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After ObamaCare

The Affordable Care Act (ACA) or Obamacare increased the number of people holding insurance *cards* but failed to increase access to quality and affordable *health services.* Unfortunately, the cost of health care is higher than ever for Pennsylvanians and the state opted to expand a flawed Medicaid program, which enrolled about 50,000 more people than state officials projected. It's time to put patients, not government bureaucrats, in charge of health care decisions.

Broken Promises of the ACA

- **Insurance has become more expensive:** President Obama promised the ACA would lower premiums by $2,500 for the average family of four. Six years later, basic insurance for a Pennsylvania family of four on the individual market has risen by more than $650 a month. The average exchange premium increase hit 32% for 2017.
- **You couldn't always keep your plan or your doctor:** Many individuals and families that purchase their own insurance face regular plan cancellations. For example, former PA lawmaker Ross Schriftman had his plan canceled twice and at least half of exchange plans are now using narrow networks to hold down costs.
- **Massive tax increases on the middle class:** President Obama promised no family making less than $250,000 a year would face a tax increase. Yet, many of the ACA's 21 taxes impact the middle class, including the individual mandate non-compliance tax.

How to Make Health Care Affordable

- **End government mandates.**
  - The guaranteed issue mandate requires insurance companies to offer health policies regardless of a consumer's health status. This mandate allows patients to wait until they are sick to seek insurance, undercutting the basic premise of insurance and forces responsible consumers to bear the costs via higher premiums. Before the ACA, states like New Hampshire and Washington implemented guaranteed issue only to repeal it after costs skyrocketed.
  - The community rating mandate imposes price controls on health policies by preventing insurers from adjusting prices based on health status. In practice, the young and healthy are forced to pay more in order to subsidize costs for older enrollees. Major insurers note allowing more variation in rates to reflect utilization of health care services—specifically a 5 to 1 age band ratio instead of the ACA's 3 to 1 ratio—could lower premiums.
  - States should reduce coverage mandates. Before the ACA, Pennsylvania had more than 50 mandates on the books. The ACA added even more. Altogether, experts estimate coverage mandates raise the cost of health insurance between 10 to 50%.
- **Protect alternative models of care.** Alternatives to insurance are reducing the cost of care. Direct primary care and cost sharing ministries provide affordable health care services outside of the traditional insurance model. Insurance regulations should not apply to these and future innovations.

- **Expand scope of practice for mid-level practitioners.** Providers like nurse practitioners and dental therapists are prevented from practicing in underserved rural areas because of stringent licensing regulations. There is no evidence these regulations produce better health outcomes.
- **Enhance consumer control.** Move from the model of third party payment and expand the flexibility of Health Savings Accounts. Health costs have risen because third-party insurance shields consumers from the true cost of care and encourages over-utilization. A better solution is encouraging out-of-pocket spending on routine medical care, while preserving insurance for catastrophic events.
- **Equalize the tax treatment of health insurance received through an employer or on the individual market.** Currently only employer-paid premiums and most employee paid-premiums are exempt from federal income and payroll taxes. Tax deductions, credits, or list billing would promote fairness for those who don't receive employer-provided health insurance, and end the danger of losing your coverage when you change jobs.
- **Foster interstate competition.** Permitting shopping in neighboring states with nearby networks could spur further competition between insurers and drive down costs. For regulatory competition to be effective, Washington must reestablish states as the primary regulatory authority for health insurance.

How to Improve the Health Care Safety Net

- **Secure a block grant for Medicaid.** Providing quality care to the most vulnerable requires that Medicaid be sustainable and responsive to patients. Currently Medicaid enrollees obtain only 20 to 40 cents of value for each dollar the government spends on their behalf. Accepting a federal per-capita block grant would cap Medicaid spending in exchange for the flexibility to innovate.
    - With flexibility, the state can pursue reforms that target assistance to the truly needy while helping the able-bodied transition to affordable private insurance. These reforms could include choice counseling, work requirements, tiered premiums, subsidizing private insurance for Medicaid eligible residents, cost-sharing, and incentives for healthy behavior.
- **Focus Medicaid on the neediest.** Previous research suggests Medicaid for able-bodied adults significantly decreases job-search activity, employment, and enrollment in employer-sponsored health coverage. Freezing enrollment, as demonstrated in Arizona, would allow Medicaid recipients to transition into work in a relatively short period of time—a reform with broad public support.
    - Expansion takes resources away from those in need. Nationwide, government spending on Medicaid expansion enrollees is nearly 50% higher than originally projected. In Pennsylvania, Medicaid expansion enrolled about 15% more people than officials predicted would ever be eligible.
- **Protect people with pre-existing conditions.** Alternative ways to provide affordable care for high-cost patients include high risk pools, targeted subsidies for insurers, special HSA provisions, and protections for maintaining continuous coverage.
    - Invisible high risk pools: In 2011, Maine's individual market was near collapse, thanks to regulations like community rating. The state created a hybrid high-risk pool and reinsurance program. People with pre-existing conditions accessed the same insurance plans as the healthy, but the state subsidized insurers for covering these patients through $28 million in assessments on all insurance plans. The program cut premiums in half and revived the individual market.

