Policy Analysis
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Obamacare
What We Know Now

by Michael Tanner

Executive Summary

For all intents and purposes, the Patient Protection and Affordable Care Act (ACA), also known as Obamacare, has been fully implemented. And while much of the media coverage has been dominated by the technical failures of the program's initial rollout, we are also learning much about the impact of health care reform on employers, providers, patients, taxpayers, and individual consumers. Much of this was suspected even before the law was passed, but it is now becoming clear as implementation moves forward. For example:

- Millions of Americans who are happy with their current health insurance will not be able to keep it;
- Americans may find it difficult to keep their current doctor unless they are willing to pay more;
- While there will be both winners and losers when it comes to the cost of insurance, millions of Americans will find themselves paying higher premiums or facing higher out-of-pocket expenses;
- The law's final cost is difficult to predict, but is likely to exceed early projections;
- Far fewer Americans will be covered than expected, leaving millions still uninsured;
- The law is already having serious economic consequences and will likely lead to a loss of jobs and slower economic growth; and
- There is a significant danger that young and healthy people will not enroll, leading to an "adverse selection death spiral."

In short, the more we have learned about ACA, the more it looks like its critics were right. The law's problems go far beyond a failed website. By imposing a bureaucratic, centralized, top-down approach to health care reform, Obamacare has created far more problems than it solved.

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Introduction

In March of 2010, as the debate over passage of the Patient Protection and Affordable Care Act (ACA) was winding down, House Speaker Nancy Pelosi (D-CA) famously said "we have to pass the bill so that you can find out what is in it."[1] It has now been nearly four years since the legislation passed, and most of its key components have taken effect, giving us a fair opportunity to "find out what is in it."

The law was deliberately designed so that many of the provisions apt to be most popular would take effect first. Thus, provisions such as allowing children to stay on their parents' policy until age 26 started on September 23, 2010.[2] However, the law's key provisions—the individual mandate, prohibitions on medical underwriting of preexisting conditions, subsidies, Medicaid expansion, and the operation of exchanges in all 50 states and the District of Columbia—all started on January 1, 2014. (Another important provision, the employer mandate, was also scheduled to begin on January 1, but the Obama administration postponed the effective date until January 1, 2015.)

Recent news coverage has been dominated by the "train wreck" that has been the rollout of the exchanges and the computer problems that accompanied it.[3] However, most of those issues have been corrected. And, as President Barack Obama has repeatedly reminded us, the health care law is "not just a website. It's much more."[4]

In fact, in many ways, the system's computer problems have actually obscured the much more significant problems with the law. Those problems go much deeper than a failed website. They could result in millions of Americans being forced to change insurance plans, even if satisfied with their current policy, and in millions more being unable to keep seeing their current doctor (at least not without significant additional expenses). In addition, while there will be both winners and losers when it comes to the cost of insurance, millions of Americans will find themselves paying higher premiums or facing higher out-of-pocket expenses. The law is also likely to slow economic growth and kill jobs.

Some of these consequences can already be seen. Others are easily predicted. But some important questions remain. We do not yet know whether the program's adverse selection problems will be severe enough to cause the entire system to crash and burn. We do not know how doctors will react to systemic changes and reduced reimbursements. And we still don't know the outcome of legal challenges to the law that are still making their way through the courts.

But from everything we can see so far, ACA is turning out to be every bit as bad as critics predicted—or worse.

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA), more colloquially known as Obamacare, was more than 2,500 pages and 500,000 words long,[5] and in the years since its passage, various agencies of government have issued more than 70,000 pages of regulations and guidance to implement it.[6] It created dozens of new agencies, boards, commissions, and other government entities.[7] Several parts of the law have been changed or postponed, often by executive order.[8] A few provisions have even been repealed or amended by Congress.[9] It has been both upheld and altered by the courts. And there has been a great deal of misinformation, conjecture, and rumor circulating in both the mainstream and alternative media. No wonder, then, that many Americans remain confused by the law itself and its impact on them, their health plans, and their businesses.

Despite the complexity of the law itself, and the well-reported difficulties of its implementation, ACA boils down to five key components.

Individual Mandate

As of January 1, 2014, every American is

required to obtain health insurance coverage that meets the government's definition of "minimum essential coverage." Those who don't receive such coverage through government programs, their employer, or some other group must purchase individual coverage on their own, or pay a penalty. This year, that penalty will be 1 percent of the individual's adjusted gross income (AGI) or $95, whichever is greater.[10] But it ramps up quickly after that—the greater of $325 or 2 percent of annual income in 2015, and the greater of $695 or 2.5 percent of annual income after that. In calculating the total penalty for an uninsured family, children count as half an adult, which means that in 2016 an uninsured family of four would face a minimum penalty of $2,085 ($695+$695+$347.50+ $347.50), prorated on the basis of the number of months that the person was uninsured over the course of the year.[11]

While the mandate technically began on January 1, individuals actually have until March 31, 2014, to sign up for insurance and still satisfy the requirement. This is because the law allows for individuals to be uninsured for "brief periods" (up to three months) over the course of a year without violating the mandate. Therefore, if a person uses their entire three-month grace period at the start of 2014, they could go until March 31 before running afoul of the mandate. This is likely to become very important since most uninsured Americans remain unenrolled as of January 1.

It is important to point out that simply having insurance is not necessarily enough to satisfy the mandate. To qualify, insurance would have to meet certain government-defined standards for "minimum essential coverage." This is only logical. If a person could theoretically pay $1 for an insurance plan with a $10 million deductible, it would defeat the whole purpose of the mandate.

Many of the required benefits are common sense and already included in nearly all insurance plans. These include outpatient care, emergency room treatment, hospitalization, and laboratory tests. Others, however, are less common, and their inclusion subject to greater debate. These include maternity and newborn care, mental health and substance abuse treatment, prescription drugs, rehabilitative and habitative services, a wide variety of preventative and wellness services, chronic disease management, pediatric services, and dental and vision care for children. Beyond the specific benefits, plans are required to have an actuarial value (the average percentage of health care expenses that will be paid by the plan) of at least 60 percent. In addition, qualified plans must also comply with all the various insurance regulations included in the ACA.[12]

Thus, the individual mandate is not just a mandate to have insurance, but a mandate to have the specific type of insurance that the government has directed.

This provision, of course, was the subject of a major Supreme Court decision in 2012. In the case of *NFIB v. Sebelius*, the Court upheld the insurance requirement not as a mandate, but rather as a tax on uninsured individuals.[13] Ironically, however, in upholding the mandate in this manner, Chief Justice Roberts, who wrote the deciding opinion, was in effect saying that the mandate was a tax because it was so small that it would not actually force individuals to buy insurance. Roberts was effectively acknowledging that it is cheaper to "pay" than to "play." As we have seen, that could lead to serious adverse selection issues going forward.[14]

Late in December 2013, President Obama announced that the individual mandate would be waived, at least for 2014, for individuals who had their policies cancelled because those policies did not fully comply with ACA requirements (see below).[15]

The number of people who will be affected by this delay is in dispute. The White House suggests that only about 500,000 people will fall into this category, while some outside health care experts suggest the number could run as high as several million.[16]

Employer Mandate

The law also contains an employer man-

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date. Starting January 1, 2015, all businesses with 50 or more full-time employees must provide health insurance coverage to their workers or pay a penalty.

There are two possible ways for companies to calculate the penalty for failing to provide insurance—with companies required to pay the *lesser* of the two amounts. Under method one, the company must pay a tax penalty of $2,000 for every person they employ full time (minus 30 workers). Thus a company employing 100 workers would be assessed a penalty of $2,000 x 70 workers or $140,000. In the alternative, the company could pay $3,000 for each uninsured employee who qualifies for a subsidy through an exchange. For example, if 60 of the workers in our hypothetical company qualified for a subsidy, the potential penalty would be $3,000 x 60 workers or $180,000. In this case, the company would have to pay $140,000. On the other hand, if only 40 workers qualified for subsidies, the potential penalty under mechanism two would be $120,000 ($3000 x 40 workers), which becomes the penalty that the company would pay.

The law originally specified that this provision was to take effect on January 1, 2014, at the same time as the individual mandate. However, in September 2013, President Obama, by executive order, postponed the implementation until 2015.[17]

As with individuals, in order to satisfy the mandate, businesses' insurance must meet the government's definition of an acceptable plan. Employer-provided insurance (with a partial exception for self-funded ERISA plans) must meet the same requirements as individual plans, fulfilling the "essential minimum benefits" package and all requisite insurance regulations.

In order to satisfy the mandate, businesses' insurance must meet the government's definition of an acceptable plan.

Initially this mandate is likely to affect relatively few companies. Roughly 96 percent of companies with more than 50 employees already provide health insurance.[18] And, while many of the plans currently offered are not in full compliance with ACA requirements (for example, deductibles may be too high or they may not provide all the benefits specified), those plans are "grandfathered," meaning companies can keep them in place for now. However, as with individual plans, any "substantial change" invalidates the grandfathering. Therefore, many—if not most—employer plans will also have to change in order to comply with the mandate (see below).

Insurance Regulation

The Affordable Care Act imposes a host of new federal insurance regulations that significantly change the way the health insurance industry does business. Some of these regulatory changes have been among the law's most initially popular provisions, but many are likely to have unintended consequences.

Perhaps the most popular insurance reform allows parents to keep their dependent children on their policies until the child reaches age 26.[19] It is estimated that roughly 2.5 million children have taken advantage of this provision since it began in 2010.[20] A second popular reform prohibits insurers from imposing lifetime limits on benefit payouts.[21] In a similar vein, the law also bans "rescissions," or the practice of insurers dropping coverage for individuals who become sick.[22]

In addition, the law requires insurers to maintain a medical loss ratio (that is the ratio of benefits paid to premiums collected) of at least 85 percent for large groups and 80 percent for small groups and individuals.[23] Insurance companies that pay out benefits less than the required proportion of the premium must rebate the difference to policy holders on an annual basis beginning in 2011. This requirement is intended to force insurers to become more efficient by reducing the amount of premiums that can be used for administrative expenses (and insurer profits). Already, insurers have been forced to provide more than $1.59 billion in rebates to individuals and businesses.[24]

But perhaps the most significant regulatory reform is the ban on insurers denying coverage because of preexisting conditions.

Under the Patient Protection and Affordable Care Act, insurers are prohibited from making any underwriting decisions based on health status, mental or physical medical conditions, claims experience, medical history, genetic information, disability, other evidence of insurability, or other factors to be determined later by the secretary of Health and Human Services (HHS).[25] Specifically, the law requires insurers to "accept every employer and individual . . . that applies for such coverage."[26]

Finally, there are limits on the ability of insurers to vary premiums on the basis of an individual's health. That is, insurers must charge the same premium for someone who is sick as for someone who is in perfect health.[27] Insurers may consider age in setting premiums, but those premiums cannot be more than three times higher for their oldest than their youngest customers.[28] Smokers may also be charged up to 50 percent more than nonsmokers.[29] The only other factors that insurers may consider in setting premiums are geographic location and whether the policy is for an individual or a family.[30] These provisions started for children in 2010, and for everyone else on January 1, 2014.

It should be noted that, while the ban on medical underwriting may make health insurance more available and affordable for those with preexisting conditions, and reduce premiums for older and sicker individuals, it will increase premiums for younger and healthier individuals (see below).

Overall, most of the law's insurance reforms have been among the more politically popular aspects of the new law. Although their ultimate impact may be smaller and help fewer people than is commonly believed, they do address real problems. Any alternative to ACA will also have to find ways to deal with these issues.

On the other hand, as we will see, ACA's insurance regulations will also have a number of unintended consequences.

Exchanges

Health Exchanges, rebranded as "marketplaces" by the Obama administration, have been a technological train wreck in recent weeks, but they remain a key component of the ACA.

The exchanges are designed to function as clearinghouses—wholesalers or middlemen—matching customers with providers and products. Exchanges also allow individuals and workers in small companies to take advantage of the economies of scale, both in terms of administration and risk pooling, currently enjoyed by large employers. Finally, exchanges are the mechanism through which individuals receive subsidies to help pay for insurance.

The legislation gave states the option of setting up an exchange, or, if they chose not to do so, the federal government would establish and operate an exchange in that state. States could also operate part of an exchange, leaving the federal government to operate the rest.[31] As it turns out, state decisions broke largely, but not entirely, along partisan lines. Sixteen states and the District of Columbia chose to operate their own exchanges, while the federal government ended up running—in whole or part—34 exchanges (Figure 1).[32]

The insurance sold through an exchange is offered by one or more private insurers. Plans are grouped into four categories based on actuarial value: bronze, the lowest cost plans, providing 60 percent of the actuarial value; silver, providing 70 percent of the actuarial value; gold, providing 80 percent of the actuarial value; and platinum, providing 90 percent of the actuarial value.[33] In addition, exchanges may offer a special catastrophic plan to individuals who are under age 30 or who have incomes low enough to exempt them from the individual mandate.[34]

Nationwide, some 74 issuers are offering more than 1,483 plans through the exchanges, but the number of plans available on each exchange varies greatly, as does the number of insurers offering those plans.[35] Despite claims of increased choice and competition on the exchanges, an analysis of federal data by the insurance consulting firm

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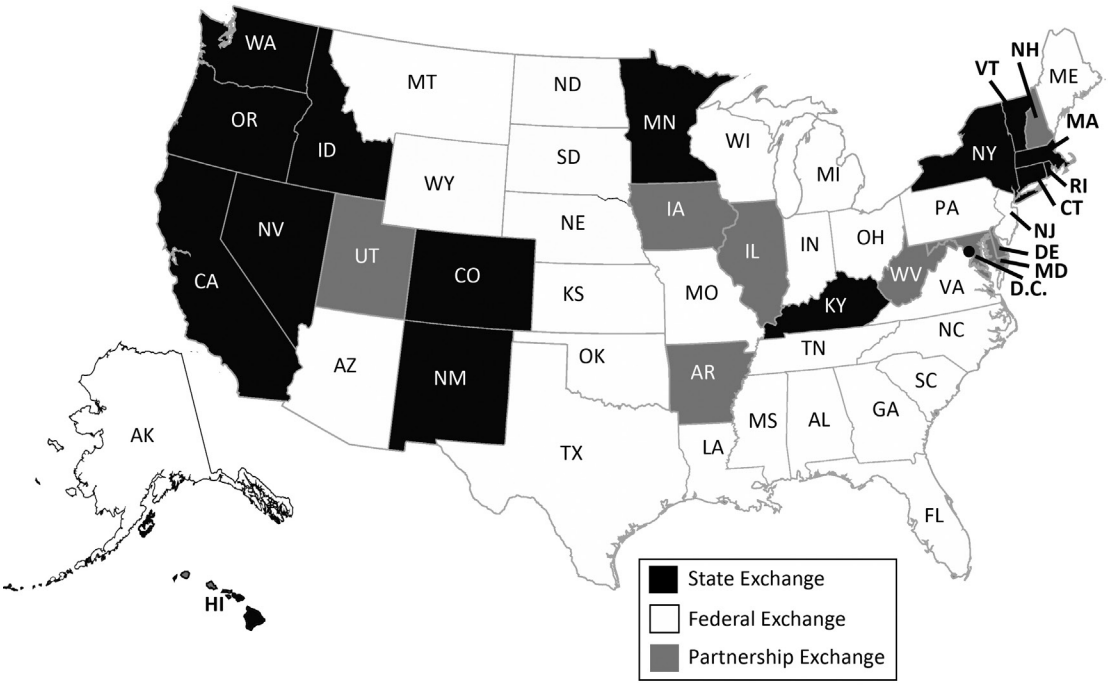
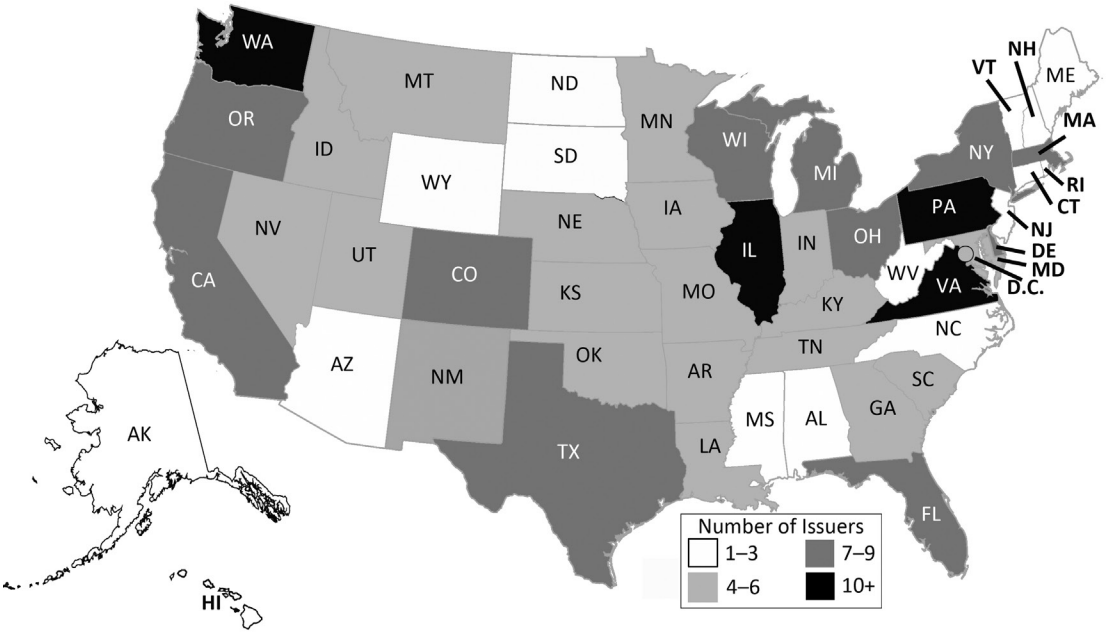
Figure 1
State Health Insurance Exchange Decisions



