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Health Care: Issues Impacting Cost and Coverage

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Mr. Chairman and members of the committee, thank you for inviting me to testify. My name is Edmund F. Haislmaier and I am the Preston A. Wells, Jr., Senior Research Fellow in Domestic Policy Studies at the Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

We now have three full years of data on the effects of the major provisions of Affordable Care Act (or Obamacare). For perspective, it should be noted at the outset that during that three-year period the ACA was being implemented by a strongly supportive Administration. Thus, the results and trends for the period reflect implementation policies that were, or at least were intended to be, favorable to achieving the law's objectives.

Health Insurance Enrollment

A principal objective of the ACA was to increase health insurance enrollment. The design for achieving that goal was based on three key policies: 1) offering income-related subsidies for individual market coverage purchase through the new exchanges; 2) expanding Medicaid eligibility, and; 3) applying regulatory mandates, most notably tax penalties on individuals who fail to obtain qualifying coverage and on employers of 50 or more workers who fail to offer qualifying coverage.

The effects of the law on coverage can be seen from the enrollment data for the individual market, employer-sponsored coverage and Medicaid reported in Table 1.[1]

Over the three year period, enrollment in individual-market plans increased by 5.3 million individuals, from 11.8 million individuals at the end of 2013 to almost 17.1 million at the end of 2016.

For the employer-group coverage market, enrollment in fully insured plans dropped by 8.6 million individuals, from 60.6 million individuals at the end of 2013 to 52 million as of the end of 2016. During the same three years, enrollment in self-insured employer plans increased by 5 million individuals, from 100.6 million in 2013 to 105.6 million in 2016.

The combined effect of the changes in individual-market and employer-group coverage was a net increase in private sector coverage of just 1.7 million individuals during the three-year period.

[1] Private market coverage figures are from data reported in state insurer regulatory filings accessed through the Mark Farrah Associates subscription data service (http://www.markfarrah.com). Medicaid/CHIP enrollment figures are from reports published by the Centers for Medicare and Medicaid Services (CMS), based on program reporting by states to the CMS. For more detail, see: Edmund F. Haislmaier and Drew Gonshorowski, " 2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed," Heritage Foundation *Issue Brief* No. 4743, July 26, 2017, at http://www.heritage.org/health-care-reform/report/2016-health-insurance-enrollment-private-coverage-declined-medicaid

Meanwhile, net Medicaid and Children's Health Insurance Program (CHIP) enrollment grew over the three years by 14 million individuals, from 60.9 million at the end of 2013 to 74.9 million at the end of 2016. In those states that adopted the ACA Medicaid expansion enrollment increased by 11.7 million, while in the states that did not adopt the expansion enrollment increased by 2.3 million individuals.

Thus, for the three-year period the combined enrollment growth for both private and public coverage was 15.7 million individuals—with 89 percent of that increase attributable to additional Medicaid and CHIP enrollment. Furthermore, higher Medicaid enrollment in states that adopted the ACA Medicaid expansion accounted for almost three-quarters (73.5 percent) of total (public and private) enrollment gains during the three-year period.

Table 1

Changes in Health Insurance Enrollment Relative to Prior Period, by Market Segment

	Change in 2014	Change in 2015	Change in 2016	Change over three years
Individual Market	4,738,257	1,109,156	-582,841	5,264,572
Fully Insured Employer Market	-6,654,985	-932,066	-1,049,725	-8,636,776
Self-insured Employer Market	2,131,690	1,858,189	1,045,322	5,035,201
Subtotal Employer Market	-4,523,295	926,123	-4,403	-3,601,575
Total Private Market	214,962	2,035,279	-587,244	1,662,997
States Expanding Medicaid	8,389,474	2,178,566	1,141,172	11,709,212
States Not Expanding Medicaid	603,251	587,743	1,112,318	2,303,312
Total Medicaid and CHIP	8,992,725	2,766,309	2,253,490	14,012,524
Total Private and Public Coverage Change	9,207,687	4,801,588	1,666,246	15,675,521

Looking at enrollment over time, the data show that the largest changes occurred in the first year of implementation (2014) and tapered off by the third year (2016).

