Backgrounder

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Obamacare: The One-Year Checkup

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Abstract: *On its one-year anniversary, Obamacare's unpopularity is growing. Its hodgepodge of mandates and regulations have reduced competition in health insurance markets and increased the cost of coverage. Overall, Obamacare has increased government control of Americans' health care choices and limited consumer choice. The more than 1,000 waivers already granted tacitly acknowledge that Obamacare's "benefits" are not worth its costs. Congress should replace Obamacare with consumer-focused reforms and sensible changes in health care entitlement programs.*

One year ago, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA).[1] The PPACA was unpopular when it was enacted in March 2010, but its proponents believed that it would gain broad acceptance once people discovered the law's benefits.

One year later, public opinion has not warmed to the law because many of its "benefits" have been either underwhelming or detrimental. The most recent Rasmussen survey shows that 62 percent of likely voters want the law repealed.[2] In fact, in a suit brought by 26 states and the National Federation of Independent Business, Federal District Judge Roger Vinson ruled that the PPACA is unconstitutional,[3] leaving its implementation in limbo.

Many of Obamacare's key provisions—such as the creation of health insurance exchanges, costly subsidies to purchase coverage, the massive expan-

Talking Points

- Obamacare's insurance mandates have increased the price of insurance and caused companies selling child-only policies to exit markets.
- Obamacare's regulations mean that millions of individuals will not be able to keep coverage that the President promised they would be allowed to keep.
- The more than 6,500 pages of regulations that have been written and over 1,000 waivers that have been granted show that Obamacare means much greater government control of health care.
- The evidence suggests that Obamacare's early-retiree reinsurance program shifts the costs of unsustainable promises made to public and private unionized labor onto taxpayers.
- Obamacare's "benefits" come at the costs of increased insurance premiums, increased taxes, fewer choices, and reduced competition in health care markets.

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sion of Medicaid, and the individual and employer mandates—do not take effect until 2014. However, several important provisions—such as minimum loss ratio regulations, the small-business health insurance tax credit, high-risk pools, and coverage mandates on insurance companies—have already taken effect. Obamacare has already added over 6,500 pages of regulations to the *Federal Register*. The Obama Administration has struggled to implement many of these regulations, and the number of waivers that exempt entities from complying with the law has passed 1,000 and is growing by the day.

Obamacare has increased government control of Americans' health care choices, raised the cost of insurance, forced insurers to stop offering child-only policies, broken the promise that an individual can keep his insurance unaltered, and bailed out underfunded union early-retiree health care plans. The early results suggest that Obamacare's "benefits" are not worth their costs.

Insurance Mandates

Several of Obamacare's mandates on insurance companies have already been implemented. No insurance plan can now limit lifetime benefits, and group plans cannot have annual benefit limits. Additionally, all insurance plans must offer coverage for dependent children under the age of 26 (about half of the states had already mandated this).[4] These provisions also apply to plans that receive grandfathered status.

One year later, mandating certain benefits has raised the cost of providing insurance, and this higher cost has been passed on to policyholders in the form of higher premiums. For example, Regence BlueCross BlueShield of Oregon has attributed 3.4 percentage points of its 17.1 percent rate increase to Obamacare, while Celtic Insurance Company in Wisconsin and North Carolina has attributed 9 percentage points of its 18 percent rate increase to Obamacare.[5]

Child-Only Health Insurance

A child-only health insurance policy is a policy that parents or grandparents may wish to purchase to cover only one particular child. Obamacare requires insurers that sell child-only plans to offer coverage to all new applicants without regard to the child's preexisting health condition.

One year later, an unintended consequence of the ban on considering preexisting conditions is that insurers in at least 34 states have exited the market and 20 states now have no insurers offering child-only plans.[6] The insurers fear that the ban encourages parents to wait until their children are sick before looking for insurance coverage.