Source: Kaiser Family Foundation, *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, as of November 22, 2013* (Washington: Kaiser, 2013).

Figure 2
Issuer Competition by State, Individual Market



Source: Avalere Health Analysis, *QHP Individual Medical Landscape* (Washington: Avalere State Reform Insights, September 2013).

HealthPocket found that the average number of plans offered in a state decreased from 117 health plans in 2013 to only 41 in the exchanges. Granted there is some variation, with some states seeing an increase in the number of plans offered and some seeing significantly fewer choices, but it is a far cry from a uniform increase in plan choices.[36] For example, in 16 states, just three or fewer insurers are offering plans (although in some states each insurer may offer multiple plans). In another 19 states and the District of Columbia, fewer than 7 insurers are competing. That means that in two-thirds of states, consumers have a half dozen or fewer providers to choose from (Figure 2).[37]

Moreover, the listed number of insurers is on a statewide basis, but is not evenly spread throughout the state. In rural areas, which traditionally have had fewer insurance options, the lack of competition is even greater. An analysis done for the *New York Times* found that in 58 percent of the counties nationwide where the federal government is running health care exchanges, the marketplaces "have plans offered by just one or two insurance carriers," and in approximately 530 mostly rural counties, "only a single insurer is participating."[38]

It would be an understatement to say that the initial rollout of the exchanges, on October 1, 2013, did not go as planned. The computer system designed to manage the exchanges in the 34 states operated by the federal government has had one problem after another, making enrollment extremely difficult. Many state-run exchanges suffered from similar computer glitches. While some of the issues were addressed, by the end of December 2013, access problems continued.[39] In addition, portions of the computer system, notably those needed to pay insurers and arrange subsidies, were not complete as of January 1, 2014.

Subsidies and Medicaid Expansion

The number-one reason that people give for not purchasing insurance is that they cannot afford it.[40] Therefore, the legislation's principal mechanism for expanding coverage (aside from the individual and employer mandates) is to pay for it, either through government-run programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) or through subsidizing the purchase of private health insurance.

For low-income individuals, subsidies come in the form of increased access to Medicaid. Starting this year, states are able to increase eligibility for Medicaid so that all individuals with income levels below 138 percent of the federal poverty level (FPL) would be eligible for the program, an increase in eligibility that mainly affects the childless adult population.[41] The federal government will pick up much of the cost for this expansion population, at least initially, financing all of the costs for the first three years before gradually phasing down to 90 percent.[42]

This Medicaid expansion was intended to be mandatory: all federal Medicaid funding would be withdrawn if states refused to expand, but in *National Federation of Independent Business v. Sebelius*, the Supreme Court ruled that the Medicaid expansion "violates the Constitution by threatening States with the loss of their existing Medicaid funding if they decline to comply with the expansion," and struck down the provision allowing HHS to withhold existing Medicaid funds for failure to comply with the expansion.[43] This ruling effectively made the Medicaid expansion optional. To date, only 21 states and the District of Columbia have expanded their programs. Some of the states with the largest uninsured populations—Florida, Texas and Pennsylvania—have so far declined to expand, fueling uncertainty as to how many people will enroll due to the Medicaid expansion, and how much it will cost (Figure 3).[44]

The State Children's Health Insurance Program will be continued until September 30, 2019. Between 2014 and 2019, the federal government will increase its contribution to the program, raising the federal match rate by 23 percentage points (subject to a 100 percent cap).[45] States must maintain

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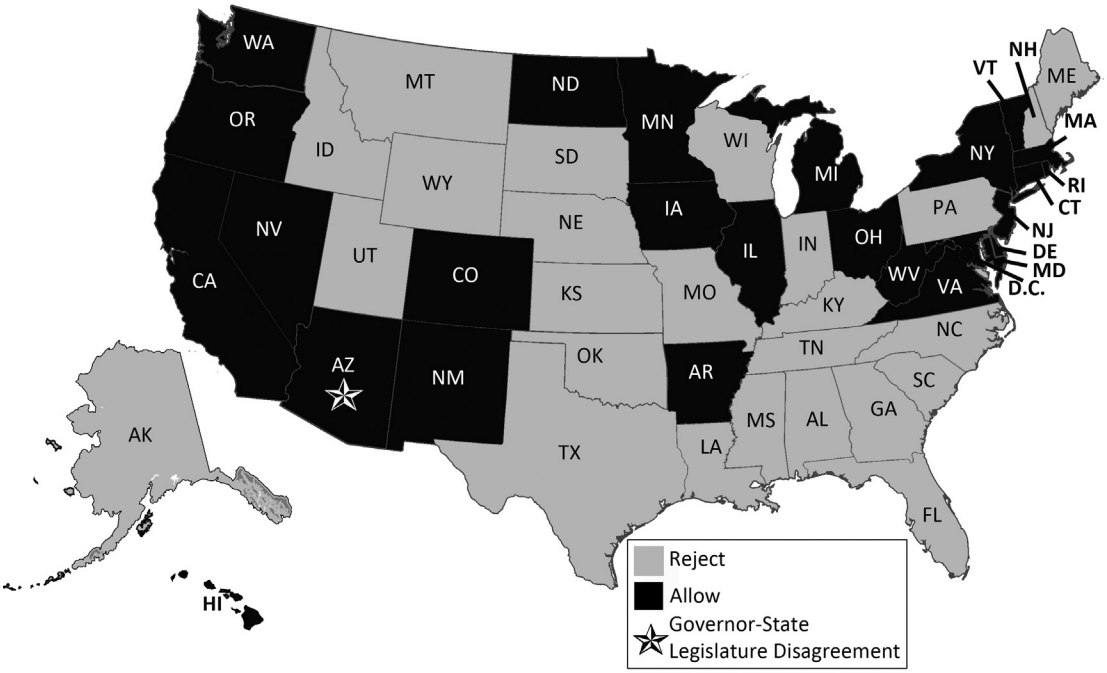
Figure 3
State Medicaid Expansion Decisions



Sources: Kaiser Family Foundation, *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion, as of November 22, 2013* (Washington: Kaiser, 2013); Advisory Board Company, *Where the States Stand on Medicaid Expansion, November 6, 2013* (Washington: Advisory Board, 2013).

their current income eligibility levels for the program.[46]

Individuals with incomes too high to qualify for Medicaid but below 400 percent of the poverty level ($88,000 per year) are eligible for subsidies to assist their purchase of private health insurance.

The subsidies are paid out as two separate credits designed to work more or less in conjunction with one another. The first is a "premium tax credit."[47] The credit is calculated on a sliding scale according to income in such a way as to limit the total proportion of income that an individual would have to pay for insurance.[48] Thus, individuals with incomes between 133 and 200 percent of the poverty level will receive a credit covering the cost of premiums up to four percent of their income, while those earning 300–400 percent of the poverty level will receive a credit for costs in excess of 9.5 percent of their income.

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The second credit, a "cost-sharing credit," provides a subsidy for a proportion of out-of-pocket costs, such as deductibles and copayments. Those subsidies are also provided on a sliding income-based scale, so that those with incomes below 150 percent of the poverty level receive a credit that effectively reduces their maximum out-of-pocket costs to 6 percent of a plan's actuarial value, while those with incomes between 250 and 400 percent of the poverty level would, after receiving the credit, have maximum out-of-pocket costs of no more than 30 percent of a plan's actuarial value.[49]

What We Know Now

The news over the last several months has been dominated by the fiasco surrounding the healthcare.gov website and the initial rollout of the health care exchanges. Howev-

er, as President Obama has said, health care reform is "not just a website."

Most of ACA's key aspects are now operational. The first provisions to take effect were some insurance regulations, such as provisions allowing children to stay on their parents' policy until age 26, a ban on medical underwriting for children, and minimum loss ratio requirements, all of which started in the fall of 2011. Several of the law's new taxes went into effect in 2013, and in addition, Medicaid payments for primary care doctors were temporarily boosted and open enrollment on the health insurance exchanges began. On January 1, 2014, the central aspects of the law, including the individual mandate, Medicaid expansion, subsidies, and key insurance regulations began.

A few provisions, such as the employer mandate, have been postponed, and a handful, notably the excise tax on "Cadillac" insurance plans and the Independent Payment Advisory Board (IPAB) that will set Medicare reimbursement rates, are scheduled to start down the road. But enough of the law is now in place for us to begin to form judgments about its likely impact on patients, providers, businesses, and taxpayers. The evidence suggests that that impact will be mostly negative. For example:

You Probably Can't Keep Your Current Insurance

One thing we now know for sure is that President Obama's promise that "if you like your health-care plan, you'll be able to keep your health-care plan, period"[50]—a promise he repeated at least 32 times[51]—has, in the president's own words "ended up not being accurate."[52]

As of December 2013, roughly 5.4 million Americans with individual policies have had their current insurance policy cancelled because it did not meet ACA's requirements.[53] Another 3 to 8 million are expected to lose their policies in the coming months.[54]

The president has made the point that this is only "a small amount of the population."[55] He is correct that the individual insurance market, in which most cancellations have occurred so far, represents only about 5 percent of Americans. However, this is only the tip of the iceberg.

Because the president has postponed the employer mandate, the 55 percent of Americans who receive their insurance through work have seen far fewer cancellations than people in the individual market (except in cases where employers have dropped coverage; see below). But the same ACA provisions that have resulted in the cancellation of individual policies will start to affect employer-sponsored plans by late 2014.

Why all these cancellations? In essence, the problem starts with the law's mandates themselves. As noted above, if the government is going to require you to buy or provide insurance, then it must define what is and is not insurance. To satisfy the mandate, insurance has to meet certain government-defined standards for "minimum essential coverage."[56] If you have insurance, but it does not meet those standards, you cannot continue with that plan, even if you like your plan.

Individuals and businesses that had insurance prior to March 31, 2010 are grandfathered in, meaning they theoretically do not have to change their current insurance to meet the new minimum benefit requirements.[57] However, if there was any substantial change to the plan after March 2010, or there is any such change in the future, the plan loses its grandfathered status and can no longer be sold by the insurer. It does not matter whether those changes are/were instigated by the individual or by the insurer. If there is a substantial change, the plan must change in order to comply with the ACA requirements.

The Affordable Care Act did not specify what would be considered a substantial change, but the Department of Health and Human Services subsequently issued regulations defining substantial change as signifi-

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cantly cutting or reducing benefits, raising co-pays by more than $5 (or the rate of medical inflation), increasing deductibles over a certain threshold, lowering employer contributions, and raising coinsurance charges.[58]

As a result, millions of current plans in the individual market have lost their grandfathered status. (The group or employer market will be discussed below). And since many of those plans did not meet ACA requirements, those plans are being cancelled.

But that is not the only reason that some individuals are losing their plans. In some states, notably California, Idaho, Kentucky, Vermont, Virginia, and the District of Columbia, insurance commissioners and state legislatures prohibited insurers from participating in the state insurance exchanges unless they agreed to immediately cancel all non-grandfathered insurance plans sold in the state.[59] The contract that insurers must sign with the California exchange, for example, says:

> Contractor agrees that effective no later than December 31, 2013, except as otherwise provided in State Law, *it shall terminate or arrange for the termination of all of its non-grandfathered individual health insurance plan contracts or policies which are not compliant with the applicable provisions of the Affordable Care Act*. Contractor agrees to promote ways to offer, market and sell or otherwise transition its current members into plans or policies which meet the applicable Affordable Care Act requirements. This obligation applies to all non-grandfathered individual insurance products in force or for sale by Contractor whether or not the individuals covered by such products are eligible for subsidies in the Exchange.[60] [emphasis added]

As a spokesman for California Blue Cross explained, "In order to participate in Covered California as a qualified health plan, the contract required us to cancel non-ACA-compliant plans on December 31."[61]

The president attempted to reduce the number of cancellations by allowing insurers, if they wished, to reinstate noncompliant plans for one year, if state insurance commissioners agreed.[62] However, it turned out that this was much more difficult to carry out in practice than the presidential directive indicated.

