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Why Expanding Obamacare Is Not the Answer

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KEY TAKEAWAYS

Obamacare is fundamentally flawed. Expanding it and having the government control more of our health system is the wrong approach to stemming COVID-19 pandemic.

Obamacare has pushed up health insurance premiums, limited choice in health care options, and narrowed the pool of doctors that Americans can see.

The solution is giving states more flexibility to protect the poor, help those with preexisting conditions, and expand private coverage options.

Most policymakers agree that the Affordable Care Act (ACA, popularly known as Obamacare) has failed to achieve its promised objectives. Some progressives argue for a more radical government intervention in health care through Medicare for All. Other liberals support a public option or massive bailouts. These approaches miss the point. The ACA has failed to reduce insurance costs, increase choice, or bend the cost curve down because it depends on a centralized, top-down approach that is insulated from the real-life problems that most Americans face in health care. A better solution would be for the dollars and power of decision to be closer to the American people. The Health Care Choices Proposal offers such a plan that would move the resources and regulatory control to the states, guarantee protections for the poor and those with preexisting conditions, and give individuals more affordable health plan options.

During recent debate on the COVID-19 response bill, Speaker of the House Nancy Pelosi (D–CA) proposed to expand Obamacare by making taxpayer subsidies available to more people further up the income scale. This policy is not a targeted or temporary modification to address the current COVID-19 emergency.[1] Rather, it represents a massive expansion of government control of health coverage. Moreover, it ignores the fundamental flaws embedded in Obamacare that no amount of taxpayer money can resolve.

Promises vs. Reality

Ten years ago, during bitter congressional debates when the law was enacted, proponents made some very high profile promises concerning the ACA, especially on cost, spending, and access to coverage and care.[2] However, this signature legislative achievement did not deliver. Many Americans were not able to keep their plans and their doctors.[3] In addition, they continue to face premium increases, not decreases; have less choice, not more; and must deal with health care costs that are higher, not lower.[4] The facts are in:

1. **The ACA dramatically increased health insurance premiums and cost-sharing in the individual market.** In 2013, the last year before full implementation of the ACA, the average monthly premium paid for individual market coverage was $244 per member per month.[5] In 2018, the national average premium paid in the individual market was $550 per member per month. In other words, premiums more than doubled—with a 125 percent increase in the cost of health insurance—during the first five years of ACA implementation. At the same time, the average deductible for a bronze-level plan sold on the federal exchanges increased from $5,089 in 2014 to $6,165 in 2019.[6] Furthermore, 57 percent of the plan designs offered on Healthcare.gov in 2018 had out-of-pocket maximums that were too high for the plans to qualify for pairing with a health savings account (HSA), which meant that people with those plans could not make tax-deductible contributions to an HSA to fund their deductibles and other out-of-pocket expenses.[7]

2. **The ACA collapsed insurer competition in the nation's individual markets.** At the state level, there were 395 insurers offering individual market coverage in 2013. By 2019, there were just half as many (202) offering such coverage through the ACA exchanges.[8] At the same time, 77 percent of U.S. counties had only one or two insurers

offering exchange plans in 2019, and 42 percent of all enrollees had access to only one or two insurers.[9]

3. **The ACA failed to meet official enrollment targets in the individual markets.** For example, the Congressional Budget Office initially projected that in 2018, 24 million Americans would be enrolled in the health insurance exchanges.[10] In fact, as of March 2019, only 10.6 million persons had secured coverage in the ACA exchanges.[11]

4. **The ACA is pricing middle-class Americans out of individual market coverage.** Federal regulations of insurance under Obamacare has resulted in higher, not lower, premiums, making coverage unaffordable for many middle-class families who pay the full cost of coverage. Between 2015 and 2016, according to the Centers for Medicare and Medicaid Services (CMS), 10 states experienced declining enrollment in their individual markets, with the biggest declines among middle-class people who face the full cost of coverage. From 2016 to 2017, 44 states experienced declining enrollment, with the biggest declines among the same group, and the decline in middle-class enrollment in individual markets was as high as 40 percent in six states.[12]