Insurers have dropped out of the market even though the U.S. Department of Health and Human Services (HHS) has ruled that insurers can limit enrollment to open-enrollment periods as long as insurers do not "selectively deny enrollment for children with a preexisting condition while accepting enrollment from other children outside of the

1. Public Law 111–148.
2. Rasmussen Reports, "Health Care Law," March 14, 2011, at *http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/health_care_law* (March 15, 2011).
3. *State of Florida v. U.S. Department of Health and Human Services*, No. 3:10-cv-91-RV/EMT (N.D. Fla. filed January 31, 2011), at *http://www.flnd.uscourts.gov/announcements/documents/10cv91doc151.pdf* (March 10, 2011).
4. David Schepp, "Health Insurance for Your Dependent Until Age 26? That Depends," DailyFinance, June 6, 2010, at *http://www.dailyfinance.com/story/insurance/employers-reluctant-to-add-older-dependents-sooner-rather-than-l/19502338* (March 9, 2011).
5. Janet Adamy, "Health Insurers Plan Hikes," *The Wall Street Journal*, September 7, 2010, at *http://online.wsj.com/article/SB10001424052748703720004575478200948908976.html* (September 21, 2010).
6. Sarah Kliff and J. Lester Feder, "Child-Only Health Plans Endangered," *Politico*, January 27, 2011, at *http://www.politico.com/news/stories/0111/48299.html* (March 10, 2011).
7. U.S. Department of Health and Human Services, "Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions," October 13, 2010, at *http://www.hhs.gov/ociio/regulations/children19/factsheet.html* (March 16, 2011).

open-enrollment period."[7] Moreover, in response to insurers pulling out of the child-only health insurance market, the Administration has decided that insurers "can adjust their rates based on health status until 2014, to the extent state law allows."[8]

Annual Limits and Mini-Med Plans

Many health plans, particularly mini-med plans,[9] limit annual benefits. Limiting annual benefits is one way to reduce people's premiums and make insurance affordable. Obamacare prohibits insurance plans from limiting lifetime benefits and prohibits group plans from limiting annual benefits. Many employers, such as McDonald's, have mini-med health coverage plans. Their employees would likely lose coverage if the plans were subject to the annual limit requirement.

Under HHS regulations on plan years starting between September 23, 2010, and September 22, 2011, plans are prohibited from limiting annual coverage of essential benefits (e.g., hospital, physician, and pharmacy benefits) to less than $750,000. The restricted annual limit will be $1.25 million for plan years starting on or after September 23, 2011, and $2 million for plan years starting between September 23, 2012, and January 1, 2014. The regulations prohibit any limit on coverage of essential health benefits for plans issued or renewed beginning January 1, 2014.[10]

An unintended consequence of the ban on considering preexisting conditions is that insurers in at least 34 states have exited the market and no longer enroll additional children in child-only plans.

One year later, over 1,000 sponsors of health plans have received waivers from Obamacare's annual limit requirements. In February 2011, HHS approved 94 percent of waiver applications. The largest waiver thus far is for the United Federation of Teachers Welfare Fund in New York and its 351,000 enrollees.[11]

Medical Loss Ratio Regulation

Obamacare requires health plans, including grandfathered plans, to report the percentage of premiums spent on claim reimbursement, quality improvements, and other costs. Large-group plans must spend at least 85 percent on paying claims and undertaking quality improvement activities, and plans in the individual and small-group markets must spend at least 80 percent. Plans that fail to meet these thresholds must rebate the difference to consumers.

Rowen Bell, chairman of the medical loss ratio (MLR) regulation work group at the American Academy of Actuaries, warned that the MLR provision may cause insurers to leave the individual market.[12] Many state insurance commissioners are concerned about how the MLR requirement will affect their states. In a letter to HHS Secretary Kathleen Sebelius, they warned:

> [W]e continue to have concerns about the potential for unintended consequences arising from the medical loss ratio. As we noted in our letter of October 13th, consumers will not benefit from higher medical loss ratios if

