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The Obamacare Two-Year Checkup: More Reasons for Repeal

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Abstract

On its second anniversary, Obamacare remains unpopular. The provisions currently in effect have fallen short of expectations and disrupted the market, causing even greater uncertainty for the future. Overall, Obamacare has increased government control of Americans' health care choices and limited consumer choice. The recent controversy over the preventive care benefit mandates are a good indication of things to come. The fundamental structure of Obamacare is based on centralizing the financing, delivery, and management of health care, and is completely incompatible with patient-centered, market-based reforms.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2666**

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Two years 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, and although its proponents hoped it would gain broad acceptance as people learned more about the law, not much has changed since then.

Public opinion surveys continue to show that more people oppose the health care law than support it. The latest Rasmussen poll shows that 56 percent of likely voters "somewhat favor" repeal of the health law, of which 46 percent "strongly favor" repeal.[2]

Many of Obamacare's key provisions—such as the creation of health insurance exchanges, costly subsidies to purchase coverage, the massive expansion of Medicaid, and the individual and employer mandates—do not take effect until 2014. However, as noted in "Obamacare: The One-Year Checkup,"[3] 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.

There have been several significant developments over the past

Talking Points

- The Patient Protection and Affordable Care Act (PPACA) is at least as unpopular today as when it was enacted in 2010. The latest Rasmussen poll shows that 56 percent of likely voters "somewhat favor" its repeal, of which 46 percent "strongly favor" repeal.
- There have been significant developments over the past year—the decision by the Supreme Court to hear a case on the constitutionality of the PPACA, the halting of the CLASS Act, and the new preventive-care benefit mandates. But, the outcomes continue to underscore that the PPACA is unworkable and not worth its enormous cost.
- America urgently needs to reform its health care system—increasing health care spending is consuming ever-larger shares of household and government budgets. Obamacare falls short of genuine reform because its alleged benefits increase not only government spending but also the cost of private health insurance—all on the backs of taxpayers.

year—the decision by the Supreme Court to hear a case on the constitutionality of the law, the halting of the Community Living Assistance Services and Supports (CLASS) Act, and the new preventive care benefit mandates. The outcomes continue to underscore that this health care law is unworkable, unsettled, and not worth its cost.

Constitutionality

More than 30 legal cases have challenged various aspects of the PPACA. The largest, *Florida v. Department of Health and Human Services*, involves 26 states and the National Federation of Independent Business (NFIB). This case calls into question the constitutionality of the individual mandate and the Medicaid expansion. The plaintiffs argue that Congress exceeded its constitutional authority by requiring individuals to buy health insurance or pay a penalty. It also argues that the law's Medicaid expansion is a coercive infringement on state sovereignty.[4]

Two years later: On November 15, 2011, the U.S. Supreme Court agreed to hear the case brought by the 26 states and the NFIB. The Supreme Court will hear oral arguments during the last week of March 2012, and will likely release its decision by late June. The Court will hear arguments related to: whether the Court can proceed to hear the case, whether Congress overstepped its constitutional authority to regulate interstate commerce by requiring all Americans to maintain minimum coverage, whether the individual mandate can be severed from the rest of the law, and whether the Medicaid expansion is a coercive infringement on state sovereignty.[5] The decision by the Supreme Court to hear the case further underscores that the health care law is unsettled business. A number of states have indicated that they will not pursue further action relating to implementation until a decision by the Supreme Court has been reached.[6]

Child-Only Health Insurance

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

Many insurers fear that this new requirement encourages parents to wait until their child is sick before securing health insurance, increasing costs. Trying to avoid a massive exodus of these plans, the U.S. Department of Health and Human Services (HHS) ruled that insurers may limit enrollment to open-enrollment periods as long as insurers do not "selectively deny enrollment for children with a pre-existing condition while accepting enrollment from other children outside of the open-enrollment period."[7] Moreover, the Administration decided that insurers "can adjust their rates based on health status until 2014, to the extent state law allows."[8]

Two years later: The unintended consequences remain. In an August 2011 report by the U.S. Senate Committee on Health, Education, Labor, and Pensions, 17 states indicated that no insurers were selling child-only policies to new enrollees, and 39 states responded that at

1. Public Law 111–148. Known as "Obamacare."
2. "Health Care Law: 56% Favor Repeal of Health Care Law," Rasmussen Reports, March 19, 2012, at *http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/health_care_law* (March 21, 2012). For a full list of health care poll tracking, see "Repeal of Health Care Law: Favor/Oppose," Real Clear Politics, at *http://www.realclearpolitics.com/epolls/other/repeal_of_health_care_law_favoroppose-1947.html* (March 7, 2012).
3. Brian Blase, "Obamacare: The One-Year Checkup," Heritage Foundation *Backgrounder* No. 2532, March 17, 2011, at *http://www.heritage.org/research/reports/2011/03/obamacare-the-one-year-checkup.*
4. Office of the Attorney General of Florida, "The States' Lawsuit Challenging the Constitutionality of the Health Care Reform Law," 2010, at *http://www.healthcarelawsuit.us/* (March 7, 2012).
5. For more discussion, see Hadley Heath, "ObamaCare and the Constitution," Independent Women's Forum *Policy Focus*, Vol. 2, No. 2 (February 2012), at *http://www.iwf.org/publications/2786915/ObamaCare-and-the-Constitution* (March 7, 2012).
6. Brett Norman and Jason Millman, "States Waiting on SCOTUS Could Hamper Exchanges," *Politico*, January 23, 2012, at *http://www.politico.com/news/stories/0112/71846.html* (March 7, 2012).
7. Centers for Medicare and Medicaid 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://cciio.hhs.gov/resources/files/factsheet.html* (March 7, 2012).
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 7, 2012).

