

# The Facts Speak for Themselves: Claims, Promises and the Reality of the President's Health Care Law



A Staff Report by Senate Finance and HELP Committees  
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## Executive Summary

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President Obama and his administration have made many claims to the American people about the Patient Protection and Affordable Care Act (PPACA). Four years since the bill was signed into law, the outcomes are far from what was promised.

This staff report summarizes the following claims made by the Obama administration about PPACA and contrasts them with the law's realities:

Claim I: Enrollment targets were met.

Reality: The Obama administration is overstating the new insurance exchange enrollment numbers and has not reached either its goal of enrolling enough young and healthy people or of dramatically reducing the number of uninsured.

Claim II: Coverage is more affordable.

Reality: PPACA regulations have increased premiums and out-of-pocket costs for many Americans. Affordability remains the biggest barrier to coverage.

Claim III: Transparency and access to care have increased.

Reality: The PPACA exchanges are not transparent about limited drug coverage and narrow doctor and hospital networks.

Claim IV: PPACA strengthens the economy and reduces the deficit.

Reality: PPACA adds to the deficit, increases health care spending, burdens employers, increases taxes, and disincentivizes work.

Claim V: The exchanges were ready and would work.

Reality: The federal government and some states have wasted millions of dollars creating dysfunctional exchanges. None of the exchanges were properly equipped to verify eligibility for taxpayer-funded subsidies.

Claim VI: Healthcare.gov is working well with states to enroll individuals in Medicaid.

Reality: Error-ridden Medicaid application data from Healthcare.gov is imposing significant burdens on states.

Claim VII: Medicaid expansion means more people will have health care.

Reality: Medicaid is a broken program and does not guarantee access to health care.

Claim VIII: PPACA strengthens Medicare Advantage.

Reality: PPACA cuts billions from the popular Medicare Advantage program and reduces seniors' benefits.

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## Introduction

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In promoting the Patient Protection and Affordable Care Act (PPACA) to the American people, the Obama administration made numerous claims about how the legislation would change the health insurance marketplace for the better, improve affordability, and preserve access for millions of Americans, all while boosting the economy and reducing the deficit. Four years later, the outcomes have been, in many cases, far from what was promised. Instead of increasing access to affordable insurance, many enrollees are coping with higher premiums and out-of-pocket expenses. Instead of allowing policyholders to keep their doctors, provisions in the law have led insurance companies to craft narrower networks that sometimes exclude key hospitals and providers. Instead of boosting the economy and helping to create jobs, PPACA's taxes and mandates have been a deterrent to businesses expanding or hiring new employees—further hindering a fragile economic recovery. Instead of reducing the deficit, the law is on track to increase deficits by at least \$340 billion. Instead of making it easier for Americans to comparison shop for insurance and enroll in Medicaid, the government has wasted millions of taxpayer dollars creating broken exchanges. And, instead of strengthening Medicare, PPACA cuts billions of dollars from the popular Medicare Advantage program and reduces seniors' benefits. The myths proclaimed by administration officials and PPACA supporters have misled taxpayers, employers, health care consumers, and others. The facts speak for themselves.

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**Claim I: Enrollment targets were met.** *“We now know that the number of Americans who’ve signed up for private insurance in the marketplaces has grown to 8 million people—8 million people. Thirty-five percent of people who enrolled through the federal marketplace are under the age of 35.”*

– President Barack Obama, April 17, 2014<sup>1</sup>

**Reality:** The Obama administration is overstating the new insurance exchange enrollment numbers and has not reached either its goal of enrolling enough young and healthy people or of dramatically reducing the number of uninsured.

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### 8 Million “Enrolled”

President Obama used the terms “signed up” and “enrolled” interchangeably in his April 17 White House press conference, but they do not mean the same thing. An individual who signs up for a health insurance plan does not have coverage until he or she completes enrollment by paying the premium. The truth behind the 8 million number that President Obama reported is buried in the administration’s May 1 “Health Insurance Marketplace Summary Enrollment” report, which states: “[The Centers for Medicare & Medicaid Services] does not yet have comprehensive and accurate data about effectuated enrollment.”<sup>2</sup> The administration chose to stop releasing monthly sign-up reports after this May 1 report, and has yet to release the number of people who are actually receiving coverage from insurance purchased through the federally-run exchange.<sup>3</sup>

The number of individuals enrolled in insurance through the exchanges, as reported by insurance companies and predicted by the Congressional Budget Office (CBO), is far lower than the White House’s claim of 8 million enrollees. Several large insurers have estimated that 80 to 90 percent of those who sign up for a plan actually pay their first month’s premium, suggesting that actual exchange enrollment through April 19, 2014, ranges between 6.4 million and 7.2 million.<sup>4</sup> The CBO estimated in its April 2014 updated budget projections report that the

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<sup>1</sup> The White House, Office of the Press Secretary. (2014, April 17). [Press conference by the President, 4/17/14](#). whitehouse.gov.

<sup>2</sup> U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2014, May 1). [Health insurance marketplace: Summary enrollment report for the initial annual open enrollment period](#). aspe.hhs.gov.

<sup>3</sup> Cheney, Kyle. (2014, May 21). [Administration stops monthly ACA enrollment reports](#). www.politico.com

<sup>4</sup> Japsen, B. (2014, April 2). [Blue Cross says '80-85' percent of Obamacare enrollees are paying](#). *Forbes*.; Ritger, C. (2014, April 30). [3 reasons why Obamacare’s outlook is rosy for insurers](#). *National Journal*.

exchanges will support an average of 6 million enrollees throughout the year.<sup>5</sup> These numbers fall short of the number being touted by the administration.

### 39 Percent Young and Healthy Enrollment

The administration has routinely emphasized that hitting a benchmark of approximately 39 percent of 18- to 35-year-olds enrolled in the exchanges is critical to keeping costs down.<sup>6</sup> When the open enrollment period closed, President Obama announced that 35 percent of enrollments were individuals under age 35.<sup>7</sup> Not only does his number reflect sign-ups instead of enrollments, it also includes children under 18, a group not previously cited by the White House as important to enroll in order to keep premiums low.<sup>8</sup> President Obama did not highlight that only 28 percent of sign-ups in the federally-run exchange were 18- to 35-year-olds, a proportion that falls short of the administration's benchmark for a healthy enrollment mix.<sup>9</sup> The Kaiser Family Foundation said in December 2013 that if only 25 percent of marketplace enrollees are 18-35 year olds, this would be a "worst-case scenario" that would trigger higher premiums in 2015.<sup>10</sup>

### Cancelled Plans

The *Associated Press* calculated that at least 4.7 million people had their existing insurance plans cancelled for 2014, despite the promise made by President Obama that, "If you like your health care plan, you can keep it."<sup>11</sup> As Americans expressed outrage about cancelled plans, the administration made a last-minute fix to the health care law that allowed an estimated 2.3 million people to stay on their plans for at least one more year and then extended that fix for another two years.<sup>12</sup> The administration's last-minute fix came too late for approximately 2.4 million Americans who were unable to keep their plans. These individuals were given a

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<sup>5</sup> Congressional Budget Office. (2014, April). [Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014](#). cbo.gov.

<sup>6</sup> Millman, J., & Kenen, J. (2013, June 30). [5 messaging challenges for Obamacare](#). *Politico*.; Franke-Ruta, G. (2013, July 18). [The White House is optimistic about its limited Obamacare goals](#). *The Atlantic*.

<sup>7</sup> The White House, Office of the Press Secretary. (2014, April 17). [Press conference by the President, 4/17/14](#). whitehouse.gov.

<sup>8</sup> Kessler, G. (2014, April 22). [Spinning Obamacare success: The president highlights a less relevant number](#). *The Washington Post*.

<sup>9</sup> U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2014, May 1). [Health insurance marketplace: Summary enrollment report for the initial annual open enrollment period](#). aspe.hhs.gov.

<sup>10</sup> Levitt, L., & Claxton, G. (2013, December 17). [The numbers behind "young invincibles" and the Affordable Care Act](#). The Henry J. Kaiser Family Foundation.

<sup>11</sup> The Associated Press. (2013, December 26). [Policy notifications and current status, by state](#). *Yahoo! News*.; Holan, A.D. (2013, December 12). [Lie of the year: 'If you like your health care plan, you can keep it'](#). *Tampa Bay Times*.