8. Robert Pear, "U.S. to Let Insurers Raise Fees for Sick Children," *The New York Times*, October 13, 2010, at *http://www.nytimes.com/2010/10/14/health/policy/14health.html* (March 8, 2011).
9. Mini-med plans cover some basic health benefits with relatively low benefit limits. For a discussion of mini-med plans, see David R. Henderson, "Mini-Med Plans," National Center for Policy Analysis *Brief Analysis* No. 727, October 21, 2010, at *http://www.ncpa.org/pdfs/ba727.pdf* (March 4, 2011).
10. Center for Consumer Information and Insurance Oversight, "Annual Limit Waivers," at *http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html* (March 9, 2011).
11. Jerry Geisel, "Mini-Med Health Plan Waivers Top 1,000: HHS," *Business Insurance*, March 8, 2011, at *http://www.businessinsurance.com/article/20110308/BENEFITS11/110309939* (March 16, 2011).
12. Allison Bell, "Actuary: Act Fast, or Individual Health Insurers Will Flee," *National Underwriter: Life & Health, May 3, 2010*, at *http://www.lifeandhealthinsurancenews.com/News/2010/5/Pages/Actuary-Act-Fast-Or-Individual-Health-Insurers-Will-Flee.aspx* (March 1, 2011).

the outcome is destabilized insurance markets where consumer choice is limited and the solvency of insurers is undermined.[13]

One year later, Obamacare has resulted in insurance companies exiting markets, thereby reducing consumer choice. Joshua Raskin, an analyst at Barclays Capital, has noted that it "is harder and harder for smaller plans to compete in a more regulated environment."[14] Shortly after Obamacare was enacted, Principal Financial Group, which provided insurance to over 800,000 people, decided to stop selling health insurance. The company's decision reflected its assessment of its ability to compete in the environment created by the law, which Principal believes harms relatively small insurers that lack "significant concentration in any one market."[15]

This regulation was well publicized because McDonald's 30,000 employees with mini-med plans were at risk of losing coverage because of a low MLR, even with the waiver from annual limits on the plan. McDonald's mini-med plan incurs significant administrative costs because of the high turnover rates among its employees.[16] The MLR regulation published on December 1, 2010, exempted mini-med plans from the requirement for 2011 by requiring them to meet only half of the "official" MLR. The regulation requires that these plans must submit certain figures to HHS, which HHS will use to determine whether or not to extend the waiver in 2012 and 2013.[17]

Shortly after Obamacare was enacted, Principal Financial Group, which provided insurance to over 800,000 people, decided to stop selling health insurance.

HHS expects 20 states eventually to apply for MLR waivers.[18] As of March 14, 2011, Florida, Kentucky, Maine, Nevada, and New Hampshire have applied for waivers, and Maine has been granted a waiver.[19]

Multiple and Uncertain Requirements for Grandfathered Plans

During the debate on the legislation, President Obama repeatedly assured Americans that Obamacare would not affect individuals who were satisfied with their current health insurance. Current insurance plans were supposed to be "grandfathered in" and thus protected from the numerous mandates and regulations in the health care law. In theory, an insurance plan that gains grandfathered status is not subject to the new requirements, so a plan that was offered before Obamacare could still be offered after the law's passage.

One year later, the President's assurances have been disproven. Health insurance plans cannot be grandfathered unless they meet a variety of requirements. Furthermore, HHS's vague grandfathering regulations indicate that plans can lose their grandfathered status for changes that are not deemed "reasonable changes routinely made."[20] Initial regulations indicated that a plan could lose

13. Jane Cline, Susan Voss, Kevin McCarty, Kim Holland, Roger Sevigny, and Sandy Praeger, letter to Kathleen Sebelius, U.S. Secretary of Health and Human Services, October 27, 2010, at *http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf* (March 1, 2011).
14. Avery Johnson, "Principal Financial Quits Writing Health-Care Policies," *The Wall Street Journal*, October 1, 2010, at *http://online.wsj.com/article/SB10001424052748704789404575524281126700388.html* (March 10, 2011).
15. Reed Abelson, "Insurer Cuts Health Plans as New Law Takes Hold," *The New York Times*, September 30, 2010, at *http://www.nytimes.com/2010/10/01/health/policy/01insure.html* (March 10, 2011).
16. Janet Adamy, "McDonald's May Drop Health Plan," *The Wall Street Journal*, September 30, 2010, at *http://online.wsj.com/article/SB10001424052748703431604575522413101063070.html* (March 4, 2011).
17. *Federal Register*, Vol. 75, No. 230 (December 1, 2010), p. 74880.
18. *Ibid.*, p. 74864.
19. Sarah Kliff and Jennifer Haberkorn, "Johanns Gets Aggressive on H.R. 4," *Politico*, February 24, 2011, at *http://www.politico.com/politicopulse/0311/politicopulse456.html* (March 15, 2011).
20. *Federal Register*, Vol. 75, No. 116 (June 17, 2010), p. 34546.