least one insurer exited the child-only market since the new law took effect.[9]

Annual Limits and Mini-Med Plans

Many health plans, particularly so-called mini-med plans,[10] limit annual benefits as a way to reduce premiums and make health care more affordable. Obamacare prohibits insurance plans from limiting lifetime benefits and prohibits group plans from limiting annual benefits. But many employers, such as McDonald's, offer mini-med health coverage plans. Their employees would likely lose their current coverage if the plans were subject to the annual limit requirement.

Under HHS regulations, plans that were in effect between September 23, 2010, and September 22, 2011, were prohibited from limiting annual coverage of certain health benefits (e.g., hospital, physician, and pharmacy benefits) to any amount below $750,000.The restricted annual limit is $1.25 million for plans in effect on or after September 23, 2011, and $2 million for plans in effect between September 23, 2012, and January 1, 2014. Finally, the regulations prohibit any limit on coverage for the yet to-be-defined essential health benefits (EHB) for plans issued or renewed beginning January 1, 2014.[11]

Two years later: The Department of Health and Human Services has granted temporary waivers for more than a thousand plans. On June 17, 2011, the Administration announced that it would not accept waivers beyond September 22, 2011, thus ending the waiver option.[12] As of January 2012, 1,722 sponsors[13] of health plans covering more than 4 million individuals have received approval for waivers from Obamacare's annual limit requirements. The two largest approved waivers are for the United Federation of Teachers Welfare Fund with its 351,000 enrollees, and for the District Council 37 Health and Security Plan with 303,164 enrollees.[14]

As these waivers expire, the 1,722 employers will have to decide whether to change their current policies to more expensive coverage, or drop coverage for the 4 million people.

Medical Loss Ratio Regulation

Obamacare requires health plans, including grandfathered plans, to report the percentage of premiums spent on medical-claim reimbursement, quality improvements, and other costs. Large group plans must spend at least 85 percent on medical claims and 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.

The medical loss ratio (MLR) regulations have multiple consequences. As noted by Heritage Foundation health policy analyst Edmund Haislmaier, "Reporting or publicizing insurer loss ratios does not, in and of itself, create problems. The problems only occur when governments use a comparative measure, such as this one, as

9. Michael B. Enzi, "Ranking Member Report: Health Care Reform Law's Impact on Child-Only Health Insurance Policies," U.S. Senate Committee on Health, Education, Labor and Pensions, August 2, 2011, at *http://www.help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%202,%202011.pdf* (March 7, 2012).
10. 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 15, 2011).
11. "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," *Federal Register*, Vol. 75, No. 123 (June 28, 2010), p. 37188, at *https://www.federalregister.gov/articles/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual* (March 7, 2012).
12. Centers for Medicare and Medicaid Services, "CCIIO Supplemental Guidance: Concluding the Annual Limit Waiver Application Process," Insurance Standards Bulletin Series, June 17, 2011, at *http://www.cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf* (March 7, 2012).
13. These include 722 self-insured employers, 417 multi-employer plans; 34 non-Taft Hartley union plans; 50 health insurance issuers; five state-mandated plans; three association plans; and 491 Health Reimbursement Arrangements.
14. Centers for Medicare and Medicaid Services, "Annual Limits Policy: Protecting Consumers, Maintaining Options, and Building a Bridge to 2014," at *http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html* (March 7, 2012).
15. Edmund F. Haislmaier, "Effects of the PPACA's Minimum Loss Ratio Regulations," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, September 15, 2011, at *http://www.heritage.org/research/testimony/2011/12/effects-of-the-ppacas-minimum-loss-ratio-regulations*.

the basis for setting and enforcing a required minimum standard."[15] The likely result of these regulations will be "reduced insurance competition, higher premiums, and more erroneous or fraudulent claim payments."[16]

Two years later: HHS allowed states to apply for a waiver to temporarily lower the MLR threshold to the state's individual market insurers if the Secretary determines that imposing the 85 percent threshold "has the likelihood of destabilizing the individual market and result in fewer choices for consumers."[17] Seventeen states applied for the MLR waivers, arguing that the regulations would destabilize their markets. HHS fully approved one (Maine). Six states (Georgia, Iowa, Kentucky, Nevada, New Hampshire, and North Carolina) received partial waivers and HHS rejected 10 states' waiver requests (Delaware, Florida, Indiana, Kansas, Louisiana, Michigan, North Dakota, Oklahoma, Texas, and Wisconsin).[18]

Meanwhile, the MLR regulations have already forced insurers out of the market. The American Enterprise Group cited the MLR regulations as one of the main reasons that it was pulling out of some markets.[19] There is a growing list of insurers leaving the market due to this regulation and other changes in the health care law.[20]

A recent study, conducted by Milliman Consulting for the American Bankers Association HSA Council, raises new concerns for individuals with health savings accounts (HSAs), which combine a high-deductible health plan with a tax-preferred savings account.[21] In its press release, the Bankers Association notes that "consumers who rely on HSA-qualified plans to finance their health care may experience greater costs in their current health plans and may eventually have to find more expensive replacement coverage."[22] Thus, the 11 million people who have HSA plans may not be able to keep them under Obamacare.[23]

Grandfathered Plans

During the debate, President Obama repeatedly assured Americans that Obamacare would not affect individuals who were satisfied with their current health insurance. Current insurance plans could be "grandfathered," and thus protected from the numerous mandates and regulations in the health care law. In theory, an insurance plan with 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.