In the case of Medicaid—which accounted for the vast majority of the total increase in coverage—enrollment grew by almost 9 million individuals in 2014, for an increase in program enrollment of almost 15 percent in a single year. However, subsequent enrollment growth was four percent in 2015 and three percent in 2016, part of which was the result of additional states adopting the Medicaid expansion.[2]

The pattern is even clearer when looking at the subset of 25 states that have had the expansion in effect since the beginning (January 2014). Table 2 shows that for that

[2] Alaska, Indiana and Pennsylvania implemented the expansion in 2015, and Louisiana and Montana implemented it in 2016.

group of states Medicaid enrollment increased 23 percent in 2014, but then only grew by a further 3.5 percent in 2015 and by one percent in 2016.

Table 2

Medicaid Enrollment in States That Adopted the Medicaid Expansion at the Beginning of 2014

	2013	2014	2015	2016
Total	33,606,965	41,540,951	42,991,324	43,456,143
Change	-	7,933,986	1,450,373	464,819
Percentage Change	-	23.6%	3.5%	1.1%

With respect to the individual-market, the addition of 4.7 million persons to that market in 2014 represented a 40 percent enrollment jump relative to the preceding three years during which total individual-market enrollment had fluctuated between 11.8 million and 12 million people. Individual-market enrollment grew by a further seven percent in 2015, but then declined by three percent in 2016, as shown in Table 3.

Table 3

Individual-Market Enrollment by Subsidy Status

	2013	2014	2015	2016
Total	11,807,534	16,545,791	17,654,947	17,087,652
Percentage Change	-	40.1%	6.7%	-3.2%
Subsidized	0	5,430,106	7,375,489	7,648,001
Percentage Change	-	-	35.8%	3.7%
Unsubsidized	11,807,534	11,115,685	10,279,458	9,439,651
Percentage Change	-	-5.9%	-7.5%	-8.2%

Table 3 also shows a similar pattern for the subset of individual-market enrollees that obtained subsidized coverage through the new health insurance exchanges. The number of individuals with subsidized coverage through the exchanges was 5.4 million at the end of 2014, increasing to 7.4 million at the end of 2015, and 7.6 million at the end of 2016. Thus, after growing by 36 percent in 2015, the number of subsidized exchange enrollees grew by less than 4 percent in 2016.

It is notable that the flattening of enrollment trends for both subsidized and unsubsidized individual-market coverage, as well as for Medicaid, predates the current Administration and Congress. That suggests that, even without any changes to the law, future Obamacare enrollment gains would likely be, at best, only marginal.

Indeed, just last week the Department of Health and Human Services noted that while its spending on advertising to promote the 2016 annual open enrollment period was about $100 million—double the $50 million it spent on advertising the 2015 open season—new enrollments dropped by 42 percent in 2016 and the number of people

buying coverage through Healthcare.gov declined from 9.6 million in 2015 to 9.2 million in 2016.

In sum, after three years the ACA's coverage effects appear to have already reached a point of diminishing returns. That situation is unlikely to change. Escalating premiums will continue to discourage enrollment of more healthy individuals. It is unlikely that the individual mandate penalty for not obtaining coverage will be sufficient to overcome price resistance. Indeed, escalating premiums could increase the number of people qualifying for an affordability exemption from the individual mandate penalty because the cost of a bronze-level plan exceeds the affordability threshold of 8.16 percent of household income.[3]

It is also worrying that in 2016 the number of persons with unsubsidized individual-market coverage declined by 839,807 while the number with subsidized coverage increased by only 272,512. Furthermore, Table 3 shows that the unsubsidized individual-market has shrunk at successively larger rates in each of the past three years. After declining 5.9 percent in 2014, the number of unsubsidized individual-market enrollees fell a further 7.5 percent in 2015, and then dropped another 8.2 percent in 2016.

