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Bailouts Will Not Bring Lasting Stability to the Health Insurance Market

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Congress reportedly is contemplating appropriating more federal funding to prop up the Affordable Care Act (ACA, also known as Obamacare) and its harmful policy regulations.[1] This bailout approach is wrong and should be abandoned. It is fiscally imprudent and unnecessary. Worse, it is not a lasting solution; instead, it will simply mask, through new taxpayer funding, the law's fundamental flaws and put off much-needed action.

The radical and unnecessary changes in insurance regulations made by the ACA created much bigger problems in the insurance market that upended existing federal and state regulation of health insurance, destabilized the individual health insurance market, and resulted in higher costs and fewer choices.[2]

Ultimately, Congress can help Americans who are suffering from higher costs and premiums by resuming efforts to address the cause of this suffering by repealing and replacing Obamacare itself. Instead of a bailout, a good place to start would be to give states the flexibility to stabilize their markets. Such an effort would represent the beginning of the longer process of disentangling the maze of insurance regulations and other Obamacare provisions that have driven up the cost of coverage and left fewer choices for individuals in the market.[3]

This paper, in its entirety, can be found at
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The ACA's Overreach

Many of the insurance problems that Obamacare claimed to address, including protecting Americans' ability to buy health insurance even when they have pre-existing conditions, were very limited and narrow at the time. Yet the ACA made radical changes in the regulation of insurance that created much bigger problems in the insurance market.

Defenders of Obamacare overstate the size and scope of the problems in the insurance market and ignore the fact that before enactment of the ACA, there were federal and state laws in place that already addressed most of the concerns highlighted by ACA proponents.

In 2010, nearly 90 percent of Americans with private health insurance were covered by employer-group coverage,[4] in which reasonable federal rules, including rules providing protections for those with pre-existing conditions and people who lost employer coverage, had been in effect since 1996.[5] These federal rules did not apply to situations where individuals wanted to replace one individual market insurance policy with another. However, those buying individual health insurance constituted only 11 percent of the total market for private health insurance.[6]

In those circumstances, state rules applied. Some states adopted a more extreme approach similar to the approaches later enacted under the ACA, such as narrow community-rating rules or a total ban on any pre-existing condition exclusions. These state experiments proved to do more harm than good.[7] Other states adopted more measured and balanced approaches.

The ACA overrode those prior federal and state rules and imposed an aggressive regulatory regime on both the employer and individual markets. Most nota-

bly, the ACA imposed a blanket federal prohibition on pre-existing condition exclusions under *any* circumstances. Unlike previous federal rules, this requirement was imposed without regard to whether applicants had prior coverage. That significantly eroded the proper incentive for people to buy insurance *before* they need it. That, along with other changes in the ACA, effectively allowed people to wait until they needed medical care before buying coverage, which significantly increases costs. Making matters worse, the ACA also added costly new benefit mandates and very restrictive age rating rules that effectively raised the prices of health insurance above what many people were willing to pay.

The Consequences: Higher Costs, Fewer Options, Declines in Private Coverage

As predicted, this regulatory overreach upended existing federal and state rules and resulted in an unstable market marred by higher costs, fewer options, and a decline in private coverage.[8] Specifically, the ACA has led to:

Higher Costs. Premiums in the Obamacare exchanges have doubled since 2013. According to analysis by the U.S Department of Health and Human Services, average annual individual market premiums increased from $2,784 in 2013 to $5,712 in 2017.[9] For 2018, post-open enrollment data from eHealth indicate that premiums for individual coverage increased 16 percent from 2017.[10] The eHealth report found that average premiums were $440 per month for individuals and $1,168 per month for family coverage.

Individuals and families also continue to face increasing out-of-pocket costs for Obamacare coverage. Analysis by Avalere, a national health care consulting firm, found that coverage deductibles reached $5,873 for Obamacare bronze plans in 2018, up from $5,249 in 2015, and $3,937 for Obamacare silver plans in 2018, up from $2,658 in 2015.[11]

Fewer Options. In 2013, 395 insurers sold coverage in the individual market. By contrast, only 181 insurers are selling coverage in the Obamacare exchanges in 2018. Heritage Foundation analysis found that 51.3 percent of all counties had only one insurer selling coverage in the Obamacare exchanges; 10 states had only one insurer in all counties, and 19 states had no more than two insurers selling in any county.[12]

1 Doug Badger, Marie Fishpaw, and Michael Needham, "The GOP's Coming Obamacare Capitulation," *National Review*, February 5, 2018, https://www.nationalreview.com/2018/02/obamacare-gop-republicans-prepare-back-bailout/ (accessed March 6, 2018).

2 Edmund F. Haislmaier, "Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets," Heritage Foundation *WebMemo* No. 3111, January 20, 2011, https://www.heritage.org/health-care-reform/report/obamacare-and-insurance-rating-rules-increasing-costs-and-destabilizing.