But the theory looks different in practice. Health insurance plans cannot be grandfathered unless they meet a variety of requirements. Furthermore, HHS regulations indicate that plans can lose their grandfathered status for modifications that are not deemed "reasonable changes routinely made." Such changes include: (1) increasing cost sharing, (2) increasing deductibles or out-of-pocket limits, (3) increasing co-payments for services by more than the specified allowance, (4) decreases in employer contribution rates, and (5) changes to annual or lifetime limits.[24]

16. *Ibid.*
17. Centers for Medicare and Medicaid Services and Department of Health and Human Services, "OCII Technical Guidance: Process for a State to Submit a Request for Adjustment to the Medical Loss Ratio Standard of PHS Act Section 2718," Insurance Standards Bulletin Series, December 17, 2010, at *http://cciio.cms.gov/programs/marketreforms/mlr/12-17-2010ociio_2010-2a_guidance.pdf* (March 7, 2012).
18. Jason Millman, "MLR Watch: The Scoreboard," *Politico*, February 17, 2012.
19. Julian Pecquet, "Two Health Insurers Leave Florida, Citing Health Law Regulations," *The Hill*, October 27, 2011, at *http://thehill.com/blogs/healthwatch/health-reform-implementation/190285-two-insurance-companies-exit-florida-as-fight-over-health-law-waiver-heats-up* (March 21, 2012). See also, American Enterprise Group, letter to Texas Commissioner of Insurance, October 27, 2011, at *http://www.cciio.cms.gov/programs/marketreforms/mlr/states/texas/tx_american_enterprise_letter.pdf* (March 7, 2012).
20. Grace-Marie Turner, "A Radical Restructuring of Health Insurance: Millions to Lose the Health Coverage They Have Now," Galen Institute, December 2011, at *http://www.galen.org/assets/Radical_Restructuring.pdf* (March 14, 2012).
21. "Impact of Medical Loss Ratio Requirements Under PPACA on High Deductible Plans/HSAs in Individual and Small Group Markets," Milliman Client Report for American Bankers Association, at *http://www.aba.com/aba/documents/abia/Report-ABAImpactofMedicalLossRatioRequirements.pdf* (March 7, 2012).
22. News release, "Milliman Study Highlights the Impact of Medical Loss Ratio Rules on HSAs," American Bankers Association, February 13, 2012, at *http://www.aba.com/aba/documents/abia/MillimanReportPressRelease.pdf* (March 8, 2012).
23. "January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)," America's Health Insurance Plans Center for Health Policy and Research, June 2011, at *http://www.ahipresearch.org/pdfs/HSA2011.pdf* (March 14, 2012).
24. "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," *Federal Register*, Vol. 75, No. 116 (June 17, 2010), p. 34546.

Two years later: Securing and now preserving grandfather status remains uncertain. In a recent PricewaterhouseCoopers survey of employers, 51 percent of surveyed employers indicated they did not maintain their "grandfathered" status.[25]

Even the Administration admits that employers will lose their grandfathered status. It estimates 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.[26] Furthermore, former HHS Deputy Assistant Secretary for Planning and Evaluation John Hoff writes that "the Administration [can] decide on an ad hoc basis, and without standards, which changes a plan can make and still remain grandfathered."[27] The HHS's wide discretion to deem some changes unacceptable leaves even greater uncertainty.

"Free" Preventive Services

Obamacare requires that insurance plans, including Medicare but excluding grandfathered plans, must provide first-dollar coverage (without cost sharing) 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 by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention as well as additional preventive care and screenings listed in the comprehensive guidelines supported by the Health Resources and Services Administration.

In 2010, the Administration published regulations related to coverage of preventive services under the PPACA. The number of required measures included in the regulation exceeded forty. Then, in August 2011, HHS added a new set of coverage mandates specific to women's health, which included a wide range of controversial services, such as abortion-inducing drugs, sterilization, and contraceptives.