its grandfathered status simply by changing insurance companies. HHS has since changed this provision after being informed that it would give current insurance companies bargaining leverage and discourage competition, but nothing prevents HHS from reinstating its initial ruling at some future date.

The Administration has estimated that 49 percent to 80 percent of small-employer plans, 34 percent to 67 percent of large-employer plans, and 40 percent to 67 percent of individual insurance coverage will not be grandfathered by the end of 2013.[21] Even the unaffected plans are subject to HHS's wide discretion to deem changes in policies unacceptable. Former HHS Deputy Assistant Secretary for Planning and Evaluation John Hoff has written that "the Administration [can] decide on an *ad hoc* basis, and without standards, which changes a plan can make and still remain grandfathered."[22]

"Free" Preventive Services

Obamacare requires that insurance plans, including Medicare but excluding grandfathered plans, must provide first-dollar coverage for preventive services rated A or B by the U.S. Preventive Services Task Force. Moreover, insurance must cover without cost-sharing immunizations that are recommended from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention as well as additional preventive care and screenings stated in the comprehensive guidelines supported by the Health Resources and Services Administration.

One year later, HHS has not clarified the preventive care regulations, and this has produced additional uncertainty in health insurance markets. This is worrisome to insurers because there are substantial fines for failure to comply.[23] Moreover, the mandate requiring insurance companies to pay for preventive services with no cost-sharing has increased premiums while reducing consumer opportunity to select from a variety of plans, including ones with various degrees of cost-sharing.

During the debate, President Obama repeatedly assured Americans that Obamacare would not affect individuals who were satisfied with their current health insurance. One year later, the President's assurances have been disproven.

In a 2009 *Health Affairs* article, Louise Russell wrote:

> [H]undreds of studies have shown that prevention usually adds to medical costs instead of reducing them. Medications for hypertension and elevated cholesterol, diet and exercise to prevent diabetes, and screening and early treatment for cancer all add more to medical costs than they save.... [In fact] 80 percent add more to medical costs than they save.[24]

Reviews of "Unreasonable" Premium Increases

Obamacare requires the Secretary to work with states to establish an annual review of "unreasonable" rate increases, to monitor premium increases, and to award grants to states to carry out their rate review process. The health law does not define an "unreasonable" rate increase and does not specify the rate review process. Health insurance premium

21. *Ibid.*, p. 34553. The Administration estimates that the change in the regulation made on November 17 permitting a change in issuer will "result in a small increase in the number of plans retaining their grandfathered status." *Federal Register*, Vol. 75, No. 221 (November 17, 2010), p. 70118.

22. John S. Hoff, "Broken Promises: How Obamacare Undercuts Existing Health Insurance," Heritage Foundation *Backgrounder* No. 2516, February 7, 2011, at *http://www.heritage.org/Research/Reports/2011/02/Broken-Promises-How-Obamacare-Undercuts-Existing-Health-Insurance*.

23. Edmund F. Haislmaier, "Obamacare and Insurance Benefit Mandates: Raising Premiums and Reducing Patient Choice," Heritage Foundation *WebMemo* No. 3110, January 20, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Insurance-Benefit-Mandates-Raising-Premiums-and-Reducing-Patient-Choice*.

24. Louise Russell, "Preventing Chronic Disease: An Important Investment, But Don't Count on Cost Savings," *Health Affairs*, Vol. 28, No. 1 (January 2009), pp. 42–45.

reviews are already a typical state government function as 43 states have rate review processes. The state rate reviews primarily ensure that premiums are high enough to ensure the insurer's solvency rather than guard against "unreasonable" premium increases.

