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BACKGROUNDER

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Chronic Conditions: Obamacare's Market Malfunctions, 2014–2018

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Abstract

The Affordable Care Act of 2010 (also known as Obamacare) is a cluster of broken promises and persistent problems. Its supporters promised Americans that Obamacare would improve the performance of the American health care system. Today, many of President Obama's high-profile promises seem outlandish: that Americans who liked their health plans and doctors would be able to keep them, that the American middle class would escape additional taxation, and that the law would not be a government takeover of health care. The thickening cluster of Obamacare's major problems—from the rise in health insurance costs to the multiple dysfunctions that plague those who enroll in the individual and small-group markets—are largely the result of a pattern of persistent policy failures. Under Obamacare's complex array of rules, regulations, and administrative guidelines, the federal government spends the money, sets the rules, and controls the individual and small-group markets—to the detriment of the American public.

> It [the Affordable Care Act] will provide more security and stability to those who have health insurance. It will provide insurance for those who don't. And it will slow the growth of health care costs for our families, our businesses, and our government.
>
> *—President Barack Obama, Address to Congress, September 9, 2009*

The Affordable Care Act of 2010—commonly known as "Obamacare"—is a cluster of broken promises and persistent problems. Its supporters promised the American people that the 2010 enact-

Key Points

- Since 2014, middle-class Americans have experienced rapidly rising insurance costs, coverage disruptions, declining access to doctors, erosion of choice, a resurgent rise in health care costs, and higher taxes. Obamacare's multiple problems are chronic, not episodic.
- Faced with Obamacare's persistent problems, policymakers who supported Obamacare are now attempting to shift blame for the results of their own handiwork to President Trump.
- The Health Care Choices Proposal, developed by conservative policy analysts, is a promising framework for expanding choice and lowering consumer costs.
- The proposal would replace the Obamacare spending scheme with block grants to the states and provide states new flexibility to restore their broken private markets.
- The proposal would allow much greater choice of private coverage options, and would also allow persons enrolled in public programs to use that public funding for the private health plans of their choice.

This paper, in its entirety, can be found at **http://report.heritage.org/bg3344**

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ment of President Barack Obama's health reform agenda would improve the performance of the American health care system in general, and the functioning of the health insurance markets in particular.

Today, many of President Obama's high-profile promises seem outlandish: that Americans who liked their health plans would be able to keep their health plans,[1] that the law would not compromise patients' relationship with their doctors,[2] that the American middle class would escape any additional taxation, that American taxpayers would not be coerced into financing abortion,[3] and that the law would not be a government takeover of health care, even though it engineers detailed federal control over every key facet of health coverage.[4]

The thickening cluster of Obamacare's major problems—from the rise in health insurance costs to the multiple dysfunctions that plague persons who enroll in the individual and small-group markets—are largely the result of a pattern of persistent policy failures.[5] These problems surfaced almost immediately with Obamacare's full implementation in 2014, and were baked into the design of the law itself.[6] The law's most significant change was the federal government's takeover, centralization, and expansion of its involvement in America's health markets. The law expanded Medicaid eligibility and created a new entitlement in which spending rose dollar for dollar with every price increase by insurers. It also imposed unprecedented mandates and penalties on individuals, employers, and health plans, while enforcing new reporting and compliance requirements on providers. Under Obamacare's complex array of rules, regulations, and administrative guidelines, the federal government spends the money, sets the rules, and controls the individual and small-group markets.

Four-Year Pattern of Negative Results. Consider the unhappy experience over the past four years: A radical reduction or elimination of consumers' health plan choices; the virtual collapse of health plan choice and competition in most of the counties of the nation; the continuation of skyrocketing premium increases and soaring deductibles; a steady decline in patient access to physicians and specialists in narrowing health plan networks; a general resurgence of health care and entitlement costs; and, despite President Obama's promises to the contrary, increased middle-class taxation. These problems were all foreseen and avoidable with a different approach to health reform. From the very beginning, independent analysts correctly predicted negative results, particularly problems of cost and coverage, and the loss of personal and economic freedom.[7]

Shifting Blame. Faced with these problems, policymakers who sponsored, voted for, or supported the health law are attempting to shift blame for the

1. "Nothing in our plan requires you to change what you have." Barack Obama, Address to Congress, "Transcript: Obama's Health Care Speech," CBS News, September 9, 2009, https://www.cbsnews.com/news/transcript-obamas-health-care-speech/ (accessed August 9, 2018).
2. PolitiFact, "Obama: 'If You Like Your Health Care Plan, You'll Be Able to Keep Your Health Care Plan,'" http://www.politifact.com/obama-like-health-care-keep/ (accessed August 9, 2018). PolitiFact reports that President Obama or his Administration officials claimed that persons could keep their plans or doctors a total of 37 times.
3. "There are no plans under health reform to revoke the existing prohibition on using federal taxpayer dollars for abortions." President Barack Obama remarks to Organizing for America National Health Care Forum, DNC Headquarters, Washington, DC, August 20, 2009, C-SPAN video, https://www.c-span.org/video/?c1376856/clip-presidential-remarks-organizing-america-forum (accessed August 10, 2018). In fact, under Section 1303 of the ACA, the law allows federal taxpayer money to go to health plans that fund abortion, a dramatic break from previous law.
4. "The law has never been a government takeover of health care despite cries to the contrary." See Melanie Arter, "Obama: 'This Has Never Been a Government Takeover of Health Care,'" CNS News, June 25, 2015, https://www.cnsnews.com/news/article/melanie-hunter/obama-has-never-been-government-takeover-health-care (accessed August 10, 2018).
5. "Intoxicated by their own ideas, the architects argued that regulations that (allegedly) worked in Massachusetts would work in Mississippi and Montana. That has proved false." "Should States Allow Insurers to Offer Bare Bones Health Plans with Fewer Mandated Benefits?" *The Wall Street Journal*, June 24, 2018, https://www.wsj.com/articles/should-states-allow-insurers-to-offer-bare-bones-health-plans-with-fewer-mandated-benefits-1529892240 (accessed August 13, 2018).
6. For an account of the law's problems, year by year, see Robert E. Moffit, "Year Six of the Affordable Care Act: Obamacare's Mounting Problems," Heritage Foundation *Backgrounder* No. 3109, April 1, 2016, https://www.heritage.org/health-care-reform/report/year-six-the-affordable-care-act-obamacares-mounting-problems. See also Robert E. Moffit, "Four Years of Obamacare: Early Warnings Come True," Heritage Foundation *Backgrounder* No. 2907, April 28, 2014, https://www.heritage.org/health-care-reform/report/four-years-obamacare-early-warnings-come-true.
7. See, for example, Grace Marie Turner, James Capretta, Thomas Miller, and Robert Moffit, *Why Obamacare Is Wrong for America* (New York: Harper Collins, 2011), and Josh Blackman, *Unraveled: Obamacare, Religious Liberty, and Executive Power* (New York: Cambridge University Press, 2016).

