



THE BROKEN PROMISES OF THE AFFORDABLE CARE ACT

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October 2016

Proponents of the Affordable Care Act (ACA) made several promises before and since the law passed. The most notorious of these was President Barack Obama's assurance that people could keep their insurance plan if they liked it.¹ However, other important promises were made that have garnered less media coverage, including how many people would enroll for coverage in the new health insurance exchanges, the law's effect on health insurance premiums, the amount of choice and competition in health insurance markets, and the law's impact on overall costs and the deficit. These promises arguably helped ensure some of the votes necessary for the controversial legislation to pass Congress.

More than six years after the ACA's passage, these promises can be measured against reality. It turns out that

- while the percentage of individuals without insurance has declined, enrollment in the exchanges is far below projections;
- exchange enrollees are much older and poorer than expected;
- competition in the individual market has decreased rather than increased;
- rather than falling, premiums have increased significantly in both the individual and employer-sponsored markets;
- the law's Medicaid expansion, which is responsible for the vast majority of rate decline in uninsured Americans, came at a far higher cost than expected;
- the law has increased, rather than decreased, overall healthcare spending; and
- the ACA has negatively affected economic growth, despite promises to the contrary.

The following policy brief summarizes some of the findings of researchers for the Mercatus Center at George Mason University, especially those of Senior Research Fellow Brian Blase in his writing for *Forbes* on the consequences of the Affordable Care Act. These consequences will be juxtaposed with the promises made by supporters of the law. (All emphases in bold are ours.)

EXCHANGE ENROLLMENT MUCH LOWER THAN EXPECTED

“When the PPACA was enacted in 2010, CMS projected 24.8 million people would enroll [in 2016], while the Congressional Budget Office (CBO) projected 21 million enrollees.”

—House Committee on Energy and Commerce, September 2016.²

One of the most important purposes of the ACA was to reduce the number of uninsured Americans through new health insurance exchanges. To date, the exchanges have enrolled far fewer people than expected, with 2016 enrollment less than half of an average of initial projections for the year.³ These dismal numbers are largely a result of healthy people—who are ineligible for significant subsidies—finding the cost of coverage to be a poor value. Actual enrollment ended up being about 5 million in 2014 and 9.5 million in 2015. Enrollment this year will likely be below 11 million.

The ACA has consistently underperformed expectations, forcing the CBO to dramatically revise predictions within a short window.

*“In its March 2015 estimates, CBO projected 21 million exchange enrollees in 2016. . . . In the estimates released yesterday [January 25, 2016], CBO decreased those projections to just 13 million enrollees. . . . **Therefore, in the last 10 months, CBO has downgraded its overall enrollment expectation by 38%**, its expectation of subsidized enrollment by 27%, and its expectation of unsubsidized enrollment by 67%.”⁴*

Multiple organizations incorrectly projected that the increasing penalty for being uninsured would drive increased exchange enrollment in 2016.

*“Most of the organizations projected a major increase in enrollment in 2016 as the size of the individual mandate penalty reaches its peak. . . . Last June, **CBO experts projected that exchange enrollment would nearly double between 2015 and 2016**, largely because of both an increase in awareness of the mandate and the increase in the penalty size. **In stark contrast to the projections of CBO and others, sign-ups increased by less than 10% between the 2015 and 2016 open enrollment periods.**”⁵*

In addition to the disappointing number of initial sign-ups each year, enrollment in the exchanges actually falls during the year as far more people drop their coverage midyear than sign up after open enrollment.

*“The key finding . . . is the large drop in net exchange enrollment in the 3rd and 4th quarters of the year. **In total, the exchanges lost 1.13 million net enrollees during that six-month period**—a decline in net enrollment of 6.3% from June 30 to September 30 followed by a decline in net enrollment of 5.4% from September 30 to the end of the year.”⁶*

EXCHANGE ENROLLEES MUCH OLDER AND POORER THAN EXPECTED

“The requirement that people have insurance would also encourage a broad range of people to take up coverage in the exchanges.”

