THE COST OF REPEAL:

Examining the Impact on Consumers and Businesses of Repealing the New Federal Health Care Law

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EXECUTIVE SUMMARY

On March 23, 2010, after a long congressional debate, President Barack Obama signed into law comprehensive federal health care reform legislation, known as the Affordable Care Act or ACA. But the enactment of the law did not end the debate. Even the law's strongest proponents acknowledge the need for improvements. And across the country, state legislators and Governors have been urged to slow or stop work on implementation of key provisions. The courts are considering legal challenges to the law. Members of Congress will consider attempts to repeal both the law as a whole and its key provisions. This report examines the costs and benefits of repeal for the nation's consumers, and businesses.

The Consequences of Repeal

Coverage Denials and Discriminatory Pricing on the Individual Insurance Market: Repeal of the law would allow insurers to deny coverage to the 57,152,000 Americans who have pre-existing health conditions, if they seek individual coverage. Women in the individual market would continue to pay higher rates than men for their health insurance coverage.

Health Insurance Options for Young Adults: 2 million uninsured young adults in the United States will lose the opportunity to purchase affordable coverage through their parents' plans if the Affordable Care Act is repealed. For many of these young adults, there will be no source of coverage or the only offer of coverage they will be able to find will be expensive and exclude many important covered services that they need.

Cost and Quality of Coverage on the Individual Market: Repeal of the reformed state health insurance marketplaces, known as "exchanges," would lead to premiums that are 14-20% higher for the same coverage than they would be under current law. Repeal would also increase the tax burden for the 28.6 million Americans who would otherwise benefit from new health insurance affordability tax credits.

Costs of Employer-Sponsored Coverage: A report commissioned by the Business Roundtable estimates that cost-saving reforms in the Affordable Care Act could reduce the rate of growth in health care costs, generating more than $3,000 in savings per employee with health insurance per year by 2019. Repeal of these provisions would force American workers and businesses to pay more than $3,000 more per employee.

Cost Burdens Facing Small Business: If the new law is fully repealed, small businesses could not pool their buying power in the exchanges. And more immediately, more than four million American small businesses will lose eligibility for tax credits which can cover as much as 35% of the average small business' health care costs.

Impact on Job Creation: By reversing provisions like the exchanges, which are designed to provide options to those without job-based insurance and to hold down costs, repeal

would impair workers' ability to change jobs or open small businesses, costing the national economy between 2 million and 4.5 million jobs by 2019.

Funding for Community Health Centers: Repeal would eliminate new funding for 8200 new or expanded health centers across the country.

Examining the Arguments in Favor of Repeal

Reform opponents contend that certain provisions in the law will harm the United States, but U.S. policy makers should not accept these claims without careful scrutiny.

The Minimum Coverage Requirement: Opponents have suggested that the law's requirement that all residents purchase qualifying insurance plans or pay a fine will burden consumers with costly insurance. But a similar coverage requirement, implemented by the state of Massachusetts, actually resulted in a 20% reduction in premiums, by ensuring that people did not wait till they got sick or injured to start paying into an insurance plan.

Expansion of Medicaid: The Affordable Care Act requires every state Medicaid program to cover all eligible people with incomes up to 133% of the Federal Poverty Level, as of 2014. Opponents of the law have claimed this will result in an increased burden to the states. But 100% of the cost of the Medicaid changes in the first five years and 90% of the cost over the long term will be borne by the federal government. This increase in federal Medicaid dollars will inject $443.5 billion into state economies by the year 2019.

Medicare Advantage: The new health care law requires privately-run insurance options within Medicare (called "Medicare Advantage" plans) to compete for beneficiaries with lower levels of government subsidies than they have enjoyed in recent years. Proponents of repeal contend that this new system will hurt Medicare Advantage beneficiaries. But in fact, these changes have already led to the announcement of a decrease in Medicare Advantage premiums for the calendar year 2011.

Recommendations and Conclusion

The evidence suggests that the costs of repeal are substantial and many of the asserted benefits of repeal do not stand up under scrutiny. But policy makers have additional options. They instead should work to implement the law properly in the states and take the steps to lower health care costs which the federal law fails to take. Paths open to state and federal policy-makers include:

- Establishing strong state health insurance exchanges can ensure that this new health insurance market is adapted to the needs of each state's consumers and businesses.
- Accelerating administrative streamlining and reducing health care paperwork can lower costs for consumers, providers, and insurers.
- Limiting the worst marketing practices of the drug and medical device industries can deliver more affordable medical treatments.

