing convention and what you can do is you can sort of categorize them in bands. The problem there is, yes, you have compressed to the point where you have increased the costs for young adults——

Mr. LEWIS. And priced them out of the market.

Mr. HAISLMAIER. You have reduced them for older people and priced them out of the market. Yeah, it was one of the things that really even from the perspective of a supportive of this law did not make a lot of sense to start with because those are people who are most likely to be price sensitive about insurance.

Mr. LEWIS. I think Milton Friedman warned us about price controls at one point, right, in the surpluses and charges. All right, thank you. Madam chair, I yield back my time.

Mr. ROKITA [presiding]. Gentleman yields. Mr. Boyle is recognized for 5 minutes.

Mr. BOYLE. Thank you and thank you for recognizing me and I very much appreciate being on this committee. Regret that this morning it was service on my other committee has a hearing meeting at exactly same time, so trying to run back and forth to the two. I will have questions for Dr. Blumberg, but I first just want to reiterate something that I said on the House floor last week and go into a little more detail since I have more than a minute.

It is interesting that about 16 years ago, I was sitting in a graduate school class at Harvard's Kennedy School and there was a fellow from the Heritage Foundation, Stuart Butler, saying that he had an idea that was an alternative to what was then characterized as "Hillary Care" before it was demonized Obamacare, it was first demonized as Hillary Care.

And the alternative to a government-run, single-payer system, essentially Medicare for all, was the pool the uninsured together through a series of taxes and tax credits combined with a mandate to purchase insurance and banning a discrimination against those

with pre-existing conditions. Pool these people together and instead of having a government provided single payer, we would instead pool them together and enable them to purchase private health insurance plans.

In fact, that was the genesis of the bill that was introduced by then, Republican Senate leader Bob Doyle and 17 Republican senators in the mid-1990s. Fast forward two decades, we know it and the root of it is Obamacare and suddenly, it is an idea that is akin to socialism.

So, if the other side really wants to repeal and replace what was the market solution to the Democratic plan of the 1990s and wants to instead repeal it and maybe replace it with a single-payer system or some sort of Medicare for all, I would be someone on this side of the aisle that would be interested in that sort of repeal and replace conversation.

Now, let me address some of the rhetoric we have heard recently in the media because I am confused about it. We keep hearing that Obamacare is in a "death spiral" and that it will "collapse under its own weight," but then I actually look at the facts and I see 22 million people who are insured. I see that in 2010, the percentage of Americans uninsured was approximately 16 percent. Today, it is one half of that, 8 percent. The lowest percentage in American history.

So, Dr. Blumberg, could you rectify these clear discrepancies between the rhetoric of a "death spiral" and the actual facts?

Ms. BLUMBERG. Sure. The Affordable Care Act markets are not in a death spiral. Coverage is increasing in them and there some—substantial percentage of the population lives in areas where there has been either modest increases in prices or actually, decreases and not—lowest options that are available there.

So, there are some markets that have had bank percentage increases because they were correcting for earlier underpricing and then, there is a set of states that are having issues related to lack of competition and either their insurer or provider markets and adverse selection. And those are the markets that we should be addressing with policy, but we should not be presuming that this is one big market that is collapsing. That is absolutely not true.

Mr. BOYLE. Yeah, and I think a couple of those States are Minnesota, like we heard Arizona, I think is another one. They have their own unique challenges that are not necessarily representative of the Nation as a whole.

Ms. BLUMBERG. That is correct.

Mr. BOYLE. I did want to—because I cited the figure of 22 million people that are now enrolled through the exchanges, but, in fact, if we were to repeal the Affordable Care Act, the number of people that would lose their health insurance is upwards of 30 million. Is that not correct, and can you expand upon that?

Ms. BLUMBERG. Our estimate is that 29.8 million would lose their coverage in 2019 and that would be a consequence of repealing all the financial assistance and the individual mandate that bring in the healthy population into the pool while leaving in place the consumer protections that prohibit discrimination against the sect. Those two things going together end up not just eliminating

the coverage for people who gained it under the law, but collapse the market for people that were buying with their own funds.

Mr. BOYLE. Okay and of course, finally, since I am down to 10 seconds, the 29.8 million figure does not even include the number of seniors in my districts that have gotten benefits such as, lower prescription drug costs because of other changes that came in with the Affordable Care Act.

Ms. BLUMBERG. Right, because they would not become an insured.

Mr. ROKITA. The gentleman's time is expired. We will now hear from Mr. Bergman for 5 minutes.

Mr. BERGMAN. First, thank you, Madam Chairman, for giving me the opportunity as a member of the new committee—Budget Committee to be here and ask questions today. As a new member, I came to Congress with a promise to my constituents of Michigan's First District to serve them and to make sure we are being responsible stewards of their hard-earned tax dollars. So, it is only fitting that we are here today to discuss the harmful effects of Obamacare.

This law has raised taxes on families and small business, discouraged economic growth and job creation and has ultimately placed the government in the driver's seat for personal healthcare decisions. I am looking forward to working with my colleagues across the aisle, here in this committee, and in Congress in general on meaningful, real reform to our healthcare system.

My first question for Ms. Turner. The authors of Obamacare tried to setup tools to help small business get access to health coverage, such as the small business tax credit, a special insurance exchange, known as the shop exchange. Are small businesses better off or worse off because of Obamacare?

Ms. TURNER. The polls that are taken by the National Federation of Independent Business and other organizations say absolutely not because their costs are still so high and they were very disappointed at the effect of the promise that they would have tax credits and relief which they have not seen and felt they had to jump through way too many bureaucratic hoops and the tax credits were far too restrictive to be of use to them.

Mr. BERGMAN. Okay. Again, Ms. Turner, what are the lessons that we should take from our last 6 years of Obamacare to truly provide access of affordable health care for the small businesses? And my district has a tremendous number of small businesses. What are the lessons?

Ms. TURNER. The lessons are to listen to them; that they want to provide health insurance for their members. They cannot do it if the policies that they are required to offer are so extraordinarily full of benefits that the prices are prohibited. It hurts everyone to try to promise them everything and they cannot afford it.

Mr. BERGMAN. Thank you. Dr. Book.

Mr. BOOK. Yes.

Mr. BERGMAN. As we prepare to legislate in this area to provide patient-centered healthcare reforms, what are the biggest lessons from the Obamacare experience that we should heed? Conversely, are there positive aspects of the healthcare law that have performed better than anticipated that we should be aware of? So, pros and cons.

Mr. BOOK. So, I think the most important lesson is patients have a better idea of what type of coverage they want than people sitting here in Washington telling them what to want. People should have the right, if they wish, to buy a comprehensive healthcare plan that covers everything imaginable.

If they wish to choose a more basic plan, that should be an option. If they wish to choose a more, you know, more catastrophic plan, which is with the $9,000 deductible, that should be an option as well. What they should not have to do is buy a comprehensive plan with a catastrophic deductible, which is basically the only option that people in the individual market have right now.

I think the goal of allowing people to buy insurance without—even if they have pre-existing conditions is an admiral goal, is an important goal, it is an essential goal, however, the ACA went about this in a completely wrong way that left millions of people unable to afford coverage. It also left insurance companies not covering a lot of conditions.

You know, in the first year of the ACA, there were actually fully compliant ACA health plans that did not cover cancer treatment at all because that was not one of the essential services required by law. I guess someone just forgot to list that.

Mr. BERGMAN. Thank you.

Mr. BOOK. Yeah, sorry.