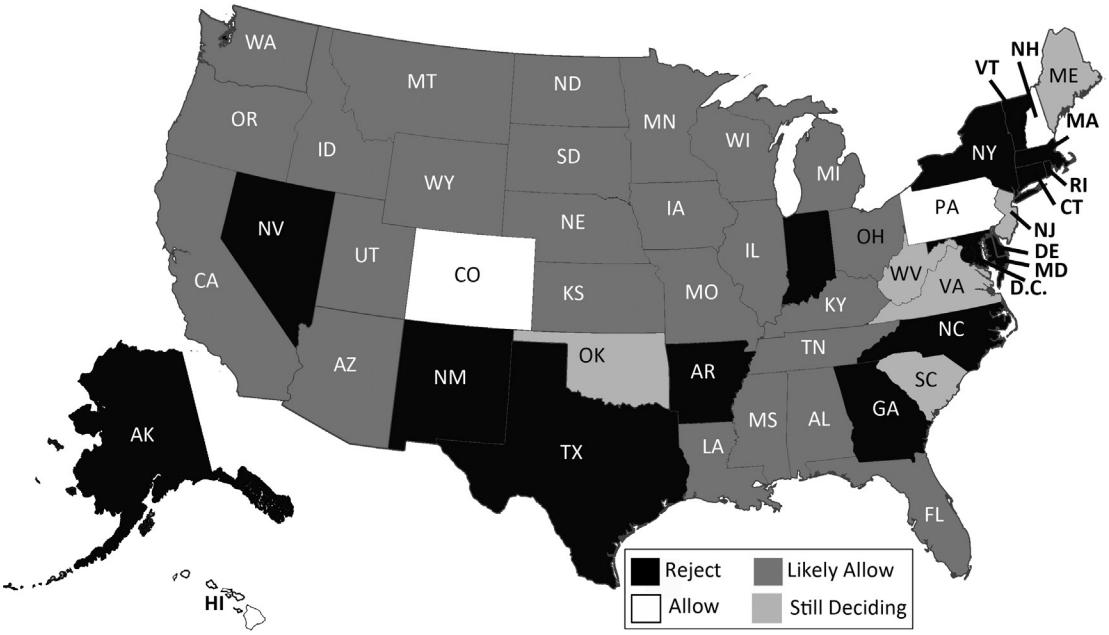
Insurance plans are not simply a list of benefits on a piece of paper. They are the product of a complex interrelationship among benefits, the pool of insured customers, a network of providers, and so on. And, because for three years insurers had been told that they could not sell noncompliant plans, many of those plans simply didn't exist anymore. Even where they could be recreated, it is a time-consuming and costly process. Moreover, many of those who have had their plans cancelled have already bought new policies, sometimes with different insurers. As a result, insurers have been reluctant to continue to offer policies they had planned to end in accordance with the administration's fix because they are wary of injecting even more uncertainty into 2014. The fragile balance of young and healthy people to higher cost, less healthy people they planned for in pricing these plans could be thrown off kilter and could force them to significantly increase premiums in 2015 in an attempt to recalibrate these plans.

State insurance commissioners were also less than receptive. Commissioners in 17 states and the District of Columbia have refused to allow insurers to reinstate noncompliant plans. This includes many of the states with the largest number of cancellations, such as California (see Figure 4).[63]

As of January 2014, there is no accurate tally of how many plans were ultimately reinstated. But the anecdotal evidence suggests that very few have been.

Moreover, the president's directive allows reinstatement only for one year. That means that when the next enrollment and renewal period begins in the fall of 2014, those plans that had been reinstated in December 2013 will be cancelled once more.

Figure 4
State Decisions on Insurance Cancellation Fix



Source: Commonwealth Fund, "State Decisions on the Health Insurance Policy Cancellations Fix," November 27, 2013, http://www.commonwealthfund.org/Blog/2013/Nov/State-Decisions-on-Policy-Cancellations-Fix.aspx.

The president has also announced that individuals who have had their policies cancelled, and have been unable to find an "affordable" alternative, would not be subject to the individual mandate, at least through 2014, or could purchase a catastrophic insurance plan (that had previously only been an option for those under age 30.)

Even plans that are still grandfathered may not stay that way for long. That is because while the plan is grandfathered for those who are currently covered by them, the plan itself remains closed to new entrants. That is, insurers cannot continue to sell that plan to any new participants. As a result, as some of those currently covered begin to leave the plan for various reasons, the pool of people covered under it will shrink. The smaller the pool of participants, the more difficult it becomes to provide actuarially sound coverage because the costs are so concentrated. Eventually, such plans will become nonviable, and will be cancelled by insurers. As a result, virtually all non-ACA compliant plans will eventually be cancelled.

Some have argued that the only plans affected were exceptionally skimpy plans that failed to provide basic health care benefits, "subpar," as the president put it.[64] The *New York Times* even wrongly suggested that the plans being cancelled fail to cover some basic benefits like hospitalization.[65]

No doubt, some individual plans *were* less than comprehensive. However, most plans failed ACA compliance for relatively minor reasons. According to HealthPocket, a health insurance consulting firm, fewer than 2 percent of individual policies in place in 2013 met all ACA requirements.[66] The most frequent reason for noncompliance was not a failure to cover hospitalization, but a lack of pediatric care, including vision and dental care for children. Just 24 percent of individual plans provided that benefit.[67] But, for childless individuals, it's hard to see the lack of such a benefit rendering the policy "subpar."

Most insurance plans failed to comply with the Affordable Care Act for relatively minor reasons.

Most Americans receive their insurance through their job. What will happen to them?

The other frequently missing benefits included maternity and newborn care (not included in 64 percent of plans), drug and alcohol rehabilitation (46 percent), and mental health benefits (39 percent).[68] There may indeed be reasons, such as enlarging risk pools and cross-subsidization, for wanting men or those beyond childbearing age to purchase maternity care, for nondrinkers to purchase alcohol rehabilitation, and so on, but that is far different from claiming that those plans do not offer adequate benefits to the purchasers themselves.

As noted, so far nearly all of the cancelled policies have been individual plans, a relatively small part of the insurance market. Most Americans receive their insurance through their job. What will happen to them?

Employer plans change frequently today. Most of those changes are relatively minor, and employees may not even notice the difference. In a technical sense, it could be said they are not keeping their current insurance plan today. However, the ACA will expand and accelerate this process and the change in insurance for many employees will become far more significant.

As noted above, under the ACA group insurance sold through the employer market is subject to the same requirements as individual insurance. However, large numbers of employer plans do not fully meet those requirements.

As with individual policies, plans that were in place prior to March 2010 are grandfathered so long as there is no substantial change in the plan.[69] However, because company plans frequently undergo routine changes, barely a third of covered workers are in grandfathered employer-sponsored plans. Interestingly, small businesses, which have been aggressively trying to "lock in" their current plans, are more likely to be grandfathered than larger employees. A bit more than half of the businesses with 50 or fewer workers have a grandfathered plan, while only 30 percent of companies with more than 5,000 employees offer one.[70]

The mix of grandfathered and noncompliant plans varies and does not perfectly overlap. Smaller firms are more likely to offer noncompliant plans, but be grandfathered. Larger companies may not be grandfathered, but are more likely to be compliant. Overall, according to Avik Roy of the Manhattan Institute, roughly half of the employer-based insurance market is currently neither grandfathered nor compliant.[71] Given the frequency with which companies make changes to their plans, as noted above, few companies will maintain their grandfathering over the long run.[72] In 2011, the Congressional Research Service estimated that, due to these restrictions, 66 percent of small employer plans and 51 percent of all plans will lose grandfathered status by the end of 2013.[73]

In addition, grandfathering is not likely to be sufficient protection in the long run. As with individual policies, noncompliant plans are closed to new entrants (with the exception of new employees at an employer offering the plan). For the reasons discussed above, such plans are unlikely to remain viable for long. Thus, eventually even currently grandfathered companies may be forced to change the plans that they provide. At the time the ACA was enacted, the Department of Health and Human Services estimated that 66 percent of small businesses and 45 percent of larger businesses would eventually have to change their plans.[74] That would mean as many as 78 million workers could lose their current employer-provided plan.[75]

Some of the noncompliant employer plans are truly minimal policies. Known as "mini-med" plans, these very inexpensive policies, intended primarily for low-wage workers in the fast-food industry or seasonal workers, provide few benefits. For example, roughly 106,000 mini-med policies discontinued in New Jersey did not provide coverage for outpatient drugs, prenatal care, or ambulance services, and covered only $700 per year for doctor visits.[76] But mini-med policies make up less than 1 percent of employer plans.[77]

Unlike with individual policies, there is no comprehensive survey data available to

show exactly where existing employer plans may fall short of ACA compliance. Still, it seems likely that the majority of noncompliant employer plans suffer from the same noncompliance issues as individual plans. They cover basic insurance benefits, but fail to offer one or more of the ACA specified benefits such as maternity care or alcohol rehabilitation.

Workers forced to change plans because their current policy does not cover alcohol rehabilitation services may not feel that their plan was inadequate.

It is also worth mentioning one other ACA provision that may force changes in many employer health insurance plans. Starting in 2018, employer-provided insurance plans with actuarial values greater than $10,200 for an individual or $27,500 for a family will be subject to a 40 percent excise tax.[78] This tax, often referred to as a tax on "Cadillac plans," will be assessed against the insurer offering the plan. This may result in many insurers cancelling such plans. If the insurer continues to offer the plan, the cost of the tax is expected to be passed through to the employer, making it likely that the employer will switch to a lower value plan. Some estimates suggest that 6.6 percent of individual plans and 6.3 percent of family plans will be subject to the tax in 2018.[79] However, other observers have put the number much higher. For example, a survey by the International Foundation for Employee Benefit Plans found that as many as 40 percent of businesses may fall under the provision.[80] A survey of Fortune 1000 companies by Towers Watson found that as many as 60 percent of companies say that even though the Cadillac tax doesn't take effect for several years, it is already having a "moderate" or "significant" influence on benefits decisions for 2014 and 2015.[81]

Finally, we need to look at those workers who have either lost or will lose their insurance because ACA encourages their employer to drop coverage.

Providing insurance to workers is expensive. The average cost of an employer-sponsored plan in 2013 was $5,884 for an individual, and $16,351 for a family.[82] The average employer pays roughly 82 percent of individual premiums and 71 percent of family premiums.[83]

Employers can avoid this cost in two ways. First, if not required to provide a particular worker or dependent with coverage, they can simply drop that coverage. That appears to be what many companies are doing in the case of spousal coverage or part-time workers.

For example, while the law mandates that companies offer insurance to dependents under the age of 26, it imposes no such obligation for spouses. In the face of increased cost burdens associated with Obamacare, many companies are imposing spousal surcharges or dropping spousal coverage as a way to mitigate these cost increases. For instance, United Parcel Service (UPS) was one of the more notable recent cases; dropping 15,000 spouses from their employer-sponsored plans because general increases in health care costs "combined with the costs associated with the Affordable Care Act, have made it increasingly difficult to continue providing the same level of health care benefits to our employees at an affordable cost." United Parcel Service estimates that this move will save them roughly $60 million in health care costs annually.[84]

United Parcel Service is hardly the only company to pursue this strategy. According to a survey by benefits consulting firm Towers Watson, 12 percent of employer plans will not include spousal coverage in 2014—three times more than in 2013.[85]

Part-time workers are perhaps even more likely to lose coverage. Already we have seen examples of companies choosing to no longer offer health benefits to these workers. Home Depot, for example, dropped coverage for more than 20,000 part-time workers in 2013.[86] Both Universal Orlando and Sea World have recently announced that they will no longer offer mini-med health plans to part-time workers.[87] Similarly, the East Coast–based grocery chain Wegmans

Twelve percent of employer plans will not include spousal coverage in 2014—three times more than in 2013.

has decided to drop coverage for part-time workers starting in 2014.[88]

Retirees, too, could be shifted off their current employer-provided coverage. Already, IBM has announced it will move about 110,000 retirees off its company-sponsored health plan and instead give them a payment to buy coverage on a health-insurance exchange.[89] Similarly, Time Warner has said that it will move its retirees from their employer-provided insurance to exchange-based policies.[90] Several cities, including Detroit and New York, are also reportedly considering this option for retired public employees.[91]

Second, employers can simply choose to forgo coverage and pay the penalty instead. Even using the potential high penalty of $3,000 per worker, that penalty is still less than the cost of insurance. Of course, the provision of insurance provides other value to employers, particularly as a retention and recruitment tool. Perhaps that is why large numbers of employers have not yet dropped coverage in response to ACA. However, as premium costs rise (see below) dropping coverage is likely to become more common.

Overall, the Congressional Budget Office (CBO) estimates that 7 million workers will eventually be dropped.[92] Other surveys suggest a much higher number. For instance, an analysis by the Deloitte Center for Health Solutions found that 65 million workers could eventually lose their employer-sponsored insurance.[93] These people are not just being forced to change from one employer plan to another, but losing employer-based coverage altogether.

Taking all of this together, it has become apparent that many—perhaps most—Americans will not be able to keep their current insurance plan.

Of course, losing your current insurance is not necessarily the same as losing insurance altogether. Most workers with employer-provided insurance who lose their current plan can expect to be offered another plan by their employer. The new plan will be ACA compliant with the full range of required benefits and meeting all relevant regulations. It will therefore offer more expansive and comprehensive coverage, providing benefits and protections that the worker lacked before. It is also likely to be more expensive.

Those workers who are dropped entirely from an employer plan will be able to purchase individual plans through their state's exchange. The cost of the new insurance is likely to be substantially higher, but some of that cost may be offset by government subsidies available to those who purchase insurance through an exchange. Workers may also receive some type of contribution from their employers toward the cost of purchasing an individual plan. That contribution would reflect the fact that the employer is no longer paying a share of the plan. It could be in the form of a direct contribution toward insurance or in higher wages. No such contribution is required however, and there is no guarantee that workers will receive one.

Those people buying insurance on the individual market today who lose their current plans will likewise have to purchase insurance through an exchange. Their new plans will be ACA compliant—and, thus, "better" than their old plan according to ACA advocates—but will likely cost more. Some of that cost, however, will be offset by subsidies as discussed above. Whether or not those subsidies will be sufficient for those individuals to avoid having to pay more will vary according to income, location, and other factors. Already, anecdotal tales of "rate shock" are plentiful.[94]

The cost of the new insurance is likely to be substantially higher, but some of that cost may be offset by government subsidies.

You May Not be Able to Keep Your Current Doctor

Those who are forced to change their insurance plan may also have to change their doctors. Not every plan includes every doctor in their network. Even a change from one employer-sponsored plan to another may leave workers with a new network that does not include their previous physician.

The problem is more pronounced for those forced to buy a new plan through an exchange. Insurance plans available on the exchanges—and in most states the selection of available plans is extremely limited—have been rapidly dropping doctors and hospitals from their networks. According to a survey by the Medical Group Management Association, nearly 40 percent of doctors are uncertain about whether they will be included in networks of plans being sold through the exchanges.[95] And a new study by PricewaterhouseCoopers warns that "insurers passed over major medical centers" in their California, Illinois, Indiana, Kentucky, and Tennessee networks, among others.[96]

In New York, for example, many exchange-based plans exclude the Memorial Sloan-Kettering Cancer Center, widely regarded as one of the world's premier cancer facilities.[97] In Illinois, Blue Cross and Blue Shield said that at least some of its plans will no longer include Rush University Medical Center or Northwestern Memorial Hospital in their networks.[98] In California, most insurers won't include UCLA Medical Center, and none will include Cedars Sinai.[99] Vanderbilt Hospital is being excluded from many plans in Tennessee.[100] In New Hampshire, Anthem Blue Cross Blue Shield, the only insurer participating in the exchange, covers just 16 of the state's 26 hospitals, and has dropped about a third of the physicians who used to be part of its network.[101] Even the Mayo Clinic has been excluded from most plans sold in Minnesota.[102]

In most cases the decision to exclude providers from a plan has been made by insurers. The Affordable Care Act's regulations, such as requiring coverage of individuals with pre-existing conditions, mandating new benefits, and prohibiting annual or lifetime limits, have driven up costs for insurers. While insurers have offset some of the increased costs through higher premiums (see below), there are limits to their ability to raise prices, especially for plans sold through exchanges. As a spokesman for Primera Blue Cross, the dominant insurer in the Seattle area explained, its decision to exclude Seattle Children's Hospital from its network was because the hospital's "non-unique services were too expensive given the goal of providing affordable coverage for consumers."[103]

In other cases it is the physician or hospital that rejects participation in a plan because reimbursement rates are too low. Insurers have been slashing reimbursement rates for plans sold through the exchanges. In some cases insurers will reimburse physicians and hospitals at levels barely higher than Medicaid. UnitedHealth Group, for example, has cut reimbursements to some New York City doctors to less than $40 for a typical office visit, and about $20 for reading a mammogram.[104] Many physicians and hospitals are likely to decide that participation in the exchange-based plans is just not worth it.