Two years later: The HHS regulations mandating coverage for free abortion-inducing drugs and contraception provided a very limited exception to houses of worship, but not for other religious employers. This created an outcry from members of many faiths who feel this decision is an attack on religious freedom and their ability to serve communities across the country. Despite the claims of an "accommodation" by the President at his February 10 press conference, HHS submitted its final regulations with *no* changes.[28]

The controversy over these abortion and contraception mandates is just the start. As Scott Gottlieb, a health scholar at the American Enterprise Institute, points out, "It's all a reminder that President Obama's decision on contraception isn't a one-off political intervention but the initial exploit of an elaborate new system."[29] Moreover, these preventive benefits are not "free." Indeed, the federal government itself estimates that the preventive services will cause premiums to increase by 1.5 percent, on average.[30]

Reviews of "Unreasonable" Premium Increases

Obamacare requires the Secretary of HHS 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

25. PricewaterhouseCoopers, "Health and Well-Being Touchstone Survey Results," May 2011, Slides 5 and 62, at *http://www.pwc.com/en_US/us/hr-management/assets/PwC_2011_Health_and_Wellbeing_Touchstone_Survey_Results.pdf* (March 9, 2012).
26. "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan," *Federal Register*, p. 34553. The Administration estimates that the change in the regulation made on November 17, 2010, permitting a change in issuer will "result in a small increase in the number of plans retaining their grandfathered status." "Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," *Federal Register*, Vol. 75, No. 221 (November 17, 2010), p. 70118.
27. 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*.
28. Edmund Haislmaier and Jennifer Marshall, "Nothing but Squid Ink," *The Corner*, February 11, 2012, at *http://www.nationalreview.com/corner/290859/nothing-squid-ink-ed-haislmaier* (March 8, 2012).
29. Scott Gottlieb, "Meet the ObamaCare Mandate Committee," *The Wall Street Journal*, February 16, 2012, p. A-13. See also, John S. Hoff, "Implementing Obamacare: A New Exercise in Old-Fashioned Central Planning," Heritage Foundation *Backgrounder* No. 2459, September 20, 2010, at *http://www.heritage.org/research/reports/2010/09/implementing-obamacare-a-new-exercise-in-old-fashioned-central-planning*.
30. Departments of Treasury, Labor and Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," *Federal Register*, Vol. 75, No. 137, July 19, 2010, pp. 41726–41760, at *http://edocket.access.gpo.gov/2010/pdf/2010-17242.pdf* (March 16, 2012).

their rate review process. The health care law does not define an "unreasonable" rate increase and does not specify the rate review process. Health insurance premium reviews are already a typical state government function as 43 states already 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.

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."[31]

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 website, but the rate increase would still move forward.[32]

Two years later: HHS is still giving grants to the states to expand rate reviews. On September 20, 2011, the Secretary announced a second round of state rate review grants totaling $109 million for 28 states and the District of Columbia. According to HHS, "These grants build on the $48 million that have been awarded to 42 states, the District of Columbia and five territories since the passage of the Affordable Care Act."[33]

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. It is worth noting that Florida and Oklahoma returned their original rate review grants.[34]

Early Retiree Reinsurance Program (ERRP)

Obamacare established a temporary reinsurance program (the ERRP), available through 2014, to reimburse companies for a portion of the costs associated with providing health care benefits to individuals between the ages of 55 and 65 who retire early. Participating plan sponsors are eligible for partial federal reimbursement of health benefit claims incurred after May 31, 2010, for an early retiree and the retiree's spouse and dependents. The PPACA made $5 billion available for this program.

Two years later: As of May 5, 2011, the Department of Health and Human Services stopped accepting new applications to the program, nearly three years earlier than scheduled.[35] One factor may be greater than expected costs. According to the Government Accountability Office:

> Through June 30, 2011... CCIIO [Center for Consumer Information and Insurance Oversight] approved more than $2.7 billion in reimbursements to plan sponsors for eligible health costs for early retirees. This represents nearly 54 percent of the $5 billion appropriated for the program. The largest share—about 46 percent—of the $2.7 billion in ERRP reimbursements approved as of June 30, 2011, went to government entities.[36]

Such a program clearly shifts the costs of paying for unsustainable promises made to public and private employees to federal taxpayers, and further underscores how the true cost of implementing the health care law exceeds original estimates.

High-Risk Pools

Obamacare creates high-risk health insurance pools for individuals to purchase highly subsidized insurance if they have preexisting conditions and have been uninsured

31. "Rate Increase Disclosure and Review," *Federal Register*, Vol. 75, No. 246 (December 23, 2010), p. 81007.
32. *Ibid.*, p. 81008.
33. Centers for Medicare and Medicaid Services, "Review of Insurance Rates," at *http://cciio.cms.gov/programs/marketreforms/rates/index.html* (March 8, 2012).
34. For Florida, see National Conference of State Legislatures, "States Return Federal Grants After Florida Judge Ruling," in *Affordable Care Act: State Action Newsletter*, February 25, 2011, at *http://www.ncsl.org/documents/health/ACANews3.pdf* (March 8, 2012); for Oklahoma, see News release, "Commissioner Doak to Return ObamaCare Grant," State of Oklahoma Insurance Commissioner, April 14, 2011, at *http://www.ok.gov/triton/modules/newsroom/newsroom_article.php?id=157&article_id=1709* (March 8, 2012).
35. Centers for Medicare and Medicaid Services CCIIO, "Early Retiree Reinsurance Program," at *http://cciio.cms.gov/programs/errp/index.html* (March 8, 2012).
36. "Private Health Insurance: Implementation of the Early Retiree Reinsurance Program," letter to The Honorable Michael B. Enzi, Government Accountability Office, September 30, 2001, p. 3, at *http://www.gao.gov/assets/590/585544.pdf* (March 8, 2012).

for six months. The high-risk pools may be operated by the states or by the federal government. Before the enactment of Obamacare, 35 states already had high-risk pools of their own.