Mr. BERGMAN. Thank you. I want to get to—because I have about 30 seconds left. Mr. Haislmaier, can you explain the difference between subsidized and unsubsidized coverage and what that means for individuals who are purchasing coverage?

Mr. HAISLMAIER. Well, the Affordable Care Act has a set of very general subsidies for people who meet income and other criteria and purchase through the Exchange. So, what I am talking about the market, those are the people I am referring to who are receiving subsidies, as subsidized enrollees. You could also refer to people who are on a public program as a subsidized enrollee. The other two are buying in the same market——

Mr. ROKITA. The gentleman's time is expired. We will now hear from the gentleman from Massachusetts, Mr. Moulton, for 5 minutes.

Mr. MOULTON. Mr. Chairman, thank you. You know, there has been a lot of discussion here back and forth about conflicting ideas. Perhaps, alternative facts, but I just want to get down to some facts we can all agree on. Some simple things about the situation we find ourselves in now here in Congress.

The first is that, Republicans have tried to repeal the ACA 65 times; 65 times, they have voted to repeal the ACA without a replacement. Not on the first try; not on the fourth try; not on the 12th try; not on the 65th try. I heard Madam Chairman discuss at length, her anecdotal evidence for places where Obamacare has come up short. Not once did I hear her propose an alternative. If we want to fix this, then let's propose a plan, and hope is not a plan. Ideas are not a plan.

Second, we get lectured in this committee a lot by the other side of the aisle about fiscal discipline; about how if American families and small businesses can balance their checkbook, then Congress ought to be able to, too. And you know what? I agree with that.

I strongly agree with that and yet, here we are where repealing the ACA without a replacement as the Republicans have already begun to do, would cost roughly $350 billion through 2027.

In fact, it will be so bad for the deficit that Republicans had to repeal the rule that bans reconciliation from being used to increase deficits. They had to repeal that rule so that they can increase the deficit dramatically by repealing Obamacare. It is going to break our bank.

The gentleman from California said, "Is it not shocking that we have a trillion dollars spent on health care and yet there are some people who are left out?" What is shocking to me is that you want to spend even more than that and yet leave 30 million people without health care.

Now, the third thing that we can all agree on is that the Congressional Budget Office estimates that repealing the major coverage provisions of the Affordable Care Act will terminate coverage for—sorry, not 30, but 32 million people.

I would just like to put that number in perspective. No, sorry, not the slide of the people who did not show up for the inauguration. Can you see the next slide? Yes, the Women's March, right. This Saturday, roughly 3 million Americans gathered in cities all over the country for the Women's March. The largest single day protest in American history. If you multiple that number by 10, that is how many Americans would lose their access to the affordable, quality care they receive from the ACA. We are just looking at Washington here.

Three million Americans all over the country, multiply that by 10, that is now many people we are talking about losing their care. I am a veteran myself. I am particularly proud of the fact that between 2013 and 2015, the un-insurance rates for non-elderly veterans fell by an estimated 42 percent—42 percent and we are going to put a lot of those vets out in the street without health care if we follow through on this. Two leading doctors at Harvard Medical School have concluded that 43,000 people will be killed annually if the ACA is repealed without a replacement. And not just a replacement, but a comparable replacement, a comparable replacement.

Madam Chairman lectured us on how we should govern by anecdote because she cited some people who are not happy with their current care. Those 43,000 people are not just anecdotes. They are people too, who will lose their care if this is repealed. For your Congressional district, that is about 1 in 17 people in your Congressional districts, that is what that will mean; who will die if this is gone. Thank you, Mr. Chair. I yield back.

Mr. ROKITA. Gentleman yields back. I will remind the gentleman that in 2015, when the Obamacare appeal got to the President's desk, had he signed it, the deficit could have nearly been erased because CBO scored that as a $500 billion savings. Gentleman from New York, Mr. Faso, is recognized for 5 minutes.

Mr. FASO. Thank you, Mr. Chairman. A number of the witnesses have discussed the age banding, and we know that there are approximately 8 million people have chosen to not buy coverage either because they cannot afford it; they do not know enough about it; or, they have just simply decided it is a better deal for them to pay the penalty. I am wondering if—I know Ms. Turner and Dr.

Blumberg have both referenced in their testimony the 3-to-1 ratio which is in statute as I understand it. What should—if the panel could each offer us—what should that ratio be if we are to amend that portion of the law?

Ms. TURNER. This would be a decision best left up to the States, but a 5-to-1 age band was previously considered a good standard, but it is something that is very difficult for the Federal Government to make one standard.

Ms. BLUMBERG. From my perspective, you cannot change the—you should not change the 3-to-1 age band to something broader unless we provide more financial protection for older adults because the point of putting those tighter age bands in was to make it so coverage was not excessively unaffordable for older adults paying for their full premium.

So, if you can put in where consumer protections, financial protections, everyone over 400 percent of poverty pays only—no more than eight and one-half percent of their income for a standard policy. Then you can loosen to 5-to-1 because what you are doing is you are redistributing these very high costs that we accrue as we get older by income instead of by age—but for now I would not move up——

Mr. FASO. Thank you.

Ms. TURNER. But the effect has been to discourage young people to getting it and actually it harms older people now currently because the young people simply do not enroll because of this 3-to-1 band.

Ms. BLUMBERG. It does not harm older people and I think you have far overstated the circumstances.

Ms. TURNER. But they are paying higher premiums.

Ms. BLUMBERG. This is my turn now. You far overstated the circumstances because age is very inversely correlated with income. So actually, a very large percentage of our young adults are eligible for financial assistance, which caps what they have to pay relative to their income when they enroll through the marketplaces and that protects them. Our analyses found that there is no difference in coverage as a consequence of 3-to-1 versus 5-to-1. It is a matter of who is going to be a little more uninsured; older adults who need a lot more care or younger adults who need less.

Mr. FASO. Thank you, Dr. Blumberg. Dr. Book, did you have something to add to that?

Mr. BOOK. Yeah, thank you. To answer your first question, I would recommend not specifying that in that ratio in the statute. Prior to the ACA, some states did not have that in their State statutes either and the ratio was usually 5-to-1. We find with the ACA premiums even for older Americans have increased relative to what they were before. So, I do not think this 3-to-1 is necessarily saving them money, because they are paying more.

Mr. FASO. Okay. Mr. Haislmaier, do you have something to add to that?

Mr. HAISLMAIER. Congressman, yes. I can supply you with a study that was done by the American Academy of Actuaries that has looked at the relationship between age and health care expenditures. And basically, when you look at that, if you assume that there is a blended rate, meaning that you are not differentiating

between men and women, because women tend to be more expensive younger and then that flips and men are more expensive when they are older, but if you assume a blended rate, then the approximately 5- to 6-to-1 range is the natural variation in health care spending.

Mr. FASO. Thank you. One last question that the panel, if you could briefly answer since I have 1 minute and 19 seconds, the essential benefits, my understanding that is done through strictly regulation now at HHS. What changes would you recommend in that regard, Ms. Turner?

Ms. TURNER. There are 10 specified categories in the ACA. The HHS secretary has a broad license to redefine those and I think that is something that the American people would like to have looked at again so that they can have more flexibility.

Mr. FASO. Dr. Book.

Mr. BOOK. Yeah, I would like to say a word about preventative care, which is listed as a general category, but somehow, in reality, preventative care does not include anything that actually prevents you from getting sick. For example, high blood pressure medicine is not included, cholesterol medicine is not included, blood thinners for people who had strokes are not included. It just includes things like vaccines, screening tests, and contraception. So, a lot of the things that actually prevent people from getting sick and prevent people needing more expensive treatments are actually not counted as preventive care, according to the ACA and its regulations.