—Congressional Budget Office, November 2009⁷

One major goal of the ACA was to make health insurance affordable for every American regardless of health status. The law requires insurers to offer coverage to anybody who applies and bars insurers from considering individual health status when pricing that insurance. The result of this requirement is that insurers must overcharge younger and healthier enrollees while undercharging older and sicker enrollees, relative to these populations’ expected health-care spending. To induce younger and healthier people to enroll, the ACA contains subsidies for lower-income individuals and an individual mandate that levies a tax penalty on those who remain uninsured. For insurers, large numbers of young and healthy enrollees have been necessary to offset the losses that insurers have sustained from older and sicker enrollees.

So far, however, not enough younger and healthier individuals are signing up, leaving more expensive enrollees as a disproportionately high percentage of those insured. Furthermore, the pool of exchange enrollees is largely low-income and reliant on large subsidies, which will tend to increase the per-enrollee cost that the federal government will bear over time.⁸

Large losses stemming from older and sicker enrollees were an immediate problem for insurers offering qualified health plans (QHPs)—ACA-compliant products certified to be sold on exchanges—as data from 2014 showed.

“Using available data, mostly from the administration, I estimate that **insurance companies likely lost at least 12% on ACA plans in 2014**. There are two explanations for such large losses, with both probably true to some extent. First, a larger share of older and sicker people enrolled for ACA coverage than insurers projected. Second, some insurers underpriced plans in order to capture market share and then raise rates in future years.”⁹

Forecasts by the CBO and the Urban Institute regarding the income levels of exchange enrollees were again way off the mark.

“In January 2015, the Urban Institute projected that 36% of 2016 enrollees would have income below 200% of the FPL [federal poverty level] and 25% of enrollees would have income above 400% of the FPL. Based on the most recent data released by the Department of Health and Human Services, **about 64% of 2016 enrollees have income below 200% of the FPL and only 3% earn income above 400% of the FPL**.”¹⁰

This failure to attract younger and healthier enrollees has resulted in higher average premiums, higher deductibles, and less choice as many insurers flee the exchanges.

DECLINE IN COMPETITION AND CHOICE IN INDIVIDUAL MARKETS

“We’ll do this by creating a new insurance exchange—a marketplace where individuals and small businesses will be able to shop for health insurance at competitive prices. Insurance companies will have an incentive to participate in this exchange because it lets them compete for millions of new customers.”

—President Barack Obama, September 2009¹¹

Insurers, ranging from large insurance corporations to small cooperatives established by the ACA, have suffered from the failure of young and healthy people to purchase QHPs. For many larger insurers—most notably UnitedHealthcare, Humana, and Aetna—this largely means exiting the exchanges as losses become unbearable. For many cooperatives, this means being shut down by regulators. In fact, only 6 of the 23 cooperatives funded by the ACA are still operating—a number that continues to drop.

Insurers suffered large and unsustainable losses on the individual market in 2014.

*“Assuming that a fully-funded risk corridor program would have subsidized about two-thirds of insurer losses, **insurers likely lost around \$400 per enrollee in 2014.** Since insurers enrolled about 8 million people in 2014, **they likely lost about \$3.2 billion overall selling individual QHPs.**”¹²*

Losses in 2015 were significantly worse, driven by a large increase in medical costs.

*“Combining what happened in 2014 with the estimates of premium and spending increases in 2015, my back-of-the-envelope calculations (shown below) indicate that **insurers potentially lost upwards of \$1,000 per enrollee in 2015,** even accounting for payments insurers will receive through the reinsurance program. . . . Assuming about 30% more enrollees in 2015 than 2014—about the percentage year-over-year increase in exchange enrollment—**insurers’ aggregate 2015 losses selling individual QHPs potentially exceeded \$10 billion.**”¹³*

As insurers exit ACA marketplaces, the share of counties left with only one individual-market option is growing at an alarming rate.

*“**Nearly a third of the nation’s counties look likely to have just a single insurer offering health plans on the Affordable Care Act’s exchanges next year,** according to a new analysis, an industry pullback that adds to the challenges facing the law.”¹⁴*

PREMIUM INCREASES IN EMPLOYER-SPONSORED AND INDIVIDUAL MARKETS

“I will sign a universal health care bill into law by the end of my first term as president that will cover every American and cut the cost of a typical family’s premium by up to \$2,500 a year.”

