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HEALTH POLICY prescriptions

Myths and Realities of Obamacare

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INTRODUCTION

Three years ago on March 23, 2010, the Patient Protection and Affordability Act (Obamacare) was signed into law. With the U.S. Supreme Court ruling on June 28, 2012 that the individual mandate is constitutional under Congress' power to tax and the November 6 election results, the law is in effect. It is noteworthy that 52 percent of Americans would still like to see the law repealed and replaced. There is no question that affordable, accessible, quality care is the key goal for everyone.

Eleven days before the bill was passed, then Speaker of the House Nancy Pelosi made her famous statement "We have to pass this bill so we can find out what's in it." The American people are now finding out what is in it. Between now and 2014, many Americans and employers are going to be shocked by what this law means for their future health care. The question is: what can be done to reduce the impact of Obamacare between now and January 2017? I decided that it would be useful to present the myths and realities of the law in a format that all Americans could understand.

MYTHS AND REALITIES

Universal Coverage

Myth 1: Obamacare will achieve universal coverage.

Reality: According to the Congressional Budget Office (CBO), there will still be 30 million uninsured in 2016. This is even after adding 12 million people to the Medicaid program and 18 million who will receive subsidies from the federal government.

Cost

Myth 2: Obamacare will reduce cost.

Reality: The U.S. annually spends about 18 percent of GDP or $2.6 trillion on health care. The original Obamacare cost estimate from the CBO was $940 billion over ten years. In early 2013, the CBO revised the estimate up to $1.3 trillion between 2013 and 2022. Since most of the cost drivers (Medicaid expansion, the individual mandate, the employer mandate, and the subsidies) in Obamacare do not go into

effect until 2014, the cost will probably exceed $2.6 trillion between 2014 and 2023. The cost curve will not "bend down."

Insurance Premiums

Myth 3: The average family will see the cost of its health insurance premium decline by $2,500.

Reality: The CBO estimated in the days leading up to the law being passed that the premium for the average family will increase by $2,100. The Kaiser Family Foundation predicted that in 2012, a family plan would cost $15,745, up 4.6 percent over 2011. The IRS estimates that a family plan in 2013 will be $20,000.

Individual Mandate

Myth 4: Everyone, starting in 2014, will have health insurance or pay a penalty.

Reality: The penalty for being uninsured starting in 2014 will be $95 or 1 percent of income, rising in 2016 to $695 or 2.5 percent of income. The CBO estimates that 24 million will be exempt from the mandate in 2016. About 6 million will go without coverage and pay $45 million in penalties. Because the penalty is so low, it is expected that young people will forego insurance. If the young and healthy do not purchase individual insurance in the state exchanges, the pool will consist of older, sicker patients who will drive up the cost of insurance. This could ultimately force insurance companies out of the market if they cannot cover costs.

Employer Mandate

Myth 5: The President said "If you like your health insurance and you like your doctor, nothing will change."

Reality: The CBO estimates that about 7 million will lose their employer-based coverage. This is because any employer with 50 or more employees who does not offer coverage will pay a fine of $2,000 per employee. As the average employer-provided family plan will cost $20,000 in 2013, it is expected that many employers will drop coverage, pay the penalty, and recommend that employees purchase their insurance in the state, federal, or partnership exchanges. In a more ominous study, the consulting firm McKinsey predicted that up to one-third of the 130 million who have employer-based coverage will lose their insurance. Already, a number of employers in the service sector, restaurants in particular, are dividing their companies up into units of fewer than 50 employees and reducing hours from 30 (considered full-time) to 25 or 26.

Taxes

Myth 6: The President claimed that no middle class family earning under $250,000 would see their taxes increase.

Reality: According to the CBO, there are about $1 trillion in new taxes under Obamacare including:

- **a $28 billion excise tax on drug company sales through 2019.**
- **a 2.3 percent medical device tax on sales which will have a negative impact on innovation. In the case of the medical device tax, AdvaMed predicts that 43,000 jobs out of a total of 400,000 will be lost. Firms such as Stryker, Zimmer, Covidien, and Cook Medical have already trimmed their workforces.**
- **a tax on health insurance plans (HIT) in 2014.**
- **a .9 percent increase in the Medicare Payroll Tax for individuals with incomes above $200,000 and couples earning over $250,000.**
- **a new Medicare tax of 3.8 percent on unearned income affects the same levels of income as the payroll tax.**
- **Starting in 2018, there will be a 40 percent "Cadillac Tax" on employer plans costing over $10,200 for individual and $27,500 for family plans. It is expected that this tax will raise $32 billion in revenue. Union leaders are now becoming disenchanted with this tax.**

All of these taxes will be passed on to consumers in the form of higher prices for products.