Mr. FASO. Dr. Blumberg.

Ms. BLUMBERG. One must remember before you remove something from an essential health benefit or remove all essential health benefit requirements, is that as soon as you take something out of that benefit package it is out of the sharing of healthcare risk across the population. Any individual who needs that particular type of care is going to have to pay for it completely out of their own funds, and this will make that unaffordable care, in many circumstances, for many individuals.

Mr. ROKITA. The gentleman's time has expired.

Mr. FASO. Thank you, Mr. Chair.

Mr. ROKITA. The gentlelady from New Mexico, Ms. Lujan Grisham, is recognized for 5 minutes.

Ms. LUJAN GRISHAM. Thank you, Mr. Chair, and while I had not intended to have this be the focus of my question, and I hope I do not lose all my time as a result. What is really hard about these hearings is that both sides have a limited amount of time to shoot out their sound bite and these falsisms or truisms do not get us anywhere closer to dealing with real healthcare reform. For somebody who has worked in health care for more than 30 years—I remember HMOs and I remember Medicare Part D and the problems with formularies—I can tell you that insurance companies and pharmaceutical companies are not trying to make it affordable for anyone, and I know that we have had lots of debates that have been bipartisan in Congress about hospital costs, and I just am really struck by the conversation about what HIPAA does and does not do.

Most people in Congress, I will bet, have no idea that it is a privacy portability law that made some changes to the prior COBRA

protections, which basically means when you lose your job or change your job there ought to be some way to take that insurance protection with you. But what we do not talk about is it was the full cost and it is time limited out, and if you do not get into another group plan after 24 months and you do not know to appeal, and you do not have a lawyer or you do not have me, then you do not get an extension.

And if you had cancer, you are in real trouble, which is why we have so many bankruptcies and why people are so frustrated because while somebody on my side of the aisle did not quite get that right, her point was it does not really work in the way that we thought it did and most high risk polls around the country did not provide subsidies, which meant you were still paying the full cost of your care when you were excluded by a pre-existing condition, which is why so many Americans are so frustrated and we in Congress are not dealing with the real perpetrators of cost.

You want to talk to doctors, which I do nearly every month, bipartisan, all different practices and relationships. They do not want to work insurance companies, not worrying about bureaucrats nearly as much as they are worried about corporations that tell them what they can and cannot do.

You want a patient-centered system, take out the people that I have no control over. I have access to my doctor, but I cannot deal with my insurance company or pharmaceutical company that will not put any of the drugs—Dr. Book, that you just mentioned—as preventative care.

It is not the ACA. We do not allow any negotiations with any of those pharmaceutical companies and, until we start to do real work in that regard, then the issues that you have by both members of this committee, including the mother pregnant with twins, husband loses his job, without the ACA, no way—and they are born prematurely—can she deal with it with the ACA.

Another one of my constituents because insurance companies and hospitals do all sorts of interesting things, including in hard to serve places like my State, but certainly not just like New Mexico, but all across the country. We do interesting things like this, so this hospital is in my network and this hospital does women's care, which means they do maternity care, which means they got to have a neonatal wing. But guess what, that hospital is going to contract out with a Florida company that is going to provide those neonatal services.

Now, I do not have any access to that information. I choose a plan. I go to the hospital in my plan. I give birth to triplets, prematurely. Those triplets are very sick, one survives. No complaints about the quality of care by this neonatal team. Now you need specialty care for the twin that survives. It is severely disabled and guess what I got? I got a $30,000 bill just for the first couple of weeks in neonatal care. You know why? Because they were not part of that network, and the ACA did not prevent that, the ACA did not cause that. Insurance companies cause that. Now, I was able as a member of Congress to solve that problem.

I have legislation, ladies and gentleman, that would prohibit that. I do not think it has ever gotten here, and anybody who wants to get on that bill call me after. There are plenty of problems

with large corporations and hospitals who have created huge cost problems and practices in this country. The real, one of the real issues; it is not the only one; we do not embrace public health in this country. Every other country that deals with reasonable healthcare costs and you want to get to prevention, then let's do public health.

So, my questions were, are there any proposals, to Linda Blumberg, that you have seen in Congress. I will not even pick on Republicans, because I know about the Health Savings Account and I know about privatizing Medicare that would actually reduce deductibles or out of pocket costs, which I would agree I would love to see those go down. Any?

Ms. BLUMBERG. No.

Ms. LUJAN GRISHAM. Me either. Not for 30 years.

Mr. ROKITA. The gentlewoman's time has expired. We will hear from the gentleman from Pennsylvania. Thank you, Mr. Smucker, for 5 minutes.

Mr. SMUCKER. Thank you, Mr. Chair. I would like to thank the panelists for being here today. You know, I think it is important we not lose sight of the goal that I think is shared by everyone up here today, both sides of the aisle, and that is, we want to ensure that individuals—Americans—have access to quality health care at a price they can afford. And I am looking forward to working with my colleagues on both sides of the aisle to design such a system, because we know ACA has not done that—has not worked—and granted there are some who have had access to health care for the first time through ACA.

And we are not going to pull the rug out from under them. We want to ensure we have a system that gives them better coverage, better care, but what I have been hearing and I, of course, like so many others—I am a first-time freshman member—have come through a 12 months campaign primary in general and the Obamacare system has been top of the list in people's minds. And what I have heard from constituents in my district is what we have been talking about today.

People have seen extraordinary increases. People who had health insurance before have seen extraordinary increases in the cost of their premiums, 25 percent average increase in premiums across the country. It is higher than that in my area. I have talked to people who have seen doubling of their premiums, and then I have heard of others who have lost their insurance altogether, who have been forced onto a plan that they did not want.

So, clearly, what we have is not working. I think there are better solutions and I am looking forward to working with the college to achieve that. My background is small business owner. I have been a small business owner for 25 years prior to serving in the State Senate, and I have spoken to a lot of small business members over the last year as well.

I will just share one brief story. A husband and wife team, who operated a small machine shop in Elizabethtown in the Lancaster County portion of my district, and they prided themselves—they have 10 to 15 employees, I forget the exact number—but have been in business for quite some time, have always prided themselves in

creating a kind of family atmosphere among their employees. They see their employees as family.

They have always provided quality health care, seen that as an important part of their pay and benefit package, and literally believed that they may not be able to do that any longer and were very, very worried, not only about how it would impact their business and their profitability, but how it would impact their employees and their employees' families.

I think this is one of the impacts of the Affordable Care Act that we have to find better solutions to allow employers to continue to provide that kind of service to their employees that they think is very, very important. But I want to get back, and I have taken most of my time—but I do have a quick question and I think, Mr. Haislmaier, you had talked about self-insurance. As a business owner, myself, we were one of those businesses that were self-insured and we found it an effective way to control costs, because you created a partnership with your employees and with the company.

You designed a system that worked for employees and then created incentives for control and costs and so on, and just recently I talked to a business owner who said over the last 5 years they have not had the kind of increases that many others have seen in health insurance, many other businesses have seen. And when I asked why, he said well, we are self-insured.

So, we have had a very, very good experience with that. I think you mentioned that we have seen a slight increase in self-insurance after ACA and I guess I would be interested in learning more about that and whether you see this is as an important part of the solution.