<sup>12</sup> Kessler, G. (2014, March 17). [Boehner's claim that Obamacare has resulted in a 'net loss' of people with health insurance](#). *The Washington Post*.

“hardship exemption” from the individual mandate for one year—meaning, as journalist Ezra Klein put it, “for these people...Obamacare itself is a hardship.”<sup>13</sup>

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<sup>13</sup> Klein, E. (2013, December 19). [The individual mandate no longer applies to people whose plans were canceled.](#) *The Washington Post*.

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**Claim II: Coverage is more affordable.** *“You should know that once we have fully implemented, you’re going to be able to buy insurance through a pool so that you can get the same good rates as a group that if you’re an employee at a big company you can get right now — which means your premiums will go down.”*

*-President Obama, July 16, 2012<sup>14</sup>*

**Reality: PPACA regulations have increased premiums and out-of-pocket costs for many Americans. Affordability remains the biggest barrier to coverage.**

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### Affordability

High premiums and out-of-pocket costs are preventing many Americans from purchasing health insurance, despite the federal government spending \$38 billion in 2014 to help more Americans afford coverage.<sup>15</sup> An Enroll America poll found that affordability was the barrier to coverage for 21 percent of consumers who attempted to, but ultimately did not, enroll in a plan.<sup>16</sup> Additionally, a recent Kaiser Family Foundation poll found that cost is the biggest deterrent to getting covered, with 36 percent of uninsured respondents indicating high costs as their primary reason for remaining uninsured.<sup>17</sup>

A study by Milliman, Inc., confirms the significant out-of-pocket costs that patients face under PPACA plans. The company’s actuaries examined the health insurance exchanges’ Silver plans, which comprised 65 percent of the plans selected during this open enrollment season.<sup>18</sup> The study found that Silver plans are almost four times more likely to combine the deductibles for medical and pharmacy benefits than typical employer-sponsored plans—46 percent of plans compared to 12 percent, respectively.<sup>19</sup> Such combined deductibles lead to higher pharmaceutical costs for most individuals with these plans because the individuals must cover

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<sup>14</sup> The White House, Office of the Press Secretary. (2012, July 16). [Remarks by the President at a Campaign Event](#). whitehouse.gov

<sup>15</sup> Congressional Budget Office. (2014, April). [Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014](#). cbo.gov.

<sup>16</sup> Warren, M. (2014, April). [Enroll America’s grassroots campaign and early lessons learned, November 2013-February 2014](#). *Enroll America*.

<sup>17</sup> Hamel, L., Firth, J., & Brodie, M. (2014, April 29). [Kaiser health tracking poll: April 2014](#). The Henry J. Kaiser Family Foundation.

<sup>18</sup> U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2014, May 1). [Health insurance marketplace: Summary enrollment report for the initial annual open enrollment period](#). aspe.hhs.gov.

<sup>19</sup> Gaal, M., Gomberg, J., & Filipek, T. (2014, May 13). [Impact of the health insurance marketplace on participant cost sharing for pharmacy benefits](#). Milliman, Inc.



the full cost of prescription drugs until the deductible is met, at which point the insurer will require a copay or coinsurance fee for prescription benefits. Milliman reports that a “typical Silver plan with a combined deductible results in member cost sharing for pharmacy benefits that is 230 percent of the member cost sharing in a typical employer plan.” Additionally, the study found that the overall member cost sharing for a typical Silver plan is 38 percent higher than the typical cost sharing in an average employer plan.<sup>20</sup>

Many Americans will still struggle to find affordable insurance. The average deductible for a Bronze plan was \$5,081 a year, and the average for a Silver plan was \$2,907.<sup>21</sup> The most recent Federal Reserve Survey of Consumer Finances found that roughly 52% of Americans had less than \$3,000 in non-retirement liquid savings.<sup>22</sup> Even with subsidies to offset premiums, deductibles and other cost-sharing requirements could quickly deplete an average American’s savings.

### 2014 Costs

President Obama promised that his signature health care law would reduce annual premiums for an average family by \$2,500.<sup>23</sup> The reality instead is that a vast majority of Americans are facing premium increases. Avik Roy of the Manhattan Institute for Policy Research calculated that premiums in the individual market increased by an average of 41 percent nationwide between 2013 and 2014.<sup>24</sup>

PPACA’s overregulation of the market and the unpredictability of the administration’s policy changes are causing health insurance rates to rise at a pace faster than medical inflation. An April survey of current coverage rates conducted by Morgan Stanley found the “largest acceleration in small and individual group rates in any of the 12 prior quarterly periods when [the survey] has been conducted.”<sup>25</sup> The study attributes insurance price acceleration to PPACA’s restrictions on commercial underwriting, restrictions on age rating, new requirements for plan benefits, and the creation of new excise taxes on insurance plans.<sup>26</sup>

Additionally, several studies have shown that out-of-pocket costs have increased significantly under PPACA—costs that for most Americans are not reduced by subsidies. A study

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<sup>20</sup> *Ibid.*

<sup>21</sup> Coleman, K., & Geneson, J. (2013, December 12). [Deductibles, out-of-pocket costs, and the Affordable Care Act](#). *HealthPocket*.

<sup>22</sup> Board of Governors of the Federal Reserve System. (2012, June). [Changes in U.S. family finances from 2007 to 2010: Evidence from the survey of consumer finances](#). federalreserve.gov.

<sup>23</sup> Pipes, S. (2013, August 19). [Obama’s 2009 promise of cheaper healthcare has morphed into 2013 price hikes](#). *Forbes*.

<sup>24</sup> Roy, A. (2013, November 4). [49-state analysis: Obamacare to increase individual-market premiums by average of 41 percent](#). *Forbes*.

<sup>25</sup> Gottlieb, S. (2014, April 7). [Health plan premiums are skyrocketing according to new survey of 148 insurance brokers, with Delaware up 100%, California 53%, Florida 37%, Pennsylvania 28%](#). *Forbes*.

<sup>26</sup> *Ibid.*

by HealthPocket, Inc., published in December 2013 found that the average individual deductible for a Bronze plan was \$5,081 a year, or 42 percent higher than the average deductible of \$3,589 for a plan purchased by an individual in 2013.<sup>27</sup> A separate HealthPocket, Inc., study published in February found that the plans offered in the exchanges averaged a 34 percent increase in drug cost-sharing compared to copayments and coinsurance fees in the pre-reform market.<sup>28</sup> Patients needing specialty drugs, often those who are the sickest, have seen the biggest cost sharing increases: copayments for specialty drugs increased by 226 percent for a bronze plan and by 185 percent for a silver plan.<sup>29</sup>

## 2015 Costs

A number of factors may further cause premiums to increase in 2015. This year's exchange plans have narrower provider networks and lower provider payment rates than employer plans, according to CBO's April 2014 report. The agency predicts, however, that as enrollment in exchange plans grows, "many plans will not be able to sustain provider payment rates that are as low or networks that are as narrow as they appear to be in 2014" and this pattern will "put upward pressure on exchange premiums over the next couple of years."<sup>30</sup> As enrollment growth forces exchange plans' rates and networks to change, premiums are likely to rise.<sup>31</sup>

Only 28 percent of this year's health insurance exchange sign-ups were 18 to 35 year olds--short of the 39 percent that the administration said is needed "for the marketplaces to work."<sup>32</sup> Failure to attract enough "young invincibles" to the exchanges this year places a financial burden on insurers that may lead to further increases in insurance rates next year. Robert Zirkelbach, spokesman for America's Health Insurance Plans, warned of the consequences of not enrolling enough young and healthy Americans, saying, "If only people who are older and have high health care costs decide to purchase coverage now, that's going to mean that next year, when open enrollment comes around again, premiums may be significantly higher than we see today."<sup>33</sup>

Another upward force on next year's premiums is the higher demand for expensive medical care demonstrated by this year's enrollees. Analysis by Express Scripts found that enrollees in the exchanges have a 47 percent higher use of specialty medications than those in commercial plans. Specialty medications place a significant financial burden on insurers and patients: even

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<sup>27</sup> Coleman, K., & Geneson, J. (2013, December 12). [Deductibles, out-of-pocket costs, and the Affordable Care Act](#). *HealthPocket*.