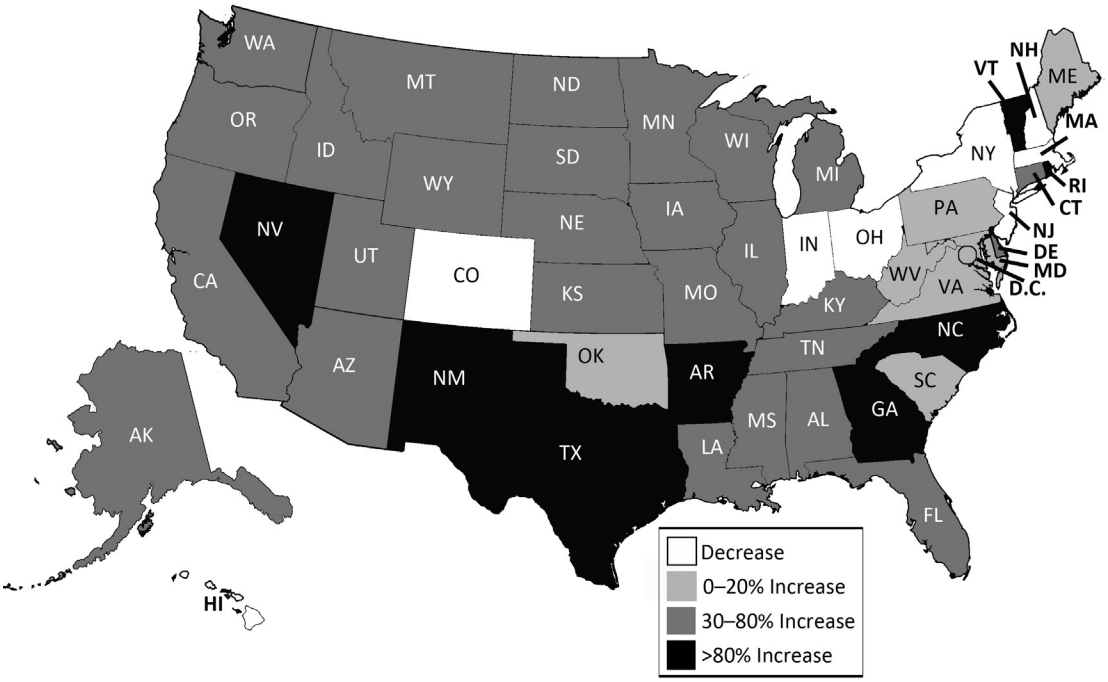
The problem is made worse by the limited choice of insurance plans available through the exchanges (see above). If the only available insurer or insurers decide to exclude your physician or hospital from their network, there may not be an alternative plan available.

Of course, one can always see a physician outside the plan's network. In such cases, insurers generally pay a far lower percentage of the cost. A McKinsey and Company analysis found that 47 percent of the 955 plans available in the first 13 states to make plan filings public were health-maintenance organizations or similarly designed plans, which usually pay nothing for providers that are not part of their networks.[105]Most other plans were preferred-provider organizations, which pay only part of the charges for doctors and hospitals outside their network. In New York, for example, not a single insurance plan offered through the exchange pays anything for out-of-network providers.[106]

The bottom line, as Dr. Ezekiel Emmanuel, one of the architects of ACA and a top adviser to the Obama administration, explained on Fox News, is that you can keep your current doctor "if you want to pay more."[107]

Those who are forced to change their insurance plan may also have to change their doctors.

Figure 5
Exchange Premium Increases Map



Source: Avik Roy, "49-State Analysis: Obamacare to Increase Individual-Market Premiums By Average Of 41%," *Forbes*, November 4, 2013.
Note: No data available for Hawaii.

Many People Will Pay More

The impact of ACA on insurance premiums is a highly complex issue that does not lend itself to the easy analysis suggested by some observers on both the left (lower premiums) or right (higher premiums). Some consumers will indeed pay less for their insurance (especially after fully accounting for subsidies), but others will almost certainly pay more.

Take those purchasing insurance through exchanges, for example: Appendix A shows the lowest available premium for the major categories of exchange-based insurance plans for different age groups in all 50 states and the District of Columbia. There is enormous variation from state to state. A bronze plan for a 27-year-old, for example, costs $271.05 per month in Wyoming, but just $100.37 in Oklahoma. A platinum plan in Wisconsin costs a whopping $548.30 per month, but you can by a similar plan in Arizona for just $175.01.[108]

The average state will face underlying premium increases of 41 percent.

The administration has trumpeted the fact that exchange-based premiums are lower than previous projections from CBO.[109] (That's not quite accurate; technically, premiums are lower than CBO's original projected premiums for 2016, reverse engineered to provide a 2013 estimate.[110]) But the fact that CBO possibly overestimated premiums tells us little about whether individuals are paying more or less than they do now.[111]

A study by Avik Roy of the Manhattan Institute compared premiums for policies available through exchanges with the average cost of the five least expensive pre-ACA plans for the most populous zip code in every county, after adjusting for the denial and surcharge rates of these plans, which increase the effective premium amount. He analyzed premium increases for three ages: 27, 40, and 64. The Affordable Care Act's effect on premiums varies by age group, but overall the average state will face underlying premium increases of 41 percent (Figure 5).[112]

Premiums themselves only tell part of the story. For instance, as noted above, many purchasers will receive subsidies that will offset all or part of the premium (or more accurately, shift costs to taxpayers). This may make a substantial difference for lower-income Americans. "Sticker shock" means less if you are not paying the sticker price. However, the *National Journal* conducted an in-depth independent analysis and concluded that "for the vast majority of Americans, premium prices will be higher in the individual exchange than what they're currently paying," even after accounting for subsidies.[113]

In looking at the cost of insurance, one must also consider out-of-pocket cost sharing, including deductibles, copayments, and coinsurance. Bronze plans, for example, have the lowest premiums of any plans on the exchanges, but have much higher cost-sharing provisions.[114]

An analysis by Avalere, a health insurance consulting group, found that deductibles for an individual silver plan, generally considered the benchmark plan, varied from a low of $1,500 to a high of $5,000. Overall, silver plan deductibles averaged $2,550. In comparison, the average deductible for a pre-ACA individual plan was approximately $3,500.[115] On the other hand, the average deductible for employer-sponsored plans in 2013 was just $1,135. So, an individual forced out of his employer plan and onto the exchange could face higher deductibles.[116]

Other forms of cost-sharing such as copayments and coinsurance could also be quite high.[117] For example, the Avalere study found that most exchange plans have high coinsurance requirements for non-preferred brand drugs and higher-cost specialty drugs, averaging around 40 percent of the drug cost. In addition, copayments for primary care physician visits ranged from $5 to $50, and averaged $30 per visit for silver plans.[118] For the most inexpensive bronze plans, total out-of-pocket expenses run up to $6,350 for individuals and $12,700 for families.[119] In fact, some bronze plans require people to pay all out-of-pocket expenses before the plan will pay *anything*. In Miami, for example, 40 percent of bronze plans require consumers to pay the full out-of-pocket requirement before coverage kicks in.[120]

Notably, ACA was supposed to cap the total amount of out-of-pocket insurance costs. However, the Department of Labor has delayed the enforcement of those caps for some insurers.[121] This means that at least some consumers could face much higher out-of-pocket costs.

Of course, averages are just that. Different groups will be affected differently. In particular, younger and healthier Americans are more likely to see their premiums increase, while older and sicker Americans are more likely to find reduced premiums. Indeed, such cross subsidization is fundamental to the design of ACA.

Moreover, those young and healthy Americans who previously had policies in the individual market were more likely to have inexpensive plans with limited benefits and high deductibles. The new more comprehensive ACA-compliant policies will almost certainly be more expensive. On the other hand, younger workers are more likely to have lower incomes, theoretically making them eligible for larger subsidies.

The evidence so far suggests that young people are indeed paying more under ACA. Avik Roy's study found that 27-year-olds would face an average premium increase of 77 percent for men and 18 percent for women.[122] An earlier study by the actuaries at Oliver Wyman found that "young, single adults aged 21 to 29 and with incomes beginning at about 225 percent of the FPL, or roughly $25,000, can expect to see higher premiums than would be the case absent the ACA, even after accounting for the presence of the premium assistance."[123]

For employer-sponsored plans, estimates of how ACA will affect premiums are even harder to come by. At the time ACA was signed into law, CBO estimated that premiums would double by 2020. According to CBO projections, small businesses would see increases roughly in line with that base-

The evidence so far suggests that young people are indeed paying more under the Affordable Care Act.

line under ACA, while larger businesses could see increases slightly (about 5 percent) below the baseline.[124]

More recent studies suggest that premiums for small businesses will actually be higher under ACA than they would have otherwise been. A recent survey by Milliman, for example, found that small group premiums in the six states analyzed would increase between 6 and 12 percent above what they would have been in the absence of ACA.[125] And, a report for the House Committee on Energy and Commerce projected increases ranging from 13 to 101 percent, based on responses from a limited sample of 17 insurers throughout the country.[126]

Millions of people, especially middle-income Americans, are likely to see their premiums and other out-of-pocket expenses rise substantially.

Meanwhile, large employers expect their cost of health care benefits to rise 7 percent in 2014, according to an annual survey conducted by the National Business Group on Health. This comes on top of a similar increase in 2013.[127]

At least some of the increase in premiums for employers will translate into increased costs for employees. In fact, there is already evidence that employers are raising workers' premium contributions, steering them toward plans with much higher out-of-pocket costs, and requiring them to pay a larger proportion of coverage for dependents.[128]

Of course, one should be careful about projecting a trend from one year's worth of premiums. We will know much more about the impact of ACA on premiums next fall, when rates for 2015 are announced. By then, insurers will have had much more time to digest the impact of who has and has not purchased insurance on the exchanges, the behavior of employers, and other results from ACA. The Obama administration has already pushed the deadline for 2015 enrollment back from October 15 to November 15, giving insurers an extra month to set their 2015 premiums.[129] But some information on whether this year's price spikes will continue should be available by late summer.

Finally, it should be noted that any discussion of future premium increases and other insurance costs may be complicated by what happens to health care costs more generally. Insurance premiums are fundamentally driven by the overall cost of health care. As discussed in depth below, health care costs have been growing more slowly over the last few years than they traditionally have. If this slowdown continues, premiums will grow more slowly. But if costs return to their historic rates of growth, premiums will rise more quickly as well. At the moment, there is no way to know which will happen, although as noted below, there is reason to be skeptical about the duration of this slowdown and the part played by ACA.

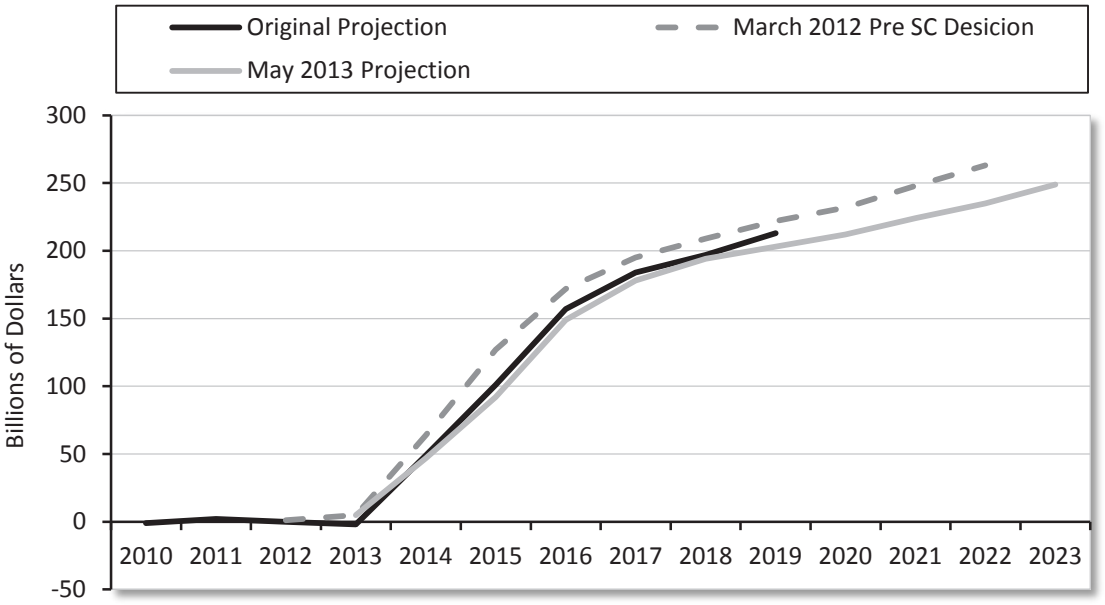
What we can say for certain, though, is that there will be winners and losers under ACA. When all factors, including subsidies, are fully accounted for, many Americans will end up paying less for health care than they do today. But millions more, especially middle-income Americans, are likely to see their premiums and other out-of-pocket expenses rise substantially.

It Will Cost Taxpayers More than Originally Projected

Government programs have a history of costing more than originally projected. The Affordable Care Act seems likely to be yet another example of this tendency.

When the ACA was passed in 2010, CBO scored the coverage provisions of the legislation, the Medicaid expansion and exchanges, as costing $938 billion over 10 years, from 2010–2019.[130] However, CBO's most recent estimates put the cost at almost $1.8 trillion from 2013–2023.[131] Much of the increase in estimates is due simply to the extended projection window. But since nearly all ACA spending occurs from 2014 onward (only $13 billion was spent from 2010–2013), this is, in fact, likely to be a more accurate 10-year window. After this initial cost projection, each successive estimate saw year over year increases until the Supreme Court decision in *NFIB v. Sibelius* made the Medicaid expan-

Figure 6
Comparison of Cost Projections of the Major Coverage Provisions of the ACA



Source: Congressional Budget Office, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," May 14, 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf; Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 13, 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf; Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," March 20, 2010, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

sion optional, which significantly lowered the cost projections (Figure 6).

It is also important to remember that such CBO estimates significantly understate the actual costs of the health care law. For instance, the initially projected cost failed to include discretionary costs associated with the program's implementation. The legislation does not provide specific expenditures for these items, but simply authorizes "such sums as may be necessary." Because the costs are subject to annual appropriation and the actions of future congresses are difficult to predict, it may be impossible to put a precise figure to the amount. However, CBO suggests that they could add as much as $100 billion to the 10-year cost of the bill.[132] For example, HHS has passed out $4.4 billion in grants to states this year, and plans to spend an additional $1.2 billion by the end of next fiscal year. The law also includes between $5 billion and $10 billion over 10 years for the IRS to enforce aspects of the law, and an additional amount for the Department of Health and Human Services. The operation of exchanges in the 34 states where they are being run by the federal government is expected to be $3.5 billion for 2013–2014 and more in subsequent years.[133] None of this money is included in ACA cost estimates.

In addition, estimates of ACA's impact on the budget deficit double count both Social Security taxes and revenue and savings from Medicare. Scoring of ACA anticipates $390 billion in Medicare savings through 2019.[134] The law will also bring in additional payroll tax revenue through the 0.9 percent increase in the Medicare payroll tax, and the imposition of the tax to capital gains and interest and dividend income. This money is fun-

The Affordable Care Act's real 10-year cost appears close to $2.4 trillion.