Mr. HAISLMAIER. Yeah, the most notable shift has been a significant drop off in fully insured employer plans, which is where you go and buy the coverage from an insurer on a group basis, and the insurer retains the risk. Those tend to be smaller and medium size businesses. Up until recently, the self-insured market has largely been large employers, but it is moving down the firm size scale. That is, by far, just to give you a relative concept, that has grown, but it has been a steady two percent sort of growth every year, but it is already from high base of about 100.

It started out at about 100 million people in that. One of the reasons that—and I have been looking for this—I have not seen a significant acceleration in the data, but because of the ACA, if you get out from under——

Mr. ROKITA. I am sorry, the gentleman's time is expired. The gentleman's time is expired. Mr. Gaetz of Florida, you are recognized for 5 minutes.

Mr. GAETZ. Thank you, Mr. Chairman. Hope is not a plan, was the admonishment we received from the gentleman from Massachusetts. It is perhaps also a fitting title for the obituary of the last 8 years. Time and again, we have heard our Democratic colleagues on this committee say, "There is no replacement. There is no plan that Republicans have offered."

And whether they are here with us or back in their offices admiring their names on the wall, I would suggest that they look at the legislation offered by Mr. Rokita, where he has said that we functionally block grant Medicaid to the states, then we can experience

the great vibrance of a Federalist system, where best practices will be attempted and copied and sure, there will be some who miss the mark, but that is sort of the deal we get in a constitutional republic, and certainly join Mr. Rokita in attempting to advance those efforts.

I want to, for a moment, speak about emergency room visits. There was a promise in Obamacare that we would see a reduction in emergency room visits, but I have noted a 2015 study from Northeastern University suggesting that emergency room visits post Obamacare in Illinois are up. Another 2015 survey from the American College of Emergency Room Physicians where three in four emergency room physicians are experiencing higher emergency room volume, not lower volume, following Obamacare.

And a February 2016 study, from the Center of Disease Control, suggesting that there has really been no reduction in emergency room visits as a consequence of this law, and so I guess my question for Dr. Blumberg is, why has Obamacare failed to reduce the number of emergency room visits?

Ms. BLUMBERG. Well, first of all, I think it is not fair to assume that any change in emergency room visits is inappropriate use. There are always provider shortage areas where people tended to use emergency room care more. Those provider shortage areas were prior to the ACA and they still exist. But in addition, when you see an increase under the Affordable Care Act, what you are doing is you are lowering the price of medical care to people. And so, people who could not afford necessarily to go and get an emergency room care when they needed emergency room care, now have financial access to do so. So, it is not necessarily just because you have seen an increase that that is an increase in inappropriate use.

Mr. GAETZ. Reclaiming my time, I am glad you mentioned that. So, let's then turn to the State of California. The State that has perhaps most enthusiastically embraced the expansion of Medicaid, where currently one in every three Californians is on their Medicaid product—13 million people—across the board reductions in reimbursements to providers.

We read in the Los Angeles Times the story of Kevin Hill, 58 years old. He was one of these Americans who was added to the Medicaid roles. He had to call 15 doctors in the Long Beach area. Either the doctors were not even answering the phones or they were not taking California Medicaid patients anymore because reimbursement rates were so low. And where did Mr. Hill end up? Back in the emergency room. So, I guess, you know, the question is if you have got a circumstance where you have got enrollment that is spiking beyond the ability to raise taxes to pay for it and reductions in what we pay providers, what is the hope looking forward?

Ms. BLUMBERG. Well, we should not make public policies based on anecdote, and I do appreciate the story of your one constituent. But there are a lot of people who are getting Medicaid coverage now who have a usual source of care and we can demonstrate this through household surveys that never had a usual source of care before, and that is outside of——

Mr. GAETZ. Reclaiming my time. You know, it is sort of like shifting ground. When I state the statistics that indicate that there is

rising participation in our emergency rooms, the statistics cannot be trusted. When we cite the individuals who cannot go and obtain care, then we cannot trust the anecdote.

Ms. BLUMBERG. But I did say when you lower the price of medical care, more people have access to use it. But that does not mean we are not also increasing access to usual sources of care for people who are uninsured for the first time under the Medicaid program, because the evidence is very strong that we are.

Mr. GAETZ. Well, then let me conclude my time with some bipartisan agreement with the gentlelady from New Mexico. I agree wholeheartedly with her statements that we have real cost problems and cost drivers. I think frequently aided by a hospital industrial complex and an insurance system that, for the most part, has been supportive of the Affordable Care Act and does not want its repeal, and so the very people that the Democrats on this committee criticize for being the drivers of cost are the very same entities that are bellied up to the trough draining resources away from those who are truly vulnerable.

So, I join the bipartisan sentiment about trying to attack those cost drivers, but it seems as though focusing only on coverage, which is illusory, which does not lead to real care, it just leads to more folks in the emergency room. It is not the better way that we should all be pursuing.

Mr. ROKITA. I thank the gentleman. The gentleman yields back. The gentleman from Texas, Mr. Arrington, is recognized for 5 minutes.

Mr. ARRINGTON. Mr. Chairman, thank you, and I am honored to represent West Texas. I am honored to be on this committee and to the ranking member Mr. Yarmuth, I look forward to working you and our colleagues on the other side of the aisle. The jury is not out in West Texas on Obamacare. Never—and I have been around public policy and politics a long time—never has there been a greater disparity or irony between the title and intent of legislation and its outcomes for the American people.

It is not affordable care. It is the Unaffordable Care Act. It is the Raise a Trillion Dollars in Tax on Americans Act. It is the Kill More Small Businesses and Jobs Act. It is Crush the American Economy When it is Coming Up for Air from the Recession Act.

It is the Weaken the Medicare Act by taking $800 billion from that program. It is make it more difficult on middle class and working class families. Let me tell you something, in West Texas, we do not care about the names on the halls and walls of Congress. We care about the people that have their names on their shirts and on the back of their belts, and they are getting creamed. How serious is this that we act now? That we act swiftly and with confidence that this paradigm, that this top down government run, centrally planned, one size fits all health care has failed us? How urgent is it that we act? How serious is it that we act, Ms. Turner?

Ms. TURNER. Absolutely crucial, and a new system cannot be built on the wreckage of Obamacare. You have to repeal it first. That is why members of Congress could not pass or replace legislation because the President vetoed the repeal bill.

Mr. ARRINGTON. Other members of the panel?

Mr. BOOK. It is clear that simply repealing the ACA will not bring back the system that was destroyed by the ACA. That previous system also had a lot of problems with it and this is an opportunity to create a more caring and more feasible and more affordable and more economically rational system in which people can actually obtain the care they need, instead of just obtaining their $9,000 deductibles.

Mr. ARRINGTON. See, I am just a freshman congressman, you know, and I am trying to make sense of all this and this alternate universe and facts that have been mentioned. And I see the American healthcare system as a patient on the operating table or in the emergency room bleeding out and we are expected to take an Ace bandage and an aspirin and somehow allow it to live to see another day. The people I represent do not believe that. I am not disparaging or questioning the intent. The intentions were to provide affordable care. The outcomes were that it did not, period.

And it is only the responsible thing to do for those who lead our country and represent the good people of these United States to step in and do something, and provide solutions, real patient-centered solutions, market-oriented solutions, flexibility to States, empowerment of the patient, to actually be a consumer of health care and create real markets where health insurance companies are competing for our business, driving the cost down and quality up. Good old fashion free enterprise, American way. I come from middle America.