That trend, particularly when viewed in the context of flattening growth in subsidized individual-market enrollment and no net change in employer-plan enrollment (see Table 1), is a disturbing indicator that Obamacare may be shifting from insuring the uninsured to un-insuring the previously insured.

Insurer Competition

Supporters of the ACA also expected that the law would generate increased insurer competition. On that score the performance was initially somewhat mixed, but then turned negative. That pattern can be seen in the number of insurers offering exchange coverage in the states each year.

In 2013, the last year before implementation of the exchanges and the ACA's new insurance market rules, 395 insurers sold coverage in the individual market across all states and the District of Columbia.[4] In 2014 there were 253 insurers offering coverage on the exchanges. That figure increased to 307 in 2015, but then declined to 287 in 2016, and to 218 in 2017. While insurer contracts for 2018 have not yet been signed, based on announced withdrawals and entries it appears that there will be only 194 insurers offering exchange coverage in 2018.

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[3] See: Seth Chandler, "New Research Shows Many In Middle-Aged, Middle Class Can't Afford ACA Policies in 2018," *Forbes*, August 17, 2017, at https://www.forbes.com/sites/theapothecary/2017/08/17/new-research-shows-many-in-middle-aged-middle-class-cant-afford-aca-policies-in-2018/#1fd04b5b461f

[4] Insurers that offer coverage through more than one subsidiary in a state are properly counted as one carrier (the parent company), while insurers that offer coverage in more than one state are counted for each state (as market participation is a state-level decision). The pre-ACA figure does not include insurers with fewer than 1,000 covered lives in a state's individual market on the presumption that those insurers were not actively selling new policies in the state at that time.

In 2014, New Hampshire and West Virginia each had only one insurer offering exchange coverage. New Hampshire then gained four carriers in 2015, leaving West Virginia as the only state with one exchange insurer. While West Virginia gained a second exchange insurer in 2016, the states of Alaska and Wyoming dropped to one carrier apiece that year. In 2017, those two states were joined by Alabama, Oklahoma and South Carolina, bringing to five the number of states with only one insurer offering exchange coverage. That list is set to expand in 2018 to include Delaware, Mississippi and Nebraska, for a total of eight states with just a single exchange insurer.

For consumers, the more relevant measure of competition is at the county level. That is because health plans are offered (and priced) on a local basis, and many insurers do not offer coverage statewide. Therefore, state-level figures can overstate the extent of choice available to many consumers.

Seventeen percent of U.S. counties had only one exchange insurer in 2014. That figure decreased to only six percent in 2015 and seven percent in 2016, but soared to 33 percent for 2017.[5] The most recent projection from HHS is that 47 percent of counties will have only one exchange insurer for 2018.[6]

In sum, it appears that during the first several years, despite uncertainties about the composition of the risk pool, most insurers were at least willing to try offering coverage through the new ACA exchanges. That is no longer the case. By next year the major national carriers (Aetna, United, Humana and Cigna) will have exited the market either entirely or in all but a few states. For those insurers individual market coverage is only a small piece of their total business, and the marginal increase in enrollment from the Obamacare individual market has proven to not be worth the risk of incurring additional losses. Thus, it is unlikely that they will resume offering Obamacare coverage anytime in the foreseeable future.

Implications for the Future

The ACA's coverage requirements and subsidy design were deliberately intended to provide comprehensive benefits with limited cost sharing to low-income individuals needing medical care, with the cost of their coverage heavily subsidized by taxpayers.