Insurance Exchanges

Myth 7: Individuals and small businesses will be able to purchase insurance in state-based exchanges which must open for enrollment on October 1, 2013. They must be fully operational by January 1, 2014.

Reality: There is a lot of doubt as to whether the exchanges will be open for business in fall 2013. The Administration thought that all states would set up their own exchanges. In reality, 26 states are letting the federal government operate their exchanges. The law did not provide funding for the federal government to provide subsidies to individuals who purchase insurance in exchanges not operated by a state. There is an important legal challenge in Oklahoma over this issue. Seventeen states and DC are operating their own exchanges and seven states are in partnerships with the federal government. Individuals earning between138 and 400 percent of the Federal Poverty Level will be eligible for tax subsidies on a sliding scale. The CBO predicts the cost of subsidies at $1 trillion between 2014 and 2023.

In July 2010, the federal government provided temporary funding of $5 billion for individuals with pre-existing conditions and who had been uninsured for six months or more. The Administration predicted that 375,000 out of 4 million would sign up. Only 100,000 participated. The funds were to be available till 2014 when the exchanges become operational. However, HHS closed enrollment on February 15, 2013 as the funding limit was reached.

Medicare Advantage Plans

Myth 8: The President said Medicare Advantage plans for seniors were unpopular and too expensive. Hence, he wanted to eliminate these very popular plans.

Reality: President Obama pulled back on cutting the program because 2012 was an election year and seniors were upset at the prospect of losing their MA coverage. However, on February 19, 2013, HHS announced that funding to Medicare Advantage in 2014 will be cut by 2.2 percent. It is projected that 14.5 million seniors will be enrolled in the program in 2014. This cut will hurt seniors because reimbursements rates will be reduced for doctors. As a result, seniors will find it difficult to find doctors who will treat them.

Medicare

Myth 9: The President said Medicare would be cut by $500 billion over 10 years to fund the Medicaid expansion under Obamacare. He also said that the cost of the program, at nearly $500 billion a year, was too expensive.

Reality: The CBO has revised upward the cost of the Medicare cuts to $716 billion over 10 years. This will adversely affect seniors' access to doctors and care. Doctors are currently reimbursed 20 percent below what they receive for treating private patients. As a result, 52 percent of doctors have limited seniors' access to their practices and 26 percent have already closed their practices to Medicare patients.

The CBO reports that Medicare will be bankrupt by 2022 at a cost of $1 trillion, double the cost today. Three new organizations are part of Obamacare: Independent Payment Advisory Board (IPAB), Accountable Care Organizations (ACOs), and the Patient Centered Outcomes Research Institute (PCORI). The objective of each of these groups is to cut the cost of Medicare. In effect, they are rationing boards which will result in denied care to seniors.

Medicaid

Myth 10: Under Obamacare, 12 million low-income people will be eligible for Medicaid. According to the President, this will give them access to good care and reduce the number of uninsured.

Reality: States are compelled under the law to expand their Medicaid coverage in 2014 to those with incomes below 138 percent of the Federal Poverty Level. However, under the 2012 Supreme Court decision (7-2), the federal government cannot force the states to expand their Medicaid programs. The federal government will fund the cost of the expansion through 2016 and reduce it to 90 percent starting in 2020. Because of the financial problems facing the federal government, there is no guarantee that this funding will be available in the future.

Seven Republican governors from the following states have decided to accept Medicaid funding from the federal government: Ohio, Michigan, Arizona, Nevada, New Jersey, New Mexico, and North Dakota. Florida Governor Rick Scott (R) had agreed to accept the funding but the legislature denied approval.

Small Business Tax Credits

Myth 11: Tax credits will be available to small business for providing insurance to their employees.

Reality: The tax credit proved to be very complex and limited. Firms can qualify based on the number of employees and average wages. In 2010, only 170,300 businesses out of about 4 million qualified for the credit. The General Accounting Office (GAO) released a study showing that the credit was too weak and too confusing. The average credit was $2,700 and therefore was not large enough to incentivize employers to begin offering insurance. A Gallup survey reported that 85 percent of small business owners said they were not looking for new employees. Forty-eight percent of those said it was because of the rising cost of health care.

