

2011-PB-10  
October 2011

## **Why ObamaCare Must Be Repealed So We Can Begin Real Health Reform**

**Grace-Marie Turner**

**Abstract:** There is no question that we need changes in our health sector. But numerous independent studies have shown that the Affordable Care Act will fail to achieve its goals and will cause harm by trying to inflict too much change too suddenly. Medicaid and job-based health insurance are just two examples. As many as 25 million people will be added to Medicaid's rolls; this means those already on the program will be competing for the limited number of physicians, especially specialists, who treat Medicaid patients, making it even more difficult for those on the program to access care. The legislation also will cause tremendous disruption in employment-based insurance, with estimates that as many as 80 million people will not be able to keep the coverage they have now and will be forced to have coverage directed by Washington. The law also is deterring employers from hiring new workers until they know the cost of the mandated insurance. In the next phase of the health policy debate, leaders in Congress must develop a smaller, more reasonable approach to health reform that empowers consumers as partners in managing health care and health spending decisions, with more choices of coverage in a market where insurers are competing to provide the best policies at the most affordable prices.

**About the Author:** **Grace-Marie Turner** is president of the Galen Institute, a public policy research organization that she founded in 1995 to promote an informed debate over free-market ideas for health reform. She has been instrumental in developing and promoting ideas for reform that transfer power over health care decisions to doctors and patients. She speaks and writes extensively about incentives to promote a more competitive, patient-centered marketplace in the health sector. Turner is founder and facilitator of the Health Policy Consensus Group which serves as a forum for analysts from market-oriented think tanks around the country to analyze and develop policy recommendations. She is the editor of *Empowering Health Care Consumers through Tax Reform* and produces a widely-read weekly electronic newsletter, *Health Policy Matters*.

**Keywords:** PPACA, Medicaid, health reform, employment-based health insurance.

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*A not-for-profit health and tax policy research organization*

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## **Why ObamaCare Must Be Repealed So We Can Begin Real Health Reform**

By Grace-Marie Turner

There is no question that we need changes to our health sector. Health costs continue to rise faster than inflation and tens of millions of people do not have health coverage. The Patient Protection and Affordable Care Act (PPACA) was passed on the promise that it would reduce the cost of health insurance, provide near-universal coverage, make health coverage more secure for families, improve the sustainability of Medicare, reduce the burden on businesses so they could be more competitive, cut the federal budget deficit, and offer people more choices of better health insurance.

But numerous independent studies have shown that the legislation will fail to achieve these goals and will cause many other problems in its wake.

Studies show the legislation will:

- increase the cost of health care and health coverage<sup>1 2</sup>
- create major distortions in health insurance markets that will force millions of people to lose their current coverage<sup>3</sup>
- drive many people who currently have private coverage into taxpayer-supported plans<sup>4</sup>
- threaten access to care for millions of seniors<sup>5</sup>
- take money out of Medicare not to enhance its solvency but to fund new entitlements<sup>6 7</sup>

- burden businesses with expensive health costs that will impede job creation and cause some companies to drop coverage<sup>8 9 10</sup>
- burden the states with billions of dollars in costs to comply with federal mandates<sup>11 12</sup>
- increase taxes on the middle class<sup>13</sup>
- impede innovation in care delivery and medical treatment<sup>14 15 16</sup>
- force individuals to purchase expensive, government-prescribed health policies<sup>17</sup>
- put significant financial stress on health care providers that could force them out of business and limit access to those who still provide care.<sup>18</sup>

More than a year and a half since the legislation was enacted, it already is clear that the law is causing harm to our health sector and that it will not meet the goals set forth by its proponents. Let's first look at the impact of PPACA and then turn to ideas for better solutions.

### **"First, do no harm"**

One of the central teachings of medicine is "First, do no harm." Yet we already see the harm that will be caused by trying to inflict too much change too suddenly on U.S. health care.

Take two examples: Medicaid and job-based health insurance.