results of their own handiwork to President Donald Trump. Meanwhile, the President is taking administrative steps to provide Americans relief from the law's painful consequences, namely high insurance costs and sharply reduced health plan choices.

Since 2014, the first year of the law's full implementation, exchange insurance costs have been climbing relentlessly. And, as researchers for Avalere, a prominent Washington-based research firm, observe, "Exchange enrollment lagged behind projections well before Trump took office."[8]

President Trump's 2017 regulatory changes have had only a limited impact on costs in 2018 and 2019.[9] His major administrative proposals—the expansion of association health plans, short-term plans, and health-reimbursement accounts—all announced in 2017, have not yet been fully implemented. If implemented, in all three cases, those major proposals would have only a limited impact on exchange premiums,[10] but they would expand consumer options and lower costs for millions of Americans.[11] Moreover, President Trump's tax and regulatory reform agenda is stimulating economic growth and increasing employment, with the predictable result of expanding employer-sponsored health coverage. In 2018, private employers offered health benefits to 69 percent of employees, compared to 67 percent in 2017, the first percentage increase since 2012.[12]

A New Direction. Executive actions, though important, are limited; and they are no substitute for the major course correction achievable through serious legislation. Members of Congress must return to the urgent and difficult task of health reform, and liberate Americans from this unacceptable status quo.

Members of Congress must return to the urgent and difficult task of health reform, and liberate Americans from the unacceptable status quo.

Health insurance markets are consolidating at a rapid pace, reducing competition and increasing costs.[13] The Health Care Choices Proposal, developed by conservative policy analysts, is a promising framework for improving choice and lowering consumer costs. The proposal would be a serious down payment on comprehensive reform.[14] Among many other items,

8. Caroline F. Pearson, Elizabeth Carpenter, and Chris Sloan, "Uncertainty Reigns as Consumers Begin to Make Health Insurance Decisions for 2018," Avalere, October 25, 2017, http://avalere.com/expertise/managed-care/insights/uncertainty-reigns-as-consumers-begin-to-make-health-insurance-decisions-fo (accessed August 13, 2018).
9. In fact, for 2019, it appears that premium cost growth will slow down: "Health insurers are proposing relatively modest premium bumps for next year, despite doomsday predictions from Democrats that the Trump administration's changes to ObamaCare would bring massive increases in 2019." Jessie Hellman, "Modest Premium Increases Hurt Democrats' Midterm Messaging," *The Hill*, July 26, 2018, http://thehill.com/policy/healthcare/398912-modest-premium-increases-hurt-democrats-midterm-messaging (accessed August 15, 2018).
10. The Congressional Budget Office estimates that introducing association health plans and short-term plans would increase exchange premiums between 2 percent and 3 percent. See Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 23, 2018, p. 11, https://www.cbo.gov/publication/53826 (accessed August 23, 2018).
11. For example, providing consumers the opportunity to enroll in short-term, limited-duration health plans would enable them to pay premiums that range between 50 percent and 80 percent less than Obamacare plans. See Alex M. Azar II, "Obamacare Forgot About You. But Trump Didn't," *The Washington Post*, August 15, 2018, https://www.washingtonpost.com/opinions/trump-wants-to-help-the-forgotten-people-hurt-by-obamacare-heres-how/2018/08/15/d4609aaa-9ff6-11e8-b562-1db4209bd992_story.html?noredirect=on&utm_term=.dff5bf09a1fc (accessed August 21, 2018).
12. See James Freeman, "TrumpCare Beats ObamaCare: An Encouraging Expansion in Private Insurance Coverage," *The Wall Street Journal*, July 23, 2018, https://www.wsj.com/articles/trumpcare-beats-obamacare-1532370778 (accessed August 13, 2018).
13. "Many markets are now dominated by one or a small number of powerful health systems or health insurers (in some cases both), with more on the way. A firm that dominates a market and faces little competition doesn't have to lower prices or costs, push for better quality, or focus on innovation." Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg, "Making Health Care Markets Work: Competition Policy for Health Care," Brookings Institution, April 13, 2017, p. 1, https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/ (accessed August 13, 2018).
14. Health Policy Consensus Group, "The Health Care Choices Proposal: Policy Recommendations to Congress," Medium, June 19, 2018, https://medium.com/@consensusgroup2018/the-health-care-choices-proposal-policy-recommendations-to-congress-a4660182d830 (accessed August 13, 2018). See Also Edmund F. Haislmaier, Robert E. Moffit, and Nina Owcharenko Schaefer, "The Health Choices Proposal: Charting a New Path to a Down Payment on Patient-Centered, Consumer-Driven Health Reform," Heritage Foundation *Backgrounder* No. 3330, July 11, 2018, https://www.heritage.org/health-care-reform/report/the-health-care-choices-proposal-charting-new-path-down-payment-patient.

the proposal would restore most insurance regulation to the states; replace the Obamacare spending scheme with block grants to the states that help the nation's more vulnerable—the sick and low-income—access private coverage. Notably, the proposal would also dramatically expand personal choice by allowing persons enrolled in public programs to redirect funding that currently goes to public coverage to a private health plan of their choice.

