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Statement of

LINDA BLUMBERG*

Senior Fellow, Urban Institute

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"The Failures of Obamacare: Harmful Effects and Broken Promises"

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*The views expressed are my own and should not be attributed to the Urban Institute, its trustees or its funders.

2100 M Street NW
Washington DC 20037

urban.org

Chairman Black, Ranking Member Yarmuth, and members of the Committee, I appreciate the opportunity to testify before you on the Affordable Care Act (ACA), the implications of its repeal, and alternative policies for addressing the problems with the law. The views that I express are my own and should not be attributed to the Urban Institute, its trustees, or its funders. My testimony, submitted for the record, is based on two recent papers that I wrote with Urban Institute colleagues. I summarize them here.

The first paper, "Implications of Partial Repeal of the ACA through Reconciliation," written with Matthew Buettgens and John Holahan, compares future health care coverage and government health care spending under the ACA and under passage of a reconciliation bill similar to one vetoed in January 2016. The coverage effects we estimated in this December 2016 analysis are consistent with those released by the Congressional Budget Office on January 17, 2017. Our analysis finds that the key effects of passage of the anticipated reconciliation bill are as follows:

- The number of uninsured people would rise from 28.9 million to 58.7 million in 2019, an increase of 29.8 million people (103 percent). The share of nonelderly people without insurance would increase from 11 percent to 21 percent, a higher rate of uninsurance than before the ACA because of the disruption to the nongroup insurance market.
- Of the 29.8 million newly uninsured, 22.5 million people would become uninsured as a result of eliminating the premium tax credits, the Medicaid expansion, and the individual mandate. The additional 7.3 million people would become uninsured because of the near collapse of the nongroup insurance market.
- Eighty-two percent of the people becoming uninsured would be in working families, 38 percent would be ages 18 to 34, and 56 percent would be non-Hispanic whites. Eighty percent of adults becoming uninsured would not have college degrees.
- There would be 12.9 million fewer people with Medicaid or CHIP coverage in 2019.
- Approximately 9.3 million people who would have received tax credits for private nongroup health coverage in 2019 would no longer receive assistance.
- Federal government spending on health care for the nonelderly would be reduced by $109 billion in 2019 and by $1.3 trillion from 2019 to 2028 because the Medicaid expansion, premium tax credits, and cost-sharing assistance would be eliminated.
- State spending on Medicaid and CHIP would fall by $76 billion between 2019 and 2028. In addition, because of the larger number of uninsured, financial pressures on state and local governments and health care providers (hospitals, physicians, pharmaceutical manufacturers, etc.) would increase dramatically. This financial pressure would result from the newly uninsured seeking an additional $1.1 trillion in uncompensated care between 2019 and 2028.

- The 2016 reconciliation bill increased funding for uncompensated care very little beyond current levels, and this additional federal funding would account for less than 4 percent of the increase in uncompensated care that would be sought. Unless a different action is taken, this approach would place very large increases in demand for uncompensated care on state and local governments and providers. The increase in services sought by the uninsured is unlikely to be fully financed, leading to even greater financial burdens on the uninsured and higher levels of unmet need for health care services.
- If Congress partially repeals the ACA with a reconciliation bill like that vetoed in January 2016 and eliminates the individual and employer mandates immediately, in the midst of an already established plan year, significant market disruption would occur. Some people would stop paying premiums, and insurers would suffer substantial financial losses (about $3 billion); the number of uninsured would increase right away (by 4.3 million people); at least some insurers would leave the nongroup market midyear; and consumers would be harmed financially.
- Many, if not most, insurers are unlikely to participate in Marketplaces in 2018—even with tax credits and cost-sharing reductions still in place—if the individual mandate is not enforced starting in 2017. A precipitous drop in insurer participation is even more likely if the cost-sharing assistance is discontinued (as related to the *House v. Burwell* case) or if some additional financial support to the insurers to offset their increased risk is not provided.

This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than before the ACA. To replace the ACA after reconciliation with new policies designed to increase insurance coverage, the federal government would have to raise new taxes, substantially cut spending, or increase the deficit.

The second paper, entitled, "Instead of ACA Repeal and Replace, Fix It," was written with John Holahan and was released January 16. This paper describes the challenges of replacing the ACA without reducing insurance coverage, reducing affordability, or impeding access to care for those with health care needs, while identifying new sources of revenue and creating sufficient Congressional consensus for passage. To that end, we propose a range of policies that would address critics' concerns and also strengthen the law, expand coverage, improve affordability, increase market stability, and lower the high premiums that exist in some markets. We propose the following:

- Replace the individual mandate with a modified version of the late enrollment penalties currently used in Medicare Parts B and D.
- End the employer mandate. The limited gains in coverage and the revenue it generates have not been worth the controversy it has caused.
- Replace the Cadillac tax with a cap on the tax exclusion for employer-based insurance while correcting valid concerns that apply to both approaches.
- Improve affordability by reducing premiums, deductibles, and other cost-sharing requirements for modest-income individuals, and extend to higher-income individuals a cap on premiums at 8.5 percent of income.
- With a premium cap at 8.5 percent of income applied to all, relax the 3:1 age rating rule to be more in line with actual differences in spending for younger and older individuals.
- Examine the essential health benefits package, recognizing that eliminating certain benefits would eliminate risk pooling for those services, shifting all costs to individuals needing those services. That is problematic for any service, but particularly so for prescription drugs, mental health, and substance use disorder treatment.
- Stabilize the Marketplaces by taking steps to increase enrollment. This would include investing in additional outreach and enrollment assistance and allowing states to extend Medicaid eligibility to 100 percent of the federal poverty level (FPL) rather than 138 percent of FPL. People with incomes between 100 and 138 percent of FPL would move from Medicaid to Marketplace coverage and thereby benefit from the affordability provisions mentioned above. Further, it should be made easier for working families to be eligible for income-related tax credits.
- Address the impact of insurer and provider concentration on nongroup market premiums by capping provider payments in those plans at Medicare rates or some multiple thereof—an approach currently used by the Medicare Advantage program. This would limit the use of market power by large provider systems and make it easier for insurers to enter new markets.
- Use a broad-based source of revenue (e.g., assessments on all health insurance and stop-loss coverage premiums or general revenues) to permanently protect nongroup insurers from the consequences of enrolling a disproportionate share of very high-cost enrollees, as is done in Medicare Part D and Medicare Advantage.

Most of these steps have had bipartisan support in other contexts and therefore can provide a framework for a bipartisan compromise.