The government spends money now, while pretending that it will be available in the future to pay for future Medicare benefits.

neled through the Medicare Trust Fund.[135]

Government trust fund accounting methodology counts these additional funds as extending the trust fund's solvency and being available to pay future Medicare benefits. But in reality, the funds would be used to purchase special-issue Treasury bonds. When the bonds are purchased, the funds used to purchase them become general revenue, and are then spent on the government's annual general operating expenses. What remains behind in the trust fund are the bonds, plus an interest payment attributed to the bonds (also paid in bonds, rather than cash). Government bonds are, in essence, a form of IOU. They are a promise against future tax revenue. When the bonds become due, the government will have to repay them out of general revenue.[136]

In the meantime, however, the government counts on that new general revenue to pay for the cost of the new health legislation. Thus, the government spends the money now, while pretending it will be available in the future to pay for future Medicare benefits. This results in a double counting of roughly $398 billion. As Medicare's chief actuary points out, "In practice, the improved [Medicare] financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."[137]

The same is true regarding $53 billion in additional Social Security taxes generated under the ACA. The CBO assumes that, as discussed above, many employers may ultimately decide that it is cheaper to "pay than play," and will stop offering health insurance to their workers. The CBO assumes that in those cases workers will receive higher wages to offset at least some of the loss in nonwage (insurance) compensation. However, the workers will have to pay taxes, including Social Security payroll taxes, on those additional wages. The additional revenue from those taxes is counted in CBO's scoring of the Patient Protection and Affordable Care Act. However, because they are paying additional taxes, those workers are also accruing additional Social Security benefits. Yet, because those benefits will be paid outside the 10-year budget window, the cost of the additional benefits is not included in the scoring. Only one side of the revenue-benefit equation is included.

When all additional costs are included, ACA's real 10-year cost appears to be much closer to $2.4 trillion (see Figure 7). Since the legislation includes roughly $1.18 trillion in new or increased taxes through 2023 to pay for the benefits it provides, a calculation of the law's full costs suggests it will add $1.16 trillion to the national debt over that period.[138]

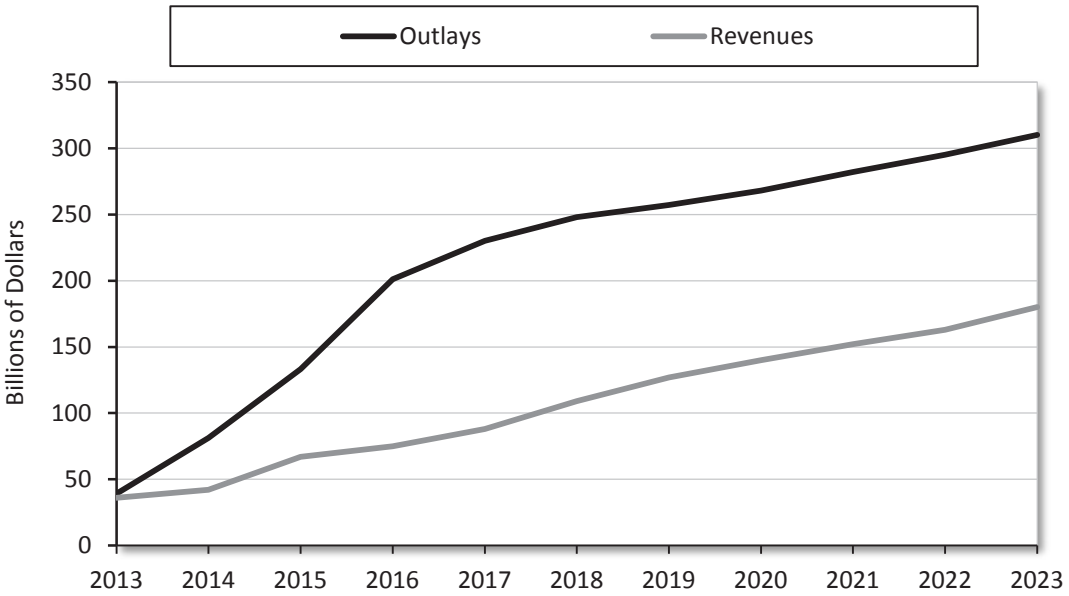
Moreover, as Figure 7 shows, the cost trajectory at the end of the 10-year budget window is headed higher. Thus, we can anticipate even higher costs, additional taxes, and an added debt burden in the out years.

Even the most recent CBO estimate is from May 2013, making it somewhat dated in light of recent events. Indeed, future costs are increasingly difficult to project.

For example, if people who sign up for subsidized insurance are older and sicker than expected (see below) the cost of their subsidies could be much higher than predicted. In announcing its decision to allow insurers to temporarily reinstate cancelled policies, the Obama administration promised to reimburse insurers for a significant portion of the costs incurred as a result of adverse selection.[139] There is still a large degree of uncertainty regarding how much this will ultimately cost taxpayers, and HHS declined to put forward any concrete numbers in their proposed rule: "[b]ecause of the difficulty associated with predicting State enforcement of 2014 market rules and estimating the enrollment in transitional plans and in QHPs, we cannot estimate the magnitude of this impact on aggregate risk corridors payments and charges at this time."[140]

But perhaps the biggest unknown factor is the future growth in overall health care costs. Since 2010, the real per capita annual

Figure 7
ACA Outlays and Revenues Through 2023



Sources: Congressional Budget Office, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," May 14, 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf; Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 24, 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

growth rate of national health expenditures is just 1.3 percent, less than one third of the long-term historical average growth rate of 4.5 percent annually, and substantially below the average growth rates recorded from 2000–2007 and over the three years immediately prior.[141] Should this trend continue, it would significantly reduce the cost of ACA.

The reasons for this slow down are unclear. Most observers believe that the recession, which lowered demand for health care as consumers responded to higher unemployment and lower incomes by decreasing their utilization of healthcare, was the most important factor. However, some experts now make the case that some provisions of ACA may have contributed to the slower growth.

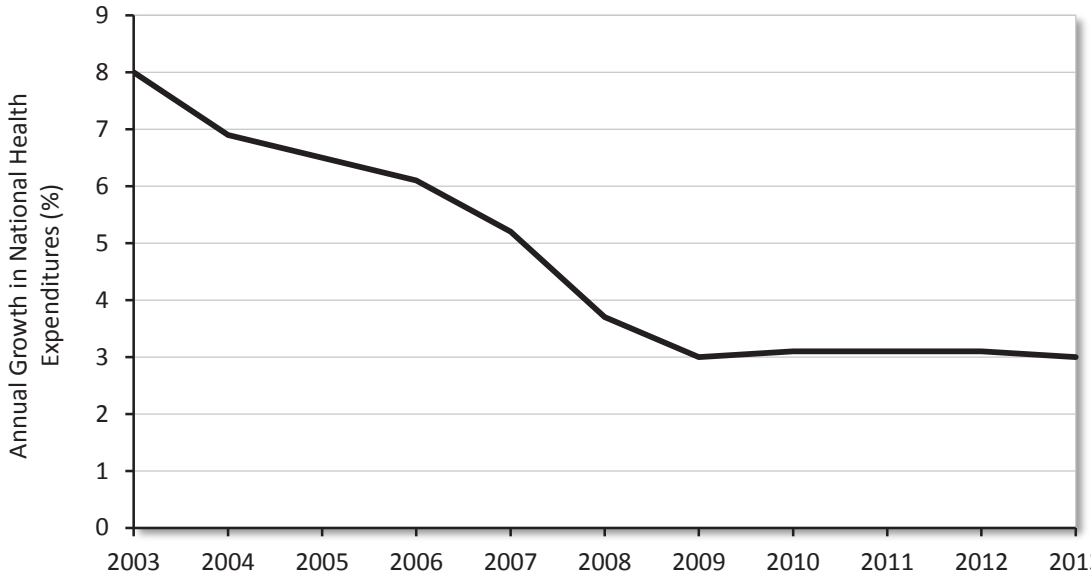
Clearly there are some provisions of ACA that are having a positive impact on health care costs. For example, the law introduced penalties to hospitals with high readmission rates, and the overall 30-day hospital readmission rates for Medicare patients are now nearly 1.5 percentage points below their average level from 2007–2011. While it is not clear how much of this reduction the law is responsible for, it is likely that it has had some positive effect, and these lower readmission rates do produce some cost savings.[142]

Other provisions are designed to reduce costs, such as creating Accountable Care Organizations (ACOs), narrower provider networks, excise taxes on expensive 'Cadillac' health insurance, and cuts to reimbursement rates for Medicare, but their success is as yet undetermined.[143]

Yet, one can easily go too far in attributing the slowdown in health care costs to ACA. As Figure 8 shows, the reduction actually began in 2003 and accelerated significantly in 2008–2009.[144] This later reduction was almost certainly impacted by the recession, although there's been no rebound during the recovery.

Perhaps the biggest unknown factor is the future growth in overall health care costs.

Figure 8
Annual Growth in National Health Expenditures



Sources: Center for Medicare and Medicaid Services, "National Health Expenditure Projections 2012–2022, Table 1 National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960–2012," September 18, 2013, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf.

There is reason to believe that the growth in health care spending might have been even lower without the Affordable Care Act.

At best, therefore, ACA may have helped hold cost increases at a stable, post-recession level.

On the other hand, there is reason to believe that the growth in health care spending might have been even lower without ACA. For example, the Centers for Medicare and Medicaid Services (CMS) recently reduced its estimate for future health care spending by $574 billion over the next 10 years.[145] The CMS provides four reasons why it changed its projections: 1) Medicare/Medicaid/other programs "unrelated to the ACA" (50.7 percent of improvement); 2) other factors "unrelated to the ACA" (26.1 percent); 3) updated data on historical spending growth (21.8 percent); and 4) updated macroeconomic assumptions (6.1percent). Working against those improvements, however, is ACA, which CMS estimates will increase spending by 3.7 percent, or $27 billion.[146]

Therefore, it's possible that there is a long-term trend toward slower cost growth in health care, but that it would be even more pronounced without ACA. Still, if the trend can be sustained it ultimately may mean lower long-term ACA costs than currently projected.

Government economists and actuaries appear divided about whether or not the trend is sustainable. As noted, CMS has lowered its projections for future health care cost growth. On the other hand, Medicare's trustees believe that the slow-down is a temporary phenomenon, and project a return to 4.3 percent annual growth in the future.[147] Similarly, CBO has left its projections for health care costs essentially unchanged. The CBO also sees ACA as adding to the burden that health care costs impose on the federal budget. It attributes 26 percent of the cost growth in federal health programs to implementation of this single law, and calls the program one of the biggest sources of future fiscal strains.[148]

There remains much uncertainty around how much ACA will cost. However, it seems a safe bet that the program will ultimately

cost significantly more than originally predicted.

It Will Hurt the Economy and Kill Jobs

Economic growth in the aftermath of the recession of 2009 has been sluggish, slower than recovery from most previous recessions. And unemployment remains high; it was 7.0 percent in November 2013.[149] Even this elevated unemployment rate could be masking how bleak the actual jobs picture is, as the employment population ratio remains near historic lows. Economists from across the political divide continue to debate the reasons for the slow recovery. However, the evidence continues to pile up suggesting that ACA has been a contributing factor to slow growth.

As discussed above, ACA requires business with 50 or more full-time employees to provide health insurance coverage to their workers or pay a penalty. That magic number of 50 becomes extremely important, since companies with fewer than that number of workers are not subject to the mandate; that is, they suffer no penalty for not providing insurance to their workers. Suppose, therefore, that a firm with 49 employees does not provide health benefits. Hiring one more worker will trigger a penalty of $2,000 per worker multiplied by the entire workforce, after subtracting the statutory exemption for the first 30 workers. If you were that small business owner with 49 employees, how fast would you run out to hire that fiftieth worker? (In France, another country where numerous government regulations kick in at 50 workers, there were 1,500 companies with 48 employees and 1,600 with 49 employees in 2011, but just 660 with 50 and only 500 with 51.)[150]

In fact, according to a Gallup poll conducted in the summer of 2013, 41 percent of small business owners said they have already held off on plans to hire new employees, and 38 percent said they've pulled back on plans to expand their businesses in other ways.[151] Another survey, conducted by the U.S. Chamber of Commerce and the International Franchise Association of businesses just above the 50-employee threshold found that 59 percent of franchises and 52 percent of non-franchises say that they "will make personnel changes to stay below the 50 full-time equivalent threshold."[152]

In addition to laying off workers, some companies appear to be trying to reduce the number of employees subject to the mandate either by reducing the number of current employees to under 50, or by shifting full-time workers to part time, for whom the mandate doesn't apply. According to a survey by Gallup, 19 percent of small businesses indicate that they have already laid off workers and a similar number have cut back their employees' hours.[153]

Even more significantly, numerous companies have reportedly reduced the work hours of some employees, so has to keep them below the 30-hour ceiling that would define them as "full-time" employees for purposes of the mandate. For example, during the second quarter of 2013, the number of Americans working 25 to 29 hours per week in their primary job rose by 119,000, or 2.7 percent. At the same time, the number of those working 30 to 34 hours fell by a monthly average of 146,500, a 1.4 percent decline.[154] The fast food and restaurant industry has been especially hard hit. Among the national chains and franchisees that have announced that ACA is forcing them to reduce employee hours: Applebee's, Buffalo Wild Wings, Del Taco, Denny's, FatBurger, Five Guys, Hardee's, IHOP, Olive Garden, Wendy's, and White Castle.[155]

Since President Obama took office in January 2009, the country has added 1.9 million part-time jobs but just a net total of 270,000 full-time jobs, meaning roughly 88 percent of all net new jobs added during President Obama's time in office have been part-time.[156] No doubt, some of this can be chalked up to the recession, which meant job losses and slow growth early in the presi-

Forty-one percent of small business owners said they have already held off on plans to hire new employees.

dent's term. But the trend has continued into the recovery and at least some of it appears due to employers' desire to keep workers below Obamacare's 30-hour cut-off for the employer mandate.

The Affordable Care Act does provide tax credits to small businesses that may offset some of the cost of providing insurance. However, those credits are available to relatively few businesses and will be used by even fewer. To be eligible, businesses must have fewer than 25 employees and an average wage of less than $50,000. Government projections estimated that as few as 12 percent of small businesses are expected to take advantage of the tax credit.[157] Moreover, the credit is fairly small: the average credit amount claimed per business was $7,200—well below the actual cost of providing insurance for their workers.[158]

Even companies well above the 50-employee cut off will be affected.

One factor limiting the credit's use is that, as mentioned above, most very small employers do not offer health insurance, especially very small employers with low average wages, which is who this tax credit is specifically targeted at. Most companies with a high proportion of low-wage employees do not offer health insurance; those that do are more likely to offer high deductible plans. As a result, the targeting of the tax credits severely limits the pool of qualified businesses. The number of small businesses that applied and could not use the full credit percentage was 142,200, or 83 percent. Usually employers could not meet the average wage requirement to claim the full percentage, as about 68 percent did not qualify based on wages but did meet the FTE requirement.[159]

According to a GAO report, many employer representatives, tax preparers, and insurance brokers felt that the credit was not large enough to incentivize employers to begin offering insurance. Small business owners generally do not want to spend the time or money to gather the necessary information to calculate the credit, given that the credit will likely be insubstantial. Tax preparers told us it could take their clients from 2 to 8 hours or possibly longer to gather the necessary information to calculate the credit and that the tax preparers spent, in general, 3 to 5 hours calculating the credit.[160] Due to these factors, the actual impact of the tax credit has been much smaller than expected, coming in far short of initial estimates. Only about 170,300 small employers made claims for the credit in 2010.[161] The Council of Economic Advisors estimated 4 million and SBA estimated 2.6 million. Other groups making estimates included small business groups such as the Small Business Majority (SBM) and the National Federation of Independent Businesses (NFIB). Their estimates were 4 million and 1.4 million, respectively.[162] One of the few aspects of the law designed specifically to help businesses has had a minimal impact so far, and other aspects are outright hurting businesses.