Chronic Market Malfunctions: 2014–2018

The record is grim. Over the past four years, middle-class Americans have experienced rapidly rising insurance costs, coverage disruptions, declining access to doctors, the erosion of choice and competition, stagnating and declining enrollment, a resurgent rise in health costs, higher taxes, and programmatic failure. Obamacare's multiple problems are chronic, not episodic. Consider the facts:

#1: Rising Insurance Costs. President Obama repeatedly said that the "typical" American family would experience an annual decline in health care costs of an estimated $2,500.[15] One of President Obama's leading academic allies, Professor Jonathan Gruber of MIT, an "architect" of Obamacare, declared: "What we know for sure is that the bill will lower the cost of buying non-group health insurance."[16]

This promise was implausible from the beginning. As early as 2009, well before the law's final enactment, the Congressional Budget Office (CBO) estimated that premiums in the individual markets would increase between 10 percent and 13 percent.[17] While the law's new taxes on such major items as health insurance, drugs, and medical devices alone guaranteed higher health insurance premiums, the federal regulatory architecture emerged as a major contributor to higher health care costs. Specifically, four major federal regulations aggravate the adverse selection and high costs that characterize the Obamacare insurance markets: The requirement of a single risk pool in state markets; the insurance age-rating restrictions; the insurance benefit mandates; and the federal actuarial value requirements.[18]

Cost Drivers. In reviewing actuarial studies in the professional literature, Heritage Foundation analysts estimate that the age-rating rule increases insurance premiums by about one-third for young persons enrolled in the individual markets, while the federally mandated benefits generate additional premium costs anywhere from 3 percent to 17 percent, depending on the state markets. The law also determines the permissible actuarial value of health insurance plans, meaning the percentage of total average costs for the benefits that the plan must cover. Obamacare's actuarial value requirement—preventing any insurer from offering a health plan with an actuarial value less than 60 percent—increases the cost of health plans between 5.3 percent and 8.5 percent, depending on the state market. The law's requirement for a single state-market-risk pool, where younger and healthier enrollees are included with older and sicker enrollees in a common individual-market pool, accounts for the largest share of additional premium increases, with the amount of these additional premium increases dependent on the varying demographic conditions of the state health insurance markets.[19]

Rising Premiums. With the law's full implementation in 2014, persons in the individual and small-group health insurance markets—those most heavily regulated by the law—experienced an explosion in their premium costs. In 2014, individual market premiums for 27-year-olds more than doubled in 11 states, while premiums for persons at age 50 increased by more than 50 percent in 13 states.[20] Taxpayers, by fund-

15. J. B. Wogan, "Updates: No Cut in Premiums for Typical Family," PolitiFact, August 31, 2012, https://www.politifact.com/truth-o-meter/promises/obameter/promise/521/cut-cost-typical-familys-health-insurance-premium-/ (accessed August 13, 2018).
16. Cited in Avik Roy, "How Obamacare Dramatically Increases the Cost of Insurance for Young Workers," *Forbes*, March 22, 2012, https://www.forbes.com/sites/theapothecary/2012/03/22/how-obamacare-dramatically-increases-the-cost-of-insurance-for-young-workers/#4d0aa99b7e46 (accessed August 13, 2018).
17. Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009, https://www.cbo.gov/publication/41792 (accessed August 13, 2018).
18. Edmund F. Haislmaier and Doug Badger, "How Obamacare Raised Premiums," Heritage Foundation *Backgrounder* No. 3291, March 5, 2018, https://www.heritage.org/health-care-reform/report/how-obamacare-raised-premiums.
19. Ibid.
20. Drew Gonshorowski, "How Will You Fare in the Health Insurance Exchanges?" Heritage Foundation *Issue Brief* No. 4068, October 16, 2013, http://thf_media.s3.amazonaws.com/2013/pdf/ib4068.pdf.

ing subsidies, absorbed the bulk of these rate shocks on behalf of the vast majority of those enrolled in the health insurance exchanges. The steep cost increases, year by year, were borne directly by persons ineligible for generous taxpayer subsidies.[21]

In 2015, enrollees in the individual and small-group markets did not experience the same rate shock that hit them in 2014, but the premiums kept rising, well above the rate of inflation or the growth in the economy.[22] From 2013 to 2017, premiums increased by 105 percent, according to the government's own analysis.[23]

In 2018, enrollees in the standard (Silver) health plans of the Obamacare exchanges experienced an average 34 percent increase,[24] and deductibles increased substantially. In fact, soaring deductibles have also been a persistent pattern of exchange coverage. In 2014, the Silver average exchange deductible for single coverage was $2,907, but by 2018, it had reached $4,033. For family coverage, the average deductible was $6,078 in 2014, but by 2018, it had climbed to $8,292. For Bronze coverage, of course, the deductibles were much higher in 2018: $5,777 for single and $11,555 for family coverage.[25] Remarkably, Obamacare's cost sharing in the individual markets is so high that it exceeds levels allowable under current law for insurance plans with health savings accounts.[26]

For 2019, the CBO projects an average 15 percent premium hike. If that increase should happen, it would nonetheless be a significant slowdown from the current rate increases.[27] Likewise, private insurers in eight states are already projecting average premium increases below 10 percent.[28] Even if such a projected slowdown should occur, Congress must recognize that the underlying cost drivers embodied in the law would remain, continuing to undermine the efficiency of the nation's severely damaged individual health insurance markets.