—Senator Barack Obama, 2007¹⁵

Despite promises of falling premiums, the premiums for employer-sponsored insurance coverage have increased significantly since 2009—even as deductibles have also climbed substantially. In fact, average annual premiums for employer-provided family insurance have increased by over 35 percent since 2009, growing from \$13,375 to \$18,142,¹⁶ and deductibles have increased significantly as well.¹⁷

While the ACA did affect the employer sponsored insurance market, the law most fundamentally changed the individual market for insurance, which was hit hard by premium increases in 2014, the year that the ACA’s key changes went into effect.

“Manhattan [Institute] estimated **that the average state individual market premium increased 41% between 2013 and 2014.**”¹⁸

Premiums are set to skyrocket again, with rates for 2017 projected to increase an average of more than 24 percent.¹⁹

Those who have purchased insurance in the individual market have experienced not only sharp increases in premiums, but also increasing deductibles, narrowing provider networks, and decreasing choice of insurance products. These changes are the natural result of insurers adapting to a much older and less healthy risk pool than expected. A recent survey shows²⁰ that the available insurance product is becoming less popular over time as a result.

“After incurring large losses selling ACA plans in 2014 and 2015, insurers significantly raised premiums and deductibles for 2016 policies and reduced the number of doctors and hospitals covered by plans. . . . These changes are correlated with growing dissatisfaction among ACA plan enrollees. **Between 2015 and 2016, the percentage of enrollees rating their coverage as ‘not so good’ or ‘poor’ increased from 20% to 31%.**”²¹

The net effect of the ACA has been to significantly increase premiums, particularly in the individual market, while degrading the value of the insurance available as most pre-ACA products failed to meet the law’s plethora of rules and requirements.

MEDICAID ENROLLMENT AND SPENDING MUCH HIGHER THAN EXPECTED

“Based on those projections, per enrollee costs for newly eligible adults are between 27 percent and 30 percent less than per enrollee costs for other adults.”

—Department of Health and Human Services, 2014²²

A separate but critical component of the ACA is the expansion of Medicaid to nondisabled, working-age adults without regard to assets or previous standards of eligibility. The Supreme Court made expansion optional for the states, although the elevated federal reimbursement rate for the newly eligible population made expansion tempting. This elevated reimbursement rate—equal to 100 percent from 2014 through 2016 before gradually phasing down to 90 percent—is significantly higher than the 57 percent historic federal reimbursement rate for Medicaid. This aggravates structural problems with Medicaid’s financing that encourage wasteful spending.

In the 31 states that have adopted the expansion, per-enrollee spending has been much higher than expected.

“The Department of Health and Human Services’ (HHS) annual report on Medicaid’s finances contains a stunning update: **the average cost of the Affordable Care Act’s Medicaid expansion enrollees was nearly 50% higher in fiscal year (FY) 2015 than HHS had projected just one year prior.** Specifically, HHS found that the ACA’s Medicaid expansion enrollees cost an average of \$6,366 in FY 2015—49% higher than the \$4,281 amount that the agency projected in last year’s report.”²³

These higher per-enrollee costs come with higher-than-expected total enrollment as well.

“[Medicaid] enrollment is much higher than CBO expected when the ACA passed in 2010, and it is also significantly higher, particularly in 2017 and beyond, than estimated in both CBO’s 2014 and 2015 reports. **Essentially, this means that far more people—roughly 50% more—have enrolled and are projected to enroll in Medicaid in the states that expanded than was expected by CBO previously.**”²⁴

The aggregate effect has been a Medicaid expansion that is significantly more expensive than previously projected.

“For example, in April 2014, CBO projected that the Medicaid expansion would cost \$42 billion in 2015. **The actual cost was \$68 billion, about 62% higher.**”²⁵

FAILED TO BRING DOWN OVERALL HEALTHCARE SPENDING

“Whatever ideas exist in terms of bending the cost curve and starting to reduce costs for families, businesses, and government, those elements are in this bill.”