Even companies well above the 50-employee cut-off will be affected. Nearly all economists agree that the amount of compensation each worker receives is a function of his or her productivity, and the employer is indifferent to the makeup of that compensation between wages, taxes, insurance premiums, or other costs associated with that worker's employment. Mandating an increase in a worker's compensation (through the provision of health insurance) increases the worker's operating costs without increasing the worker's productivity.

Roughly 96 percent of those companies offer health insurance today.[163] But, as discussed above, ACA may drive up the cost of that insurance, both through general premium hikes and by requiring businesses to offer a more expansive—and—expensive benefits package. Either way, employers must find ways to offset the added costs imposed by the mandate. Whether that is done by reducing wages and benefits, increasing prices, or, most likely, reducing employment, the impact on the economy will be negative.

The availability of subsidies may also induce some workers to quit their jobs voluntarily, especially older workers seeking early retirement. The CBO recently warned that due to the law, the equivalent of 800,000 full-

time workers will leave the labor force over the next 10 years.[164] Similarly, Craig Garthwaite of Northwestern University estimates that ACA subsidies will lead to as many as 940,000 workers leaving the labor force.[165] Casey Mulligan of the University of Chicago predicts that, as a result of ACA, Americans will work 3 percent less in 2015 than they otherwise would have.[166]

While that may well be good news for those workers who are now able to retire earlier than they otherwise would have, the loss of those workers, many at the peak of their productivity, will hurt the economy as a whole.

Beyond the cost and pressures of the employer mandate and rising premiums, ACA includes roughly $1.18 trillion in new or increased taxes through 2023.[167]

The 2.3 percent gross income tax on medical device manufacturers alone is estimated to put as many as 43,000 jobs at risk.[168] A tax on insurers is projected to jeopardize another 125,000 to 249,000 jobs, according to the National Federation of Independent Businesses.[169] The impact of other taxes is harder to specify, but by raising taxes on capital, for example, ACA will reduce the availability of funding for future investment.[170]

Moreover, it's not just the direct cost of the taxes that will burden businesses. It is estimated that businesses will have to spend at least 127.6 million hours complying with the law.[171] That represents a significant loss of productive manpower.

Chris Conover of the Center for Health Policy and Inequalities Research at Duke University estimates that ACA's tax and regulatory burdens will reduce economic growth in this country by $157–550 billion over the next decade, and kill 1,139,000 to 1,625,000 jobs.[172]

On the other side of the equation, ACA advocates argue that if the law is successful in reducing health care costs it will add to economic growth and job creation. In addition, they say, by reducing insecurity and the fear of losing insurance, ACA can increase mobility between jobs and encourage entrepreneurs to start their own businesses.[173]

In the end, most observers agree that ACA will reduce total employment, although the exact mix of voluntarily induced departures and involuntary terminations is difficult to parse. Still, when one looks at the law in its entirety, it's hard to see it as anything but a job killer.

It Will Cover Fewer People than Projected

Passage of health care reform was heralded by some in the media as providing "near universal coverage."[174] Indeed, President Obama made it clear that one of the primary reasons he was pushing for health care reform was "it should mean that all Americans could get coverage."[175] But by this standard, the ACA falls far short of its goal.

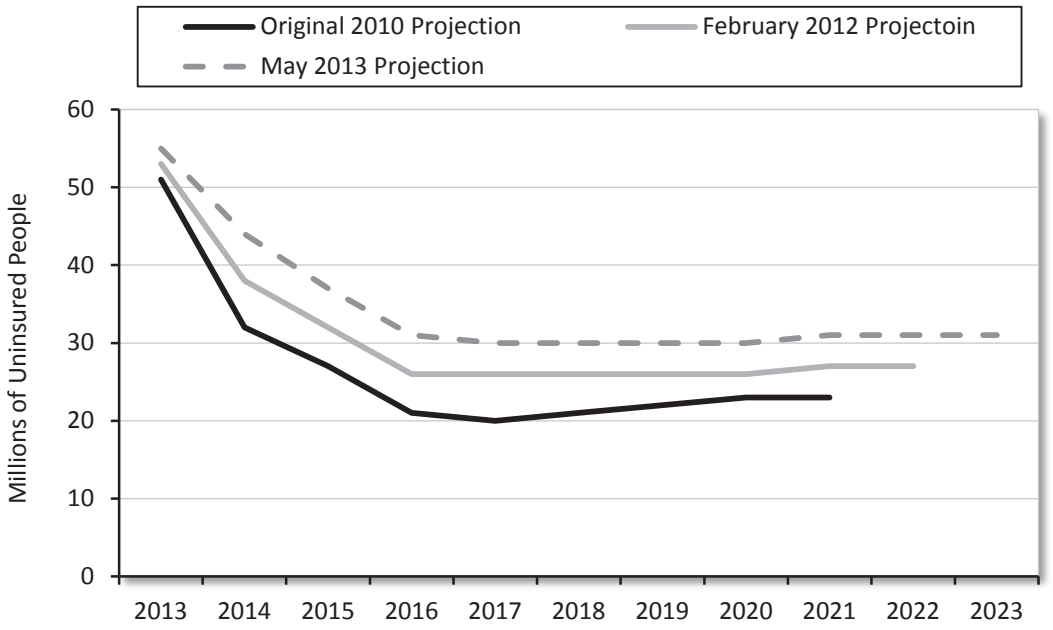
The CBO estimates that there were roughly 57 million uninsured Americans in 2013, and, in the absence of ACA, the number of uninsured Americans would remain roughly the same through 2023.[176] Despite the rhetoric surrounding the health care law, ACA was never intended to cover all uninsured Americans. Indeed, at the time the law passed, CBO estimated that roughly 32 million uninsured Americans would either be covered through Medicaid or private insurance, leaving some 28 million uninsured.

However, as Figure 9 shows, each successive estimate reduced the number of people who would gain coverage. The most recent estimates suggest that as few as 25 out of the 56 million uninsured would be covered as a result of ACA. Roughly 13 million of those would be enrolled in Medicaid, meaning just 12 million previously uninsured would receive private insurance coverage.

Part of the reason that coverage projections are lower than they were previously stems from the decision of 25 states not to expand their Medicaid programs. According to Kaiser, if those states maintain their opposition to the expansion, it would increase the number of Americans who remain uninsured by almost 5 million.[177] However,

The 2.3 percent gross income tax on medical device manufacturers alone is estimated to put as many as 43,000 jobs at risk.

Figure 9
Changing Estimates of ACA Effect on Uninsured Population



Sources: Congressional Budget Office, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," May 14, 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf; Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 13, 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf; Congressional Budget Office, "H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation)," March 20, 2010, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

another contributing factor is an increase in the number of Americans expected to forgo insurance and pay the penalty instead. A Gallup poll in December 2013 indicated that at least 28 percent of currently uninsured Americans say they will not purchase insurance under the ACA, despite the law's mandate.[178]

Moreover, ACA provides an exemption from the individual mandate for individuals who cannot find affordable coverage in their area (defined as costing less than 9.5 percent of their income).[179] It is notable that a study published in Health Affairs concludes that most of those remaining uninsured will be low-income workers.[180] Thus, even by its own standards for success, ACA appears to be coming up short.

Even by its own standards for success, the Affordable Care Act appears to be coming up short.

What We Still Don't Know

As former Defense Secretary Donald Rumsfeld said in another context, "[t]here are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know."[181]

In this case, while many of ACA's problems have already become apparent, some crucial questions remain. What we have learned in the years since ACA became law has exposed fundamental flaws in the law and serious consequences for patients, providers, taxpayers, and businesses, but the yet unanswered questions may be even more im-

portant to whether or not the law can survive at all.

Will Adverse Selection Cause a Systemwide Collapse?

As we have seen, enrollment in exchange-based health insurance has been far lower than anticipated. Both administration and CBO projections anticipated that roughly 7 million Americans would purchase health insurance through exchanges by March 2014. Although there is still time remaining before the deadline, fewer than 2.1 million people have selected a plan so far.[182] Some observers now believe that something in the range of 4 million will sign up before the deadline, far fewer than the 7 million initially projected.[183]

This by itself is not an insurmountable problem. More important is who is enrolling.

By and large, young people are healthier and use fewer health care services than do those who are older. For example, only 2.7 percent of those aged 18–34 rate themselves in "fair" or "poor" health, while 5.3 percent of those aged 35–50 and 9.6 percent of those aged 51–64 do so. Those 18–34 year olds see a doctor only 2.7 times per year on average, but 35–50 year olds average 3.3 physician visits per year, and those aged 51–64 average 4.8 visits.[184]

If the insurance pool is composed largely of people who are older and sicker, and who therefore use more (and more expensive) health care, insurance prices will rise to cover their costs. That rate increase will then cause even more young and healthy people drop their insurance, leaving the pools comprised of more older and sicker individuals than before. That raises premiums yet again, leading to the healthiest remaining participants to drop out, and so on. Actuaries refer to this as the "adverse selection death spiral."

In order to avoid such a death spiral, the Obama administration estimated that it will need roughly 38 percent of people buying insurance through the exchanges to be under the age of 35.[185] The early demographic data suggests that actual enrollment is falling far short of this goal. Enrollment data released in January by HHS estimated that just 24 percent of those signing up for insurance were aged 18–35.[186] Data available from individual states appears equally troubling. For example, in Connecticut and Kentucky, fewer than 20 percent of those buying insurance on the exchanges were under 35. In Maryland, the early numbers are only slightly better, at around 27 percent.[187] Even in California, where the website has functioned more smoothly (presumably making it more attractive for young people), just 22 percent of those enrolling are young and healthy, while 56 percent of those signing up are over the age of 45.[188] Humana, one of the nation's largest insurers, reports that, so far, enrollment in its exchange-based plans has been far "more adverse than previously expected."[189]

Of course, the federal government (as well as most states) has not yet reported demographic information on their enrollees, and there is still time for things to change before the open enrollment period ends on March 31. The experience with the Massachusetts health plan passed in 2006, commonly referred to as "Romneycare," suggests that young people may sign up late in the process.[190] And the problems with the website rollout have distorted the entire process. Still, if the trend continues, it's hard not to see a significant adverse selection problem developing.

It's not difficult to understand the underlying problem. The young and healthy frequently see less need for health insurance, leading health care experts to refer to this group as "young invincibles." As Solicitor General Donald Verilli explained while defending the individual mandate before the Supreme Court, "healthy individuals have an incentive to stay out until their need for insurance arises while, at the same

Health and Human Services estimated that just 24 percent of those signing up for insurance were aged 18–35.

time, those with the most serious immediate health care needs have a strong incentive to obtain coverage."[191]

As noted above, ACA compounds the problem because the law's ban on medical underwriting and limitations on age-based premiums means that the young and healthy are, in effect, being asked to overpay for their insurance. The individual mandate is designed to encourage those young invincibles in particular to enroll, but the penalty is small enough that it may not be especially successful in doing so. Despite the mandate, it is generally cheaper to "pay" than to "play." For example, a study by the National Center for Public Policy Research found that roughly 3.7 million of the estimated 6 million childless Americans aged 18–34 who are eligible to purchase insurance through exchanges would save at least $500 per year if they decided to forgo insurance and pay the law's tax penalty instead.[192]

The young and healthy can go uninsured (paying the penalty) while they remain healthy and buy insurance later if they become sick.

And, since ACA requires insurers to cover individuals with preexisting conditions, the young and healthy can go uninsured (paying the penalty) while they remain healthy and buy insurance later if they become sick.[193]

Recent evidence suggests that there may be additional problems that are making adverse selection worse. For example, younger Americans may be disproportionately enrolling in Medicaid. The early data indicates that Medicaid enrollment, brought about largely by ACA's expansion of the program's eligibility, has vastly exceeded the purchase of private insurance.

Significantly, the Medicaid expansion primarily extended the program to single, childless individuals, a category that heavily includes many young people. The Robert Woods Johnson Foundation estimates that more than half (52 percent) of those newly eligible for Medicaid as a result of ACA–nearly 5.4 million people—are aged 19–34.[194] Similarly, a study by scholars at the University of Michigan predicts that new Medicaid enrollees will be younger and healthier than current beneficiaries. In fact, the study suggested that the influx of young, healthy Medicaid patients would be so large that it would drop the average age of program participants from 38.7 years to 36.3. In addition, more than three quarters of likely new Medicaid recipients report that they are currently in "good" or "excellent" health.[195]

If large numbers of young and healthy enrollees continue to be enrolled in Medicaid rather than exchange-based private insurance, it will significantly reduce the pool of young and healthy available to the exchanges.

There may also be a problem with the way ACA's subsidies work in practice. Since subsidies are income-based, and since income generally rises with age, ACAs subsidies should be of particular benefit to young people, offsetting a large portion of their potential costs. But it may not be working out that way.

Recent analyses have shown that subsidies can actually be more generous to older people than younger ones.[196] This is because the subsidy calculation is based on the costs of the second lowest silver plan (on the federal exchanges, with most of the state exchanges choosing the same benchmark), a benchmark that is significantly higher for older workers than for younger ones, meaning the older workers may qualify for higher subsidies. If these older workers then purchase a cheaper bronze plan rather than the benchmark silver plan, the subsidies could in some cases be high enough that they end up paying less than a young person.

Take Alaska, for example: the benchmark silver plan premium for a 27-year-old is $312.30; for a 50-year-old, it is $532.23; and for a 64-year-old, it rises to $894. The benchmark plan that is used to calculate subsidies for the 64-year-old is close to three times higher than the one used to calculate subsidies for the 27-year-old. Therefore, if the 64-year-old and the 27-year-old person have the same income, the 64-year-old qualifies for significantly higher subsidies. He can then take those subsidies and choose to get a less expensive bronze plan, and the

higher subsidies would reduce his monthly premium to less than what the 27-year-old would have to pay.

The subsidy structure, therefore, encourages older and sicker Americans to enroll in the exchanges, but does not do much to encourage the young and healthy to buy insurance. A recent poll by Harvard's Institute of Politics found tepid interest in enrolling among these young, healthy people: among the 18 to 29-year-olds currently without health insurance, less than one third said they were likely to enroll through an exchange, and only 13 percent said they will definitely enroll.[197]

Finally, President Obama's decision to allow people to renew noncompliant insurance plans through 2014 may also increase adverse selection issues. Younger and healthier people are more likely to try to reclaim their previous, less expensive policies. Older and sicker consumers are more likely to forgo those plans and take advantage of the more comprehensive policies sold through state exchanges. Karen Ignagni, president of America's Health Insurance Plans (AHIP), the lobbying organization representing most insurers, warns that "The latest rule change could cause significant instability in the marketplace."[198]

The president compounded this by allowing individuals with cancelled policies to purchase catastrophic policies that would otherwise be available only to those under age 30, or to go without insurance altogether without facing a penalty under the individual mandate. For obvious reasons, healthy people are far more likely to take advantage of this option than sick people.

The ACA does have some safeguards against an adverse selection death spiral, at least in the first year. These include risk corridors, essentially a form of cost-sharing, between high- and low-performing health plans. If there is a significant level of adverse selection with a particular health plan, resulting in claims that greatly exceed estimates that were used to set initial premiums, the risk corridor program reimburses the plan for a portion of the plan's losses. While the risk-corridor will not cover all potential loses, it does create a modest level of protection, picking up 78 percent of claim costs between $45,000 and $250,000 per insured individual. The potential cost, paid for by a surcharge on insurance, is at least $25 billion. This bailout of the insurance industry is set to run through 2016. The administration has also promised additional bailouts for insurers who encounter added costs because of the changes to ACA that the administration has ordered. But those subsidies will encounter significant opposition in Congress.