Five ACA Repeal Myths

1. **Myth:** *Under repeal of the ACA, one million Pennsylvanians will lose their insurance.*
   Fact: Many of these Pennsylvanians were covered before the ACA.

   This myth erroneously assumes everyone purchasing insurance on the exchange or enrolled in Medicaid will lose all access to insurance. U.S. Census data shows the number of uninsured Pennsylvanians declined by only 469,000 residents from 2010 to 2015. This gap implies many Pennsylvanians on the exchange or in Medicaid were insured before the ACA. In fact, the state reports almost 16% of newly eligible Medicaid expansion enrollees were previously enrolled in another type of health care insurance.

   It's also important to note that the state shifted 73,000 individuals *already enrolled* in Medicaid to the expansion Medicaid population. This was done entirely as an accounting gimmick to ensure the federal government would pick up a larger portion of Medicaid costs.

2. **Myth:** *Hospitals will lose $1.6 billion in revenues leading to possible closures.*
   Fact: The ACA did not improve hospitals' long-term sustainability.

   Hospitals are struggling because the cost of medical care is rising. Focusing on redistribution schemes rather than driving down the cost of care is no solution. The Department of Human Services(DHS) states health care providers received more than $1.8 billion dollars in payments for serving newly eligible Medicaid expansion enrollees. However, these payments aren't covering the full cost of the care. Medicaid pays on average 61% for physician services.

   A May report from the Health Care Cost Containment Council found an 8.6% decline of general acute-care hospital uncompensated care in 2015 compared to 2014. Yet, more hospitals reported negative operating margins. Between 2012 and 2014, 34 hospitals realized average losses, but from 2013 to 2015, 46 hospitals realized losses.

   Reducing the cost of uncompensated care through more taxpayer subsidies is a payment shift that will ultimately leave local economies weaker.

3. **Myth:** *Repeal will cost 137,000 jobs by 2019 and reduce the state GDP by $76 billion.*
   Fact: These forecasts are based on debunked models that assume government spending creates jobs.

   The job loss estimate comes from the Commonwealth Fund, which wrongly assumes any ACA alternative will eliminate all insurance subsidies.

   In reality, Pennsylvania lost jobs due to the ACA's mandates and taxes. The American Action Forum estimates Pennsylvania lost 15,680 small business jobs due to the law in 2015. Statewide unemployment remained above the national average throughout last year. In fact, we experienced the second largest increase in unemployment during 2016.

   On the other hand, the ACA failed to live up to economic projections. According to DHS, Medicaid expansion created 15,500 jobs in 2015, but a 2013 RAND study estimated expansion would create about 37,500 jobs in 2015.

4. **Myth:** *Repeal will add $7.8 billion in Medicaid state spending over the next ten years, increasing the state budget deficit.*
   Fact: Medicaid with or without expansion will increase our budget deficit.

   Continuing the existing Medicaid expansion will raise spending. The expansion will cost $230 million this year and $460 million annually come 2020. These costs are likely underestimated given enrollment has outpaced projections. Originally, officials believed expansion would top out at 600,000, but the state has enrolled almost 700,000 just two years into expansion.

   From a taxpayer perspective, it doesn't matter how much of the burden the state bears versus the federal government. In the end, costs are going up, Medicaid expansion enrollees cost almost 50% more, on average, than the government projected one year ago. Yet there is no evidence of health improvements.

   In contrast, freezing the Medicaid expansion could result in cost-savings without terminating benefits for the needy. The Urban Institute analysis assumes little migration from CHIP and Medicaid, but evidence from expansions in other states shows freezing enrollment results in significant attrition over time. In Arizona, nearly half of those enrolled in an earlier expansion of Medicaid had transitioned out of the program within twelve months as their income rose.

   Repeal or no repeal, Pennsylvania will begin to experience a net outflow of funds as the Medicaid expansion federal match reduces through 2020.

5. **Myth:** *Repealing Medicaid expansion will harm low-income Pennsylvanians.*
   Fact: Medicaid provides substandard care at a high cost. A block grant will raise the quality of care and reduce costs.

   According to the Wolf administration, the state can't afford Medicaid expansion without the federal government picking up most of the cost. Three years ago expansion opponents warned against depending on the federal government to continue funding an incredibly expensive program. In truth, Medicaid spending was unsustainable and growing faster than revenues long before the expansion. Nothing has changed except the scope of the problem.

   Sec. Ted Dallas and other administration leaders are opposing a per-capita block grant. However, funding states based on how many people they serve versus how much they spend will refocus providers on improving the quality of care.