A 2005 academic paper estimated that approximately 1 million Americans without health insurance were uninsurable, typically because of a preexisting condition.[37] 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.[38] Even at the time, it was thought that the $5 billion set-aside for Obamacare's high-risk pools would be grossly inadequate.

Two years later: Enrollment remains far below early predictions. Twenty-seven states chose to create their own pools, and the federal government set up risk pools in the remaining 23 states. Only 48,879 people (roughly 13 percent of the initial estimate) had obtained coverage through the PPACA high-risk pools by the end of 2011.[39] At the same time, medical-claims costs have been 2.5 times higher than initially projected, and the high-risk pools may still exhaust or exceed the available funding, even though they serve such a small portion of those they were intended to help.[40]

Small-Business Health Tax Credit

Obamacare provides tax credits to small employers that provide health insurance for workers who earn relatively low average wages. The credit is available for a maximum of six years and for only two years after the exchanges begin operating in 2014. The credit amount 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 up to 15 workers, the tax credit phases out at an average wage around $41,000;
- For a firm of up to 20 workers, the tax credit phases out at an average wage around $32,000; and
- For a firm of up to 25 workers, the tax credit phases out at an average wage of $25,000.[41]

Two years later: The number of firms that used the tax credit was far lower than expected.[42] "The volume of claims for the Credit has been low despite IRS efforts to inform 4.4 million taxpayers who could potentially qualify for it. According to the IRS, as of mid-May 2011, just more than 228,000 taxpayers had claimed the Credit for a total amount of more than $278 million."[43] At the time of passage, the Congressional Budget Office (CBO) and the Joint Committee on Taxation warned that

> 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

37. 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 8, 2012).
38. Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services, April 22, 2010, at *https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf* (March 8, 2012).
39. Center for Consumer Information and Insurance Oversight, "Covering People With Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program," February 23, 2012, at *http://cciio.cms.gov/resources/files/Files2/02242012/pcip-annual-report.pdf* (March 14, 2012).
40. *Ibid.*
41. 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 8, 2012).
42. Catherine Clifford, "Health Care Tax Credits: Many Left Wanting," CNN Money, September 28, 2011, at *http://money.cnn.com/2011/09/28/smallbusiness/health_care_tax_credit/index.htm* (March 8, 2012).
43. News release, "The Number of Claims for the Small Business Health Care Tax Credit Was Much Lower than Anticipated," Treasury Inspector General for Tax Administration, November 7, 2011, at *http://www.treasury.gov/tigta/press/press_tigta-2011-78.htm* (March 8, 2012).

> percent lower, on average, compared with that cost under current law.[44]

In its FY 2013 budget, the Administration proposes an additional $14 billion over the next 10 years to expand the number of small business that would be eligible for the tax credit.[45] The result could be yet another provision of the health care law that will cost taxpayers more than they were originally told.

HSA and FSA Restrictions

Obamacare limits the benefit of health savings accounts (HSAs) and flexible spending accounts (FSAs). As of January 2011, 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 increases the penalty for making non-qualified purchases with an HSA to 20 percent, and starting in 2013 FSA annual contributions are limited to up to $2,500 year.

Approximately 11 million people have HSAs,[46] and approximately 30 million have FSAs.[47] 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.[48]

Two years later: As expected, the ban on over-the-counter medications went into effect. While the impact is unclear, a 2011 Nielsen Homescan survey found 52 percent of FSA holders used their tax benefits in 2010 to purchase OTC medications. The survey also suggests that many will now request a prescription for OTC drugs or will ask about prescription medications to replace OTC drugs.[49] *The Wall Street Journal* has reported that the restrictions on HSAs and FSAs are increasing burdens on doctors and pharmacies, who must now write and process these prescriptions for everyday products.[50] The increased penalty for non-qualified withdrawals from HSAs has also gone into effect as planned. Next to come are the limitations on FSA contributions in 2013.

Medicare Advantage Cuts and Medicare Part D Beneficiary Drug Rebate

Obamacare cuts payments to seniors' private health plans under the Medicare Advantage (MA) program. The PPACA freezes payments for 2011 at 2010 levels, and beginning in 2012, payments are gradually reduced each year to directly reflect per-beneficiary spending in traditional Medicare fee-for-service.[51] The cuts will be fully phased in by 2017.

Once the cuts are fully phased in, plan payments will be $1,800 less, on average, than under current law.[52] The range of consequences of such a change include higher premiums, fewer benefits, and less choice for MA plan enrollees. According to the Medicare Actuary,

> The new provisions will generally reduce MA rebates to plans and thereby result in less generous