New Rules for Insurance Companies

Myth 12: The President said that insurance companies were partly responsible for the high cost of health care and why so many are uninsured. He said that controls were needed to cure these two problems—high cost and the uninsured.

Reality: Starting in late 2010, insurers must provide insurance for "children" up to age 26 on their parents' plans, not charge co-pays or deductibles for preventive care services, phase out by 2014 annual limits and lifetime caps on insurance; and end discrimination on insurance for children with pre-existing conditions. According to the CBO, all of these changes will add to the cost of insurance rather than reducing it.

Essential Benefit Plan

Myth 13: Under Obamacare, HHS, rather than insurance companies, determines what must be included in an essential health plan. The agency says such mandates need to be included in plans to protect people and lower costs.

Reality: The EHB plan (final rules on what must be included were released February 22, 2013) will add to the cost of insurance and motivate many young people to pay the penalty tied to the individual mandate. Ten broad categories of benefits have been developed that every plan sold to individuals and small businesses must cover in 2014. HHS said there will be no Basic Health Plan available until 2015. This is most likely because the Administration wants to lure people into the exchanges before offering a low-cost plan that would cover catastrophes.

What Now?

With Obama being re-elected President in November 2012 and the Democrats keeping control of the Senate, what can be done now to stall the full implementation of Obamacare? Three things are possible: repeal parts of the legislation, defund parts of the law, and see positive results from the many court challenges.

Repeal

- **Health Insurance Tax (2014)**
- **2.3 percent tax on medical device sales (2013)**
- **IPAB (2013)**
- **3.8 percent Medicare tax on unearned income.**

Many of these repeal bills have bi-partisan support. The issue will be, even if they pass the Senate, will the President sign the legistlation to repeal them?

Defund

Reduce funding for the Medicaid expansion in 2014 and reduce the income level for qualifying for tax subsidies (138-400 percent of the FPL). The income for an individual at 400 percent of the FPL in 2013 is $45,960.

Court Challenges

There are a number of lawsuits working their way through the courts on the following parts of the law:

- **federal subsidies for states who decided to let the federal government run their exchanges (26 states)**
- **the Liberty University case on the constitutionality of the employer and individual mandate**
- **the constitutionality of the individual mandate as a tax as it originated in the Senate rather than the House,**
- **almost 50 lawsuits over the contraception mandate forcing employers, with the exception of Catholic churches, to provide coverage for birth-control and related procedures. Under a recent accomodation, if an employer does not want to provide this coverage for religious reasons, the insurance company must provide the coverage.**

Some of these lawsuits may make their way to the U.S. Supreme Court. If successful, there could be dire implications for the future survival of Obamacare.

The Way Ahead: A Long-term Replacement Agenda in 2017

- Empower doctors and patients.
- Change the federal tax code so that individuals have the same tax treatment for purchasing insurance as those with employer-based coverage.
- Provide funding to supplement high risk pools until we have a properly functioning competitive insurance market.
- Work towards transparency in pricing.
- State medical malpractice reform.
- Medicare reform: means testing, raising the age for eligibility, and premium support.
- Medicaid: block grant federal funds to the states so they can design their own plans to meet the needs of their beneficiaries and those of their state budgets. Encourage states to consider using Medicaid dollars to buy private insurance through the exchange for the expansion population. Arkansas is moving forward with this innovative idea.
- Expand tax breaks for Health Savings Accounts, Flexible Savings Accounts, and Health Reimbursement Accounts.
- Reduce state mandates and regulations on insurance plans and also reduce mandates under HHS' Essential Health Benefit plan.
- Allow purchase of insurance across state lines.
- Reverse the costly mandate forcing doctors and hospitals to install electronic health records.

Conclusion

The question for the American people is: who do they want to control their health care decisions—an HMO bureaucrat, a government bureaucrat, or themselves? Universal choice is the key to universal coverage. Under Obamacare, taxes will go up, the deficit will increase, long waits for treatment, care will be rationed, and the quality of our health care will decline. Where will the best doctors go and where will we as patients go, if legislators do not vote to repeal and replace Obamacare? This is a long-term fight. If not repealed and replaced, America will be on the "Road to Serfdom" and there will be no off-ramp.

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