Consequently, it should not be surprising that the exchanges have produced a risk pool consisting mainly of lower-income individuals needing medical care. One telling

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[5] See: Edmund F. Haislmaier and Alyene Senger, "The 2017 Health Insurance Exchanges: Major Decrease in Competition and Choice," Heritage Foundation *Issue Brief* No. 4651, January 30, 2017, at http://www.heritage.org/health-care-reform/report/the-2017-health-insurance-exchanges-major-decrease-competition-and-choice

[6] Centers for Medicare and Medicaid Services, "2018 Projected Health Insurance Exchange Coverage Maps: Insurer Participation in Health Exchanges (08/30/2017)," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2018-Projected-Health-Insurance-Exchange-Coverage-Maps.html

indicator is that in each of the years 2014, 2015 and 2016, of the enrollees receiving premium tax credit subsidies a consistent 67 percent also received reduced cost-sharing. In other words, over three years consistently two-thirds of subsidized enrollees had incomes below 250 percent of the federal poverty level (FPL) and picked silver-level plans with reduced cost sharing.

Given the structure of the ACA there is no reason to expect that risk profile to improve in the future. Indeed, the resulting, and substantial, increases in premiums have made Obamacare coverage even less attractive to healthier individuals, and particularly so for those with incomes above 250 percent of FPL. This reality has several implications:

First, while there will continue to be people moving in and out of the subsidized coverage pool as a result of changes in incomes and health status, there is unlikely to be much growth in coming years in the aggregate number of subsidized enrollees above the current level of about eight million enrollees. The only obvious exception would be an economic downturn that resulted in more people in poor health facing a simultaneous loss of access to employer coverage and reduced incomes.

Second, the number of insurers offering exchange coverage is likely to continue declining for the next couple years, particularly at the county level. Not only have some insurers entirely exited the exchanges, but also a number of those that remain have reduced their geographic footprints in the states where they still participate on the exchanges.

Third, the eventual norm will likely be a situation in which major metropolitan areas still have two or three insurers offering exchange coverage but the less populous areas have only one carrier offering exchange coverage.

Fourth, the carriers most likely to continue offering exchange coverage will be those that have significant Medicaid managed care contracts, and thus substantial experience providing coverage to subsidized low-income populations. This summer, when it looked like a number of counties would have no exchange insurer for 2018, it was carriers whose principal business is Medicaid managed care that stepped in to fill the gaps (such as Centene in several states and CareSource in Ohio).

Despite concerns this summer, the possibility is still low that some parts of the country will have no insurer offering subsidized exchange coverage. That is because subsidized exchange coverage can still be a profitable market niche if an insurer has a monopoly—particularly for insurers with a business focus on serving Medicaid-like populations. While the covered population will be costly, thanks to the ACA-subsidy structure those higher costs will simply be passed on to federal taxpayers. Thus, an insurer with an exchange monopoly will have sufficient pricing flexibility. Functionally, the result will be very similar to pricing a contract for serving a predetermined subset of the Medicaid population.

More concerning are the instances of insurers ceasing to offer ACA-compliant coverage outside of the exchanges to the unsubsidized population. In that subset of the market there is more danger of a so-called "death spiral" setting in as escalating premiums price more customers out of the market. To prevent that occurring, lawmakers need to reverse or significantly amend a number of the ACA's regulatory provisions that have made coverage more expensive. Failing that, the ACA could effectively shift in the coming years from insuring the uninsured to un-insuring the previously insured—particularly the self-employed and small business owners who comprised the pre-ACA individual market.

Conclusion

While there was a significant increase over the first two years in enrollment in individual-market policies, those gains have tapered off and may even be in the process of reversing as a result of the law significantly driving up premiums in that market. Lower-income individuals who qualify for premium subsidies for coverage purchased through the exchanges are largely insulated from those costs. However, middle-income self-employed persons—the more typical pre-Obamacare individual market customers—do not qualify for subsidies and are finding coverage to be increasingly unaffordable or even unavailable. The danger now is that, if the ACA's most costly insurance regulations remain in place, the law will effectively force more of those middle-income individuals to drop their coverage. That would mean that the ACA was actually causing some of the insured to become uninsured.

Mr. Chairman, this concludes my prepared testimony. I thank you for inviting me to testify today. I will be happy to answer any questions that you or the other members of the Committee may have.

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