44. Douglas W. Elmendorf, Congressional Budget Office, letter to Senator Evan Bayh (D–IN), "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009, p. 5, at *http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf* (March 8, 2012).
45. News release, "Administration's FY2013 Budget Proposes Tax Policy to Boost Growth, Create Jobs and Improve Opportunity for Middle Class," U.S. Department of the Treasury, February 13, 2012, at *http://www.treasury.gov/press-center/press-releases/Pages/tg1414.aspx* (March 14, 2012).
46. "January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)," America's Health Insurance Plans Center for Health Policy and Research, and News release, "Administration's FY2013 Budget Proposes Tax Policy to Boost Growth, Create Jobs and Improve Opportunity for Middle Class."
47. Jordon Rau, "FSAs Could End Up On Chopping Block in Hunt for Health Overhaul Money," Kaiser Health News, June 12, 2009, at *http://www.kaiserhealthnews.org/Stories/2009/June/12/FSA.aspx* (March 8, 2012).
48. 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.
49. 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 8, 2012).
50. Janet Adamy, "In Health Law, Rx for Trouble," *The Wall Street Journal*, March 9, 2011, at *http://online.wsj.com/article/SB10001424052748704629045761665541 1 0739560.html* (March 8, 2012).
51. James C. Capretta, "Obamacare and Medicare Advantage Cuts: Undermining Seniors' Coverage Options," Heritage Foundation *WebMemo* No. 3113, January 20, 2011, at *http://www.heritage.org/research/reports/2011/01/obamacare-and-medicare-advantage-cuts-undermining-seniors-coverage-options*.
52. This estimate represents the impact of the cuts to MA plan payments alone; when combined with other changes in the law to Medicare, the net effect on payments to MA plans will be a reduction of $3,700. See Robert A. Book and James C. Capretta, "Reductions in Medicare Advantage Payments: The Impact on Seniors by Region," Heritage Foundation *Backgrounder* No. 2464, September 14, 2010, at *http://www.heritage.org/Research/Reports/2010/09/Reductions-in-Medicare-Advantage-Payments-The-Impact-on-Seniors-by-Region*.

benefit packages. We estimate that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent.[53]

Within Medicare Advantage, Obamacare also introduced bonus payments for plans that receive a four-star or five-star ranking on certain quality measures. High-performing plans receive a 1.5 percent increase in their benchmark payment in 2012, which increases to 5 percent by 2014.

Other enacted changes to Medicare include a $250 rebate to beneficiaries who fell into the Part D coverage gap (the "doughnut hole") in 2010. After paying an annual deductible of $320, seniors enrolled in Medicare Part D (the prescription drug benefit) pay 25 percent of the cost of their prescription drugs until the total bill reaches $2,930. Above $2,930, enrollees pay the full cost of their prescription drug bill until total out-of-pocket spending reaches $4,700. After 2010, seniors receive a drug discount—50 percent discount on brand-name drugs and 14 percent on generic drugs—until they spend an additional $3,727.50.[54] At that point, catastrophic coverage kicks in and enrollees pay 5 percent of the remainder of the bill for the rest of the year. The National Council on Aging estimates that about 4 million people fall into the doughnut hole each year.[55]

Two years later: The Administration delayed the dramatic impact to Medicare Advantage plans until 2014. Rather than implement the new payment system for MA plans as indicated by statute, the Centers for Medicare and Medicaid Services "used its broad authority to create and fund demonstration projects" to set up an alternate method for awarding quality bonuses that includes bonuses for plans that receive an average rating.[56] Under the Medicare Advantage Quality Bonus Payment Demonstration project, bonuses of 3 percent and above are available for plans ranked with three or more stars until 2014, using $6.7 billion in funding provided by the PPACA for demonstration projects. As a result, hundreds of MA plans, and most insurers who participate in the program, received bonus payments, offsetting the impact of the payment reductions and delaying the real effects of the law until 2014.

Meanwhile, HHS estimates that only 3.6 million of the more than 46 million seniors on Medicare benefited from the Medicare prescription drug discounts in 2011.[57]

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.

Two years later: Only Connecticut, Minnesota, and the District of Columbia have taken advantage of this provision to increase Medicaid coverage to childless adults whose income falls below 138 percent of the poverty level.[58] A few other states appear to be using the traditional Medicaid waiver option to expand coverage ahead of the 2014 deadline.[59]

However, regardless of current state action, the 2014 requirement mandating that all states expand coverage to this population will have a significant negative impact on the states. The expansion is expected to add approximately 16 million more people to Medicaid, increasing the

53. Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services Office of the Actuary, April 22, 2010, p. 11, at *http://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf* (March 14, 2012).
54. "The Medicare Prescription Drug Benefit," Kaiser Family Foundation *Fact Sheet*, November 2011, at *http://www.kff.org/medicare/upload/7044-12.pdf* (March 14, 2011).
55. James Firman, "Beyond Health Reform: Opportunities for the Aging Network in the Affordable Care Act," *Innovations*, No. 2 (Summer 2010), at *http://www.ncoa.org/assets/files/pdf/100728_Innovations_Summer-2010_R6-FR.pdf* (March 8, 2012).
56. Health Affairs, "Medicare Advantage Plans," *Health Policy Brief*, June 15, 2011, at *http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_48.pdf* (March 14, 2012).
57. "3.6 Million in Medicare Saved More than $2.1 Billion on Prescription Drugs in the Donut Hole in 2011," Centers for Medicare and Medicaid Services *Fact Sheet*, February 2, 2012, at *http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4257&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=donut+hole&keywordType=All&chkNewsType=6&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date* (March 8, 2012).
58. Robin Rudowitz, "On the Road to 2014: Medicaid and CHIP Eligibility and Enrollment Conference," Kaiser Commission for Medicaid and the Uninsured, presentation, September 8, 2011, p. 5, at *http://www.medicaid.gov/State-Resource-Center/downloads/CoverageofLow-IncomeAdultsUnderHealthReformLessonsfromStateExperience_508.pdf* (March 8, 2012).
59. *Ibid.*, presentation notes CA, NJ, WA, and DC.