One year later, under regulations issued on December 23, 2010, a premium increase may be flagged as potentially unreasonable if the average weighted increase in the rate filing exceeds 10 percent. A formal review will then decide whether the premium increase was unreasonable based on underlying factors. Plans in the large-group market are not subject to this review. HHS would defer to the state's determination of unreasonableness "if the state has an effective rate review program for rates filed in a particular market."[25]

HHS grants to states to expand rate reviews are unnecessary given competition among insurance companies and current state regulatory oversight. Even if they were necessary, the regulation is unenforceable.

Yet it is important to note that HHS cannot enforce its determination. If an insurer proceeds with an "unreasonable" increase, the insurer would be required to post its preliminary justification, HHS's determination, and its final justification on its Web site, but the rate increase would still move forward.[26]

Despite the lack of authority to reject premium increases, HHS is still giving grants to the states to expand rate reviews. In 2010, HHS awarded $46 million to 45 states and the District of Columbia. On February 24, 2011, HHS announced another $200 million in available grants "to help states develop programs that will make health insurance premiums more transparent and to give states the power to stop unreasonable premium increases from taking effect."[27]

These grants are unnecessary given competition among insurance companies and current state regulatory oversight. Even if they were necessary, the regulation is unenforceable. Hence, taxpayer dollars devoted to this regulation are being wasted.

Early-Retiree Reinsurance Program

Obamacare created a temporary reinsurance program available through 2014 to help companies that provide early-retiree benefits for individuals between the ages of 55 and 65. Participating plan sponsors are eligible for partial reimbursement of health benefit claims incurred after May 31, 2010, for an early retiree and the retiree's spouse and dependents. The health care law made $5 billion available for this program.

As of December 31, 2010, more than 5,000 plan sponsors had been approved for participation. However, only 253 plans (less than 5 percent) had received funding by that date.[28]

Based on a report from the Obama Administration, the program appears to be mostly a bailout for public-sector and union health benefit programs for early retirees.[29] Government plans received almost $300 million of the $535 million paid out between October 1, 2010, and December 31, 2010. The California Public Employees' Retirement System received $58 million, the largest amount received by any government plan. Michigan plans received $142 million of the money spent, led by the United Auto Workers Retiree Benefits Trust, which had 11,679 early retirees with claims above the cost

25. *Federal Register*, Vol. 75, No. 246 (December 23, 2010), p. 81007.
26. *Ibid.*, p. 81008.
27. HealthCare.gov, "Nearly $200 Million Available to Help States Fight Health Insurance Premium Increases," U.S. Department of Health and Human Services, February 24, 2011, at *http://www.healthcare.gov/news/factsheets/ratereview02242011a.html* (March 1, 2011).
28. U.S. Department of Health and Human Services, "Report on Implementation and Operation of the Early Retiree Reinsurance Program During Calendar Year 2010," March 2, 2011, at *http://www.healthcare.gov/center/reports/retirement03022011a.pdf* (March 4, 2011).
29. *Ibid.*

threshold (about 20 percent of the total population of early retirees in this program with such claims).

The evidence suggests that this program shifts the costs of paying for unsustainable promises made to public and private unionized labor onto taxpayers.

Creation of High-Risk Pools

Obamacare creates high-risk pools for individuals to purchase health insurance if they have preexisting conditions and have been uninsured for six months. Prior to Obamacare, 35 states already had high-risk pools, but Obamacare offers a relatively generous subsidy for individuals who buy coverage in its high-risk pools. A 2005 academic paper estimated that approximately 1 million Americans without health insurance were uninsurable, typically because of a preexisting condition.[30]

As of February 2011, approximately 12,500 people (roughly 3 percent of the initial estimate) had obtained coverage through the high-risk pools.

The Office of the Actuary at the Centers for Medicare and Medicaid Services initially estimated that 375,000 individuals would enroll in the Obamacare high-risk pools by the end of 2010.[31] At the time, it was thought that the $5 billion set aside for Obamacare's high-risk pools would be grossly inadequate. The high-risk pools may be operated by the states or the federal government, and 27 states chose to create their own risk pools. The federal government set up the risk pools in the remaining 23 states.