I come from rural America, and as I said on the floor the other day, when America is sick and believe me, the folks in the 29 counties in Texas District 19 would reaffirm this statement. When America is sick, and they are sick from Obamacare, and they are sick of Obamacare, and they are sick of big government being thrust upon them as the solution for every problem that ails us. But when America is sick, rural America is in the ICU: small businesses, family farms, community banks, rural hospitals.

Put the slide back up, please, if you would of the 80 rural hospitals that have gone away, 600 on the brink of going away. How are we going to bring the food, fuel, and fiber to America if we do not have health care infrastructure? But the $58 billion in additional regulatory cost, we cannot do it. So, if you want to feed and clothe the American people.

Mr. ROKITA. I thank the gentleman. The gentleman's time is expired. Now, I will hear from the gentleman from Georgia, Mr. Ferguson, for 5 minutes.

Mr. FERGUSON. Mr. Chairman, Ranking Member, thank you so much for the opportunity to address the panel. I thank you each for your time and thank you all for coming. I am going to start with a question and I do not mean to sound facetious, how many of you all sitting at that panel have delivered health care as a provider to someone in a rural community living below the poverty level. You have—in the last 24 months?

Ms. BLUMBERG. Yeah, I am a volunteer for Remote Area Medical, so I work in Appalachia delivering care.

Mr. FERGUSON. Good, okay. So, a lot of the conversation that we will have, we will be able to connect with, okay. As I go through this, one of the things that I want to explore is the regulatory cost

that has been added to health care delivery. Can you all explain to me, in the Affordable Care Act, how there is an intentional effort to lower regulatory cost in the delivery of health care? And I will start with Dr. Book.

Mr. BOOK. Within the ACA? Within the ACA, I do not believe there is any attempt to do any of that.

Mr. FERGUSON. Okay, thank you. Would you all agree that there is increased regulatory cost as a result of the Affordable Care Act? Mr. Haislmaier, I will ask you that question.

Mr. HAISLMAIER. Yes, so it is not evenly spread. I mean, certainly more in certain sectors than others, but yeah, it is a significant increased regulatory cost.

Mr. FERGUSON. With that increased regulatory cost, as a provider, this is something that I live with every single day. We are spending more and more time on regulation and less and less time on the most important part of health care delivery and that is the intimate conversation between a doctor and a patient. As I move forward every day with treatment with my patients, the single most important thing that I have to be able to do is to communicate in an effective way with my patient the value of the health care that is being delivered. And I do that every single day.

What I have seen in recent times is we have less and less time to do that. Just because you have access to health insurance does not mean you have access to care. I am sure that has been said many, many times around here. It is true. Has the Affordable Care Act looked at the other barriers to access to care besides simply access to insurance? I will tell you in my practice I treat patients every single day from folks that are trying to figure out how to get their next meal to a family with unlimited needs. I do it every single day in my dental practice. There are a lot of other barriers to care for those that are caught in the cycle of poverty.

Dr. Blumberg, you working in Appalachia can probably see that, too. Transportation issues, education issues, all of those types of things. So, a lot of times we are trying to solve a problem by providing an insurance product that really does not address the fundamental issues of access. We all assume that the number one reason that people do not receive care is because they do not have insurance. I will argue that that certainly can be an issue, but it is also not the only problem there. So, Ms. Turner, have you looked at the other issues surrounding the cycle of poverty and the access to care?

Ms. TURNER. We have particularly looked at how discouraged physicians are—all medical providers are—because of the regulations that you point out. They went to medical school to treat patients and they are forced to deal with so much bureaucracy that it is really discouraging and forcing them out of the practice of medicine—far too many of them—reducing the supply of people that are available and this is particularly acute in rural areas. So, yes, I am very concerned about this, I hope, unintended consequence of the regulation, overregulation of our health sector, but it is very real for patients.

Mr. FERGUSON. Okay, thank you. Dr. Book, Ms. Turner touched on something that I think is very important and that is the brain drain out of the healthcare industry. Can you make a quick com-

ment on that? Do you see that trend continuing or do you see it reversing as a result of the Affordable Care Act?

Mr. BOOK. We have seen increases in physicians retiring early. I know very few physicians who would tell their children to become physicians. Most of them tell them not to, avoid as much as possible. On the regulatory side, I have heard comments from physicians that now that their mandated to keep electronic medical records, it sounds like a great idea, but none of the systems talk to each other and it ends up just taking more time to accomplish the same thing they accomplished before.

Mr. FERGUSON. Dr. Book, I am going to reclaim my last 20 seconds. I hope that as we move forward with this and find solutions that we are able to truly drive the conversation back to the two most important people in the room, and that is the healthcare provider and the patient. That intimate conversation cannot be had by an insurance company or a government regulator. It has to be had between those two individuals. Thank you.

Mr. ROKITA. I thank the gentleman. The gentleman's time has expired. The gentleman from Wisconsin, Mr. Grothman, is recognized for 5 minutes.

Mr. GROTHMAN. We have a couple of questions. First thing, in general, I think one thing we have not touched upon is the degree to which Obamacare discourages work, discourages full time work, both because of, you know, discouraging hiring of full time employees and on an individual basis, cliffs where you can be substantially penalized for working overtime or getting a raise.

I know one of the problems we have in our country is we are having a hard time getting the wages up on the middle class. I would like some of you to comment on the degree to which Obamacare, or the way it was set up, punishes people who want to work full time, sticks people in a situation in which maybe that have to go for two jobs into one job, as well as according to my account I talk to, forces people into a situation in which they have to make sure they do not make too much money.

Ms. TURNER. Well, one of the problems with the law is that it redefined a full-time work week as 30 hours, which very few employers felt the full-time work week was 30 hours, and I have talked to far too many, especially small business owners, who have said that what this means is that if they have more than 50 employees, and are therefore subject to this, that they have to reduce the hours and often reduce hiring.

Mr. GROTHMAN. Right. Have you heard stories, and my accountant has told me stories, of people—depending upon where the cliff is—of people saying, see, I can make more than $50,000 a year, I cannot make more than $60,000 a year, it is going to cost me $3,000 or $4,000? Could you tell me if you aware of those stories or elaborate the degree to which we are discouraging people from improving their income? I mean, after all, if you are going to make $90,000 a year, first of all, you have to make $60,000 a year. And if you tell people you cannot make $60,000 or can make $50,000, it kind of stunts your growth in your career. Any comments on that, Dr. Blumberg?

Ms. BLUMBERG. The economic research is very strong that there has not been employment related negative effects as a consequence

of the Affordable Care Act. There may have been a small increase in part time work that was voluntary, but not required, and there has been no impact except for possibly a positive small one as a consequence of the Medicaid expansion.

Mr. GROTHMAN. Dr. Blumberg, honestly, talk to some accountants and you will have no problem finding people who are refusing to make more money because if they make more money it is going to cost them $3,000 or $4,000 or $5,000.

Ms. BLUMBERG. There may be people you can find like that, but they are more than offset by other individuals who are behaving differently. So, on that, there is strong evidence that there has not been a significant negative impact of the Affordable Care Act.

Ms. TURNER. It is very, very difficult to capture the opportunity cost and what did not happen to people who did not get jobs, the people who were not offered jobs, the companies that did not grow as a result of this mandate.

Mr. GROTHMAN. Okay, I will give you one more quick question. Our minute thing here is—oh, there we are. I am familiar with what goes on in the private sector and there are incredible things being done, a combination of self-insurance, a combination of HSAs together with funding the HSAs on the part of the employer, a combination of in employer clinics in which we are having substantial reductions in health care costs. And this is going on and is one of the major reasons why health care costs have not gone up more at this time. Could somebody comment on a combination of those three things in the way in which private sector employers are reducing costs?