#2: Continuing Coverage Disruptions. In his 2009 address to Congress, President Obama declared: "Nothing in our plan requires you to change what you have."[29] In fact, the President's promise was impossible to keep: The mandates, regulations, and economic incentives hardwired into the law required millions of Americans to change or lose their coverage, regardless of their personal wants or needs. At the time, government actuaries[30] predicted losses in coverage among persons enrolled in both the individual and group markets.

In 2014, the first full year of the implementation of the national health law, millions of Americans lost their previous coverage—with loss estimates ranging from the Urban Institute's 2.6 million to the Associated Press's 4.7 million—in the initial coverage disruption.[31] Likewise, the small-group health insurance market, serving small businesses and their workers, was also negatively impacted. While the number of small firms offering health insurance had been declin-

21. "Roughly 5 million Americans, as of 2017, have chosen to pay those premiums without any subsidies, while 28 million other Americans remain uninsured, many priced out of coverage entirely." Azar, "Obamacare Forgot About You. But Trump Didn't."
22. Drew Gonshorowski, "2015 ACA Exchange Premiums Update: Premiums Still Rising," Heritage Foundation *Issue Brief* No. 4366, March 20, 2015, http://thf_media.s3.amazonaws.com/2015/pdf/IB4366.pdf.
23. U.S. Department of Health and Human Services, "Individual Market Premium Changes: 2013–2017," ASPE Data Point, May 23, 2017, https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf (accessed August 13, 2018).
24. Caroline F. Pearson and Chris Sloan, "Silver Exchange Premiums Rise 34 Percent on Average in 2018," Avalere, October 25, 2017, http://avalere.com/expertise/managed-care/insights/silver-exchange-premiums-rise-34-on-average-in-2018 (accessed August 13, 2018).
25. HealthPocket, "Average Market Premiums Spike Across Obamacare Plans in 2018," October 27, 2017, https://www.healthpocket.com/healthcare-research/infostat/2018-obamacare-premiums-deductibles (accessed August 13, 2018).
26. Edmund F. Haislmaier, "Obamacare's Cost Sharing Is Too High, Even for HSAs," Heritage Foundation *Issue Brief* No. 4862, June 1, 2018, https://www.heritage.org/sites/default/files/2018-06/IB4862.pdf.
27. Congressional Budget Office, "Federal Subsidies for Health Insurance for People Under the Age 65: 2018 to 2028."
28. Hellman, "Modest Premium Increases Hurt Democrats' Midterm Messaging."
29. CBS News, "Transcript: Obama's Health Care Speech."
30. See, for example, Richard S. Foster, "Estimates of the Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services, April 22, 2010, p. 7, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf (accessed August 13, 2018).
31. Lori Robertson, "'Millions' Lost Insurance," FactCheck.org, April 11, 2014, https://www.factcheck.org/2014/04/millions-lost-insurance/ (accessed August 13, 2018).

ing since 2008, this trend accelerated after passage of the law—even though it provided a new small business tax credit.[32] There was a 24 percent decline in the number of small firms offering their employees coverage between 2012 and 2016 alone.[33] Given the disruptive dynamics of the law, President Obama's iconic promise—that those who liked their health plans could keep their health plans—was never realistic.[34]

#3: Declining Access to Doctors. President Obama claimed that Americans who liked their doctors could keep their doctors.[35] This, too, was a broken promise. Access to favored physicians or specialists is largely a function of insurance contracts, and insurance networks of physicians and medical specialists in the exchanges have been progressively narrowing. In 2014, CBO analysts noted that the health plans in the individual markets had tighter networks than they had previously anticipated.[36] Problems of access to care among enrollees then started to surface in the media.[37] Nonetheless, the exchange health plans continued to narrow their provider networks. By 2018, 73 percent of Obamacare exchange plans had narrow provider networks,[38] resulting in the exclusion of some highly prized and specialized medical professionals and facilities.

#4: The Erosion of Personal Choice and Competition. Advocates for Obamacare claimed their reforms would enhance competition in the nation's health insurance markets. In his 2009 address to Congress and the nation, the President declared, "My guiding principle is, and always has been, that consumers do better when there's choice and competition. That's how the market works."[39]

Instead, millions of Americans experienced declining choice and competition. From 2013 to 2018, the number of insurers in the individual health insurance markets declined from 395 to 181.[40] At the county level, the decline in patient choice and insurance competition has been consistent and sharp. In 2018, there is just one insurer in 52 percent of the nation's counties.[41] According to Jessica Van Parys, a professor of economics at the City University of New York, there is a particularly strong correlation between the absence of competition and premium increases in these markets: "In 2018 premiums were 50 percent ($180) higher in rating areas with a monopoly insurer, compared to those in areas with more than two insurers."[42]

Today, regardless of their wants or needs, persons enrolled in the individual markets in half of American counties are already saddled with a government-sponsored monopoly in the form of a single, federally regulated and standardized health plan. Millions of Americans,