As of February 2011, approximately 12,500 people (roughly 3 percent of the initial estimate) had obtained coverage through Obamacare's high-risk pools.[32] The underwhelming enrollment suggests two explanations.

- Experts may have significantly overestimated how many Americans were without insurance because of a preexisting condition, or
- Despite generous premiums for the high-risk pool (well under the actuarially fair amount),[33] individuals either still cannot afford the premium or are simply not interested in obtaining insurance through the high-risk pool.

If the first explanation is correct, one of Obamacare's key selling points was erroneous. If the second explanation is correct, significantly reducing the number of individuals without health insurance will likely cost taxpayers significantly more than was initially estimated.

Small-Business Health Tax Credit

Obamacare provides tax credits to small employers that provide health insurance for their workers who earn relatively low average wages. The credit is available for a maximum of five years and for only two years after the exchanges begin operating in 2014. The credit is reduced as firm size increases and as the average employee wage increases. For example:

- For a firm of up to 10 workers, the tax credit phases out at an average wage of $50,000;
- For a firm of 15 workers, the tax credit phases out at an average wage around $41,000;
- For a firm of 20 workers, the tax credit phases out at an average wage around $32,000; and
- For a firm of 25 workers, the tax credit phases out at an average wage of $25,000.[34]

30. Austin B. Frakt, Steven D. Pizer, and Marian V. Wrobel, "High-Risk Pools for Uninsurable Individuals: Recent Growth, Future Prospects," *Health Care Financing Review*, Vol. 26, No. 2 (Winter 2004–2005), pp. 73–87, at *https://www.cms.gov/HealthCareFinancingReview/downloads/04-05winterpg73.pdf* (March 11, 2011).
31. Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, April 22, 2010, at *https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf* (July 21, 2010).
32. Amy Goldstein, "Enrollment in High-Risk Insurance Pools Lagging Behind Predictions," *The Washington Post*, February 10, 2011, at *http://www.washingtonpost.com/wp-dyn/content/article/2011/02/10/AR2011021004184.html* (March 1, 2011).
33. An actuarially fair premium would be equal to expected health expenditures with a margin for administrative costs and profits.

One year later, the number of firms that used the tax credit is still unknown—the tax forms for 2010 are not yet due—but based on the tax credit amounts and the phase cuts, most small firms will not qualify for the tax credit. According to the Congressional Budget Office and the Joint Committee on Taxation:

> [A] relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016. For those people, the cost of insurance under the proposal would be about 8 percent to 11 percent lower, on average, compared with that cost under current law.[35]

HSA and FSA Restrictions

Obamacare limits the benefit of health savings accounts (HSAs) and flexible spending accounts (FSAs). Because of the PPACA, consumers can no longer use HSAs and FSAs to purchase certain items, including most over-the-counter (OTC) medication unless prescribed by a physician. Moreover, the law increased the penalty for making nonqualified purchases with an HSA to 20 percent.

Approximately 10 million people have HSAs, and 35 million have FSAs. Substantial evidence indicates that, in addition to increasing consumer choice, HSAs and FSAs effectively control health care spending by encouraging individuals to make more cost-effective decisions.[36]

As of January 1, 2011, these regulations will negatively affect individuals with HSAs and FSAs. According to a Nielsen Homescan survey, 52 percent of FSA holders used their tax benefits to purchase OTC medications. The survey also suggests that many individuals will request a prescription for OTC drugs or will ask about prescription medications to replace OTC drugs.[37] *The Wall Street Journal* has reported that the restrictions on HSAs and FSAs are increasing burdens on doctors and pharmacies, which must write and process these prescriptions for everyday products so that customers can purchase them with HSAs or FSAs.[38] Conceivably, this provision could also increase health care spending as individuals replace OTC drugs with more expensive prescription medication.

The restrictions on HSAs and FSAs are increasing burdens on doctors and pharmacies, which must write and process these prescriptions for everyday products so that customers can purchase them with HSAs or FSAs.

