The Heritage Foundation
LEADERSHIP FOR AMERICA

214 Massachusetts Avenue, NE
Washington, DC 20002-4999
(202) 546-4400
heritage.org

CONGRESSIONAL TESTIMONY

Hearing on Impact of the Administration's Policies Affecting the Affordable Care Act

Testimony before Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies United States House of Representatives

February 6, 2019

Edmund F. Haislmaier
Preston A. Wells Jr., Senior Research Fellow in Domestic Policy Studies
The Heritage Foundation

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

A principal objective of the Affordable Care Act (ACA, or Obamacare) was to increase health insurance enrollment by expanding Medicaid eligibility and offering income-related subsidies for individual-market coverage purchase through the new exchanges.

The effects of the law on coverage can be seen from the enrollment data for Medicaid and the individual (or non-group) market for the first four years of implementation of the ACA's major provisions.[1]

Over that period, net enrollment in Medicaid and Children's Health Insurance Program (CHIP) grew by 13.7 million individuals, from 60.9 million at the end of 2013 to 74.6 million at the end of 2017. As Table 1 shows, that enrollment growth was primarily in the states that adopted the ACA Medicaid expansion.

Table 1

Total Medicaid and CHIP Enrollment by State Expansion Status

	2013	2014	2015	2016	2017
Non-Expansion States	20,409,763	21,013,014	21,600,757	22,713,075	22,297,261
Change		603,251	587,743	1,112,318	-415,814
Percent Change		2.96%	2.80%	5.15%	-1.83%
All Expansion States	40,532,471	48,921,945	51,100,511	52,241,683	52,312,986
Change		8,389,474	2,178,566	1,141,172	71,303
Percent Change		20.70%	4.45%	2.23%	0.14%
Jan. 2014 Expansion States	33,606,965	41,540,951	42,991,324	43,456,143	43,362,079
Change		7,933,986	1,450,373	464,819	-94,064
Percent Change		23.61%	3.49%	1.08%	-0.22%

Table 1 also shows that this coverage expansion was basically a one-time enrollment phenomenon. Indeed, removing the effects of additional states implementing

[1] Edmund F. Haislmaier, "2017 Health Insurance Enrollment: Little Net Change, But Large Drop in Non-Group Coverage," Heritage Foundation *Issue Brief* No. 4913, October 30, 2018, at https://www.heritage.org/sites/default/files/2018-10/IB4913_0.pdf

the Medicaid expansion in subsequent years provides an even clearer picture of the underlying trend.[2]

Twenty-five states had the expansion in effect from the beginning (January 2014). For that group of states, Medicaid enrollment increased 23 percent in 2014, but then grew by only a further 3.5 percent in 2015, by another one percent in 2016, and declined by two-tenths of a percent in 2017.

For the individual-market, enrollment expanded in 2014 and 2015 in response to the availability of the new exchange subsidies, but then shrank in 2016 and 2017. During the three years prior to the implementation of the ACA (2011 to 2013) enrollment in individual-market coverage was fairly stable between 11.8 million and 12 million people. The introduction of subsidies for exchange coverage produced a 40 percent enrollment surge in 2014, followed by an additional 7 percent increase in 2015. That trend reversed as the non-group market shrank by 4 percent in 2016, and then by a further 10.5 percent in 2017, as shown in Table 2.

Table 2

Individual-Market Enrollment by Subsidy Status

	2013	2014	2015	2016	2017
Total	11,807,534	16,545,791	17,647,555	16,987,025	15,211,213
Change	n/a	4,738,257	1,101,764	-660,530	-1,775,812
Percentage Change	n/a	40.1%	6.7%	-3.7%	-10.5%
Subsidized	0	5,430,106	7,375,489	7,634,007	7,505,382
Change	n/a	5,430,106	1,945,383	258,518	-128,624
Percentage Change	n/a	n/a	35.8%	3.5%	-1.7%
Unsubsidized	11,807,534	11,115,685	10,272,066	9,353,018	7,705,831
Change	n/a	-691,849	-843,619	-919,048	-1,647,188
Percentage Change	n/a	-5.9%	-7.6%	-8.9%	-17.6%

Table 2 also shows a significant divergence in the enrollment patterns for subsidized versus unsubsidized individual-market enrollment.

The number of enrollees with subsidized coverage through the exchanges was 5.4 million at the end of 2014, increasing to 7.4 million at the end of 2015, 7.6 million at the end of 2016, and declining slightly to 7.5 million by the end of 2017. Thus, ACA-subsidized exchange enrollment exhibited a trend similar to that of the Medicaid expansion—significant initial growth followed by enrollment plateauing in subsequent years.