32. For an excellent overview of the patterns of enrollment among large and small firms, see Paul Fronstin, "Fewer Small Employers Offering Health Coverage; Large Employers Holding Steady," Employee Benefits Research Institute *Notes*, Vol. 37, No. 8 (July 2016), https://www.ebri.org/pdf/notespdf/ebri_notes_07-no8-july16.small-ers.pdf (accessed August 13, 2018).
33. Haislmaier and Badger, "How Obamacare Raised Premiums."
34. Brooks Jackson, "Reality Confronts Obama's False Promise," FactCheck.org, October 29, 2013, https://www.factcheck.org/2013/10/reality-confronts-obamas-false-promise/ (accessed August 13, 2018).
35. "Fact Check: You Can Keep Your Own Doctor," CNN PoliticalTicker blog, September 26, 2013, http://politicalticker.blogs.cnn.com/2013/09/26/fact-check-you-can-keep-your-own-doctor/ (accessed August 13, 2018).
36. Congressional Budget Office, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act," April 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf (accessed August 13, 2018).
37. "In a controversial 2014 decision, a Centene health plan canceled a child patient's emergency brain surgery at Houston's Children's Medical Center. The hospital said its success rate for the surgery was close to 90 percent, while hospitals nationwide averaged only 47 percent. The insurer claimed that hospital was out of its network for the patient's plan, but relented after its decision was criticized in the media." John C. Goodman, "Obamacare Can Be Worse Than Medicaid," *The Wall Street Journal*, June 26, 2018, https://www.wsj.com/articles/obamacare-can-be-worse-than-medicaid-1530052891 (accessed August 13, 2018).
38. John Gregory, "Narrow Network Plans Make Up 73% of ACA Exchange Market," HealthExec, December 1, 2017, https://www.healthexec.com/topics/care-delivery/narrow-network-plans-make-73-aca-exchange-market (accessed August 13, 2018).
39. President Obama, 2009 Speech to Congress.
40. Edmund F. Haislmaier, "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink," Heritage Foundation *Issue Brief* No. 4813, January 25, 2018, https://www.heritage.org/sites/default/files/2018-01/IB4813_1.pdf.
41. Ashlee Semanskee et al., "Insurer Participation on ACA Marketplaces, 2014–2018," Kaiser Family Foundation, November 10, 2017, https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/ (accessed August 13, 2018).
42. Jessica Van Parys, "ACA Marketplace Premiums Grew More Rapidly in Areas with Monopoly Insurers Than in Areas with More Competition," *Health Affairs*, Volume 37, No. 8 (August 2018), p. 1247, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0054 (accessed August 15, 2018).

regardless of their personal preferences, are thus getting a de facto "single payer" system on the installment plan.

Congress also created two Obamacare insurance programs to enhance competition in the exchanges: the consumer-oriented and -operated (co-op) plans and the multi-state plans, special plans sponsored by the federal government to compete against private health plans in the exchanges. Of the 23 original co-op plans, all but four have failed; and the inappropriately named multi-state plans exist today in only one state: Arkansas.

From 2013 to 2018, the number of insurers in the individual health insurance markets declined from 395 to 181.

#5: Stagnating and Declining Enrollment. In 2010, the CBO initially projected that 8 million people would enroll in the exchanges in 2014; 13 million in 2015; 21 million in 2016; 23 million in 2017; and 24 million in 2018.[43]

Despite a rocky rollout of its website, the Obamacare exchanges did meet the initial CBO target and enrolled 8 million in 2014. In 2015, however, Obamacare's exchange enrollment fell short of the CBO target and the program enrolled just 11.7 million. In 2016, the exchanges enrolled 12.7 million, the high point of Obamacare enrollment. In 2017, enrollment fell to 12.2 million; and in 2018, it fell further to 11.8 million, less than half the original CBO projection.[44]

Conditions on the ground, particularly at the county level, got worse. Health plan enrollment is not health plan retention. For example, 11.8 million people signed up for exchange coverage for the 2018 plan year. By March 2018, however, there were just 10.6 million people with coverage in the exchanges.[45] Interestingly enough, the March 2018 enrollment numbers were a slight improvement over the March 2017 enrollment of 10.3 million.[46]

Attrition is a persistent phenomenon. In 2017, for example, when 10.3 million people enrolled, only 8.9 million enrollees stayed in their health plans for the full year.[47] Examining the data, Christopher Conover, health policy specialist at Duke University, notes that Obamacare monthly attrition rates were two-thirds higher than previous attrition rates in the non-group market.[48] According to the Centers for Medicare and Medicaid Services (CMS), "This (attrition) is likely caused by consumers struggling to pay premiums as costs continue to increase."[49]

While millions of middle-class people in the individual and small-group markets face higher health insurance costs, taxpayers subsidize "advanced premium tax credits" (premium subsidies), for persons with an annual income between 100 percent and 400 percent of the federal poverty level. Nationwide in 2018, 87 percent of exchange enrollees received advance premium tax credits; in 2017, 84 percent received premium subsidies.[50] For 2018, nationwide, the *average* monthly premium for single coverage is $597.20, and the *average* premium subsidy

43. Douglas Elmendorf, Director, Congressional Budget Office, Letter to Nancy Pelosi, Speaker of the U.S. House of Representatives, March 20, 2010, Appendix, Table 4, https://books.google.com/books?id=QpUarVy1K5YC&pg=PP1&lpg=PP1&dq=Elmendorf+to+Nancy+Pelosi+CBO+Estimate+HR+3590+March+20,+2010&source=bl&ots=fQ5jQUezk9&sig=BQBbEA1adyvokzEfoyCUlltwDIg&hl=en&sa=X&ved=0ahUKEwjDyffo95ncAhULh-AKHST4DHoQ6AEIOTAC#v=onepage&q=Elmendorf%20to%20Nancy%20Pelosi%20CBO%20Estimate%20HR%203590%20March%2020%2C%202010&f=false (accessed August 13, 2018).