<sup>28</sup> Coleman, K., & Geneson, J. (2013, February 14). [Drug coverage & the Affordable Care Act](#). *HealthPocket*.

<sup>29</sup> *Ibid.*

<sup>30</sup> Congressional Budget Office. (2014, April). [Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014](#). cbo.gov.

<sup>31</sup> *Ibid.*

<sup>32</sup> Franke-Ruta, G. (2013, July 18). [The White House is optimistic about its limited Obamacare goals](#). *The Atlantic*.

<sup>33</sup> Ydstie, J. (2013, October 25). [For Obamacare to work, it's not just about the numbers](#). *National Public Radio*.

though these drugs comprise less than 1 percent of U.S. prescriptions, they account for more than a quarter of total U.S. pharmacy spending.<sup>34</sup>

Adding to those market pressures is the uncertainty created by the Administration's haphazard regulatory changes, which Aetna's CEO Mark Bertolini reports will lead to premium increases "over double digits" in some parts of the country next year.<sup>35</sup>

Finally, a likely driver of premium cost increases for consumers next year – one that could come as a surprise after the fact for many – is the recalculation of the premium subsidy rates offered in each region. Federal premium subsidy calculations are tied to the second lowest cost silver plan in each region, the "benchmark plans." Subsidized consumers who choose a more expensive plan must pay the difference between the two themselves. If there is a change in the cost of the benchmark plan in a region from one year to the next, that will change the subsidy rates in that region.<sup>36</sup> Rate filings for 2015 indicate that such a change is likely: a survey of nine states by Avalere Health found that six of the states will have different benchmark plans next year and seven of them will have a change in the lowest costing silver plan.<sup>37</sup>

This change is likely to impact a large number of PPACA consumers without them realizing it. Consumers who do not cancel their plans or select different ones during the open enrollment period will be automatically reenrolled in the same plan for 2015. Those who automatically reenroll will receive the same subsidy in 2015 as in 2014, despite the likelihood that their region's benchmark plan will change and that subsidy amount will no longer be correct.<sup>38</sup> Many consumers will not discover that they received the wrong subsidy amount until they file their 2015 taxes, at which point they will have to pay back the difference to the IRS. Analysts suggest that automatic reenrollment will be a prevalent choice for next year. "There are lots of reasons to believe inertia will take hold here and people won't switch," said Larry Levitt of the Kaiser Family Foundation, citing the fact that most seniors enrolled in Medicare's prescription-drug benefit are unlikely to shop around for better plans after making their first year's selection. Given that 85 percent of current claimed enrollees receive subsidies from the federal government, and 3.4 million claimed enrollees, or over 40 percent, selected either a benchmark plan or one cheaper, it is highly probable that this shortcoming in transparency could impact a large number of people.<sup>39</sup>

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<sup>34</sup> Huppert, J. (2014, April 9). [First look: Health exchange medication utilization](#). Express Scripts.

<sup>35</sup> Millman, J. (2014, April 24). [Aetna: Late Obamacare changes account for half of 2015 premium increases](#). *The Washington Post*.

<sup>36</sup> Baker, S. (2014, August 5). [If you like your Obamacare plan, it'll cost you](#). *The National Journal*.

<sup>37</sup> Carpenter, E. (2014, June 26). [Exchange Plan Renewals: Many Consumers Face Sizeable Premium Increases in 2015 Unless They Switch Plans](#). Avalere Health.

<sup>38</sup> Baker, S. (2014, August 5). [If you like your Obamacare plan, it'll cost you](#). *The National Journal*.

<sup>39</sup> *Ibid.*

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**Claim III: Transparency and access to care have increased.** *“It will say clearly what each plan covers, what each plan costs. The price will be right there. It will be fully transparent....And so if you’ve ever tried to buy insurance on your own, I promise you this is a lot easier. It’s like booking a hotel or a plane ticket.”*

– President Barack Obama, September 26, 2013.<sup>40</sup>

**Reality: The PPACA exchanges are not transparent about limited drug coverage and narrow doctor and hospital networks.**

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### Lack of Transparency about Exchange Plan Coverage

The administration promised that PPACA would promote transparency and accessibility, but the reality is that many consumers were not given accurate, complete information by the exchanges on how expensive their prescriptions would be and whether their doctors and hospitals would be covered.<sup>41</sup> This lack of transparency in information diminishes access to care. As Kimberly Beer of the Arthritis Foundation recently told *The Wall Street Journal*, without easier access to information, “we’re concerned that people may be attracted to plans with low premiums and not have much drug coverage at all.”<sup>42</sup>

### Limited Drug Coverage

An analysis by Avalere Health found that more than a third — 38 percent — of plans offered on the exchanges had no information about drug coverage available.<sup>43</sup> The study found that only 52 percent of exchange plans have very or moderately accessible drug formularies (the list of generic and brand name drugs covered by a health plan). Avalere also found roughly 1 in 4 exchange plans offers insufficient information on which doctors and hospitals are covered.<sup>44</sup>

It’s critical that before enrolling, individuals are provided with accurate information on which drugs a health insurance plan will cover. This is even more critical for individuals enrolling in exchange plans, as many PPACA plans have limited drug coverage. Patients must pay the full cost for drugs that are not on an insurer’s pre-approved list. The money that patients spend on these drugs does not count toward their deductible or out-of-pocket costs, and there is no limit to what they could spend on their medication needs.<sup>45</sup>

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<sup>40</sup> The White House, Office of the Press Secretary. (2013, September 26). [Remarks by the President on the Affordable Care Act](#). whitehouse.gov.

<sup>41</sup> Miles, K. (2014, April 10). [How Obamacare leaves some people without doctors](#). *Huffington Post*.

<sup>42</sup> Beck, M. (2013, December 4). [Drug-cost surprises lurk inside new health plans](#). *The Wall Street Journal*.

<sup>43</sup> Pearson, C. (2014, April 25). [Study finds lack of transparency on drug coverage in exchanges, but better data on provider networks](#). Avalere Health.

<sup>44</sup> *Ibid.*

<sup>45</sup> Gottlieb, S. (2013, December 9). [No, You Can't Keep Your Drugs Either Under Obamacare](#). *Forbes*.

A lack of transparency about this costly issue has serious repercussions for patient access to care. Especially for the sickest and most vulnerable consumers on the exchanges, it could be a tremendous hardship on a patient to discover, after enrolling in a plan, that necessary drug treatments must be paid out-of-pocket. Randall Ellis, vice president of public affairs at Legacy Community Health Services, which treats almost three thousand patients with HIV/AIDS, said, “We never expected these drugs to be completely left off some formularies. It’s causing a lot of anxiety and confusion.”<sup>46</sup>

### Narrow Networks

Most PPACA provider networks are narrower than the networks of plans previously offered in the individual market, meaning that the plans cover fewer doctors and hospitals than plans sold on the individual market before the law took effect. A study by McKinsey and Company found that 70 percent of PPACA plans analyzed had narrow or ultra-narrow networks—those with coverage of 14 or fewer of an area’s 20 largest hospitals. Insurers that offered coverage in the same individual markets in 2013 and in 2014 offered almost three times as many narrow and ultra-narrow networks this year as they offered in the same markets in 2013.<sup>47</sup> These narrow networks, combined with the overall lack of transparency on the exchanges, mean that consumers may not know before purchasing a plan whether or not that plan will cover the doctors and hospitals they prefer.

The PPACA provider networks are also narrower than the networks of typical employer plans offered today. In California, for example, Blue Cross Blue Shield reports that only 60 percent of the doctors participating in their employer plans also agreed to be included in the individual plans offered on the state’s exchange.<sup>48</sup> Additionally, a New York State Medical Society survey showed that 44 percent of the state’s physicians did not plan to participate in any health insurance plan offered on the exchange.<sup>49</sup>

Narrower networks mean that there are fewer hospitals available to people on many exchange plans. Of the nation’s top 18 hospitals, as ranked by *US News and World Report*, only 11 accept one or two carriers’ exchange plans, according to a survey by Watchdog.org.<sup>50</sup> Further, out of 19 nationally recognized comprehensive cancer care centers, only four are covered by all of the insurance companies in their states’ exchanges, according to a survey conducted by the *Associated Press*.<sup>51</sup>

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<sup>46</sup> Cha, A. E. (2013, December 9). [AIDS advocates say drug coverage in some marketplace plans is inadequate](#). *The Washington Post*.