—President Barack Obama, December 15, 2009²⁶

A key promise made prior to implementation of the ACA was that the law would reduce overall healthcare spending, despite significantly expanding Medicaid and creating subsidies for lower-income individuals to purchase insurance. The reality is that the ACA has increased healthcare spending through its effect on Medicaid spending.

Although the growth in healthcare spending has slowed since 2008, this reduction can be better explained by the Great Recession and the introduction of health savings accounts than by implementation of the ACA.

“The results show that the decline in real per capita income because of the Great Recession probably explains 41 percent of the observed reduction in healthcare spending relative to this counterfactual. Other known factors—including insurance coverage and provider market characteristics—can account for between 32 and 57 percent of the slowdown, dependent on the particular model specification. Totaling these factors indicates that they likely account for between 73 and 98 percent of the reduction in healthcare spending growth during the 2010–2013 period. **That would leave little room for reductions because of the ACA.**”²⁷

In fact, the ACA has increased healthcare costs, largely through its huge expansion of Medicaid.

“The projected expansion of Medicaid coverage owing to the ACA will likely raise national healthcare spending in 2019 to about 1 percent higher than it would have been without the expansion.”²⁸

Expecting the ACA to lower healthcare spending defies economic theory and common sense.

“Commonsense economics shows that when the government increases health insurance subsidies, dramatically expands a healthcare entitlement program (Medicaid), and adds coverage and benefit mandates on private insurance it will lead to an increase in overall healthcare spending, which will increase healthcare inflation all else equal. This point was also made recently by the Center for Medicare and Medicaid Services.”²⁹

NEGATIVE EFFECTS ON ECONOMIC GROWTH AND EMPLOYMENT

“The best action we can do to create jobs and strengthen our economic security is pass health care reform.”

—Speaker Nancy Pelosi, March 21, 2010³⁰

Economic projections involve many uncertain assumptions and rely on complex interactions. However, many people cite projections and estimates with certainty when looking to pass new legislation. The ACA’s supporters promised that it would increase employment and strengthen the US economy. Despite these promises, however, the incentives created by the law discourage employment and hamper economic growth.

The subsidies offered to low-income enrollees significantly phase down as their income increases, discouraging additional work and productivity. This effect is most pronounced at 200 percent of the poverty line as generous cost-sharing subsidies are available to people with income below this amount.

“CBO estimates that **the ACA will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024**, almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive.”³¹

This reduction in hours worked is equivalent to at least 2 million full-time employees leaving the workforce entirely.

“**The reduction in CBO’s projections of hours worked represents a decline in the number of full-time-equivalent workers of about 2.0 million in 2017, rising to about 2.5 million in 2024.** Although CBO projects that total employment (and compensation) will increase over the coming decade, **that increase will be smaller than it would have been in the absence of the ACA.**”³²

This restriction in the supply of labor, combined with other factors, will lead to an overall negative effect on economic growth.

“The health insurance subsidies that the act provides through the expansion of Medicaid and the exchanges are phased out for people with higher income, creating an implicit tax on some people’s additional earnings. The act also directly imposes higher taxes on some people’s labor income. **Because both effects on labor supply will grow over the next few years, CBO projects, they will subtract from economic growth over that period.**”³³

CONCLUSION

The ACA has failed to deliver on several major promises that its supporters have made. The exchanges are enrolling far fewer people than predicted, premiums have increased significantly, competition has declined in the individual market, and total expenditures on health care have risen, particularly since the law's Medicaid expansion has cost taxpayers significantly more than expected.

These problems are not going away on their own and indeed are likely to worsen as transitional subsidies that insurers have received through the ACA reinsurance program expire.³⁴ Future increases in premiums will even further discourage young and healthy individuals from enrolling in exchange plans, likely worsening the risk pool and driving additional insurers to either exit the individual market or increase prices and reduce quality even further. This is the “death spiral” that the law's individual mandate was largely designed to prevent.

Without significant revisions to the ACA that make individual insurance more palatable for the young and healthy, it seems likely that the law will transform the individual market into a highly subsidized source of coverage for older and sicker people, locking millions out of affordable coverage.

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