44. News release, "Health Insurance Exchanges 2018 Open Enrollment Period Final Report," Center for Medicare and Medicaid Services, April 3, 2018, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html (accessed August 13, 2018). Meanwhile, over the past four years, the CBO also revised and reduced its anticipated enrollment targets.

45. Centers for Medicare and Medicaid Services, "Early 2018 Effectuated Enrollment Snapshot," July 2, 2018, p. 1, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf (accessed August 13, 2018).

46. CMS, "Early 2018 Effectuated Enrollment Snapshot," p. 1.

47. Ibid.

48. Chris Conover, "Reality Check: Obamacare Greatly Worsened Retention Rates in the Non-Group Market," *Forbes*, May 25, 2018, https://www.forbes.com/sites/theapothecary/2018/05/25/reality-check-obamacare-greatly-worsened-retention-rates-in-the-non-group-market/#744832ca1d61 (accessed August 13, 2018).

49. Centers for Medicare and Medicaid Services, "Early 2018 Enrollment," p. 1.

50. Ibid.

for eligible persons offsetting the premium cost is $519.89.[51] Today, for example, enrollees in Iowa have the highest average monthly premium in the nation at $988.41, offset by an average premium subsidy of $888.24.[52]

Out-of-pocket costs, such as health insurance deductibles, as noted, also affect enrollment and retention. Persons with incomes between 100 percent and 250 percent of the federal poverty level are eligible for cost-sharing subsidies, and in 2018, under current law, insurers are offsetting the out-of-pocket costs of 53 percent of all exchange enrollees.[53]

Enrollment Drop. Between 2016 and 2017, "average monthly enrollment" in the individual markets declined by 10 percent, while the premiums increased by 21 percent.[54] Persons who were ineligible for premium subsidies experienced the biggest decline over that period; their enrollment declined by 20 percent.[55]

High cost also deters enrollment. According to the CMS:

> Of uninsured consumers visiting Federal platform Exchanges in the past year, 63 percent of those who did not purchase a plan indicated high premiums as the primary motivator for the decision not to purchase, which is up from 52 percent from the end of last year's Open Enrollment Period. Among all currently uninsured participants, the primary reason provided for not having health insurance continues to be that they are unable to afford it because it is too expensive (54 percent).[56]

Between 2015 and 2016, 10 states experienced declining enrollment in their individual markets, with the biggest declines among unsubsidized persons. But from 2016 to 2017, 44 states experienced declining enrollment with the biggest declines among unsubsidized persons; in six states, there was a 40 percent decline in unsubsidized enrollment in individual markets.[57] Recent Heritage Foundation research on enrollment in the individual health insurance markets confirms the CMS findings, showing a decline in general enrollment, but among unsubsidized enrollees in particular.[58]

Compounding the persistent cost problem is the demographic imbalance in the exchanges. In 2014, Obama Administration officials expected 40 percent of the enrollees to be between the ages of 18 and 34; in 2014 and in 2015, only 28 percent of the exchange enrollees were in that highly valued age category.[59] As of 2018, only 26 percent are between the ages of 18 and 34; 65 percent are ages 35 and older.[60]

Obamacare's regulatory scheme, as noted, discourages enrollment among the young. As Alex Azar, Secretary of the Department of Health and Human Services, observes,

51. Ibid., p. 4.
52. Centers for Medicare and Medicaid Services, "Early 2018 Effectuated Enrollment Snapshot," p. 4. It is worth noting, in this context, that in 2017, Alaska had the highest average monthly premium at $1,040.46. The state successfully applied for a Section 1332 waiver, however, and managed to redirect some of the insurance-subsidy funding into a reinsurance pool for high-risk enrollees, resulting in a major decline in the statewide average premium. For a brief discussion of the Alaska waiver, see Doug Badger, "How Lawmakers Should Deal with Obamacare Cost Reduction Payments," Heritage Foundation *Issue Brief* No. 4797, December 18, 2017, https://www.heritage.org/sites/default/files/2017-12/IB4797.pdf.
53. Centers for Medicare and Medicaid Services, "Early 2018 Effectuated Enrollment Snapshot," p. 2.
54. Centers for Medicare and Medicaid Services, "Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment," July 2, 2018, p. 1, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf (accessed August 13, 2018).
55. Ibid.
56. Centers for Medicare and Medicaid Services, "The Exchanges Trends Report," July 2, 2018, p. 3, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf (accessed August 13, 2018).
57. Centers for Medicare and Medicaid Services, "Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment," p. 1.
58. Edmund F. Haislmaier and Drew Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed," Heritage Foundation *Issue Brief* No. 4743, July 26, 2017, https://www.heritage.org/sites/default/files/2017-07/IB4743_0.pdf. See also Edmund F. Haislmaier, "Obamacare Is Shrinking the Individual Health Insurance Market," The Daily Signal, March 17, 2018, https://www.heritage.org/health-care-reform/commentary/obamacare-shrinking-the-individual-health-insurance-market.
59. Robert Pear, "86 Percent of Health Law Enrollees Receive Premium Subsidies, White House Says," *The New York Times*, March 10, 2015, https://www.nytimes.com/2015/03/11/us/11-7-million-americans-have-insurance-under-health-act.html (accessed August 13, 2018).
60. Centers for Medicare and Medicaid Services, "Health Insurance Exchanges 2018 Open Enrollment Period Final Report," p. 2.