<sup>47</sup> McKinsey Center for U.S. Health System Reform. (2013, December 14). [Hospital networks: Configurations on the exchanges and their impact on premiums](#). McKinsey & Company.

<sup>48</sup> Pickert, K. (2014, January 1). [Keeping your doctor under Obamacare is no easy feat](#). *Time*.

<sup>49</sup> Campanile, C. (2013, October 29). [Docs resisting Obamacare](#). *New York Post*.

<sup>50</sup> Richards, T. (2013, October 30). [Top hospitals opt out of Obamacare](#). *U.S. News*.

<sup>51</sup> Alonso-Zaldivar, R. (2014, March 19). [Top cancer centers off-limits under Obamacare](#). *NBC News*.

The narrow networks of plans offered through the Washington state exchange were described as a “new level of degradation in children’s access to care” by Dr. Sandy Melzer, Seattle Children’s Hospital’s senior vice president and chief strategy officer.<sup>52</sup> Seattle Children’s Hospital was excluded from the networks of five of the seven insurers offering coverage in its county. The hospital is suing the state’s Office of the Insurance Commissioner for “failure to ensure adequate network coverage” on multiple plans offered on the state exchange.<sup>53</sup>

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<sup>52</sup> Landa, A. S. (2013, October 4). [Children’s Hospital sues state over exclusion from exchange plan networks](#). *The Seattle Times*.

<sup>53</sup> *Ibid.*

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**Claim IV:** PPACA strengthens the economy and reduces the deficit. *“In keeping with the President’s pledge that reform must fix our health care system without adding to the deficit, the Affordable Care Act reduces the deficit, saving over \$200 billion over 10 years and more than \$1 trillion in the second decade. The law reduces health care costs...[and] is improving our economic competitiveness[.]”*

– *WhiteHouse.gov*<sup>54</sup>

**Reality:** PPACA adds to the deficit, increases health care spending, burdens employers, increases taxes, and disincentivizes work.

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### Deficit

The reality is that PPACA increases the deficit and many of the law’s alleged savings never materialized. In order to secure passage of PPACA in 2010, the administration claimed that the law would reduce the deficit by \$124 billion.<sup>55</sup> At the time the law was passed, \$70.2 billion<sup>56</sup> of the \$124 billion in savings were to come from the Community Living Assistance Services and Supports (CLASS) Act, which the administration never implemented because the program was unworkable.<sup>57</sup> The CLASS Act was repealed by Congress with bipartisan support.<sup>58</sup>

Additional PPACA spending was to be paid for with Medicare Fee-for-Service and Medicare Advantage cuts and reductions in payments to hospitals, skilled nursing facilities, and home health centers.<sup>59</sup> These cuts have proved widely unpopular and many have been delayed or scaled back by the administration.<sup>60</sup> Even if all the Medicare cuts do go into effect, the Medicare Chief Actuary wrote in 2010 that the savings may not be realized, because the cuts would cause about 15 percent of hospitals and post-acute care facilities, like nursing homes, to go out of business.<sup>61</sup>

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<sup>54</sup> The White House. [Deficit-reducing health care reform](http://whitehouse.gov). whitehouse.gov. Accessed 22 May 2014.

<sup>55</sup> Congressional Budget Office. (2010, December). [Selected CBO publications related to health care legislation, 2009-2010](#). Page 4. cbo.gov.

<sup>56</sup> Congressional Budget Office. (2010, December). [Selected CBO publications related to health care legislation, 2009-2010](#). Page 34. cbo.gov.

<sup>57</sup> Congressional Budget Office. (2010, December). [Selected CBO publications related to health care legislation, 2009-2010](#). Page 34. cbo.gov.

<sup>58</sup> Gleckman, H. (2013, January 1). [Fiscal cliff deal repeals CLASS Act, creates long-term care commission](#). *Forbes*.

<sup>59</sup> Centers for Medicare & Medicaid Services, Office of the Actuary. (2010, April 22). [Estimated financial effects of the “Patient Protection and Affordable Care Act,” as amended](#). cms.gov.

<sup>60</sup> Hancock, J. (2014, April 8). [Obama administration retreats on private Medicare rate cuts](#). *Kaiser Health News*.

<sup>61</sup> Centers for Medicare & Medicaid Services, Office of the Actuary. (2010, April 22). [Estimated financial effects of the “Patient Protection and Affordable Care Act,” as amended](#). cms.gov.



Fifty-two billion dollars in predicted deficit reduction came from the employer penalties the government expected to collect from businesses that did not comply with the mandates to purchase health insurance.<sup>62</sup> The employer penalties have been delayed because the administration has delayed enforcing the employer mandate to provide health insurance.<sup>63</sup>

Finally, the initial estimates of deficit reduction included Medicare cuts from the unelected Independent Payment Advisory Board. This Board has yet to be appointed, so there are no deficit reduction savings at this time from this PPACA creation.

The White House recently stated that CBO projects “lower-than-expected Marketplace premiums and other recent developments will cut \$104 billion from our deficit over the next ten years.”<sup>64</sup> The claim that PPACA will “cut” \$104 billion over 10 years from our nation’s deficit is not real savings—it’s a reduction from a previous projection. In their February 2014 report, CBO and the Joint Commission on Taxation (JCT) projected the net costs to the federal government for coverage provisions of PPACA to be \$1.487 trillion over the 2015–2024 period.<sup>65</sup> The CBO and JCT now project a net cost of “[\$1.383 trillion] for the 2015–2024 period, \$104 billion less than the previous projection.”<sup>66</sup> It is misleading to state that a lower projected 10-year cost is the same thing as real savings.

Instead of reducing the deficit, PPACA could add anywhere from \$340 - \$540 billion to the deficit.<sup>67</sup>

## Rising Health Care Spending

*“Rising health care costs are a major driver of our long-term deficits, and getting them under control is crucial if we want to grow the economy, create jobs and compete in the world economy. The Affordable Care Act helps us achieve that goal...The law is improving our economic competitiveness by bending the growth curve of health care spending...”*

– WhiteHouse.gov<sup>68</sup>

<sup>62</sup> Congressional Budget Office. (2010, December). [Selected CBO publications related to health care legislation, 2009-2010](#). Page 24. cbo.gov.

<sup>63</sup> Mangan, D. (2014, February 10). [Delayed: Obamacare’s employer mandate for small businesses](#). CNBC.

<sup>64</sup> The White House, Office of the Press Secretary. (2014, April 17). [Fact sheet: Affordable Care Act by the numbers](#). whitehouse.gov.

<sup>65</sup> Congressional Budget Office. (2014, February). [The budget and economic outlook: 2014 to 2024](#). Page 105. cbo.gov.

<sup>66</sup> Congressional Budget Office. (2014, April). [Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014](#). Page 1. cbo.gov.

<sup>67</sup> Blahous, C. (2012, April 10). [The fiscal consequences of the Affordable Care Act](#). Page 5. The Mercatus Center at George Mason University.

<sup>68</sup> The White House. [Deficit-reducing health care reform](#). whitehouse.gov. Accessed 22 May 2014.