3 Edmund F. Haislmaier and Doug Badger, "How Obamacare Raised Premiums," Heritage Foundation *Backgrounder* No. 3291, March 5, 2018, https://www.heritage.org/health-care-reform/report/how-obamacare-raised-premiums.

4 Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey," Employee Benefit Research Institute *Issue Brief* No. 362, September 2011, p. 5, Figure 1, https://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=4896 (accessed March 6, 2018).

5 For a description of those rules, see Edmund F. Haislmaier, "Saving the American Dream: The U.S. Needs Commonsense Health Insurance Reforms," Heritage Foundation *Backgrounder* No. 2703, June 22, 2012, https://www.heritage.org/health-care-reform/report/saving-the-american-dream-the-us-needs-commonsense-health-insurance.

6 Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey."

7 Tarren Bragdon and Joel Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite'," Heritage Foundation *Backgrounder* No. 2582, July 19, 2011, https://www.heritage.org/health-care-reform/report/health-care-reform-maine-reversing-obamacare-lite.

8 Haislmaier, "Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets."

9 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Individual Market Premium Changes: 2013--2017," *ASPE Data Point*, May 23, 2017, https://aspe.hhg.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf (accessed March 6, 2018).

10 *BusinessWire*, "eHealth Post-Open Enrollment Report: Premiums Rise Most for Those Under Age 25; Average Family Premium Tops $1,100 Per Month," December 20, 2017, https://www.businesswire.com/news/home/20171220005267/en/eHealth-Post-Open-Enrollment-Report-Premiums-Rise-Age (accessed March 3, 2018).

11 Caroline F. Pearson and Elizabeth Carpenter, "Plans with More Restrictive Networks Comprise 73% of Exchange Market," Avalere *Press Release*, November 30, 2017, http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market (accessed March 6, 2018).

12 Edmund F. Haislmaier, "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink," Heritage Foundation *Issue Brief* No. 4813, January 25, 2018, p. 3, https://www.heritage.org/health-care-reform/report/2018-obamacare-health-insurance-exchanges-competition-and-choice-continue.

The remaining insurance plan offerings are also more restrictive. Avalere found that health maintenance organizations (HMOs) and exclusive provider organizations (EPOs) with narrow provider networks make up 73 percent of plans offered in 2018, up from 68 percent in 2017 and 54 percent in 2015.[13]

In addition, more insurers are leaving the Obamacare exchange market than are entering. Heritage Foundation analysis found that in 2015, 64 insurers entered the market, and nine exited.[14] In 2017, only 10 insurers entered the market, and 80 exited. Negative trends continue: Thus far in 2018, only seven insurers have entered, and 44 have exited.[15]

Declines in Private Coverage. The majority of gains in coverage as result of Obamacare have come through the government-run Medicaid program, not through private coverage. Due to the consequences of the ACA, fewer individuals are obtaining coverage in the individual market. Enrollment in the individual market for both subsidized and unsubsidized individuals has plateaued and is trending downward, according to analysis of 2014–2016 enrollment data.[16] In 2016, The Heritage Foundation found that unsubsidized enrollment in the individual market declined by 8.2 percent, compared to 7.5 percent in 2015.[17] Even the growth in subsidized enrollment is flattening. The Heritage report found that subsidized enrollment grew by only 3.7 percent compared to 35.8 percent in 2015.[18] Furthermore, over the three-year period, of the 15.7 million individuals who gained coverage, 89 percent of that increase was through Medicaid.[19]

More Bailouts Not the Solution

Reports indicate that Congress is considering adding additional federal funds to prop up the failing ACA infrastructure instead of addressing the underlying regulatory flaws that fuel these problems. Specifically, some Members are advocating adding additional federal dollars to offset high insurance costs through reinsurance mechanisms, and others are advocating restoring federal funding for cost-sharing reductions.[20]

While there might be value in risk-mitigation programs such as reinsurance or high-risk pools, such programs are best applied in the context of larger efforts to stabilize the market by repealing and replacing the Obamacare provisions responsible for destabilization. Moreover, as discussed later, states have authority to seek federal waivers to allow them to use existing federal funding to set up risk-mitigation mechanisms, and some already are doing so. Some might argue that funding the cost-sharing reductions could help to offset increasing costs in premiums subsidies,[21] but like funding for reinsurance, such efforts are not a response to the underlying problems of the law that fuel these increased costs: They are merely a patch that masks the real problems.[22]

Both of these approaches would make more permanent change less urgent and would be a mistake. Instead, Congress and the Administration should:

- **Reject additional federal appropriations.** Congressional efforts to add more federal funding for reinsurance or cost-sharing reductions are short-term fixes that provide no lasting policy

13 Pearson and Carpenter, "Plans with More Restrictive Networks Comprise 73% of Exchange Market."

14 Haislmaier, "2018 Obamacare Health Insurance Exchanges, Competition and Choice Continue to Shrink."

15 Ibid.

16 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, https://www.heritage.org/health-care-reform/report/2016-health-insurance-enrollment-private-coverage-declined-medicaid.