ACA was always dependent on a gamble that enough young and healthy people could be induced to enter the insurance pool, even at inflated prices, to offset the costs of covering previously uninsured high-risk individuals. There is no way to tell whether that gamble has succeeded until the final enrollment deadline passes. Indeed, the final outcome might not be fully apparent for several years.

But the initial indications suggest that the worst case scenario, an adverse selection death spiral that drags down the entire insurance system, remains a very real possibility.

Will Doctors Revolt?

Even before ACA, health care experts estimated that the United States faced a shortage of at least 150,000 physicians, given the needs of a growing and aging population.[199] In fact, we have fewer doctors per capita than such countries as Portugal or Ukraine.[200] If, as some predict, ACA drives large numbers of physicians out of practice, the consequences for the American health care system could be severe.

It is, of course, far too early to know how physicians will react in practice. However, many appear to be at least open to the possibility of leaving. A 2009 IBD/TPP poll found that 45% of doctors would at least consider leaving their practices or taking early retirement as a result of the new health care law.[201] A survey by the Physicians Foundation found

An adverse selection death spiral remains a very real possibility under the Affordable Care Act.

A large-scale exodus of physicians from the health system could cause severe disruptions to health care services.

that roughly half of doctors planned to make changes to their practice that would reduce patient access.[202] In California, the head of the largest medical association in the state estimates that as many as 7 out of 10 could decide not to participate in the state health insurance exchanges, which would dramatically restrict options for exchange enrollees in the state.[203] Of course, not every doctor who told these polls that he or she would consider leaving the field will actually do so. But if even a small portion departs, our access to medical care will suffer.

Fundamental to the affordability of ACA are efforts to reduce physician reimbursements, both for government programs, such as Medicare and Medicaid, and for private insurance. Take, for example, the Independent Payment Advisory Board (IPAB). The ACA established this 15-member board and gave it responsibility to recommend changes to the procedures that Medicare will cover, and the criteria to determine when those services would be covered, provided its recommendations "improve the quality of care" or "improve the efficiency of the Medicare program's operation."[204]

Starting in 2018, if Medicare spending grows faster than 1 percent above the growth of GDP, IPAB must provide recommendations for reducing Medicare's growth to GDP plus 1 percent. Once IPAB makes its recommendations, Congress would have 30 days to vote to overrule them. If Congress does not act, the secretary of HHS would have the authority to implement those recommendations unilaterally. The IPAB is prohibited from making any recommendation that would ration care; increase revenues; or change benefits, eligibility, or Medicare beneficiary cost-sharing (including Medicare premiums).[205] That leaves IPAB with few options beyond reductions in provider payments. Hospitals and hospices would be exempt from any cuts until 2020.[206] Thus, most of the cuts would fall on physicians.

At the same time, as we saw above, ACA's added cost for insurers is driving them to reduce reimbursements as well.[207]

Physicians can expect their income to be squeezed from all sides. Yet, medicine is a demanding field, and the average medical school graduate begins their career with almost $170,000 in debt.[208]

For a lot of older physicians, retirement in Florida may begin to look like a very good option. Roughly 40 percent of doctors are age 55 or over. Are they really going to want to stick it out for a few more years if all they have to look forward to is more red tape (both government and insurance company) for less money? Those that remain are increasingly likely to join "concierge practices," limiting the number of patients they see and refusing both government and private insurance. At the same time, fewer young people are likely to decide that medicine is a good career.

As we saw above, it is already likely to become increasingly difficult to keep your current doctor. However, a large-scale exodus of physicians from the system could cause far more severe disruptions. In addition to increased wait times, a physician shortage could harm the quality of available care overall, especially if those leaving the practice include the most experienced doctors.

Beyond the question of whether doctors leave or restrict their practice, it's important to recognize the ways in which ACA restructures medical practices.

ACA emphasized close collaboration between health care providers through Accountable Care Organizations (ACOs) and bundled payments. This has led the share of private practice physicians to decline as they are folded into hospitals. A recent report by Accenture Health found that the number of private practice physicians has dropped from 57 percent in 2000 to 39 percent in 2012. By the end of 2013, Accenture estimates the market will be comprised of only 36 percent of independent physicians.[209]

Hospitals have been stepping in to fill this void, hiring an increasingly high proportion of physicians in anticipation of increased demand and a desire to capture as much market share as possible in the first

years of ACA implementation. A recent report estimates that hospitals will account for more than 75 percent of new physician hires within two years, and this trend will likely only continue in the future as private-practice physicians are squeezed out and more power is concentrated in large networks of hospitals.[210]

The ACA does include several provisions aimed at increasing the health care workforce. For instance, it increases funding for physician and nursing educational loan programs, and would expand loan forgiveness under the National Health Service Corps.[211] It also funds new educational centers in geriatric care, chronic-care management, and long-term care.[212]

And it takes more controversial steps toward increasing the supply of primary-care physicians by shifting reimbursement rates for government programs, such as Medicare and Medicaid, to reduce payments to specialists while increasing reimbursement for primary care.[213] However, for this shift to work the federal government would have to know the proper mix of primary-care physicians and specialists and fine-tune reimbursements in a way that will produce those results. Nothing in the government's previous activities suggests that such central planning would be effective.

The ACA sets the table for a potential widespread physician shortage. We don't yet know if this will occur or whether, despite their expressed concerns, physicians will ultimately adapt to the changes brought about by ACA. However, there are clearly ominous warning signs.

What Happens in the Courts?

The June 2012 Supreme Court decision upholding the individual mandate (and allowing states to opt out of the Medicaid expansion) was widely seen as marking the last major legal challenge to ACA. But that's not true. Several important challenges to major parts of the health care law are still making their way through the courts. While none of these have the high profile of *NFIB v. Sebelius*, they nonetheless hold the potential for undoing large parts of the law. In fact, at least one case could all but make ACA unworkable.

Subsidies on Federal Exchanges

Perhaps the biggest threat to ACA comes from the case of *Halbig v. Sebelius*. Filed in the United States District Court of the District of Columbia in May 2013, the case challenges the ability of the federal government to provide subsidies through federally operated exchanges.[214] Indeed, even the Congressional Research Service has warned that *Halbig* "could be a major obstacle to the implementation of the Act."

As noted above, if a state refuses to set up an exchange, ACA gives the federal government the authority to step in and operate an exchange itself in those states. This is what has happened in 34 states. However, the plain language of the law makes it clear that subsidies for insurance are available *only* through those exchanges that the states set up themselves.

Section 1311 of the law mandates the creation of health insurance exchanges to regulate health insurance within each state; it declares that "Each State shall . . . establish" an exchange. It also directs the federal government to establish one in states that do not. Section 1321 of the law offers health insurance subsidies to certain qualified taxpayers who enroll in a qualified health plan "through an Exchange established by the State under Section 1311."

So, while the federal government does have the power to create exchanges in states that refuse to do so, it cannot offer subsidies through those federally run exchanges. Moreover, it is those subsidies that actually trigger the penalty under Obamacare for employers who fail to provide workers with insurance. Therefore, if subsidies can be provided only through a state-authorized exchange, a state could potentially block the

Several important challenges to major parts of the health care law are still making their way through the courts.

employer mandate simply by refusing to establish an exchange.

The Obama administration and the IRS, unsurprisingly, have seen this differently, arguing that it was the law's intent to permit subsidies through federal exchanges, and that failure to include language to that effect was simply a technical error. The IRS therefore has crafted rules providing for such subsidies, with the secondary effect of imposing the employer mandate in states with federally operated exchanges.[215]

Four individual taxpayers and three employers challenged the IRS rule. The case is being heard in the D.C. District Court, and the initial rulings have benefited both sides. Judge Paul Friedman has ruled against the Obama administration's motion to dismiss the case, but also ruled against the preliminary injunction sought by the plaintiffs that would have stopped the subsidies from flowing while the case was being decided.[216] Oral arguments in the case proper were heard on December 3, 2013, and a decision is expected this spring. Regardless of the outcome, the losing side is expected to appeal. The case is likely to reach the Supreme Court in 2015 or 2016.

Mandated Contraceptive Coverage and Religious Liberty

In late November, the U.S. Supreme Court agreed to hear two cases on the contraception mandate, the provision of the law which requires employers to provide birth control coverage to their workers.[217]

Two separate but related contraception mandate challenges, both making similar arguments, will be heard by the Court, one from Hobby Lobby, a chain of craft stores, and the other from Conestoga Wood Specialties, a cabinet-making company. In both cases, the owners argue that the requirement to provide employers with contraceptive coverage is a violation of their religious liberty, citing the Religious Freedom Restoration Act (RFRA), which was passed during the Clinton administration. This law allows individuals to challenge regulations that place a substantial burden on their ability to practice their religion.

So far the two cases have met different results: Conestoga Wood Specialties lost its case in the 3rd Circuit Court of Appeals while Hobby Lobby won a preliminary injunction against the health law requirement in the 10th Circuit Court of Appeals.[218] The Department of Justice appealed the Hobby Lobby decision and the Supreme Court has agreed to hear the case. In his Supreme Court petition, the solicitor general argued that the 10th Circuit Court incorrectly applied the RFRA to Hobby Lobby because it is not a 'person' and therefore not covered.[219]

The Individual Mandate/Tax Revisited

As noted above, when the Supreme Court upheld the constitutionality of ACA, it did so on the grounds that the individual mandate was actually a tax. In the case of *Sissel v. Department of Health and Human Services*, the Pacific Legal Foundation argued that if the mandate is indeed a tax as the Supreme Court previously ruled, then it unconstitutionally originated in the Senate rather than the House (where all revenue measures are required to start).

The ACA's legislative origins are, in fact, quite tangled. In 2009, Congressman Charlie Rangel (D-NY) introduced a bill in the House, H.R. 3590, the "Service Members Home Ownership Tax Act of 2009," which was designed to make a change to the tax code regarding a homebuyers' credit for veterans an uncontroversial bill which passed the House unanimously (an especially rare feat in recent Congresses, which just goes to show how minor and uncontroversial the bill was). Senate Majority Leader Harry Reid (D-NV) introduced his own version of H.R. 3590 in the Senate, taking the uncontroversial veteran's tax credit bill renaming it the "Patient Protection and Affordable Care Act," and completely changing its contents into what eventually became the Senate version of ACA. While the bill did keep its original House number from Rangel's bill in the House, the Pacific Legal Foundation and

The Affordable Care Act's legislative origins are quite tangled.

others argue that it still violates the origination clause because ACA contains none of the original content of that House bill.

On June 28, 2013, District Court Judge Beryl A. Howell rejected that argument, ruling that the Supreme Court had already decided on the law's constitutionality and that the revenue-raising portion of Obamacare was "incidental" to its main mission.[220] In response, the Pacific Legal Foundation has appealed to the D.C. Circuit Court of Appeals, where proceedings are pending, and oral arguments are expected to take place in the next year.

The case has gained some support in Congress, as 40 House Republicans filed a brief in support of the challenge.[221] If the Supreme Court were to rule that the mandate violated the origination clause, it would essentially inviolate the entire law.

The Independent Payment Advisory Board and the Delegation of Powers

In *Coons v. Geithner*, the Goldwater Institute has filed suit challenging the establishment of the Independent Payment Advisory Board (IPAB).[222] The Goldwater Institute is representing Nick Coons (a computer sales and repair businessman living in Arizona, who will face the individual mandate penalties if he fails to buy health insurance), 30 Arizona state lawmakers, and members of the House of Representatives Jeff Flake and Trent Franks. The suit makes two arguments: that the individual mandate violates the plaintiff's (Coons) rights to medical autonomy and privacy guaranteed by the Fourth, Fifth, and Ninth Amendments; and that Congress cannot constitutionally delegate its lawmaking authority to an unelected third party, in this case IPAB, because it denies Congressmen "their legislative power and right to review, debate and vote on the legislative proposals of IPAB like any other legislative proposal."[223]

The case was dismissed by Judge G. Murray Snow in the United States District Court for Arizona. The argument that the law violated Coons's right to autonomy and privacy was dismissed on the grounds that ACA does not violate the plaintiff's due-process rights because the Act provides him with the option to directly pay for health care services by paying the tax penalty. Judge Snow also dismissed the IPAB argument, ruling that Congress had followed established doctrine in passing the law, and had not unconstitutionally delegated its authority to IPAB. The Goldwater Institute has appealed to the 9th Circuit Court of Appeals. Oral arguments are scheduled for January 28, 2014.

The implications of this case may be greater for the constitutional separation of powers and Congress's long-standing practice of delegation on issues such as environmental protection other than on ACA itself. However, IPAB is an important component of ACA's financing mechanism—reducing Medicare spending and shifting those funds to ACA subsidies. If IPAB were to be struck down, it could make ACA even more financially unsustainable than it already is.

It will likely take many years for all these legal challenges to play out. Indeed, there may be additional challenges to come. But until the courts have had their final say, ACA's ultimate fate will remain uncertain.

The Independent Payment Advisory Board is an important component of the Affordable Care Act's financing mechanism.

Conclusion

Health care reform was designed to accomplish three goals: provide health insurance coverage for all Americans, reduce insurance costs for individuals, businesses, and government, and increase the quality of health care and the value received for each dollar of health care spending. With nearly four years of experience since the law passed, and with the most significant provisions finally kicking in, we can say that, judged by these goals, the new law should be considered a colossal failure.

The president and the law's supporters in Congress also promised that the legislation would not increase the federal budget deficit or unduly burden the economy. And, of course, we were repeatedly promised that

At least 31 million Americans will still be uninsured by 2023.

"If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what."[224] On these grounds too, the Patient Protection and Affordable Care Act doesn't come close to living up to its promises. Individual and employer mandates will ultimately force individuals and businesses to change their plans in order to comply with the government's new standards for insurance, even if the new plans are more expensive or contain benefits that people don't want.

It could be said that ACA comes closest to success on the issue of expanding the number of Americans with insurance. Clearly, as a result of this law, millions more Americans will receive coverage, mainly from an expansion of government subsidies and other programs, with nearly half of the newly insured coming through the troubled Medicaid program. Yet, at least 31 million Americans will still be uninsured by 2023. On this dimension, therefore, the new law is an improvement over the status quo, but a surprisingly modest one.

The law also makes some modest insurance reforms that will prohibit some of the industry's more unpopular practices. However, those changes come at the price of increased insurance costs, especially for younger and healthier individuals, and reduced consumer choice.

At the same time, the legislation is a major failure when it comes to controlling costs. While we were once promised that health care reform would "bend the cost curve down,"[225] this law will actually *increase* U.S. health care spending. This failure to control costs means that the law will add significantly to the already crushing burden of government spending, taxes, and debt. Accurately measured, the Patient Protection and Affordable Care Act will cost more than $2.35 trillion over the next 10 years, and add more than $1.16 trillion to the national debt.

It is not just government that will face higher costs under this law. In fact, millions of Americans will actually see their premiums go up faster as a result of this legislation.

The Patient Protection and Affordable Care Act will also significantly burden businesses, thereby posing a substantial threat to economic growth and job creation. While some businesses may respond to the law's employer mandate by choosing to pay the penalty and dumping their workers into public programs, many others will be forced to offset increased costs by reducing wages, benefits, or employment.

The legislation also imposes more than $1 trillion in new or increased taxes, the vast majority of which will fall on businesses. Many of those taxes, especially those on hospitals, insurers, and medical-device manufacturers, will ultimately be passed along through higher health care costs. But other taxes, in particular new taxes on investment income, are likely to reduce economic and job growth. Businesses will also face new administrative and recordkeeping requirements under this legislation that will also increase their costs, reducing their ability to hire, expand, or increase compensation.