As many as 25 million people are likely to be added to Medicaid's rolls. States estimate that this requirement together with the law's other mandates will cost them an additional \$118 billion over the decade, compromising their spending on education, roads, and public safety. But the law also will harm those already on Medicaid by putting tens of millions more people into the program who will be competing for the limited number of physicians, especially specialists, who treat Medicaid patients.

Dr. Edward Miller, dean and CEO of Johns Hopkins Medicine, argued in a 2009 *Wall Street Journal* article entitled "Health Reform Could Harm Medicaid Patients" that our system simply doesn't have the capacity to absorb so many more patients so quickly.<sup>19</sup> PPACA will dramatically expand access to coverage without increasing the supply of providers to handle the huge influx of patients. The most vulnerable will be harmed the most. They will crowd hospital emergency rooms even more than today as their main and perhaps only source of care. Dr. Miller insists the system needs much more time to absorb millions of new patients.

The legislation also is going to cause tremendous disruption in employment-based insurance. The evidence is mounting that this will happen even though congressional analysts assumed there would be relatively little disruption to employment-based health insurance when they were doing their cost estimates of the legislation.

Here's what we know so far:

- Analyst Alyssa Meade of McKinsey & Company predicted last fall that as many as 80 to 100 million people with employment-based insurance will change coverage categories in 2014 as a result of the law. The

majority of this change will be involuntary on the part of workers.

- A subsequent survey by McKinsey of employers validated this estimate. An extensive survey of large, medium, and small companies conducted by other McKinsey analysts this spring found that one-third to half of employers were seriously considering dropping coverage.<sup>20</sup> My estimates indicate that this could mean up to 78 million people would lose their coverage at work.<sup>21</sup>
- The National Federation of Independent Business found in its survey of members that 57 percent are very or somewhat likely to drop coverage once the law takes effect.<sup>22</sup>

These surveys defy the Congressional Budget Office's assumption that only 9 to 10 million people would switch from job-based coverage to subsidized coverage in the exchanges. Clearly, the CBO's estimate of the cost of ObamaCare was artificially low and must be reconsidered.

Former CBO director Douglas Holtz-Eakin, who now heads the American Action Forum, says that 110 million Americans could be eligible for subsidized coverage in the exchanges under the definitions in the law. He expects at least 35 million more of them to move into the exchanges, adding \$1 trillion to the cost of the law.

So the law will be dramatically more expensive than originally estimated at a time when the federal government is facing a crippling fiscal crisis to pay for existing entitlement programs. It is inconceivable that the government will allow these new massive, unfunded entitlement programs to grow to this scale, putting tens of millions of Americans on the federal dole and

replacing private coverage with taxpayer-subsidized coverage.

McKinsey's Alyssa Meade says that the cost of coverage, coupled with ObamaCare's rules, could entice as many as 30 to 40 million middle-income people to simply violate the federal mandate and go without coverage. They will pay the fine, knowing that if they need insurance, companies are required to sell it to them on demand at the same cost as they would pay had they been covered all along. Add these 30 to 40 million to the at least 23 million that CBO assumes will still be uninsured after the law is fully in effect and it is clear that the law will indeed exacerbate rather than solve our uninsured problem.

So, just in these two areas, we will harm the most vulnerable who have no place else to go — those on Medicaid today — by expanding the program to cover up to 25 million more people. And we will undermine the job-based insurance platform that today covers 156 million people, throwing tens of millions of people into taxpayer-supported exchanges or leaving them without coverage at all. And we are doing all of this when Washington is desperately trying to find ways to cut federal spending and to continue to finance existing entitlement programs.

This is only the tip of the iceberg of PPACA's problems. Other battles will come over the cuts to Medicare that the program's actuaries say will put up to 40% of providers out of business or force them to stop seeing Medicare patients. The other new entitlement program in ObamaCare, the CLASS Act to provide long-term care insurance, is "a Ponzi scheme of the first order," according to the chairman of the Senate Budget Committee, Democrat Kent Conrad. Even Health Secretary Kathleen Sebelius has said that the CLASS program is

"unsustainable" as it is currently configured and must be changed. HHS tried to quietly close down the CLASS office this fall as actuaries became increasingly convinced the program can't work. Chief Medicare Actuary Rick Foster has said that the program would require full participation of more than 220 million Americans — far greater than the size of the U.S. workforce — in order for it to be sustainable.