> In a free market, young people can buy insurance for about one-sixth of what it costs older people, because young people use fewer healthcare services. But the ACA imposed a price floor: Younger Americans must be charged at least one-third of what older Americans pay. This kind of price control chokes off private markets. Young people are by definition getting less than they pay for, so they opt out of the system. And then that's not a good deal for older Americans either. They're the only ones left paying into the system, so their premiums increase.[61]

#6: A Resurgent Rise in the Cost Curve. Health policy analysts, regardless of political persuasion, have long agreed that Americans are not getting the best value for the health care dollars. Sound reform would not only secure better value, but it would also control cost and bend the "cost curve" downward. President Obama said that he shared that goal and declared: "If any bill arrives from Congress that is not controlling costs, that's not a bill I can support."[62] Altering the skyward trajectory of health care spending was a key objective of the law.[63]

The key policy difference between President Obama and his critics was over the means to achieve that goal. For the Obama Administration, the main policy tools used to achieve that goal were highly centralized, government-run efforts to control costs. Rather than use free-market incentives, Obamacare would "bend the cost curve" through both large Medicare payment reductions and the adoption and enforcement of various payment and delivery initiatives, including value-based hospital purchasing, various physician "pay for performance" initiatives, payment bundling, medical homes, and the creation of accountable care organizations (ACOs). Focused primarily on Medicare, these initiatives were intended to secure health care savings while improving patient outcomes.[64]

In their 2018 report, the Medicare Trustees find that, eight years after passage of the law, the effectiveness of Obamacare's payment and delivery reforms is still uncertain:

> The ability of new delivery and payment methods to lower cost growth rates is uncertain at this time. Preliminary indications are that some of these delivery reforms have had modest levels of success in lowering costs. It is too early to tell if these reductions in spending will continue or if they will grow to the magnitude needed to align with the statutory Medicare price updates.[65]

A Mixed Picture. In 2010—the year Congress enacted Obamacare and well before its full implementation in 2014—national health expenditures grew by an average of 3.9 percent, almost matching the average annual growth in gross domestic product (GDP) at 3.8 percent. From 2011 to 2015, health spending increased from 3.5 percent to 5.8 percent.[66] In 2016 and 2017, the national spending growth slowed again by rates of 4.3 percent and 4.6 percent, respectively, but faster than the growth of the economy.[67]

61. Alex M. Azar II, "Remarks to the Heritage Foundation," Department of Health and Human Services, July 26, 2018, https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-to-the-heritage-foundation.html (accessed August 15, 2018).
62. Kaiser Health News, "Transcript: President Obama's Remarks on Health Care During Press Conference," June 23, 2009, https://khn.org/morning-breakout/obama-transcript/ (accessed August 13, 2018). Note, however, that the Office of the Actuary at the Center for Medicare and Medicaid Services estimated that in its first 10 years the law would increase health spending by an additional $311 billion. See Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended."
63. President Obama and the law's congressional authors wanted, as much as possible, to bring the growth of health care expenditures into line with the growth of the general economy as measured by GDP. For Medicare, the biggest driver in federal health care spending, they created the Independent Payment Advisory Board (IPAB) to enforce that growth target through the implementation of IPAB's recommended Medicare payment cuts. By 2018, Medicare spending was to grow by GDP plus 1 percent. Faced with bipartisan congressional opposition, that cost-control process never materialized. With the enactment of the Bipartisan Budget Act of 2018 (Public Law 115–120), Congress repealed all of the provisions related to IPAB.
64. The CBO did not anticipate that most of these Obamacare initiatives would have a significant effect on health savings. Letter from Elmendorf to the Hon. Nancy Pelosi, Table 5.
65. The 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 5, 2018, p. 190, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf (accessed August 17, 2018).
66. Ibid., p. 187.
67. Ibid., p. 185.

Champions of Obamacare say that the slow growth in health expenditures between 2010 and 2016 is evidence of the law's effectiveness in controlling health care costs.[68] A more plausible explanation is that the slowdown in health-spending growth resulted from the impact of the Great Recession and its aftermath, including a very sluggish economic recovery. With the onset of the recession, GDP growth fell precipitously from 4.9 percent to 1.9 percent between 2007 and 2008; it fell further to –2.5 percent in 2009, as the growth in health spending declined from 6.1 percent to 4.0 percent over the same period.[69]

Obamacare expanded coverage for low-income persons—but Washington could have achieved that same goal without disrupting the health coverage of millions.

In any case, the cost curve is again trending upward. As of 2018, government actuaries project total national health spending to grow by 5.5 percent, and further project such spending to rise faster than GDP for the rest of this century.[70] Government actuaries also project that the Medicare program, the largest of the components of federal health spending, will experience the fastest rates of spending growth, rising 5.6 percent in 2018 to 8.1 percent in 2021, and averaging 5.9 percent from 2028 to 2042.[71]

Health spending projections are fraught with uncertainty. They are a function of a complex interplay of dynamic and mostly unpredictable factors: the impact of new medical technologies, changing economic incentives, congressional policies and federal administrative mandates and regulations, as well as the behavioral response of doctors, hospitals, individuals, insurers, and employers to new economic incentives or state health policies. Government actuaries, it must be noted, have historically underestimated the true cost of Medicare, as well as other federal health care programs. In short, the actual slope of the cost curve under current law is likely to be steeper than current projections.

#7 Higher Middle-Class Taxes. In financing his health reform, President Obama declared in 2009, "My belief is that it should not burden people who make $250,000 a year or less."[72] In other words, the President and his congressional allies claimed that they would spare the vast American middle class any additional taxation when funding the health care reform law, including its major entitlement expansion. This claim also turned out to be untrue.