The administration credits PPACA with reducing health care costs. A document released by the White House claimed that “[h]ealth care costs are growing at the slowest level on record: Since the law passed, real per capita health care spending is estimated to have grown at the lowest rate on record for any three-year period and less than one-third the long-term historical average stretching back to 1960. This slower growth in spending is reflected in Medicare, Medicaid, and private insurance.”<sup>69</sup>

The reality is that the decline in health spending growth predates passage of PPACA, and analysis shows that the major driver of this decline is the state of the American economy. A report from the non-partisan policy journal *Health Affairs* on national health spending trends for 2012 found that the “low rate of increase has followed a steady slowdown that began in 2003,” long before the passage of the health reform law. The *Health Affairs* report indicates that the relative stability in the growth of national health spending since 2009 is due to the recession, not to legislative changes.<sup>70</sup> This finding was confirmed by an April 2013 report published by the Kaiser Family Foundation, which concluded that “the economy is by far the biggest determinant of changes in health spending overall.”<sup>71</sup>

### Employer Burden

To obtain a clearer picture of how PPACA is affecting employers, the American Health Policy Institute conducted a study of direct costs to companies from PPACA’s requirements, over and above projected employer health care cost trends without the law. This was “the first-ever study of the actual, internal PPACA-related costs to more than 100 large employers (those with 10,000 or more employees).”<sup>72</sup> This study found that over the next decade, PPACA will impose an estimated total additional cost on all large U.S. employers of between \$151 billion and \$186 billion. Those estimates translate to between \$163 million and \$200 million per large employer, or \$4,800 to \$5,900 per employee.<sup>73</sup>

As reported by the study, “[t]hese data demonstrate that the added mandates, fees and regulatory burdens associated with the [PPACA] are increasing the cost of employer-sponsored health care plans, with implications for both employers and employees.” Employers facing such high costs will be forced to make difficult decisions related to their hiring practices and the level of compensation offered.<sup>74</sup>

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<sup>69</sup> The White House, Office of the Press Secretary. (2014, April 17). [Fact sheet: Affordable Care Act by the numbers](#). whitehouse.gov.

<sup>70</sup> Martin, A., Hartman, M., Whittle, L., Catlin, A., the National Health Expenditure Accounts Team. (2014, January). [National health spending in 2012: Rate of health spending growth remained low for the fourth consecutive year](#). *Health Affairs*.

<sup>71</sup> Levitt, L. (2013, April 22). [Assessing the Effects of the Economy on the Recent Slowdown in Health Spending](#). kff.org

<sup>72</sup> Troy, T., & Wilson, D. M. (2014, April). [The cost of the Affordable Care Act to large employers](#). American Health Policy Institute.

<sup>73</sup> *Ibid.*

<sup>74</sup> *Ibid.*

## Medical Device and Health Insurance Taxes

PPACA imposes a number of new taxes on businesses and health insurance providers that will ultimately be paid by plan holders. One of the taxes imposed by PPACA is a 2.3 percent tax on all medical device tax revenue. This amounts to an over \$29 billion tax on revenue from 2013 to 2022, according to the Congressional Joint Committee on Taxation (JCT).<sup>75</sup> To determine the real world impact of this tax during its first year of implementation, AdvaMed, a medical technology trade association, conducted a survey of its member companies. The survey found that in one year, the medical device tax had already cost 33,000 jobs as employer reduced payrolls and slowed hiring. Additionally, almost 10 percent of respondents reported that they had relocated or expanded manufacturing overseas because of the tax.<sup>76</sup>

Another burdensome tax created by PPACA is the annual fee levied on health insurance providers. This tax will take more than \$100 billion out of the economy by 2022 according to the JCT, and will negatively impact Americans' incomes and the economy's job growth.<sup>77</sup> The CBO reported in 2009 that the cost of the tax would be borne by PPACA consumers, writing that it would be "passed on to purchasers and would ultimately raise insurance premiums by a corresponding amount."<sup>78</sup> At the same time, the National Federation of Independent Business (NFIB) estimates that at least 152,000 jobs would be lost by 2023 because of this tax, with 57 percent of the job losses coming from small businesses. Additionally, the NFIB estimates that there will be "a reduction of U.S. real output (sales) by between \$20 billion to \$33 billion during the same time frame."<sup>79</sup>

## Disincentivizing Work

The subsidies provided to individuals through the law decrease and eventually disappear as an individual's income increases, and therefore will discourage some workers from earning more money or working more hours. As a part of the agency's budget and economic outlook for the years 2014-2024, CBO released updated estimates of the effects of PPACA on the labor market. In this report, CBO estimated that PPACA "will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024, almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive."<sup>80</sup> Rather than add

<sup>75</sup> Barthold, T. (2012, June 15). [Revenue estimates](#). Joint Committee on Taxation, U.S. House of Representatives Committee on Ways and Means.

<sup>76</sup> (2014, February 2). [Impact of the medical device excise tax: A status report by AdvaMed](#). AdvaMed.org.

<sup>77</sup> Barthold, T. (2012, June 15). [Revenue estimates](#). Joint Committee on Taxation, U.S. House of Representatives Committee on Ways and Means.

<sup>78</sup> Congressional Budget Office. (2009, September 22). [Analysis of exchange subsidies and enrollee payments in the specifications for the Senate Finance Committee Chairman's Mark](#). cbo.gov.

<sup>79</sup> Chow, M. (2014, May 5). [Effects of the PPACA health insurance premium tax on small businesses and their employees](#). nfib.gov.

<sup>80</sup> Congressional Budget Office. (2014, February). [The budget and economic outlook: 2014 to 2024](#). Page 117. cbo.gov.

to the productivity of our economy as the administration claims, CBO asserts the effect will be the opposite: “The reduction in CBO’s projections of hours worked represents a decline in the number of full-time-equivalent workers of about 2 million in 2017, rising to about 2.5 million in 2024.”<sup>81</sup>

PPACA also creates new penalties for employers that incentivize them to cut employees hours and wages. PPACA does this by defining full-time employment as 30 hours a week and penalizing large employers that do not offer health insurance to employees who meet that definition. The penalty on employers who have over 49 full-time employees and do not offer them health insurance is \$2,000 per full-time-employee, with the first 30 being exempt, per year.<sup>82</sup> Casey Mulligan, an economics professor at the University of Chicago, explains the impact that this has on the labor market, saying, “The penalty creates an incentive to substitute part-time positions for full-time positions and to monitor part-time employee hours so that they do not exceed 29 hours per week.” Mulligan also argues that these penalties are passed onto employees in the form of wage cuts. Because the penalty is not tax deductible, Mulligan calculates that “each \$2,000 of penalty is therefore equivalent to \$3,046 of employee wages.”<sup>83</sup>

Dr. Lanhee Chen, a research fellow at Stanford University, predicts that PPACA’s 30 hour rule will disproportionately impact women and individuals without college degrees. Dr. Chen and his colleagues at Stanford analyzed the “vulnerable population” most likely to be impacted by this law, defining this population as “those Americans working at firms with more than 100 employees; who were employed between 30 and 36 hours per week; who had family incomes below 400% of the Federal Poverty Level (FPL); and who did not receive health insurance through their employers.”<sup>84</sup> The study found that, of the Americans most at risk of lost hours, 63 percent are female, 89 percent do not have a college degree, and more than half have a high school diploma or less.<sup>85</sup>

PPACA’s perverse incentive to cut employee hours is already negatively impacting the workforce, as shown by three surveys published by Federal Reserve Banks this August. The Federal Reserve Bank of Philadelphia asked manufacturers what changes they had made because of PPACA, and 18.2 percent of respondents reported that they had increased their proportion of part-time workers.<sup>86</sup> The New York Federal Reserve asked local manufacturers the same question and found that 19.3 percent had increased their proportion of part-time

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<sup>81</sup> *Ibid.*

<sup>82</sup> Mulligan, C. (2014, March). “[The ACA: Some Unpleasant Welfare Arithmetic.](#)” National Bureau of Economic Research. nber.org. Page 2.

<sup>83</sup> *Ibid.*

<sup>84</sup> Chen, L. (2014, January 28). “[Testimony Before the Committee on Ways and Means United States House of Representatives.](#)” U.S. House of Representatives Committee on Ways and Means. waysandmeans.house.gov

<sup>85</sup> *Ibid.*

<sup>86</sup> Federal Reserve Bank of Philadelphia. (2014, August). “[August 2014 Business Outlook Survey.](#)” philadelphiafed.org

workers because of PPACA.<sup>87</sup> Finally, the Atlanta Federal Reserve Bank published a survey in which 34 percent of businesses reported that they plan to hire more part-time workers than they have in the past, and that this is due in part to the rise in relative costs of full-time workers.<sup>88</sup>

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<sup>87</sup> New York Federal Reserve Ban. (2014, August). "[Supplemental Survey Report: Firms Assess Effects of Affordable Care Act.](#)" newyorkfed.org

<sup>88</sup> The Wall Street Journal Review & Outlook. (2014, August 21). "[Unemployed by ObamaCare.](#)" online.wsj.com

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**Claim V:** The exchanges were ready and would work. *“The good news is that starting October 1st, new online marketplaces will allow consumers to go online and compare private health care insurance plans just like you’d compare over the Internet the best deal on flat-screen TVs, or cars or any other product that is important to your lives.”*

*-President Obama, July 18, 2013<sup>89</sup>*

**Reality:** The federal government and some states have wasted millions of dollars creating dysfunctional exchanges. None of the exchanges were properly equipped to verify eligibility for taxpayer-funded subsidies.