17 Ibid.

18 Ibid.

19 Ibid.

20 Julie Rovner, "Congress Races the Clock in Quest to Bring Stability to Individual Insurance Market," *Kaiser Health News*, March 2, 2018, https://khn.org/news/congress-races-the-clock-in-quest-to-bring-stability-to-individual-insurance-market/ (accessed March 6, 2018).

21 Caitlin Owens and Jonathan Swan, "OMB: Funding Insurer Subsidies Will Lower ACA Premiums 15–20%," *Axios*, March 6, 2018, https://www.axios.com/white-house-aca-subsidies-lower-premiums-1520352713-cf2b15f9-9d5e-4e1b-b736-23cfc15cef67.html?utm_source=twitter&utm_medium=twsocialshare&utm_campaign=organic (accessed March 6, 2018).

22 For a discussion on cost-sharing reductions, see Doug Badger, "How Lawmakers Should Deal with Obamacare's Cost Sharing Reduction Payments," Heritage Foundation *Issue Brief* No. 4797, December 18, 2017, https://www.heritage.org/sites/default/files/2017-12/IB4797.pdf.

change in the underlying law. Worse, the additional funding obligates federal taxpayers to pay for even more costs in the future. Proponents might argue that these additional funds are temporary, but history has proven that once new federal funding is appropriated, it is rarely eliminated and in many cases might actually increase, especially if the underlying policies that are driving the need for the funding are not addressed.[23]

- **Expand Section 1332 guidance.** Section 1332 of the ACA authorizes the Secretary of Health and Human Services to grant waivers to states wishing "to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA."[24] Some states, most notably Alaska, have used this waiver to implement risk-mitigation mechanisms without the need for additional federal dollars.[25] Congress and the Administration should encourage more states to apply for these waivers and allow for consideration of additional approaches. While not a permanent solution, these waivers do not require additional federal funding and thus are preferable to congressional efforts that do.

- **Create a pathway for states to stabilize their markets.** The ACA's radical regulatory overreach has caused chaos in the individual market. As a near-term improvement, Congress should give states the flexibility to stabilize their markets. As noted, some states are already taking this on, but more can be done. Senators Lindsay Graham (R–SC), Bill Cassidy (R–LA), Ron Johnson (R–WI), and Dean Heller (R–NV) have offered a model that, with additional improvements, could provide a framework for such additional flexibility.[26]

Confronting the Real Problems

With its massive federal overreach in the insurance market, the ACA has created instability and uncertainty. Individuals and families are facing higher costs and fewer options, and the private health insurance market is declining. Something must be done. Congressional efforts to add more taxpayer money to prop up this failed experiment, however, are fiscally irresponsible, do not provide lasting solutions, and risk further cementing the failed model into the market.

Ultimately, the full scope of Obamacare and its regulatory scheme will need to be reassessed. Research to assess the effects of the various Obamacare regulations has found that regulations were further exacerbated by other policy provisions and decisions.[27] The Graham–Cassidy–Johnson–Heller model, endorsed by the Administration,[28] could be a platform to jump-start much-needed immediate action and offer a down payment on larger reforms. Such an effort represents a critical first step toward changing direction and creating policies that would allow a patient-centered, market-based system to thrive.

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23 Some proposals before Congress envision adding funding to what was a temporary three-year program of reinsurance included in the original legislation.

24 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Section 1332: State Innovation Waivers," https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html (accessed March 3, 2018).

25 Doug Badger and Rea S. Hederman, Jr., "Federal Efforts to Stabilize ACA Individual Markets Through State Innovation," *Mercatus Research*, Mercatus Center, George Mason University, February 27, 2018, https://www.mercatus.org/publications/affordable-care-act-individual-markets-state-innovation (accessed March 3, 2018).

26 Edmund F. Haislmaier and Robert Rector, "How to Ensure the Graham–Cassidy Bill Expands Markets and Choice in Health Care—Not Government Programs," Heritage Foundation *Issue Brief* No. 4765, September 20, 2017, https://www.heritage.org/health-care-reform/report/how-ensure-the-graham-cassidy-bill-expands-markets-and-choice-health-care.

27 Haislmaier and Badger, "How Obamacare Raised Premiums."

28 U.S. Department of Health and Human Services*, Putting America's Health First: FY 2019 President's Budget for HHS*, last updated February 19, 2018, p. 5, https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf (accessed March 6, 2018).