Obamacare is a major tax law, raising nearly $1 trillion in revenues over 10 years.[73] For the great bulk of middle-class Americans, the design of most of the law's tax provisions would affect them directly or indirectly. Enforcing the special tax increases on medical goods and services, such as drugs, medical devices, and health insurance, would also result in higher consumer prices and insurance premiums, mostly hitting the middle class. Lawmakers have mostly delayed the most significant of these taxes. For example, Congress delayed the health insurance tax until 2019. If that tax had been effective in 2018, for example, it would have raised an estimated $14.3 billion in revenues, adding an average of $500 annually to family health insurance premiums.[74]

68. See, for example, Jeanne Lambrew, "Dispelling Eight Myths on ObamaCare's Eighth Anniversary," The Century Fund, March 22, 2018, https://tcf.org/content/commentary/dispelling-eight-myths-obamacares-eighth-anniversary/?session=1 (accessed August 13, 2018).
69. The 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, April 23, 2012, p. 213, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2012.pdf (accessed August 13, 2018).
70. The 2018 Medicare Trustees Report, p. 185.
71. Ibid.
72. "Obama's Health Care Town Hall in Portsmouth," *The New York Times*, transcript, August 11, 2009, https://www.nytimes.com/2009/08/12/us/politics/12obama.text.html (accessed August 13, 2018).
73. As of 2017, Obamacare's projected revenues totaled $992.4 billion over the period 2017 to 2026. See Congressional Budget Office, "H.R. 1628, American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017," cost estimate, May 24, 2017, Table 2, https://www.cbo.gov/system/files?file=115th-congress-2017-2018/costestimate/hr1628aspassed.pdf (accessed August 13, 2018). Congress repealed just one major Obamacare tax—the individual-mandate penalty, and it merely delayed the Cadillac Tax until 2022, the medical device tax until 2020, and the health insurance tax until 2019.
74. Jessica Waltman, "Federal Actions That Will Impact 2018 Health Plan Rates," Kistler Tiffany Benefits, October 13, 2017, https://ktbenefits.com/2017/10/federal-actions-that-will-impact-2018-health-plan-rates/ (accessed August 13, 2018).

Another major middle-class tax is the so-called Cadillac tax, a tax on "high-value" health plans. The tax is a 40 percent tax on health plans, and, if effective in 2018 as originally provided, it would have affected all plans with premiums in excess of $10,200 for single coverage, $27,500 for family coverage. Mostly middle-class individuals and families securing their health insurance through large corporate health plans, especially those employed by companies in heavily unionized industries, would have been hit by the "Cadillac" tax. Independent research shows that the number of persons affected would greatly increase with the passage of time,[75] and would not only reduce employer health benefits, but also generate hundreds of billions in revenue.[76] Instead of levying a tax merely to raise revenue from the middle class, a much better policy would be a comprehensive reform of the inequitable and inefficient federal tax treatment of health insurance as a way to create a broad-based, consumer-driven health insurance market.[77]

The major Obamacare tax on the "rich" would also morph into a middle-class tax increase. The special "high-income" 3.8 percent Medicare tax on persons with an annual income of $200,000 and couples with an annual income of $250,000 would expand over time. Because the income thresholds are not indexed to inflation, the Medicare trustees report that it would eventually affect 79 percent of American workers.[78]

Conclusion

Today, the federal government makes the key decisions in the nation's individual and small-group insurance markets, ranging from the kind of health insurance Americans must have, the level of coverage they must have, and what kinds of benefits and preventive medical services are to be available in their health plans. Nonetheless, costs continue to rise, choices decline, and the state of health insurance markets continues to deteriorate.

Obamacare expanded coverage and improved access to care among low-income persons. Washington could have achieved that same goal, however, without disrupting the health coverage of millions of Americans or imposing enormous cost increases on millions of middle-class Americans. With the collapse of competition and choice in the individual and small-group markets, millions of Americans trapped in these markets have experienced the results of that centralized and inflexible control.

Promoting competition is the best way to lower costs and expand personal choices. Adoption of the policies embodied in the Health Care Choices Proposal is a start in the comprehensive process of health care reform. In many states, it would greatly improve market conditions on the ground. Under that proposal, Congress would return crucial regulatory power over health insurance to the elected representatives of the people of the states, thus giving them the freedom to determine how best to expand private health care choices and lower insurance costs for individuals and families. At the same time, individuals and families enrolled in public health plans would be free to use the government funding of their coverage to enroll in a private health plan of their choice.

Obamacare is a failed experiment in government central planning. It centralized power in Washington over key health decisions and the flow of health care dollars, and the results have been dysfunctional markets, reduced competition and choice, and higher costs. The best and most practical remedy is to decentralize that power, return freedom to all 50 states to regulate their own health insurance markets, and thus allow them to expand choice, lower costs and increase coverage for their citizens. This would lay the groundwork for individuals and families to control their own health care dollars and decisions.

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75. News release, "Analysis Estimates 1 in 4 Employers Offering Health Benefits Could Be Affected by the 'Cadillac Tax' in 2018 if Current Trends Continue," Kaiser Family Foundation, August 25, 2015, https://www.kff.org/health-costs/press-release/analysis-estimates-1-in-4-employers-offering-health-benefits-could-be-affected-by-the-cadillac-tax-in-2018-if-current-trends-continue/ (accessed August 13, 2018).
76. Bradley Herring and Lisa Korin Lentz, "How Can We Bend the Cost Curve? What Can We Expect from the 'Cadillac Tax' in 2018 and Beyond?" *Inquiry*, Vol. 48 (Winter 2011/2012), pp. 322–337, https://azdoc.site/how-can-we-bend-the-cost-curve-what-can-we-expect-from-the-c.html (accessed August 13, 2018).
77. Edmund F. Haislmaier, Robert E. Moffit, and Alyene Senger, "Fairness in the Federal Tax Treatment of Health Insurance: The Linchpin of Real Reform," Heritage Foundation *Issue Brief* No. 4659, February 24, 2017, https://www.heritage.org/health-care-reform/report/fairness-the-federal-tax-treatment-health-insurance-the-linchpin-real.
78. The 2018 Medicare Trustees Report, p. 27.