5. **The ACA expanded government coverage while wrecking the private individual health insurance market.** The law actually reduced private coverage in the individual markets while enrolling millions in Medicaid, a government welfare program with a poor record of access to timely and quality care.[13] Over the period from 2013 to 2017, 15.8 million Americans were newly enrolled in health coverage. An estimated 86 percent of that new coverage was attributable to government programs, like Medicaid and Children's Health Insurance Program (CHIP), not private health insurance. Over that same period, the total number of persons buying private coverage on their own in the individual markets declined by a stunning 4.1 million.[14]

6. **The ACA compromised access to care for persons—including those with preexisting medical conditions—enrolled in the nation's individual markets.** ACA health plans are characterized by narrow networks of doctors, hospitals, and other medical professionals. In 2019, 72 percent of ACA plans had restrictive networks.[15] For persons with preexisting medical conditions, particularly those

leaving group coverage, this worsened their situation. Such top medical institutions as the Mayo Clinic in Minnesota, Sloan–Kettering in New York, and MD Anderson Cancer Center in Texas were unavailable to ACA enrollees.[16]

7. **The ACA failed—and failed miserably—to attract young people into the exchange insurance pools.** Getting young and healthy individuals into the exchanges was critical to offsetting the cost of older and sicker enrollees. In 2014, the Obama Administration projected that 40 percent of the enrollees in the exchanges were between the ages of 18 and 34. Yet in 2014 and 2015, only 28 percent of the exchange enrollees were actually in that intensely sought-after age category.[17] As of 2019, only 26 percent of exchange enrollees were between the ages of 18 and 34; 65 percent of enrollees were 35 and older.[18]

8. **The ACA Medicaid expansion prioritizes able-bodied adults, many of whom are working, over the elderly, the disabled, and poor women and children.** The ACA's Medicaid expansion finances 90 percent of the cost of the new class of adult beneficiaries with incomes under 138 percent of the federal poverty level. In contrast, the average federal contribution to states is roughly 60 percent for the coverage of Medicaid's traditional beneficiaries: the elderly, the disabled, and poor women and children. This incentivizes states to focus on enrolling ACA expansion populations instead of improving access to care for those already in the program. Moreover, Administration audits have found that some states have enrolled individuals that are not actually eligible,[19] further syphoning resources away from those who really are in need.

9. **The ACA did not, as predicted, "bend the curve" of America's health care spending.** National health care spending had started to slow between 2007 and 2010, the year Congress enacted the ACA, in large part as a result of the Great Recession. However, from 2011 to 2015, annual health care spending increased from 3.5 percent to 5.8 percent.[20] Based on government actuaries' projections, between 2020 and 2028, the average growth in national health expenditures is expected to be 5.8 percent,[21] faster than the growth in wages, inflation, or the national economy.

10. **The ACA's vaunted delivery reforms did not yield the anticipated savings.** The ACA programs, such as accountable care organizations, pay for performance, and "value-based purchasing" schemes were supposed to deliver not only better outcomes, but also significant savings. After 10 years, their impact has been "modest." As the Medicare Trustees reported, "The ability of new delivery and payment methods to lower cost growth rates is uncertain at this time."[22]

A Better Plan

Today, most policymakers agree that the ACA has failed to achieve its promised objectives. Some progressives are arguing for a more radical government intervention in health care through Medicare for All.[23] Other liberals are arguing for a public option[24] or massive bailouts.[25] These approaches miss the point. The ACA has failed to reduce insurance costs, increase choice, or bend the cost curve down because it depends on a centralized, top-down approach that is insulated from the real-life problems that most Americans face in health care.

A better solution would be to move the dollars and decision-making power closer to the American people. The Health Care Choices Proposal offers such a plan that would move the resources and regulatory control to the states, guarantee protections for the poor and those with preexisting conditions, and give individuals more affordable health plan options.[26]

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Endnotes

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