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### Dysfunctional Federal Exchange

Healthcare.gov failed to launch as promised on October 1, 2013, and a report by the nonpartisan Government Accountability Office (GAO) found that CMS is largely responsible for this failure. The July 2014 GAO report found that CMS “undertook the development of healthcare.gov and its related systems without effective planning or oversight practices, despite facing a number of challenges that increased both the level of risk and the need for oversight.”<sup>90</sup> CMS reported in March 2014 that \$840 million had been obligated for the development of healthcare.gov, and this report sheds light on the mismanagement by CMS that helped lead to such a high price tag.<sup>91</sup>

The GAO report indicates that the development of healthcare.gov and its supporting systems by CMS was a rushed project wherein the top priority for CMS was for the website to go live on October 1, 2013, and of lesser concern were the full functionality of the website and the cost to taxpayers. The report concludes: “CMS program and contracting staff made a series of planning decisions and trade-offs that were aimed at saving time, but which carried significant risks...The result was that problems were not discovered until late, and only after costs had grown significantly.”<sup>92</sup>

GAO presciently warned CMS in June 2013 of many of the problems that eventually led to the limited functionality and high cost of healthcare.gov.<sup>93</sup> Instead of acknowledging the

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<sup>89</sup> The White House, Office of the Press Secretary. (2013, July 18). [Remarks by the President on the Affordable Care Act](#). whitehouse.gov.

<sup>90</sup> Government Accountability Office. (2014, July). [Healthcare.gov: Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management](#). Page 11. gao.gov

<sup>91</sup> *Ibid.* Page 9.

<sup>92</sup> *Ibid.* Page 39.

<sup>93</sup> Government Accountability Office. (2013, June). [Patient Protection and Affordable Care Act: Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges](#). gao.gov

importance of these warnings, an HHS official responded to the GAO report on June 6, 2013, by highlighting the “tremendous progress” that had been made on the website and asserting that “on October 1, 2013 a Health Insurance Marketplace will be open and functioning in every state.”<sup>94</sup>

The June 2014 GAO report warns that the federal exchange continues to face significant problems going forward: “Unless CMS takes action to improve acquisition oversight, adhere to structured governance process, and enhance other aspects of contract management, significant risks remain that upcoming open enrollment periods could encounter challenges going forward.”<sup>95</sup>

### Dysfunctional State Exchanges

The 27 states with federally-facilitated marketplaces (FFMs), 17 states with state-based marketplaces (SBMs), and 7 states working in partnership with the federal government have faced varying levels of success with their exchanges.<sup>96</sup> While some have functioned as expected, others have fallen far short of their goals. Specifically:

- **Hawaii.** The technical problems that Hawaii’s Health Connector experienced may have prevented some consumers from obtaining the premium subsidies to which they were entitled under PPACA. Although Hawaii nearly met its goal of signing up 9,000 people, a smaller proportion of consumers obtained premium subsidies than expected.<sup>97</sup> Only 38 percent of those who chose a plan were eligible for subsidies, as opposed to the national average where 85 percent of those who chose a plan were eligible.<sup>98</sup> Hawaii received \$204.3 million in federal funds to develop its exchange.<sup>99</sup>
- **Maryland.** Maryland is replacing its broken-down website with a brand new one, at a cost upwards of \$40 million.<sup>100</sup> The state already spent \$129.8 million to build and run its exchange, with 90 percent of the funding supplied by the federal government. Officials fired Maryland’s lead contractor, Noridian Healthcare Solutions, and hired Deloitte Consulting to oversee the replacement system. By mid-April, 62,003 people had signed up for private insurance plans on Maryland’s exchange, well below the original goal of enrolling 140,000.<sup>101</sup> The HHS Inspector General is investigating the extent to

<sup>94</sup> *Ibid.* Page 46.

<sup>95</sup> Government Accountability Office. (2014, July). [Healthcare.gov: Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management](#). Pages 39-40. gao.gov

<sup>96</sup> [State decisions for creating health insurance marketplaces, 2014](#). The Henry J. Kaiser Family Foundation.

<sup>97</sup> Garcia, O. (2014, May 1). [Most Hawaii exchange enrollees didn’t receive aid](#). *The Washington Times*.

<sup>98</sup> *Ibid.*

<sup>99</sup> Maer, P. (2013, December 26). [Hawaii’s health insurance exchange is no paradise](#). *CBS News*.

<sup>100</sup> Johnson, J. (2014, April 18). [Md. Spent \\$90 million on health exchange technology, according to cost breakdown](#). *The Washington Post*.

<sup>101</sup> *Ibid.*

which Maryland complied with federal requirements related to building and implementing the exchange.<sup>102</sup> Maryland received \$171 million in federal grants to build and run its exchange.<sup>103</sup>

- **Massachusetts.** Despite having a head start on building an exchange and \$170 million from the federal government, the Massachusetts Health Connector has fallen behind in terms of performance.<sup>104</sup> Massachusetts officials decided to fix their current exchange while also preparing to connect to the federal exchange for 2015 in case their fix does not work.<sup>105</sup> This “dual track” plan is estimated to cost an additional \$121 million, of which Massachusetts expects the federal government to pay \$40 million.<sup>106</sup> About 31,700 people were able to sign up for private insurance plans through mid-April, and none of them qualified for subsidies.<sup>107</sup> Massachusetts temporarily enrolled 200,000 residents in Medicaid as a stopgap measure while it works to enroll them in Medicaid or subsidized plans. This temporary fix has cost at least \$24 million thus far.<sup>108</sup>
- **Minnesota.** MNsure’s website, developed by IBM, locked out and frustrated consumers for months.<sup>109</sup> The website’s development suffered from many of the same ills as the federal website: lack of leadership and time to properly test the software. MNsure’s executive director resigned abruptly in December after she came under scrutiny for several issues, including taking a vacation when technological glitches were at their height.<sup>110</sup> Minnesota received approximately \$155 million in federal grants<sup>111</sup> and signed up roughly 47,000 in private health plans and 88,000 in Medicaid.<sup>112</sup>
- **Nevada:** Nevada is joining the federal exchange for 2015 after ending its \$72 million contract with exchange developer Xerox for creating a faulty website.<sup>113</sup> As of May 10, only 46,000 people had signed up for private coverage in Nevada, far short of the state’s 118,000 enrollment target.<sup>114</sup> Nevada received \$90.8 million in federal grants to create

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<sup>102</sup> Johnson, J. (2014, March 10). [HHS inspector general to review Md. health exchange after congressman requests probe](#). *The Washington Post*.

<sup>103</sup> Mach, A. (2014, June 11). [Federal Funding for Health Insurance Exchanges](#). The Congressional Research Service.

<sup>104</sup> *Ibid.*

<sup>105</sup> Freyer, F. (2014, June 12). [Mass. Health Connector website faces critical test in July](#). *The Boston Globe*.

<sup>106</sup> *Ibid.*

<sup>107</sup> Goodnough, A. (2014, May 5). [Massachusetts starts over on health website after troubles](#). *The New York Times*.

<sup>108</sup> *Ibid.*

<sup>109</sup> Boulton, C. (2014, January 8). [Minnesota Governor Blasts IBM for State Health Exchange Troubles](#). *Wall Street Journal*.

<sup>110</sup> Snowbeck, C. (2014, December 18). [Under fire, MNsure’s executive director abruptly resigns](#). *Twin Cities*.

<sup>111</sup> Mach, A. (2014, June 11). [Federal Funding for Health Insurance Exchanges](#). The Congressional Research Service.

<sup>112</sup> (2014, April 1). [169,000 Minnesotans enroll in quality, affordable health coverage during 2014 open enrollment](#). MNsure.