Medicare Beneficiary Drug Rebate

Obamacare provides a $250 rebate to Medicare beneficiaries who fall into Part D coverage gaps (the "doughnut" hole). After paying an annual deductible of $310, seniors on Medicare Part D (the prescription drug benefit) pay 25 percent of the cost of their prescription drugs until the total bill reaches $2,830. Above $2,830, enrollees pay the full cost of their prescription drug bill until total out-of-pocket spending reaches $4,550. At that point, catastrophic coverage kicks in and enrollees pay only 5 percent of the remainder of the bill for the rest of the year. The National Council on the Aging estimates

34. For a discussion of the small-business tax credit and its phaseouts, see Chris Peterson and Hinda Chaikind, "Summary of Small Business Health Insurance Tax Credit Under PPACA," Congressional Research Service *Report for Congress*, April 5, 2010, at *http://www.ncsl.org/documents/health/SBtaxCredits.pdf* (March 11, 2011).
35. Douglas W. Elmendorf, letter to Senator Evan Bayh (D–IN), November 30, 2009, p. 5, at *http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf* (September 21, 2010).
36. For example, see Mary E. Charlton, Barcey T. Levy, Robin R. High, John E. Schneider, and John M. Brooks, "Effects of Health Savings Account-Eligible Plans on Utilization and Expenditures," *American Journal of Managed Care*, Vol. 17, No. 1 (January 2011), pp. 79–86.
37. Dennis Callahan and Liz Yurkevicz, "Paying for OTC Medications—New Rules, Big Impact," Nielsen News, January 27, 2011, at *http://blog.nielsen.com/nielsenwire/consumer/paying-for-otc-medications-%E2%80%93-new-rules-big-impact* (March 9, 2011).
38. Janet Adamy, "In Health Law, Rx for Trouble," *The Wall Street Journal*, March 9, 2011, at *http://online.wsj.com/article/SB10001424052748704692904576166554110739560.html* (March 9, 2011).

about 4 million people fall into the doughnut hole each year.[39]

One year later, HHS estimates that only 3 million people[40] of the more than 46 million individuals on Medicare received rebate checks in 2010.[41] This means that the $250 rebate cost taxpayers about $750 million in 2010.

State Option to Expand Medicaid Coverage for Childless Adults

Beginning on April 1, 2010, states were allowed to extend Medicaid coverage to childless adults with incomes up to 133 percent of the federal poverty level. States would receive their traditional federal reimbursement percentage to help to pay for the expansion.

One year later, only Connecticut, Minnesota, and the District of Columbia have taken advantage of this provision to increase Medicaid coverage to childless adults under 133 percent of the poverty level. This suggests that the other states are not eager to expand their Medicaid rolls, which Obamacare will increase by an estimated 20 million people.[42] These states likely view this enormous program expansion as not worth the cost.

Obamacare "Benefits" Are Too Costly to Continue

America urgently needs to reform health care, as increasing health care spending is consuming ever larger shares of household and government budgets. Obamacare falls short of genuine reform because its "benefits" will both increase the cost of private insurance and government spending on health care.[43]

Congress should repeal the government-centric Obamacare law and replace it with consumer-focused reforms and sensible changes in health care entitlement programs. America simply cannot afford Obamacare's "benefits."

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39. James Firman, "Beyond Health Reform: Opportunities for the Aging Network in the Affordable Care Act," *Innovations*, Summer 2010, at *http://www.ncoa.org/assets/files/pdf/100728_Innovations_Summer-2010_R6-FR.pdf* (March 3, 2011).
40. U.S. Department of Health and Human Services, "Sebelius Announces Three Million Medicare Beneficiaries Have Received Prescription Drug Cost Relief Under the Affordable Care Act," January 21, 2011, at *http://www.hhs.gov/news/press/2011pres/01/20110121a.html* (March 16, 2011).
41. Henry J. Kaiser Family Foundation, "Total Number of Medicare Beneficiaries, 2010," May 2010, at *http://www.statehealthfacts.org/comparemaptable.jsp?ind=290&cat=6* (March 16, 2011).
42. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended."
43. Douglas W. Elmendorf, letter to Speaker of the House Nancy Pelosi (D–CA), March 20, 2010, at *http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf* (June 22, 2010).