- Encouraging state-level support for research into the best treatments, and integrating this new knowledge into health IT systems, can reduce medical errors and help doctors.
- Ending the practice of billing consumers directly when hospitals are dissatisfied with the out-of-network reimbursements paid by insurers will protect patients.

Outright repeal of the federal health care law simply is not a prudent choice, but if our elected officials decide to work together for constructive policy changes like these, opportunities exist to make real progress.

INTRODUCTION

On March 23, 2010, after a long congressional debate, President Barack Obama signed into law comprehensive federal health care reform legislation, known as the Affordable Care Act or ACA, but the enactment of the law did not end the debate. Even the law's strongest proponents acknowledge the need for improvements. And across the country, state legislators and Governors have been urged to slow or stop work on implementation of key provisions. The courts are considering legal challenges. Members of Congress will consider attempts to repeal both the law as a whole and its key provisions.

This year, elected officials across the United States will face their own choices about what to do about our health care system. But the one choice that is not tenable is to do nothing. Increasingly, policy experts, policy makers, and politicians from across the political spectrum recognize that America's health care system costs far too much and delivers too little for consumers. As many as one-third of the health care dollars spent in the American economy are wasted on expenditures that fail to improve outcomes, according to the researchers at the Dartmouth Institute for Health Policy and Practice.[1] This wasteful spending, generated by backwards incentives that encourage providers to give the most expensive and complex care, not the most effective care, and by an insurance marketplace that too often fails to offer value and security to consumers, threatens to make our entire health care system unsustainable.

It is in light of this challenge that policy-makers must consider repeal initiatives, and ask whether repeal would make our health care work better or worse for taxpayers, consumers, and businesses. A close examination of the real-life consequences of repeal, like that provided in this report, demonstrates that repeal fails that test.

But policymakers need not accept as is either the law passed by Congress, or the dysfunctions that plague our health care delivery system and insurance markets today. The Affordable Care Act, like all laws, is far from perfect, and will require fixes and improvements at both the state and federal level. But improving on current law and the current health care system will require new common-ground solutions that move past the rancor of the debate over the federal law.

[1] John E. Wennberg, et.al., "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive, February 13, 2002.

PART ONE: The Consequences of Repeal

Coverage Denials and Discriminatory Pricing on the Individual Insurance Market

The Problem:

People buy insurance so that they can be sure of their access to affordable medical care in the case of illness or accident. But as the insurance industry has confronted the increased cost of providing care, most insurers in recent years have relied heavily on a strategy of discriminating against certain beneficiaries based on their health history and other factors that are likely to predict the cost of covering them. In 2009, 57,152,000 Americans under 65 had pre-existing conditions, grounds for denial of coverage from most insurance plans sold on the individual market.[2] That amounts to 22.4% of residents under 65. 47% of people who applied for individual coverage were either denied outright or only offered coverage at a much higher premium because of a pre-existing condition.[3] For those who did secure coverage, a policy could be retroactively cancelled, through a practice known as rescission, which leaves the beneficiary to pay for treatment entirely out-of-pocket even if that treatment is already under way. Insurers have dug through enrollment paperwork in order to find trivial or accidental errors that can be used as a pretext for rescinding coverage.[4]

Another common insurer practice has been charging women more than men for the same coverage. Because of so-called "reproductive years standards," a twenty-two-year old woman can be charged up to one and a half times the premium charged to a twenty-two-year-old man.[5] Insurance companies justify this by citing costs due to women's reproductive health treatments and higher occurrences of headaches, joint and chronic pain, diabetes, and blood pressure, as well as the potential for costs associated with pregnancy.[6] But the disparities persist further into life as well. A recent study by the National Women's Law Center found that many best-selling plans charged a 40-year-old nonsmoking woman more than a 40-year-old male smoker, despite the increased health risk associated with smoking.[7] In part due to these practices, women are more likely to

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[2] *Health Reform: A Closer Look*, FAMILIES USA, May 2010, downloaded on 1/4/10 from http://www.familiesusa.org/assets/pdfs/health-reform/pre-existing-conditions.pdf.

[3] M. M. Doty, et al., *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, THE COMMONWEALTH FUND, July 2009, downloaded on 12/30/10 from http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf.