Mr. HAISLMAIER. Yeah, actually, if you do not mind congressman, I will speak to that. I think it is not just private sector employers, but unfortunately, Congressman Ferguson is not here, it is also some of the providers who are just redesigning it. I think this is one of the interesting unintended consequences of the ACA, is the ingenuity that it sparked in trying to get around the obstacles. For example, large employers are now moving towards to find contribution through private exchanges.

The other thing that I find very interesting is providers moving to direct primary care where in they get rid of all the fee-for-service paperwork. They do not even take the private insurance. You just go to them for primary care and you buy it like Netflix or cable, $130 a month. I mean, two-thirds of those practices charge $135 a month and if you need a doctor, they are on retainer. Interestingly enough, you know, they come up with terminology. The ACA actually allows for, I do not know whether they envisioned it, that to be offered with a wraparound coverage——

Dr. GROTHMAN. I am going to cut you off. I disagree that that is because of ACA. I think what is going on is there was a race between the private sector that was solving the medical crisis in this country and people who just wanted to throw in the towel. I think the innovation on the private sector would have happened with ACA or not, it is just that——

Mr. ROKITA. The gentleman's time has expired. I thank the gentleman.

The chair recognizes himself for 5 minutes. I did not get a chance to ask questions yet, so I want to first start off by saying I appre-

ciate the discussion that has occurred here today. I especially appreciate the members of the Budget Committee here for the first time or on record, and I think they did an excellent job.

I want to say, on the record, that I associate myself with the comments of Mr. Lewis, Mr. Bergman, Mr. Faso, Mr. Smucker, Mr. Gaetz, Mr. Arrington, and Mr. Ferguson. Excellent job. I look forward to working with you all.

There was some discussion, especially from my friends on the other side of the aisle that we voted to repeal this insidious law over 60 times and then little to replace it with. Well, I think, Ms. Turner, you are right. We did not have a partner in the White House to help us accomplish that, but we made the case to the American people about how insidious the law was. It was built on lies. If you wanted your plan, you could keep it. If you wanted your doctor, you could keep it; all that nonsense.

But our conference also has a replacement plan, and we have several plans from individual members, and none of those plans—in fact, you can find The Better Way Plan right here at better.gov. None of the plans are contradictory. It is not a matter of not knowing what we need to replace these things with, it is a matter of the overlapping of wills, getting it done in a way where the American people have a chance to see what could be.

I do not have to remind this panel that back under Speaker Pelosi, we had to pass a bill in order to find out what was in it. I cannot think of a more backward or wrong way to legislate. We are going to take our time and we are going to make sure that we get this right with patient-centered health care that is consumer driven, that allows for competition in a healthy marketplace.

I do have some questions. This is not speechifying on my behalf, Mr. Ranking Member—you love to hear me talk—I wanted to hear from Dr. Book and Mr. Haislmaier about a particular part of CBO. Of course, this panel has exclusive jurisdiction over the Congressional Budget Office, but they got Obamacare wrong. Dr. Book, we understand that it could be a difficult job scoring out major pieces of legislation, but can you tell us how the original CBO cost estimates have aligned with reality under current law?

Mr. BOOK. Yeah, original CBO cost estimates forecast much lower costs than we have seen and many more people being covered. They originally forecast, for example, a decrease in the uninsured population to five percent. They forecast 30 million people covered in the exchanges. The true numbers are somewhere between 10 and 15 percent uninsured depending on how you count it and about 11 million people covering the exchange, and when they made their forecast on the repeal last week, they said that they counted as people losing their insurance, 7 million of the 18 million people covered in the exchanges. When, in fact, there is 11 million people covered to start with.

It was a very optimistic forecast. I understand it is difficult to make forecasts. In general, I have a lot of respect for the people who work at the CBO. I cannot specifically say why they made those mistakes, because they do not really reveal their methods.

Mr. ROKITA. Thank you for that. In your work, do you see anything systemically errant about the way CBO has chartered or required to score major pieces of legislation? Anything you want to

help with this—you do not have to say it now. If you want to get back with us later, that is fine, but we have oversight jurisdiction here and we have pledged to do budget process reform, and this was a major error.

Mr. BOOK. Yes, it was and I would like to look into that and get back to you with some specifics.

Mr. ROKITA. Okay.

Mr. BOOK. In general, they tend to assume that the world looks exactly the same as it does, except for minor changes, and that people are not going to react and change their behavior in response to a change in the law. But, of course, that is the whole purpose of the law.

Ms. BLUMBERG. Could I comment, sir, on that?

Mr. ROKITA. No, I want to get to Mr. Haislmaier. Sorry for butchering your name earlier. In the last 59 seconds that we have, what is your account of this? Why did CBO's projections so grossly overestimate coverage gains on the ACA?

Mr. HAISLMAIER. I think it is pretty clear that they overestimated the effect that the individual mandate would have on inducing people who were otherwise healthy and not qualifying for subsidies to get coverage, and I think they are still holding to that as well. There are some other minor things that—I mean I cannot fault them on the Medicaid numbers because the court case came in and they sort of changed things; however, in terms of the enrollment and Medicaid, they overestimated the attractiveness of the exchange to people who were not being subsidized. Interestingly, when you compare to the Office of the Actuary at CMS, they expected the Medicaid expansion to ramp up slowly. In fact, it came in quite quickly and they both underestimated the cost of that.

Mr. ROKITA. Thank you, and my time is expired.

And now in closing, I would like to yield my closing time to the ranking member, my friend, Mr. Yarmuth for a thank you.

Mr. YARMUTH. I thank the chairman. I just want to thank all the witnesses and these discussions have been going on for a long time, in many different forms, and sometimes it gets pretty heated up. I apologize for any of the heat that was directed at any of the witnesses, but I thank you for your testimony and your thoughts.

Mr. ROKITA. I thank the gentleman, and I thank the witnesses as well—Ms. Turner, Dr. Book, Dr. Blumberg, Mr. Haislmaier—for appearing before us today. Please be advised that members may submit written questions to be answered later in writing and those questions and your answers will be made part of the formal hearing record.

And, again, Dr. Book, I would love to get your answers in writing, and anything you would like to add Mr. Haislmaier. Any members who wish to submit questions or any extraneous material for the record may do so within 7 days, and with that bit of business completed, I see no other business before the committee, and we remain adjourned.

[Whereupon, at 1:10 p.m., the committee adjourned subject to the call of the chair.]

"Rep. Rokita submitted the following questions for the record."

REP. TODD ROKITA (IN)
HOUSE COMMITTEE ON THE BUDGET, VICE CHAIR
QUESTIONS FOR THE RECORD FOR DR. ROBERT BOOK AND ED HAISLMAIER

The House Budget Committee has exclusive jurisdiction and oversight of the Congressional Budget Office [CBO]. It can be difficult to score large pieces of legislation and CBO got Obamacare wrong.

1) Can you tell us how the original CBO cost estimates have aligned with reality under current law?

2) In your work, do you see anything systemically errant in the way CBO is chartered or required to score major pieces of legislation?