<sup>113</sup> Goodnough, A. (2014, May 20). [Health site under fire, Nevada alters path](#). *The New York Times*.

<sup>114</sup> *Ibid.*



the exchange.<sup>115</sup> The cost of connecting Nevada’s exchange to the federal exchange is estimated to be as much as \$20 million, and Nevada expects the federal government to pay 90 percent of that cost.<sup>116</sup> Further, it will cost \$25 million for Nevada to replace the Medicaid section of its exchange, and the federal government will cover \$22.5 million of that cost.<sup>117</sup>

- **Oregon.** No Oregon residents have been able to sign up for exchange coverage through Cover Oregon, the state-based exchange website. Instead, all enrollees have applied on paper,<sup>118</sup> even though Oregon officials received nearly \$305 million in federal funds to build and run their own website.<sup>119</sup> One estimate indicated that fixing the state website would cost an additional \$78 million. Instead of fixing it, in April the state decided to convert to a federal exchange. The cost to connect to the federal exchange is likely to be about \$6 million.<sup>120</sup> The state reports that about 242,000 Oregonians have signed up for coverage. GAO is reviewing the exchange and will comment on whether or not the federal government can reclaim some of the funds.<sup>121</sup> Recently, the FBI began an investigation, reportedly to review claims that Cover Oregon made to the federal government about its progress.<sup>122</sup>

### Unable to Verify Eligibility for Taxpayer-Funded Subsidies

The Obama administration also promised that there would be adequate safeguards in place to protect taxpayer dollars from going to individuals who do not qualify for health care subsidies. PPACA required that eligibility verification safeguards be in place before the first health care subsidy payments were made, and Secretary Sebelius certified that this was so on January 1, 2014, writing: “I certify that the American Health Benefit Exchanges (Marketplaces) verify that applicants for advance payments of the premium tax credit and cost-sharing reductions are eligible for such payments and reductions...I am providing this certification before the first advance payments of the premium tax credit are made.”<sup>123</sup>

Contrary to Secretary Sebelius’ certification, a June 2014 report by the HHS Office of Inspector General (OIG) found that “the CMS eligibility system was not fully operational” as of

<sup>115</sup> [Nevada Health Insurance Marketplace Grants Awards List](#). Centers for Medicare and Medicaid Services.

<sup>116</sup> Roerink, K. (2014, May 19). [Will Nevada drop its health care exchange, Xerox on Tuesday?](#). *Las Vegas Sun*.

<sup>117</sup> Roerink, K. (2014, June 2). [Nevada’s health exchange for Medicaid to cost \\$25 million](#). *Las Vegas Sun*.

<sup>118</sup> Goldstein, A. (2014, April 24). [Oregon’s broken health insurance exchange](#). *The Washington Post*.

<sup>119</sup> Mach, A. (2014, June 11). [Federal Funding for Health Insurance Exchanges](#). The Congressional Research Service.

<sup>120</sup> Wayne, A. (2014, April 25). [Oregon to shut health site to join Obamacare exchange](#). *Bloomberg*.

<sup>121</sup> Associated Press. (2014, April 25). [Oregon gives up on state Obamacare site, switches to federal exchange](#). *CBS News*.

<sup>122</sup> Paletta, D., and Barrett, D. (2014, May 4). [FBI scrutinizing health law implementation flaws in Oregon](#). *The Wall Street Journal*.

<sup>123</sup> Sebelius, K. (2014, January 1). [Verification of Household Income and Other Qualifications for the Provision of Affordable Care Act Premium Tax Credits and Cost-Sharing Reductions](#). [www.cms.gov](http://www.cms.gov)



the first quarter of 2014. This resulted in 2.9 million inconsistencies in applicants' data in the federal exchange, 2.6 million of which were unresolvable "even if applicants submitted appropriate documentation." An inconsistency refers to a circumstance in which "the marketplace cannot verify an applicant's information through available data sources." This happens when applicant-supplied data does not match federal records, or when the federal records needed for verification are not available or do not exist. An applicant may enroll in an exchange plan and receive subsidies while inconsistencies are being resolved.<sup>124</sup>

The OIG found that 77 percent of all inconsistencies in the federal exchange were related to citizenship and income, the first and most basic qualification criteria. Worse still, the report also found that the federal exchange's citizenship and income inconsistencies were "unable to be resolved" by CMS.<sup>125</sup>

Many state exchanges also reported difficulties with inconsistencies, and four – Massachusetts, Nevada, Oregon, and Vermont – reported that they were unable to resolve their applicants' inconsistencies. State exchanges reported that inconsistencies were due in part to the outages in the Data Hub, the federal system that supplies an individual's eligibility data for verification against his or her application. Another cause of inconsistencies was the inaccuracy of information accessed through the Data Hub. For example, one state marketplace "cited situations in which infants and young children included on applications were erroneously identified as incarcerated, according to federal data."<sup>126</sup>

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<sup>124</sup> *Ibid.*

<sup>125</sup> *Ibid.*

<sup>126</sup> *Ibid.*

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**Claim VI: Healthcare.gov is working well with states to enroll individuals in Medicaid.** *“The federal system is ready to send automated reports [of Medicaid applications] and receive automated reports to try and seamlessly do this.”*

– Then HHS Secretary Sebelius, April 10, 2014<sup>127</sup>

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**Reality: Error-ridden Medicaid application data from Healthcare.gov is imposing significant burdens on states.**

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Healthcare.gov is supposed to be the one-stop shop for Americans enrolling in health insurance, with the website designed to connect with health insurance companies and with the states to complete an individual’s application for either health insurance or Medicaid.<sup>128</sup> After a disastrous rollout, healthcare.gov has made some progress toward providing functionality for the federal private insurance exchange, but it remains woefully inadequate in supporting Medicaid enrollment.

States use healthcare.gov to enroll individuals in Medicaid. Healthcare.gov’s ability to communicate with states’ IT systems, though, was not ready by October 1, 2013, for open enrollment. It was not until mid-December 2013 that states were just beginning to test the service to electronically transfer information from the federally run healthcare.gov.<sup>129</sup> On April 10, 2014, then Secretary Sebelius testified to the Senate Finance Committee that healthcare.gov was ready to send automatic reports to states of Medicaid eligibility determinations, and blamed the backlog of pending Medicaid applications on states’ IT systems.<sup>130</sup> These statements are in direct contrast to the reality on the ground: On May 28, 2014, eight months after the launch of open enrollment, the National Association of Medicaid Directors reported that the technology at the federal and state level remains so broken that states have had to resort to processing applications by hand.<sup>131</sup>

In November, when it became clear that healthcare.gov lacked the ability to transfer Medicaid applications, CMS chose to allow a shortcut option for states.<sup>132</sup> CMS announced it would allow states to use “flat files” of incomplete eligibility information from healthcare.gov to enroll people in Medicaid. Because flat files lack essential eligibility information, they limit a

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<sup>127</sup> Sebelius, K. (2014, April 11). [Key Capitol Hill Hearings](#). CSPAN.

<sup>128</sup> Cheney, K. (2013, October 24). [What makes healthcare.gov so complicated?](#). *Politico*.

<sup>129</sup> (2013, December 16). [NAMD ACA implementation snapshot – Open enrollment, week 10](#). National Association of Medicaid Directors.

<sup>130</sup> (2014, April 10). [The President’s budget for fiscal year 2015](#). United States Senate Committee on Finance.

<sup>131</sup> Teske, S. (2014, May 28). [State Medicaid programs struggle to process applications from federal marketplace](#). *Bloomberg BNA*.