It is also becoming increasingly clear that millions of Americans will not be able to keep their current coverage. While the final bill grandfathered current plans, the reality is that Americans will still be forced to change coverage to a plan that meets government requirements, if there have been any changes to their current plans since 2010. And, by forbidding noncompliant plans from enrolling any new customers, the law makes those plans nonviable over the long term. Already more than 4.5 million Americans with individual coverage have been forced to change plans. And, when the employer mandate takes effect in 2015, millions more will have to do likewise.

All of this represents an enormous price to pay in exchange for the law's small increases in insurance coverage. There is very little "bang for the buck."

Even more significantly, this law represents a fundamental shift in the debate over how to reform health care. It rejects consumer-oriented reforms in favor of a top-down, "command and control," government-im-

posed solution. As such, it sets the stage for potentially increased government involvement, and raises the specter, ultimately, of a government-run single-payer system down the road.

The debate over health care reform now moves to other forums. Numerous lawsuits have been filed challenging provisions of the law. And the law will almost certainly be a central issue in the 2014 midterm elections. But one thing is certain—the debate over health care reform is far from over.

Appendix A: Premium Rates in the Exchanges

State	Age	Minimum Bronze Rate in State	Minimum Silver Rate in State	2nd Lowest Silver Rate in State	Minimum Gold Rate in State
Alabama	27	148.28	183.78	194.95	235.82
	50	252.70	313.19	332.23	401.89
	64	424.47	526.08	558.06	675.06
Alaska	27	253.62	312.30	312.30	391.95
	50	432.21	532.23	532.23	667.96
	64	726.00	894.00	894.00	1,122.00
Arizona	27	119.12	136.17	138.15	154.99
	50	203.00	232.05	235.43	264.13
	64	340.98	389.79	395.46	443.67
Arkansas	27	169.82	215.51	224.71	249.90
	50	289.40	367.27	382.95	420.76
	64	486.12	616.92	643.26	706.77
California	27	153.90	181.63	197.96	207.52
	40	177.30	221.40	241.22	253.07
	64	440.56	519.94	566.69	594.06
Colorado	27	145.05	190.98	196.73	224.22
	40	176.89	232.90	239.91	273.43
	64	487.15	546.71	563.16	684.25
Connecticut	27	190.30	259.26	269.33	292.91
	40	232.07	316.15	328.43	357.20
	64	544.77	742.15	770.97	838.51
D.C.	27	124.04	177.76	180.69	206.32
	40	166.36	238.39	242.33	276.71
	64	372.14	533.27	542.08	618.98

Appendix A *Continued*

State	Age	Minimum Bronze Rate in State	Minimum Silver Rate in State	2nd Lowest Silver Rate in State	Minimum Gold Rate in State
Delaware	27	202.85	234.37	237.15	282.16
	50	345.70	399.42	404.15	480.86
	64	580.68	670.92	678.87	807.72
Florida	27	128.12	167.00	190.89	188.54
	50	218.34	284.60	325.32	321.30
	64	366.75	478.05	546.45	539.70
Georgia	27	163.65	187.80	195.69	214.21
	50	278.88	320.05	333.50	365.06
	64	468.45	537.60	560.19	613.20
Idaho	27	144.50	178.65	178.94	207.59
	50	246.25	304.46	304.94	353.77
	64	413.64	511.41	512.22	594.24
Illinois	27	113.72	157.03	165.57	194.08
	50	193.80	267.61	282.17	330.75
	64	325.23	449.52	473.97	555.57
Indiana	27	164.37	214.83	224.32	284.50
	50	280.12	366.11	382.29	484.85
	64	470.52	614.97	642.15	814.41
Iowa	27	122.18	157.55	162.71	177.88
	50	208.21	268.49	277.29	303.14
	64	349.74	450.99	465.78	509.19
Kansas	27	121.22	162.01	162.01	179.00
	50	206.59	276.10	276.10	305.05
	64	347.01	463.77	463.77	512.40
Kentucky	27	127.25	157.36	160.46	178.14
	40	155.18	191.83	195.67	217.24
	64	364.29	450.30	499.33	509.97
Louisiana	27	163.19	208.99	238.94	238.36
	50	278.12	356.16	407.21	406.21
	64	467.16	598.26	684.00	682.32
Maine	27	192.41	232.53	241.89	306.47
	50	327.91	396.28	412.23	522.28
	64	550.80	665.64	692.43	877.29

Appendix A *Continued*

State	Age	Minimum Bronze Rate in State	Minimum Silver Rate in State	2nd Lowest Silver Rate in State	Minimum Gold Rate in State
Maryland	27	110.04	171.87	173.96	197.02
	40	134.19	209.54	212.14	240.26
	64	315.00	492.00	498.00	564.00
Massachusetts	27	203.32	242.37	244.46	293.95
	40	232.15	276.74	279.12	335.64
	64	394.15	469.85	473.89	569.84
Michigan	27	126.58	156.17	183.75	180.64
	50	215.71	266.15	313.14	307.85
	64	362.34	447.06	525.99	517.11
Minnesota	27	94.56	126.21	126.57	147.34
	40	115.31	153.90	154.35	179.68
	64	270.69	361.29	362.34	421.80
Mississippi	27	189.37	214.78	267.84	244.96
	50	322.73	366.02	456.45	417.46
	64	542.10	614.82	766.71	701.22
Missouri	27	146.85	195.18	195.18	213.38
	50	250.25	332.62	332.62	363.65
	64	420.36	558.72	558.72	610.83
Montana	27	162.50	199.12	204.36	218.74
	50	276.94	339.34	348.27	372.77
	64	465.18	570.00	585.00	626.16
Nebraska	27	152.92	179.01	185.93	208.55
	50	260.61	305.07	316.85	355.41
	64	437.76	512.46	532.23	597.00
Nevada	27	149.72	194.45	195.41	213.18
	40	182.58	231.13	238.29	259.97
	64	428.61	556.65	559.38	610.26
New Hampshire	27	185.95	236.46	237.24	280.72
	50	316.89	402.98	404.30	478.40
	64	532.29	676.89	679.11	803.59
New Jersey	27	218.72	252.52	260.40	303.32
	50	372.74	430.34	443.77	516.92
	64	626.10	722.85	745.41	868.29

Appendix A *Continued*

State	Age	Minimum Bronze Rate in State	Minimum Silver Rate in State	2nd Lowest Silver Rate in State	Minimum Gold Rate in State
New Mexico	27	126.33	154.59	159.39	186.42
	50	215.28	263.45	271.63	317.69
	64	361.62	442.53	456.27	533.64
New York	27	332.80	332.80	332.80	332.80
	40	332.80	332.80	332.80	332.80
	64	233.18	293.93	294.41	332.80
North Carolina	27	160.85	215.10	220.57	250.27
	50	274.12	366.58	375.90	426.51
	64	460.44	615.75	631.41	716.43
North Dakota	27	174.95	217.28	222.41	241.53
	50	298.15	370.29	379.02	411.62
	64	500.82	621.99	636.66	691.41
Ohio	27	151.98	177.27	195.57	202.18
	50	259.01	302.10	333.29	344.56
	64	435.06	507.45	559.83	578.76
Oklahoma	27	100.37	150.77	157.02	193.75
	50	171.05	256.93	267.60	330.20
	64	287.31	431.58	449.49	554.64
Oregon	27	135.19	144.85	158.24	201.56
	40	164.86	176.65	192.97	245.79
	64	387.00	414.66	453.00	576.99
Pennsylvania	27	119.19	133.83	139.38	169.00
	50	203.12	228.07	237.54	288.01
	64	341.19	383.10	399.00	483.78
Rhode Island	27	173.96	224.72	241.04	273.58
	40	212.15	273.49	293.94	333.56
	64	498.00	642.00	690.00	783.00
South Carolina	27	149.84	186.32	188.65	224.32
	50	255.36	317.53	321.50	382.29
	64	428.94	533.37	540.03	642.15
South Dakota	27	196.19	207.02	216.82	251.12
	50	334.34	352.81	369.51	427.96
	64	561.60	592.62	620.67	718.86

Appendix A *Continued*

State	Age	Minimum Bronze Rate in State	Minimum Silver Rate in State	2nd Lowest Silver Rate in State	Minimum Gold Rate in State
Tennessee	27	113.05	147.34	153.37	194.14
	50	192.66	251.09	261.38	330.86
	64	323.61	421.77	439.05	555.75
Texas	27	108.53	152.56	154.75	174.01
	50	184.96	259.99	263.72	296.55
	64	310.68	436.71	442.98	498.12
Utah	27	143.16	162.34	196.67	188.01
	50	219.06	248.41	300.95	287.70
	64	308.97	350.37	424.47	405.78
Vermont	27	346.08	441.38	442.45	531.66
	40	346.08	441.38	442.45	531.66
	64	346.08	441.38	442.45	531.66
Virginia	27	139.42	188.26	207.18	213.00
	50	237.59	320.84	353.07	362.99
	64	399.09	538.92	593.07	609.72
West Virginia	27	164.22	193.93	193.93	236.00
	50	279.87	330.50	330.50	402.53
	64	470.10	555.15	555.15	676.14
Wisconsin	27	146.63	197.34	200.18	240.66
	50	249.88	336.30	341.14	410.14
	64	419.73	564.90	573.03	688.92
Wyoming	27	271.05	307.25	323.58	346.09
	50	461.93	523.62	551.45	589.81
	64	775.92	879.54	926.28	990.72

Sources: Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplace Premiums for 2014 Databook," U.S. Department of Health & Human Services, September 25, 2013, http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/Marketplace_premium_databook_2014.xlsx; state exchange data provided byYevgeniy Feyman of the Manhattan Institute from the study. Avik Roy, "49-State Analysis: Obamacare To Increase Individual-Market Premiums By Average Of 41%," *Forbes*, November 4, 2013, http://www.forbes.com/sites/theapothecary/2013/11/04/49-state-analysis-obamacare-to-increase-individual-market-premiums-by-avg-of-41-subsidies-flow-to-elderly/.

Notes

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2. United States Department of Labor, "Fact Sheet: Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families," http://www.dol.gov/ebsa/newsroom/fsdependentcoverage.html.

3. The term "train wreck" was first used by Sen. Max Baucus (D-MT), chairman of the Senate Finance Committee, on April 17, 2013, in a warning about impending problems with the exchange computer system. Senate Budget Committee hearing, April 17, 2013, Political Transcript Wire.

4. Barack Obama, "Remarks by the President on the Affordable Care Act at the Rose Garden," October 21, 2013, http://www.whitehouse.gov/the-press-office/2013/10/21/remarks-president-affordable-care-act.

5. There are 2,562 pages and 511,520 words when both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act are combined.

6. "Four Key Questions for Health-Care Law," *Wall Street Journal*, February 14, 2013.

7. Curtis Copeland, "New Entities Created Pursuant to the Patient Protection and Affordable Care Act," Congressional Research Service, July 8, 2010.

8. Among provisions that have been postponed are: the employer mandate; reporting requirements related to the employer mandate and subsidy determinations; small business exchange (SHOP) enrollment; out-of-pocket caps (in some instances); cuts to disproportionate share hospitals; and the Basic Health Plan option. The administration has also extended the deadline for the closure of state high-risk pools and the deadline for health plans to comply with the essential health benefits in the law. Most recently, the administration exempted individuals whose policies have been cancelled from the individual mandate.

9. While most of the changes to the law have been enacted by the administration, some were passed by Congress. Most recently, the American Taxpayer Relief Act of 2012 officially repealed the Community Living Assistance Services and Supports (CLASS) Act. The Middle Class Tax Relief and Job Creation Act of 2012 postponed cuts to hospitals that serve a disproportionate number of uninsured or underinsured patients. The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 repealed the requirement that businesses file a 1099 form whenever they pay a vendor more than $600 in a single year. C. Stephen Redhead and Janet Kinzer, "Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act," Congressional Research Service, November 22, 2013.

10. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Subtitle F, Part I, § 1501 (2010), as amended by the Health Care and Education Affordability Reconciliation Act, § 1002. Note this amends Subtitle D of Chapter 48 of the Internal Revenue Code of 1986.

11. Ibid.

12. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Subtitle D, § 1302(b)(1) (2010).

13. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

14. Roberts' ruling could also make it difficult to fix the adverse-selection problem, should it develop. If the penalty for noncompliance was raised to a sufficiently coercive level so as to make people buy insurance, by Roberts' logic, it would no longer be a tax, but a mandate—something that he has said would be unconstitutional. In effect, Roberts has said that ACA's individual mandate is constitutional precisely because it won't work.

15. Kathleen Sebelius, "Letter to the Honorable Mark Warner," Department of Health and Human Services, December 19, 2013.

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17. Mark Mazur, "Continuing to Implement the ACA in a Careful, Thoughtful Manner," U.S. Department of the Treasury, July 2, 2013.

18. Kaiser Family Foundation, "2013 Employer Health Benefits Survey," August 20, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf.

19. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Title 1, Part A, Subtitle II, § 2714 (2010).

20. Michael E. Martinez and Robin A. Cohen, "Health Insurance Coverage: National Health Interview Survey, January-June 2011," National Center for Health Statistics, December 2011. It should be pointed out that this provision does come with a price tag. The Department of Health and Human Services estimates that every dependent added to a policy will increase premiums by $3,380 per year. Ricardo Alonso-Zaldivar, "New Coverage for Young Adults Will Raise Premiums," Associated Press, May 10, 2010. This is likely one reason why many companies have dropped coverage for dependents altogether.

21. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Title 1, Subtitle A, Subpart II, § 2711 (2010). Before the passage of the ACA, roughly 40 percent of insured Americans already had policies with no lifetime caps. For those policies that did have a cap on lifetime benefits, that cap was usually somewhere between $2.5 and 5 million, with many running as high as $8 million—amounts that very few people ever reached. Still, some individuals with chronic or catastrophic conditions will undoubtedly benefit from this provision, although there are no solid estimates on how many.

22. Public Health Service Act, Title XXVII, Part A, Section 2712, as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Title I, Subtitle A, § 1001 (2010).

23. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Title IX, Subtitle A, § 9016(a) (2010).

24. Center for Medicare and Medicaid Services, "80/20 Rule Delivers More Value to Consumers in 2012," http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf.

25. Public Health Service Act, Title XXVII, Part A, § 2705(a)(1-9), as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Title I, Subtitle C, § 1201 (2010).

26. Public Health Service Act, Title XXVII, Part A, § 2702(a), as amended by Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Title I, Subtitle C, § 1201 (2010). The ban on medical underwriting may not be as effective as proponents hope in making insurance available to those with preexisting conditions. Insurance companies have a variety of mechanisms for evading such restrictions. A simple example is for insurers to focus their advertising on young healthy people, or they can locate their offices on the top floor of a building with no elevator or provide free health club memberships while failing to include any oncologists in their network.

27. Public Health Service Act, Title XXVII, Part A, § 2701, as amended by Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, Title I, Subtitle C, § 1201 (2010).

28. Public Health Service Act, Title XXVII, Part A, § 2701(a)(1)(A)(iii), as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, Title I, Subtitle C, § 1201 (2010).

29. Public Health Service Act, Title XXVII, Part A, § 2701(a)(1)(A)(iv), as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, Title I, Subtitle C, § 1201 (2010).

30. Public Health Service Act, Title XXVII, Part A, § 2701(a)(1)(B), as amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, Title I, Subtitle C, § 1201 (2010).

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32. Kaiser Family Foundation, "State Decisions on Health Insurance Marketplaces and the Medicaid Expansion" http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/.

33. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 Part II, Subtitle D, Subpart 2, §1302 (2010).

34. Ibid.

35. Author's analysis of information available at Department of Health and Human Services, "QHP Individual Medical Landscape," https://data.healthcare.gov/dataset/QHP-Individual-Medical-Landscape/ba45-xusy.

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