Testimony before the Health Subcommittee of the House Energy and Commerce Committee

November 14, 2013

Obamacare Implementation Problems: More Than Just A Broken Website

Avik Roy
Senior Fellow, Manhattan Institute for Policy Research

Written Statement

Chairman Pitts, Ranking Member Pallone, and members of the Health Subcommittee: thanks for inviting me to speak with you today about the Affordable Care Act.

My name is Avik Roy, and I'm a Senior Fellow at the Manhattan Institute for Policy Research, in which capacity I conduct research on health care and entitlement reform.

I am an advocate of market-based universal coverage. I believe that the wealthiest country in the world can, and should, strive to protect every American from financial ruin due to injury or illness. Furthermore, I believe that well-designed, subsidized insurance marketplaces are among the most attractive vehicles for achieving these goals.

It is for these reasons that I am deeply concerned about the way in which the ACA's insurance exchanges have been designed and implemented. Most of all, I'm concerned that the law will drive up the cost of health insurance, especially for people who shop for coverage on their own.

The ACA transforms the individual market

It is commonly thought that the market for people who shop for health coverage on their own—the so-called "non-group" or "individual" market—is relatively small. The Congressional Budget Office estimates that, in 2013, of the 268 million Americans with

health coverage, approximately 9 percent—25 million—purchased coverage on their own.

But a market does not consist merely of the people who buy a product. It also consists of the people who consider buying a product, and choose not to. In this case, that means the uninsured. The 57 million uninsured are people who have declined to purchase non-group coverage, in many cases because that coverage is too expensive.

As you know, the ACA makes substantial changes to the individual health insurance market. The law broadly bars insurers from charging different rates to the sick and the healthy, and requires insurers to raise rates on younger individuals in order to partially subsidize care for the old. It mandates that insurers cover a broad range of services that individuals might not otherwise choose to purchase. The law taxes premiums, pharmaceuticals, and medical devices in a manner that has the net effect of increasing the cost of insurance.

The Manhattan Institute study: Underlying premiums increase by an average of 41%

Earlier this month, I and two colleagues at the Manhattan Institute completed the most comprehensive study to date of individual-market premiums in 2014 relative to 2013. The analysis can be found here:

http://www.forbes.com/sites/theapothecary/2013/11/04/49-state-analysis-obamacare-to-increase-individual-market-premiums-by-avg-of-41-subsidies-flow-to-elderly/

We examined the five least-expensive plans available in the individual market for every county in the United States, averaged their premiums, and adjusted the result to take into account those who, due to pre-existing conditions, could not purchase insurance at those rates. We examined premiums for 27-, 40-, and 64-year old men and women.

We then compared those rates to the comparable ones on the ACA exchanges. Our analysis found that the average state will see a 41 percent increase in underlying premiums, prior to the impact of subsidies. Among the states seeing large increases are North Carolina (136%), Georgia (92%), Michigan (66%), Louisiana (53%), Kentucky (47%), and Illinois (43%). Our analysis did find that eight states will see average premiums decrease under the law, including New York (-40%) and New Jersey (-19%).

Of the six categories we studied, 27-year-old men face the steepest increases, with an average hike of 77 percent. 40-year-old women see the mildest increases, with an average of 18 percent.

Subsidies will mainly benefit the elderly

We also studied the impact of the law's premium assistance payments on exchange premiums. Our analysis found that, for individuals of average income, taxpayer-funded insurance subsidies primarily flow to those nearing retirement. This is because the elderly will still pay more for insurance, on average, than younger individuals, and because the subsidies are designed to fix the percentage of one's income devoted to paying health insurance premiums.

Taking subsidies into account, 64-year-old men will pay on average 19 percent less for insurance under the ACA system, whereas 27-year-old men will pay 41 percent more.

Adverse selection is likely to occur

The Manhattan Institute analysis indicates that we are indeed likely to see a fair amount of adverse selection on the exchanges. People who consume an above-average amount of health care services, such as sicker and older individuals, have a compelling economic incentive to enroll on the ACA marketplaces. Healthier and younger individuals have less of an incentive, even when one takes the individual mandate into account.

While many in the press are focused on the exchange enrollment figures that HHS released yesterday, what's more important than the *number* of people who enroll in the exchanges is the *composition* of the people who enroll in the exchanges. This will give us a sense of whether or not marketplace premiums are likely to further increase in 2015 and 2016, exacerbating the problem of adverse selection.

H.R. 3362, the Exchange Information Disclosure Act, would require HHS to provide weekly updates on exchange enrollment statistics. A greater degree of transparency and regular disclosure from HHS would be a desirable outcome. I would encourage the Health Subcommittee to consider the importance of requiring HHS to disclose the kind of information that would help us monitor adverse selection; that is to say, indicators of health status, such as age.

Higher deductibles and narrower networks

Our analysis did not directly examine the degree to which exchange-based plans have higher deductibles and narrower provider networks relative to plans available in 2013. There have been, however, many anecdotal reports of people paying higher premiums for plans with higher deductibles and narrower physician networks than the plans they previously enjoyed.

It is not inherently a bad thing for individuals to choose plans with higher deductibles and narrower networks, especially if those choices allow Americans to reduce their monthly premiums. However, in the case of the ACA, many individuals are reporting higher premiums for less attractive health coverage.

Chairman Upton has introduced a bill, H.R. 3350, that would allow individuals who wish to continue the coverage they enjoyed in 2013 to do so in 2014. This bill would almost certainly reduce the cost of coverage for millions of individuals, relative to the rate increases they would experience under the ACA. Ideally, Congress ought to modify the regulatory structure of the exchanges, in order to reduce as much as possible the

degree to which the ACA increases the underlying cost of individually purchased health insurance.

It would be one thing if the ACA was forcing Americans off of their old health insurance policies and offering them more attractive plans at a lower price. But millions of Americans are likely to see less attractive coverage at a higher price. If they do, then the Affordable Care Act will not live up to its name, and its goal of near-universal coverage will remain unfulfilled.

I look forward to your questions, and to being of further assistance to this committee.