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

While fourth-quarter 2018 data is not yet available, the indications so far are that enrollment for both Medicaid and ACA-subsidized exchange coverage was also fairly flat last year.

In sum, after four years the ACA's coverage effects appear to have reached a point of diminishing returns, with the situation unlikely to change much going forward for several reasons.

First, among the subset of individuals who were both uninsured and motivated to obtain insurance (either by a need for medical care or by a desire to cover dependents), the vast majority appear to have enrolled in coverage.

Second, the ACA appears to have had limited success in covering uninsured individuals who are less motivated to seek coverage. The theory was that the law's individual mandate would induce those individuals to enroll. However, based on IRS data on penalty payments and exemptions, it would appear that a significant portion of that category of individuals either qualified for an exemption from the mandate penalty, or elected to pay the penalty. Another factor is that some of those individuals may believe that they do not need insurance because they only occasionally need medical care, and when do need it, they are used to getting it at little or no charge from hospitals and clinics. Unless, or until, they develop a chronic condition, they are unlikely to obtain, or remain enrolled in, coverage. That can be inferred from data showing a skewed age distribution of exchange enrollees relative to the uninsured population (younger adults are significantly under-represented), as well as insurer experience with a portion of enrollees failing to maintain coverage once they have been treated.[3]

Third, the growth in employment in recent years may be providing access to employer-sponsored coverage for more working-age adults (and their dependents), who might otherwise have qualified for either ACA-subsidized coverage or Medicaid.

It should also be noted that the plateauing of enrollment in both Medicaid and subsidized individual-market coverage predates the current Administration. That suggests that, even without changes to the law or regulations, future ACA-related enrollment will likely fluctuate only marginally around current levels.

However, the troubling piece of the picture is the decline in unsubsidized individual-market coverage. Table 2 also shows that while the ACA has added 7.5 million subsidized customers to the individual market, the number of unsubsidized individual-market customers has shrunk by 4.1 million—or more than a third (34.7 percent)—from 11.8 million in 2013 to 7.7 million in 2017. Indeed, the number of

[3] Relative to their shares of the uninsured population, those between ages 18 and 34 are under-represented in the exchange coverage population while those between ages 45 and 64 are over-represented. The correlation between age and health expenditures is that adults age 64 have average health expenditures five times greater than adults age 18. For more, see: Edmund F. Haislmaier and Doug Badger, "How Obamacare Raised Premiums," Heritage Foundation *Backgrounder* No. 3291, March 5, 2018, pp. 8–10, https://www.heritage.org/sites/default/files/2018-03/BG3291.pdf.

unsubsidized customers has diminished at an accelerating pace over past four years. After declining 5.9 percent in 2014, the number of unsubsidized individual-market enrollees dropped a further 7.5 percent in 2015, shrank another 8.2 percent in 2016, and fell 17.6 percent more in 2017.

That trend reflects the reality that the ACA altered the basic composition of the individual health insurance market.

Before the implementation of the ACA, the primary customers for individual market insurance were Americans who were either self-employed or buying coverage between jobs. They were mainly seeking financial protection against potential future medical expenses.

The changes made by the ACA attracted a new set of customers responding to the law's offer of subsidized insurance to pay for their current medical expenses. That skewed the post-ACA individual market toward a risk pool disproportionately consisting of older, less healthy, and costlier-to-insure individuals. Also, in the first two years, hundreds of thousands of costlier customers migrated into the individual market from other coverage.[4] The results were sharp premium increases that, in turn, prompted a growing exodus of unsubsidized customers. It also produced an exodus of insurers, with 2015 turning out to have been the high water mark for insurer participation in the exchanges at both the state and county levels.[5]

Furthermore, the insurers that have remained in the market have increasingly limited their offerings to narrow-network plans. The share of plan offerings with less restrictive networks has declined from 52 percent in 2014 to only 27 percent in 2019.[6] Thus, not only have plans become more expensive, but plan offerings have also become less attractive to the type of customers who purchased individual-market coverage before the implementation of the ACA.

Most of the customers who exited the market likely are middle-income, since they did not qualify for the ACA's low-income premium subsidies, and self-employed, since they had been buying their own health insurance. What is uncertain is where those customers have gone. Some may have given up on self-employment and obtained jobs with employer-sponsored health insurance. Others may have instead given up on health insurance—in which case, the ACA is now un-insuring the previously insured.[7]

---

[4] Ibid.