total number of people on Medicaid to 95 million by 2022.[60] States like Nevada and Oregon will see a Medicaid enrollment increase of more than 60 percent by 2019.[61]

CLASS Act

The Patient Protection and Affordable Care Act created a new entitlement program, the Community Living Assistance Services and Support (CLASS) program, to provide assistance for individuals who have difficulty with activities of daily living and need long-term care (LTC) services. CLASS is a voluntary, government-run LTC insurance program designed to offer participants a single benefit plan with a daily cash benefit of $50, indexed to inflation. Beneficiaries would use the money to purchase *nonmedical* services to use either at home or at a facility. No limit is placed on the length of time that a person could receive benefits through CLASS. In addition, the law requires the Secretary of HHS to certify that the new entitlement program is actuarially sound for a 75-year budget window.

Even before the health care law was enacted, experts signaled warnings related to this new long-term care entitlement. In January 2010, the American Academy of Actuaries stated,

> [G]iven the way the [CLASS] program is structured, severe adverse selection would result in very high premiums that are likely to be unaffordable for much of the intended population, threatening the viability of the program.... [T]axpayer funding and/or benefit reductions may be required.[62]

More recently, President Obama's Deficit Commission recommended revamping or repealing CLASS, stating:

> The program's earliest beneficiaries will pay modest premiums for only a few years and receive benefits many times larger, so that sustaining the system over time will require increasing premiums and reducing benefits to the point that the program is neither appealing to potential customers nor able to accomplish its stated function. Absent reform, the program is therefore likely to require large general revenue transfers or else collapse under its own weight.[63]

Former Heritage analyst Brian Riedl and Heritage visiting fellow Jim Capretta noted that the CLASS program was likely added to Obamacare as a way to cover up the true cost of the health care law.[64] The CBO 10-year score of the health law included the five years when the CLASS program would collect premiums but not yet be paying out benefits. Therefore, the score did not represent the true cost of the program. The cost projection for the health care law thus benefited from the illusion of a $70 billion surplus in its first 10-year score between 2010 and 2020.[65]

Two years later: On February 1, 2012, the House of Representatives voted 267 (including 28 Democrats) to 159 to repeal the troubled CLASS program, and it now awaits consideration by the U.S. Senate.[66] The repeal vote came on the heels of the Secretary of HHS's announcement to Congress in October 2011 that HHS would stop implementation of the program due to its inability to verify that the program would be

60. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2012 and 2022*, January 2012, p. 57, at *http://cbo.gov/sites/default/files/cbofiles/attachments/01-31-2012_Outlook.pdf* (March 8, 2012).
61. "Medicaid Expansion to 133% of Federal Poverty Level (FPL): Estimated Increase in Enrollment and Spending Relative to Baseline by 2019," Kaiser Foundation *State Health Facts*, at *http://www.statehealthfacts.org/comparereport.jsp?rep=68&cat=4* (March 8, 2012). For related estimates, see Edmund Haislmaier and Brian Blase, "Obamacare: Impact on States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010, at *http://www.heritage.org/research/reports/2010/07/obamacare-impact-on-states*.
62. Alfred A. Bingham Jr., "Patient Protection and Affordable Care Act (H.R. 3590) and Affordable Health Care for America Act (H.R. 3962)," American Academy of Actuaries, January 14, 2010, p. 19, at *http://www.ltcconsultants.com/articles/2010/classactconcern/AAALetterReHealthCareReformJan14.pdf* (March 8, 2012). For further discussion, see Brian Blase and John Hoff, "Secretary Sebelius Cannot Fix CLASS," Heritage Foundation *WebMemo* No. 3193, March 16, 2011, at *http://www.heritage.org/research/reports/2011/03/secretary-sebelius-cannot-fix-class-program*.
63. National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," December 2010, at *http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf* (March 8, 2012).
64. James C. Capretta and Brian M. Riedl, "The CLASS Act: Repeal Now, or Face Permanent Taxpayer Bailout Later," Heritage Foundation *Backgrounder* No. 2441, July 22, 2010, at *http://www.heritage.org/research/reports/2010/07/the-class-act-repeal-now-or-face-permanent-taxpayer-bailout-later*.
65. *Ibid.*
66. U.S House of Representatives, "Final Vote Results for Roll Call 18," February 1, 2012, at *http://clerk.house.gov/evs/2012/roll018.xml* (March 8, 2012).

actuarially sound and financially solvent for 75 years as required by law.[67]

State Exchanges

A critical feature of Obamacare is the new federal subsidy and the Affordable Health Benefit Exchanges. These exchanges are intended to facilitate the purchase of "qualified" health insurance, and are the only place to obtain coverage with the new federal subsidy. The plans in the exchanges will reflect the to-be-determined essential health benefits and are to be ranked by actuarial value (bronze, silver, gold). The exchanges can be set up by the states, and the law puts in place a series of grant opportunities aimed at assisting states in setting up the exchanges. However, the law also requires a federal default for those states that do not set up an exchange.