### Impact on job creation

With the faltering economy and high unemployment rate at the top of the political and policy agenda for the nation, it is crucial that leaders do everything they can to address these problems. But the evidence is mounting that PPACA's employer-mandate already is freezing job creation, even before it is scheduled to take effect in 2014.

PPACA's potential impact on jobs and the economy has been the subject of debate and controversy from the start. The president promised it would be a boon to both; former Speaker Nancy Pelosi said the law would create 400,000 jobs "almost immediately." Others argued, however, that the law's costs and mandates would make businesses much *less* likely to hire new workers.

That debate should now be over. The Heritage Foundation's James Sherk, a senior policy analyst in labor economics, released a paper<sup>23</sup> comparing the rate of net job growth before and after PPACA's passage in March of 2010. The findings show that job creation came to a virtual halt after the health law was enacted.

The low point of the recession came in January 2009, when U.S. employers shed 841,000 jobs in just that one month. But the economy slowly started to recover over the next 15 months; private

employers began hiring workers at an average rate of 67,600 per month (net of layoffs). The economy's high point came with the April 2010 report, when 229,000 jobs were added. But the health law was signed into law in late March, and the hiring freeze began. In the following months, the economy added an average of just 6,500 net private sector jobs per month — less than a tenth of the pre-ObamaCare average.

This doesn't prove that the health law is a major cause of the problem. But there is no question that the jobs recovery stalled after ObamaCare passed, with no new jobs created in August and unemployment stuck at 9.1 percent. There's good reason to believe that the health law is a major contributor to the hiring halt.

In a recent U.S. Chamber of Commerce study, 33 percent of business owners cited uncertainties about the health law as either the biggest or second-biggest reason they're not hiring new workers.

Those findings were backed up by the words of Dennis Lockhart, president of the Federal Reserve Bank of Atlanta, in a speech: "We've frequently heard strong comments to the effect of 'My company won't hire a single additional worker until we know what health-insurance costs are going to be.'"<sup>24</sup>

The health law discourages hiring in several ways. First, it adds unknown costs to hiring new workers. Companies already must consider the cost of taxes for Social Security, Medicare, unemployment insurance, and workers' compensation when hiring new staff. Combined with health benefits, these costs explain why a \$50,000-a-year employee costs a company \$62,500 to \$70,000 (according to MIT business professor Joseph Hadzima).<sup>25</sup> The health law will add new costs by forcing

employers to either provide workers with expensive, government-approved insurance or pay a fine. Employers anticipating these costs are simply unwilling to add new workers.

The health law also discourages small businesses from becoming mid-size businesses because the mandate to provide insurance kicks in once you reach 50 or more employees. This is profoundly wrongheaded. Small business is the engine for job growth in America, but a recent survey found that 70 percent have no plans to increase hiring in the next year.

As for those companies that already have 50 or more workers, the burden of having to buy expensive government-approved policies or pay penalties discourages them from hiring all but essential staff. Indeed, larger companies are doing everything they can to pare back on entry-level jobs and are using automation to avoid the added cost of mandatory health insurance for lower-income workers. McDonald's and CVS drug stores, among many other large companies, are replacing some human order-takers and cashiers with electronic systems.

This especially hurts entry-level would-be workers who need jobs so they can get the skills to enter the workforce. Is it any surprise that teen unemployment has now hit 25 percent? The jobs they need are evaporating because of the president's health overhaul law.

### **Employees pay the price of higher health costs**

Many people argue that the PPACA's regulations are necessary to keep employers from cutting benefits or imposing higher and higher health costs onto their employees. But employees

actually pay the price for these higher health costs.

The cost of health coverage is part of employee compensation. A recent RAND study found that most of the pay increases that employees have received over the last ten years have been consumed by health costs.