RESPONSE TO QUESTIONS FOR THE RECORD FOR DR. ROBERT BOOK
FROM
REP. TODD ROKITA (IN)
HOUSE COMMITTEE ON THE BUDGET, VICE CHAIR

February 13, 2017

1) *Can you tell us how the original CBO cost estimates have aligned with reality under current law?*

The CBO's original projections when the ACA was passed in 2010 have differed significantly from what actually occurred. Some of the differences are due to the fact that the law as implemented is not precisely the same as the law Congress passed. Others are due to assumptions about behavior that turned out to be incorrect.

Part of the changes are due to the fact that the Obama Administration in effect unilaterally changed some significant parts of the law by implementing provisions different from the law Congress passed. For example, the Obama Administration changed the effective date of the employer mandate from January 1, 2014 to January 1, 2016 for most business, and also altered the definition of which business were covered. They also doubled the allowed deductible (relative to what the statute allows) for individually purchased coverage. In addition, many administrative decisions that the law placed within the authority of the executive branch were not made as expected. For example, open enrollment periods were expanded during the enrollment period, and the minimum covered services were not always what was previously expected.

In addition, Congress and the Supreme Court made some changes as well. A complete list of changes is available from Grace-Marie Turner of the Galen Institute (http://galen.org/assets/70-changes-so-far-to-ObamaCare-1.pdf).

However, changes in the law and its implementation are not enough to account for all the differences between CBO projections and actual results. For example, the Supreme Court made the Medicaid expansion optional for states, so it was implemented by 31 states instead of 50. However, the CBO projection for Medicaid spending *per enrollee* in the expansion population was substantially lower than the spending that occurred.

In addition, the CBO projected that there would be approximately 21 million enrollees in exchange plans in 2016. When the Medical expansion was made optional for states, they increased the projection to 22 million, reasoning that some people who would otherwise have been covered under Medicaid would enroll in (subsidized) exchange coverage. In fact, the actual enrollment turned out to be closer to 11 million – about half the forecast.

A more complete analysis of the differences between projections and actual results is available from Dr. Brian Blase (http://www.forbes.com/sites/theapothecary/2017/01/02/learning-from-cbos-history-of-incorrect-obamacare-projections/print).

2) *In your work, do you see anything systemically errant in the way CBO is chartered or required to score major pieces of legislation?*

CBO faces a task which is difficult under the best of circumstances – predicting the future under conditions subject to uncertainty. There are, however, some improvements that may be made. The well-known issue of "dynamic scoring" – forecasting macroeconomic variables, taking into account the fact that people change their behavior in response to tax and regulatory incentives – is one example that affects certain types of legislation.

Similarly, in the case of health care legislation, it is important to take into account how people respond to changes in the health insurance landscape, including both factors that tend to increase the number of people buying coverage (such as premium subsidies, and financial penalties for being uninsured) and factors that tend to decrease the number of people buying coverage (such as higher premiums and deductibles, as well as the assurance that one who remains uninsured and later develops an illness will be able to purchase coverage without any penalty for the subsequent "pre-existing" condition).

In making these projections, it is unfortunately inevitable that some "judgment calls" will have to be made, in cases where sufficient objective information is unavailable. It would be extremely helpful to both Congress and the public if CBO were to make it more clear, in their public projections and scores of major legislation, what judgments and assumptions have been made, the reasoning behind those judgments, what alternative assumptions may have been considered, and how the projections might turn out to be different if the assumptions made turn out to be incorrect.

There are clearly situations in which CBO needs to keep some information used in its projections confidential. For example, private parties, such as pharmaceutical manufacturers and insurance companies, sometimes provide CBO with proprietary data that CBO can use to make more accurate scores. This information ought not to be revealed to the public. However, CBO has been reluctant in the past to disclose assumptions it has made, the basis for its assumptions, and the mathematical relationships between various numbers in its projections. There would be no confidentiality violated if CBO were to be more transparent about, for example, its assumptions about the effectiveness of a mandate with a financial penalty on the purchase of health insurance, or the functional form of regression equations used to make statistical estimates of premiums.

In addition, when new information becomes available, CBO should be more willing to update the models and assumptions used to made subsequent projections. For example, in 2011 CBO projected the number of people enrolled in exchange coverage to be 14 million in 2015 and 22 million in 2016. Actual enrollment in 2015 was about 10 million – almost 30 percent lower than the forecast – but in mid-2015 CBO stood by its original projection that there would be 22 million in 2016. Actual 2016 enrollment was about 11 million – or about 50 percent lower than the forecast. If CBO had used the lower-than-expected enrollment in 2014 and 2015 to update its projection for 2016, they would likely have made a more accurate subsequent forecast.

EDMUND F. HAISLMAIER'S RESPONSES TO THE QUESTIONS FOR THE RECORD
SUBMITTED BY REP. TODD ROKITA
VICE CHAIR, COMMITTEE ON THE BUDGET

The House Budget Committee has exclusive jurisdiction and oversight of the Congressional Budget Office [CBO]. It can be difficult to score large pieces of legislation and CBO got Obamacare Wrong.

1) ***Can you tell us how the original CBO cost estimates have aligned with reality under current law?***

The changes made by the Affordable Care Act (ACA) are complex and wide-ranging. It should be noted that in all of their analyses the CBO admitted that scoring such legislation is rife with uncertainty. Even so, the CBO's scores of the ACA had significant influence on the debate over the law.

Consequently, it is important to understand where and why CBO's projections proved to be substantially inaccurate. The areas where actual experience diverged the most from CBO projections include: 1) enrollment estimates for both the exchanges and the Medicaid expansion; 2) premium estimates for exchange coverage; 3) the per enrollee cost for the Medicaid expansion population; 4) the profitability of insurers under the ACA, and; 5) the effects of the individual mandate..

Errors in Projecting ACA Exchange Effects

In 2010, the CBO projected that 21 million enrollees would be on the ACA exchanges by the end of 2016. That was actually on the low end relative to projections by others such as the CMS Office of the Actuary, the Urban Institute, and the Rand Corporation. Those others projected enrollment of as many as 27 million individuals. The reality is that the most recent enrollment data from CMS (as of the end of June 2016) reports effectuated enrollment of 10.4 million individuals through the exchanges, of whom 8.8 million received ACA premium tax credit subsidies.[1]

While the troubled rollout of the exchanges may have produced lower than anticipated initial enrollment,that can only partially account for why the estimates differed so greatly from the observed results three years later. One reason why actual enrollment numbers differ so much from projections has to do with the expected effect of the escalating individual mandate penalty. The expectation of CBO, and many others, was that the mandate would be strong enough by 2016 to induce significant enrollment growth. That has clearly proven to not be the case.

Misjudging the effect of the mandate also causes a ripple effect within a score. First, it skews the projected age distribution of enrollment. That is because the principal anticipated effect of the individual mandate was that it would induce enrollment among younger, healthier individuals. In reality, exchange enrollees are older than anticipated. Another implicit assumption was that the individual mandate would induce enrollment by relatively healthy individuals who, because of higher incomes would qualify for

[1] Centers for Medicare and Medicaid Services, "First Half of 2016 Effectuated Enrollment Snapshot," October 19, 2016, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

little or no premium tax credit subsidy. In reality, since the beginning CMS enrollment data has consistently reported that 67 percent of tax credit recipients also qualified for cost sharing reductions (CSR) to their coverage. Thus, because the CSRs are only available to those with incomes below 250 percent of the federal poverty level, it is clear that actual enrollment in subsidized exchange coverage has also been disproportionately skewed toward the lower end of the income scale.