Two years later: HHS has awarded millions of dollars in exchange grants. The Early Innovator grants totaling $240 million went to six states and a multistate health consortium.[68] Three of the six states—Kansas, Oklahoma, and Wisconsin—returned their grants (totaling $123 million). The Planning grants were awarded to 49 states and the District of Columbia for up to $1 million each, but Florida, Louisiana, and New Hampshire returned their grants.[69] Finally, HHS has awarded 34 Establishment grants to states (including the District of Columbia) that are "making significant progress in creating Affordable Insurance Exchanges."[70]

However, as Ed Haislmaier has noted, states should resist these grants:

> The combined effect of these regulations and grant requirements are that a state would have to agree to surrender any last vestiges of meaningful control over how Obamacare is implemented. Thus, a state would now have no more real control over an exchange it set up than over one HHS established.[71]

Two states—Arkansas and Louisiana—have explicitly decided not to create an exchange. Twelve states have had no significant activity on exchanges, 20 states are studying policy options, three states have indicated intent to establish exchanges, and 14 states have established exchanges.[72] As previously noted, many states are taking a wait-and-see approach due to the upcoming Supreme Court case. Furthermore, states continue to be frustrated with the lack of clarity about exchanges, even with new HHS regulations.[73]

The President's FY 2013 budget does include an additional $860 million for federal exchange implementation—which shows that trying to set up these government mechanisms is far more costly than originally claimed.[74]

Dependent Coverage Up to 26 Years

Under Obamacare, group health plans and insurers that provide dependent coverage are required to extend coverage for enrollees up to age 26. This requirement went into effect September 20, 2010, with the real impact occurring in January 2011 when the new plan year started for most.

Nearly two years later: The results are mixed. The Administration continues to promote the change as one of the important policy achievements of the health care law, but the impact touted by the White House is most

67. The Honorable Kathleen Sebelius, U.S. Department of Health and Human Services, letter to the Speaker of the U.S. House of Representatives, October 14, 2011, at *http://www.hhs.gov/secretary/letter10142011.html* (March 8, 2012).
68. "Early Innovator Grants to Develop the Information Technology Infrastructure Health Insurance Exchanges, 2011," Kaiser Family Foundation *State Health Facts*, at *http://www.statehealthfacts.org/comparetable.jsp?ind=915&cat=17* (March 8, 2012).
69. Alaska did not apply. "Exchange Planning Grant Awards as of August 9, 2011," Kaiser Family Foundation *State Health Facts*, at *http://www.statehealthfacts.org/comparereport.jsp?rep=89&cat=17* (March 8, 2012).
70. News release, "HHS Announces New Assistance to States: More Resources, Transparency, and Flexibility," Centers for Medicare and Medicaid Services, February 22, 2012, at *http://www.cms.gov/apps/media/press/release.asp?Counter=4283* (March 8, 2012).
71. Edmund Haislmaier, "States Must Return Obamacare Grants, Pursue Own Health Care Reforms," September 28, 2011, Heritage Foundation *The Foundry*, at *http://blog.heritage.org/2011/09/28/states-must-return-obamacare-grants-pursue-own-health-care-reforms/*.
72. "State Action Toward Creating Health Insurance Exchanges, as of March 1, 2012," Kaiser Family Foundation *State Health Facts*, at *http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17* (March 8, 2012).
73. Republican Governors Association, "RGA Statement on New Health Insurance Exchange Regulations," at *http://www.rga.org/homepage/rga-statement-on-new-health-insurance-exchange-regulations/* (March 14, 2012).
74. U.S. Department of Health and Human Services, "Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans," p. 85, at *http://www.hhs.gov/budget/budget-brief-fy2013.pdf* (March 14, 2012).

likely exaggerated.[75] Moreover, as with most of the PPACA, the policy addition is not without unintended consequences. Based on still-limited data, Paul Fronstin of the Employee Benefit Research Institute concludes there has been an increase in dependent coverage, but he also points out that "the increase in employment-based coverage as a dependent could be the result of individuals losing coverage through work and thus moving from employment-based coverage in their own name to employment-based coverage as a dependent, which was observed for persons ages 19–25."[76]

Obamacare "Benefits" Too Costly to Continue

America urgently needs to reform its health care system, as increasing health care spending is consuming ever-larger shares of household and government budgets. Obamacare falls short of genuine reform because its alleged benefits increase not only government spending, but also the cost of private health insurance—on the backs of taxpayers.

Congress should repeal Obamacare. Only then can Congress begin to focus on patient-centered, market-based reforms and sensible changes in health care entitlement programs that empower patients, reduce costs, and ensure access to quality health care.[77]

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75. Kathryn Nix, "Decrease in Young Uninsured: Does Obamacare Deserve Credit?" Heritage Foundation *The Foundry*, December 15, 2011, at *http://blog.heritage.org/2011/12/15/decrease-in-young-uninsured-does-obamacare-deserve-credit/*.
76. Paul Fronstin, "The Impact of PPACA on Employment-Based Health Coverage of Adult Children to Age 26," Employee Benefit Research Institute *Notes* Vol. 33, No. 1, January 2012, at *http://ebri.org/pdf/notespdf/EBRI_Notes_01_Jan-12.PPACA-SpndDwn.pdf* (March 8, 2012).
77. Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, eds., *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, The Heritage Foundation, 2011, at *http://www.heritage.org/research/reports/2011/05/saving-the-american-dream-the-heritage-plan-to-fix-the-debt-cut-spending-and-restore-prosperity.*