Between 1999 and 2009, a median-income family of four that received health insurance through an employer saw their real annual earnings rise from \$76,000 to \$99,000 over the ten year period. But nearly all that gain was consumed by rising health care costs, according to the paper by David Auerbach and Arthur Kellermann of RAND.<sup>26</sup>

After taking into account the price increases for other goods and services, they said the typical family had just \$95 a month more to devote to non-health spending in 2009 than they had a decade earlier. By contrast, the authors say that if the rate of health care cost growth had not exceeded general inflation, the family would have had \$545 more per month in spendable income instead of \$95 — a difference of \$5,400 per year. Workers are paying the price for higher health costs.

### **Engaging consumers as partners**

Many companies have introduced plans that engage their employees as partners in managing health costs, giving them more control over health care and health spending decisions. These companies have had success in holding down health cost increases. A 2011 survey for the National Business Group on Health on “purchasing value in health care” found that companies that offered account-based health plans, such as Health Savings Accounts or Health Reimbursement Arrangements, had coverage costs that were \$900 lower than

average for employee-only coverage and \$2,885 lower than Preferred Provider and Point of Service (PPO/POS) plans.<sup>27</sup> “The cost of [account-based health plan] coverage is considerably more affordable than either PPO/POS plan or HMO plan coverage in 2011,” the survey found. These premium savings benefit both employers and employees.

The number of people with HSA/HDHP (high-deductible health plan) coverage rose to more than 11.4 million in January 2011, up from 10 million in January 2010, 8 million in January 2009, and 6 million in January 2008.<sup>28</sup>

Of course consumer-directed plans are only one option of the wide array of policy choices offered in the private marketplace. But many employees and employers value this choice. Flexibility, rather than the top-down regulations PPACA is imposing, is essential for employers and employees to find ways to hold down health costs.

This bottom-up solution is more in concert with the reset of our economy. Meanwhile, PPACA’s top-down, bureaucracy-driven solution continues to face widespread resistance, from the Independent Payment Advisory Board, which seniors fear will become a rationing board for Medicare, to the 159 new boards and commissions created by PPACA at a time when people are crying for dramatically less government bureaucracy. And the many court challenges to the law continue to march forward, with a likely U.S. Supreme Court decision in June of 2012 on the constitutionality of the individual mandate.

### **Getting reform back on track**

The health law’s damaging effects already are being felt and will undermine our health sector and our economy. It is

essential to find a better way that allows people the flexibility to purchase the kind of health coverage that works for them, that incentivizes real competition to keep costs in check, and that allows doctors and patients, rather than Washington regulators, to be in charge of decisions.

The American people have made it very clear that they are frightened and confused by the comprehensive 2,800-page federal health legislation that attempts to overhaul one-sixth of our economy. While there is a general consensus that there are serious problems in our health sector that need to be addressed, it is also clear that people want to be engaged and consulted in a process that takes a more gradual step-by-step approach to reform. In the next phase of the health policy debate, leaders in Congress must develop a smaller, more reasonable approach to health reform.

People want health insurance that is reliable and more affordable and that does not exclude people with pre-existing conditions. Congress could start by helping states to create more functional high-risk pools and assuring people that if they have insurance, they will be able to

keep continuous coverage. Subsidies should be provided to people who make too much to qualify for Medicaid and who don't have the jobs or resources to purchase policies on their own. We need genuine competition among insurers to give people more choices over how and where they purchase health insurance, and create a path toward ownership of health insurance. And now that people know how much wasteful spending there is in Medicare and Medicaid, people want that fixed.

There is a world of policy complexity behind these initiatives, but Congress must start by respecting that people value private health insurance, and they don't want huge disruptions and losses of freedom or massive new taxes and entitlement costs. We believe they want greater consumer choice and market incentives that will lead to more robust competition and higher quality, more flexible health insurance. The most important thing for policymakers is to get the incentives right so that power and control over health care decisions rest with doctors and patients and not politicians and bureaucrats. This would be real reform.

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