<sup>132</sup> Cheney, K. (2013, December 3). [Medicaid, insurance fixes may be big trouble later](#). *Politico*.

states' ability to verify whether an applicant meets the requirements of the program, thus increasing vulnerability to duplicative and fraudulent enrollments. Kip Piper, a former senior federal Medicaid adviser, explained that this move compromised the financial stability of state Medicaid programs, saying, "[This] certainly risks big problems down the road, with greater confusion, duplication and even a degree of fraud, and abuse. The administration frankly does not care about the risk of overspending or duplicate enrollments or ineligible people getting enrolled in Medicaid in the first year."<sup>133</sup> Kyle Cheney, a health reporter at *Politico*, came to a similar conclusion about the flat files, saying, "The expedited enrollment process comes with big risks for states, and it's up to them to decide whether they're willing to risk the integrity of their Medicaid programs to sign up people faster."<sup>134</sup>

Such predictions of faulty enrollments proved accurate in many states. Texas officials reported that flat files they received from healthcare.gov were from people who do not live in Texas or who were already enrolled in Medicaid.<sup>135</sup> Florida officials reviewed their flat files and found that much of the data was unreliable, duplicative, and contained information for applicants who were clearly ineligible for Medicaid.<sup>136</sup> This spring, Arkansas removed roughly 5,000 Medicaid enrollees from its program after learning that they did not qualify for the program. The state had trusted the flat files from healthcare.gov and enrolled the applicants in Medicaid before realizing how significantly the data provided by the federal exchange was flawed.<sup>137</sup> This administration shortcut compromised the integrity and financial solvency of state Medicaid programs.

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<sup>133</sup> *Ibid.*

<sup>134</sup> *Ibid.*

<sup>135</sup> O'Donnell, Jayne. (2013, December 9). [Federal exchange sends unqualified people to Medicaid](#). *USA Today*.

<sup>136</sup> Horton, N. (2014, June 12). [Federal Bungling Of ObamaCare Verification Creating Nationwide Chaos In Medicaid Departments](#). *Forbes*.

<sup>137</sup> *Ibid.*

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### Claim VII: Medicaid expansion means more people will have health care.

*“We’ve got close to 7 million Americans who have access to health care for the first time because of Medicaid expansion.”*

*– President Obama, February 20, 2014<sup>138</sup>*

### Reality: Medicaid is a broken program and does not guarantee access to health care.

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The administration says that expanding Medicaid means increased access to care, but in reality, individuals who gain coverage through Medicaid still struggle to access the care that they need. A study by Merritt Hawkins conducted in 2013 found that less than half of the doctors in America’s largest cities are accepting new Medicaid patients. The acceptance rate has dropped by almost 10 percentage points since 2009, and is likely to drop further as more patients join the system. Physicians cite low reimbursement rates and the overly complex billing process for Medicaid as the reasons for not accepting new patients.<sup>139</sup>

Finding a pediatrician who will accept Medicaid patients is also a problem for children enrolled in Medicaid in the Children’s Health Insurance Program (CHIP). A September 2012 survey by the American Academy of Pediatrics (AAP) found that fewer than 3 out of 10 surveyed pediatricians fully participated in Medicaid. The AAP survey also found that Medicaid pays physicians poorly, at only 64 percent of the average private insurance reimbursement.<sup>140</sup>

The influx of new Medicaid patients is likely to worsen Medicaid beneficiaries’ problems of physician access. Travis Singleton, senior vice president at Merritt Hawkins, explains that administration optimism about the situation is unrealistic, saying, “To think physicians are going to change their tune and start accepting patients—it’s unlikely to happen.”<sup>141</sup>

Oregon is already experiencing these troubles first hand. Expanding Medicaid has resulted in an additional 360,000 people, almost a quarter of the state’s population, enrolled. Medicaid enrollees in Oregon are waiting months to get an appointment with a physician, and in many parts of the state, physicians have stopped accepting new Medicaid enrollees altogether.<sup>142</sup>

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<sup>138</sup> The White House, Office of the Press Secretary. (2014, February 20). [Remarks by the President at DGA dinner](#). whitehouse.gov.

<sup>139</sup> Miller, P. (2014, January 29). [2014 survey of physician appointment wait times and Medicaid and Medicare acceptance rates](#). Merritt Hawkins.

<sup>140</sup> American Academy of Pediatrics Department of Practice. (2012, September). [Pediatrician participation in Medicaid and CHIP: National and state reports](#). aap.org.

<sup>141</sup> Jaspen, B. (2014, February 1). [As ObamaCare Brings Patients, Doctors Not Warm To Medicaid](#). *Forbes*.

<sup>142</sup> Associated Press. (2014, July 23) [APNewsBreak: Medicaid Enrollees Strain Oregon](#)

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**Claim VIII: PPACA strengthens Medicare Advantage.** *“Your guaranteed Medicare benefits won’t change—whether you get them through Original Medicare or a Medicare Advantage plan. Instead, you will see new benefits and cost savings, and an increased focus on quality to ensure that you get the care you need.”*

– Then HHS Secretary Kathleen Sebelius, May 2010<sup>143</sup>

**Reality: PPACA cuts billions from the popular Medicare Advantage program and reduces seniors’ benefits.**

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In a graphic posted on the White House website on February 24, 2014, titled “The Affordable Care Act: Strengthening Medicare,” the administration claims that “premiums paid by enrollees in Medicare Advantage are about 10 percent lower now than when the Affordable Care Act was passed.”<sup>144</sup> In addition, the administration takes credit for the fact that “enrollment in Medicare Advantage plans has increased by nearly 33 percent since the Affordable Care Act became law.”<sup>145</sup> The graphic also states that the average person with Medicare will save nearly \$4,200 by 2021 because of PPACA.<sup>146</sup> In reality, the Medicare Advantage program is succeeding despite the policies of PPACA, not because of them.

According to CBO, PPACA cut \$716 billion from Medicare, \$308 billion of which specifically came from Medicare Advantage.<sup>147</sup> The implementation of these cuts over the past several years has had serious impacts on the Medicare Advantage plans being offered to seniors. According to an Oliver Wyman report, the approximately six percent cut to the program last year equated to a \$30 to \$70 per member per month cut in benefits.<sup>148</sup> Many beneficiaries also have lost their doctors as insurers change plan networks in reaction to Medicare Advantage funding cuts.<sup>149</sup> The American Action Forum estimates that PPACA’s mandated cuts combined with the administration’s regulatory changes will lead to beneficiaries facing a benefits

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<sup>143</sup> Sebelius, K. (2010, May). [Medicare and the New Health Care Law – What it Means for You](#). ct.gov.

<sup>144</sup> The White House. (2014, February 21). [The Affordable Care Act: Strengthening Medicare](#). whitehouse.gov.

<sup>145</sup> *Ibid.*

<sup>146</sup> *Ibid.*

<sup>147</sup> Congressional Budget Office. (2012, July 24). [Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act](#). cbo.gov.

<sup>148</sup> Giese, G., & Backes, K. (2014, February 27). [2015 advance notice: Changes to Medicare Advantage payment methodology and the potential effect on Medicare Advantage organizations and beneficiaries](#). Actuarial Practice of Oliver Wyman.

<sup>149</sup> Jaffe, S. (2013, December 1). [UnitedHealthcare dropping hundreds of doctors from Medicare Advantage plans](#). Kaiser Health News.

reduction of approximately \$1,538, or 13.32 percent, when compared to the level projected for 2015 in the pre-PPACA baseline.<sup>150</sup>

Analysts give no credit to provisions of PPACA when addressing the reasons behind the continued growth of Medicare Advantage. Instead, beneficiaries are attracted to effective management of care and benefit packages offered by Medicare Advantage health plans. Secondly, enrollees, who number almost one-third of all Medicare beneficiaries, tend to favor the program over traditional Medicare benefits.<sup>151</sup>

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<sup>150</sup> Book, R. (2014, April 17). [Medicare Advantage cuts in the Affordable Care Act: April 2014 update](#). American Action Forum.

<sup>151</sup> Millman, J. (2014, April 14). [Medicare reversed payment cuts, and not many are happy about it](#). *The Washington Post*.

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## Conclusion

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To sell his signature health care law to the American people, President Obama and his administration promised affordable coverage, increased transparency, greater access to care, a stronger economy, deficit reduction, strong enrollment in private insurance and Medicaid through easy-to-use exchanges, and a stronger Medicare system.

Four years after its passage, PPACA has failed to deliver. America deserves a health care system that honestly and transparently focuses on reducing health care costs, expanding access to care, and preserving quality. The Obama administration should admit that this law was an historic mistake, and work with Republicans in Congress to start over and repair the damage PPACA has done and prevent future damage with step-by-step reforms that reduce the cost of health insurance and expand freedom and choice.