[5] Edmund F. Haislmaier, "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink," Heritage Foundation *Issue Brief* No. 4813, January 25, 2018, https://www.heritage.org/sites/default/files/2018-01/IB4813_1.pdf.

[6] Avalere Health, "2017 Health Insurance Exchange Snapshot," January, 2017, at http://go.avalere.com/acton/attachment/12909/f-0419/1/-/-/-/-/Deck.pdf?nc=0&ao_optin=1 and, "Health Plans with More Restrictive Provider Networks Continue to Dominate the Exchange Market," December 4, 2018, at https://avalere.com/press-releases/health-plans-with-more-restrictive-provider-networks-continue-to-dominate-the-exchange-market.

[7] For instance, see John Tozzi, "Why Some Americans Are Risking It and Skipping Health Insurance," Bloomberg, March 26, 2018, https://www.bloomberg.com/news/features/2018-03-26/why-some-

It is that situation that the Trump Administration has been trying to address through regulatory changes intended to give unsubsidized individual-market customers more, and less expensive, coverage options. The most notable are regulatory changes designed to expand opportunities for the creation of association health plans serving small businesses and the self-employed, and reversing the changes made by the Obama Administration in November of 2016 to the prior, long-standing, regulations governing short-term plans.

While some asserted that the Trump Administration's actions would "destabilize" health insurance markets, that assertion does not appear to be supported by the data. As noted, subsidized exchange enrollment appears to have basically plateaued since 2016 and the limited data so far available for the 2019 open enrollment period doesn't point to any significant change this year.

Premiums also appear to have now plateaued as well. The pattern of rate changes for the 2019 plan year was that insurers who had substantially increased rates in the preceding years increased their 2019 rates only modestly—in other words, at or below the underlying general trend of growth in medical spending (about 6 percent)—or actually reduced their rates below what they charged in 2018. Conversely, the relatively few large rate increases in 2019 were mainly by insurers that had not increased rates as aggressively in prior years. Thus, it appears that, for most insurers, lagging premiums have finally caught up with escalating costs. However, those rates are still much higher than they were before implementation of the ACA. That suggests that the risk pool is no longer deteriorating, though it does not appear to be improving either.

Insurer participation in the market also appears to have stabilized. Though, just as premiums have stabilized at higher levels, insurer participation is stabilizing at lower levels. Table 3 shows that, despite some improvement this year, over one-third of all U.S. counties still had only one insurer offering exchange coverage for 2019, and in another 40 percent of counties only two insurers offered plans.

Table 3

Distribution of U.S. Counties by Number of Insurers Offering Exchange Plans

Insurers	2015	2016	2017	2018	2019
One	6%	7%	33%	51%	36%
Two	27%	29%	37%	30%	40%
Three	25%	27%	19%	11%	16%
Four	20%	20%	6%	5%	5%
Five or More	22%	17%	5%	2%	2%

americans-are-risking-it-and-skipping-health-insurance, and Emma Ockerman, "Doctors Who Hate Insurance So Much They Go Without It Themselves," Bloomberg, May 15, 2018, https://www.bloomberg.com/news/articles/2018-05-15/doctors-who-hate-insurance-so-much-they-go-without-it-themselves.

Consequently, any take-up of alternative coverage under the Administration's regulatory changes is more likely to be by those who have already abandoned costly ACA plans than by those still buying them. Given the significant decline in the number of unsubsidized individual market customers since the implementation of the law, it would be more accurate to view the Administration's policy changes as responses to prior, ACA-driven market destabilization than as catalysts for further destabilization.

Congress should follow the Administration's lead in developing remedies to the ACA's adverse effect of diminishing traditional individual-market customers' access to the kinds of health insurance plans that they both want and can afford.

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

****

The Heritage Foundation is a public policy, research, and educational organization recognized as exempt under section 501(c)(3) of the Internal Revenue Code. It is privately supported and receives no funds from any government at any level, nor does it perform any government or other contract work.

The Heritage Foundation is the most broadly supported think tank in the United States. During 2012, it had nearly 700,000 individual, foundation, and corporate supporters representing every state in the U.S. Its 2012 income came from the following sources:

Individuals	81%
Foundations	14%
Corporations	5%

The top five corporate givers provided The Heritage Foundation with 2% of its 2012 income. The Heritage Foundation's books are audited annually by the national accounting firm of McGladrey & Pullen. A list of major donors is available from The Heritage Foundation upon request.

Members of The Heritage Foundation staff testify as individuals discussing their own independent research. The views expressed are their own and do not reflect an institutional position for The Heritage Foundation or its board of trustees.