The CBO also misestimated the effect of the law's risk corridor program. While the CBO projected that the risk corridor program would generate surpluses, insurers were far less profitable than expected, with the result that risk corridor claims far exceeded risk corridor payments. The risk corridor deficit was $2.5 billion in 2014, and $5.8 billion in 2015. The CBO apparently based its score for the ACA risk corridor program on the observed results of a similar program for Medicare Part D. However, the "profit or loss" risks that both risk corridor programs were intended to address were very different for the two markets. Basically, because Part D created an entirely new type of product, for which insurers had essentially no relevant prior experience, the probabilities for pricing falling either above or below targets were more evenly distributed. In contrast, the ACA replicated insurance provisions that had previously been implemented by a number of states in the 1990s. The ACA experience largely tracked the experience of those previous state experiments in which results had proved to be disproportionately more negative than positive.

Errors in Projecting Medicaid Expansion Effects

In terms of the Medicaid expansion, the CBO missed the mark on the three main areas that a model needs to predict in order to provide appropriate analysis of such a policy.

First, the CBO underestimated enrollment due to the Medicaid expansion. It is difficult to compare directly the various CBO scores on expansion because of the Supreme Court ruling, but in general CBO estimates of enrollment due to expansion have been updated and increased since the initial score in 2010. In states that adopted the expansion, the CBO estimates needed to be increased by almost 50% to match actual enrollment results.

In large part, this appears to have been the result of an erroneous assumption about the timing of Medicaid expansion enrollment. That can be seen in the different assumptions applied by the CBO and the CMS Office of the Actuary in their respective scores of the legislation at the time of enactment. It appears that the CBO assumed that enrollment would gradually increase over a period of years, similar to previous experiences when Congress expanded program eligibility. In contrast, the CMS actuary stated:

> We anticipate that the intended enrollment facilitation under the PPACA—i.e., that the Health Benefits Exchanges help people determine which insurance plans are available and identify whether individuals qualify for Medicaid coverage, premium subsidies, etc.—would result in a high percentage of eligible persons becoming enrolled in

> Medicaid. We further believe that the great majority of such persons (15 million) would become covered in the first year, 2014, with the rest covered by 2016.[2]

While neither the CBO nor the CMS Actuary could have anticipated the Supreme Court ruling that made the expansion voluntary for states, it is worth noting that states that subsequently adopted the expansion experienced enrollment patterns much closer to what the CMS Actuary predicted than to what the CBO predicted.

Second, the CBO underestimated the cost associated with the expansion population. In 2014, CBO projected that the average Medicaid expansion enrollee would cost approximately $4,200 in 2015. In 2015, the actual average spending per expansion enrollee was $6,366, almost 50% higher than expected. These errors in estimation have resulted in the CBO underestimating the cost of expansion drastically. For example, in 2015 the expansion cost $68 billion, while the CBO's estimates were 40 percent lower. One possible reason for this discrepancy is that the CBO failed to take into account that the enhanced federal match rate for the expansion population (100 percent in the first three years) would induce states managing the program to be indifferent to costs for the expansion population.

Third, the CBO might have misestimated the mix of new enrollment between the previously eligible and those made eligible through Obamacare. A recent study by Professor Jonathan Gruber suggests that roughly 40 percent of the new enrollees were actually made eligible by Obamacare. While it is still uncertain who is actually right on this, given the track record of the CBO and various other organizations, the issue merits further investigation. If it turns out that a significant portion of post-ACA Medicaid enrollment increases were attributable to previously eligible individuals enrolling at a greater rate, then any estimates for the effect of repeal of the ACA that failed to account for that would likely overstate enrollment losses—since new enrollees who were eligible under pre-ACA rules would be unaffected by repeal of the expansion.

2) ***In your work, do you see anything systemically errant in the way CBO is chartered or required to score major pieces of legislation?***

It is important that complex legislation, such as the Affordable Care Act, be evaluated in the best manner possible to inform Congress and the public of the likely effects, both budgetary and non-budgetary. The CBO has been forthright in acknowledging the uncertainty surrounding scores such as its score of the ACA. However, providing cautionary disclaimers does not relieve the CBO from its obligation to improve its models and practices.

The basic issue, for both Congress and the public is that the CBO's model largely functions as a "black box." While proprietary considerations explain why for-profit entities might take such an approach, there is no inherent reason for a public organization, such as the CBO, to not publicly disclose how its model is constructed and operates. Indeed, there are other government contracted and maintained models—such as

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[2] Centers for Medicare & Medicaid Services, Office of the Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010.

ones at the Environmental Protection Agency and the Energy Information Agency[3]—that provide the kind of transparency expected for models developed by academics and private research organizations like Heritage, Urban and Rand. Greater transparency would, in fact, benefit the CBO by providing a more constructive basis for evaluating, both inside and outside the agency, those disagreements within the research community that occasionally arise with respect to the appropriateness of specific elements and assumptions.

Providing greater transparency would not diminish the CBO's assigned role and functions in the legislative process, where its scores would still be dispositive for budget purposes. However, any debate over the agency's conclusions would be more informed and likely more constructive. Another positive result might be a greater appreciation outside the agency of the inherent difficulties that the CBO faces in scoring complex legislation with numerous interactions, such as the ACA. That, in turn, might encourage Congress to take a more deliberative approach to major pieces of legislation.

Specifically the CBO should:

1) Make public the underlying assumptions used in constructing its micro-simulation model.

2) Provide more detail about the additional assumptions made when scoring specific pieces of legislation, and the rationales for those assumptions. An example would be the take up rate for the ACA Medicaid expansion. As previously noted, the CMS Actuary's Medicaid expansion enrollment projections proved to be more accurate and the Office of the Actuary did a better job of explaining the rationale for its assumptions behind those projections. Conversely, back in 2003 when it came to projecting participation in the new Medicare Part D prescription drug benefit, the CBO's participation projections proved to be more accurate than those of the CMS Actuary and the CBO did a better job of explaining the reasoning behind its projections.[4]

3) The CBO, whenever possible, should include plausible ranges in their estimates. This is important as it provides the CBO a way to formalize the uncertainty that surrounds projections. Many in Congress and elsewhere desire point estimates when in reality the models are not capable of providing such specific estimates beyond the first few years. It is important to note that CBO is already doing this when possible. Increasing the practice would be desirable.

In fairness to the CBO it is also important to note that Congress, as the Agency's customer, can also improve the process and results. Congress should:

1) When requesting scores and reports also request relevant details. For example, with respect to scoring the ACA Medicaid expansion, relevant details would include age breakouts, household income summaries, how the model accounts for differences in utilization and spending between the expansion population and the populations already covered by the program, and the likely

[3] See: https://www.epa.gov/research/methods-models-tools-and-databases and http://www.eia.gov/outlooks/aeo/info_nems_archive.cfm.

[4] See the discussion of participation projections in: The Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," July, 2004.

effects of the law on enrollment by previously eligible individuals. The presentation of more detailed analysis would serve to not only better inform Congressional debate, but also provide more insight into how scores are constructed.

2) Request that the CBO include more distributional effects, such as how policy changes would affect individuals in different income brackets. Presenting such analyses would also allow CBO to display its unique capabilities in micro-simulation.

3) Provide time in the legislative process for the CBO to develop more thorough and detailed scores of major, complex legislation. If Congress wants better and more detailed analysis from the CBO, then it has to provide the agency with appropriate time to evaluate proposed legislation in greater depth. In other words, for Congress to increase its expectations of the CBO it must adapt its own scheduling to give the agency reasonable time to comply with more extensive requests. Such refocusing would both improve the value of the CBO's products and better inform the legislative process.