[4] Murray Wass, *Corrected: WellPoint routinely targets breast cancer patients*, REUTERS, April 23, 2010,downloaded on 10/29/10 from http://www.reuters.com/article/idUSTRE63M5D420100423.

[5] Healthreform.gov, *Roadblocks to Health Care: Why the Current Health Care System does not work for Women*, 2010, downloaded on 12/29/10 from http://www.healthreform.gov/reports/women/index.html.

[6] Ibid.

[7] *Still Nowhere to Turn: Insurance Companies Treat Women Like a Preexisting Condition*, NATIONAL WOMEN'S LAW CENTER, October 9, 2009, downloaded on 12/23/10 from http://www.nwlc.org/sites/default/files/pdfs/stillnowheretoturn.pdf.

experience difficulty trying to get care, to delay needed care because of cost, and to find themselves in situations where they need to use up savings or go into debt.[8]

The New Law's Solution

The new federal law closes these avenues for discrimination. In 2010, the practice of rescinding coverage was banned. In 2014, the law will ban the use of medical history in the pricing, issuance, and renewal of all health insurance plans, guaranteeing fair and equal prices for those with pre-existing conditions. In the interim, the law established a new Pre-existing Condition Insurance Program that provides coverage options to those denied coverage due to their health history at prices that cannot exceed the customary rates for a healthy person. The law also bans the practice of charging women more than men, effective in the year 2014.

Impact of Repeal

Were the law to be repealed, today's market dynamics, where insurers rely on coverage denials and discriminatory pricing to succeed, would persist. Insurers would have every incentive to build their business plan around shedding sicker customers, not delivering care in a more effective manner or keeping their customers healthier over the long run. 57,152,000 Americans with pre-existing conditions would continue to have little hope of getting insurance, and women would face continued health insurance discrimination.

Health Insurance Options for Young Adults

The Problem

One group that has faced particularly difficult challenges in the insurance marketplace is young adults. A Government Accountability Office study found that 20% of college students lacked coverage,[9] and, among the new-graduate demographic of those aged 23-24, the rate jumps to 38%.[10] Contrary to what some opponents have said, these young persons are not "rationally uninsured," choosing to forgo coverage because they think they will not need it. In fact, many in this age cohort cannot secure coverage because of the high cost of getting individual insurance and the difficulty of finding a job with affordable, comprehensive health benefits. Even when they and their family had paid into the system by maintaining coverage for their entire life, their parents' health

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[8] *Women at Risk: Why Many Women are Forgoing Needed Health Care*, 2009, THE COMMONWEALTH FUND, downloaded on 12/29/10 from http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf.

[9] Government Accountability Office, *Most College Students Are Covered Through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage*, March 28, 2008, available at http://www.gao.gov/products/GAO-08-389.

[10] *Health Insurance Coverage for College Students*, AMERICAN MEDICAL ASSOCIATION COUNCIL ON MEDICAL SERVICE, 2007, downloaded on 12/28/10 from http://www.ama-assn.org/ama1/pub/upload/mm/372/a07cms4.pdf.

insurance plans dropped them simply because they graduated from college or had reached a certain disqualifying age. Without the option of remaining on their parents' plan and with fewer and fewer employers offering health care, they faced an individual market where comprehensive coverage could be prohibitively expensive.

The New Law's Solution

The new law requires that insurers allow all dependent children to remain on their parents' coverage until their 26th birthday. Even those who had previously been dropped from their parent or guardian's plan are entitled to re-enroll. Based on existing regulations and Census data, the White House estimates that this provision will bring relief for roughly 1.2 million young adults who could now have quality affordable coverage through their parents.[11]

Impact of Repeal

1.2 million young adults will lose the opportunity to purchase affordable coverage through their parents' plans if the Affordable Care Act is repealed. For many of these young adults, there will be no source of coverage or the only offer of coverage they will be able to find will be expensive and exclude many important covered services that they need.

Cost and Quality of Coverage on the Individual Market

The Problem

Americans who seek coverage through the individual market often do not have choices that deliver good value. Unlike larger employer plans, individuals lack the market power to negotiate effectively with insurers and they face higher administrative costs.[12] And the dizzying variety of companies, types of plans, and cost-sharing arrangements can present difficulty for consumers trying to make meaningful comparisons and choices.[13]

The consequences for prices have been serious. Nationally, a large majority of individual-market policyholders—77% —saw a premium increase from early 2009 to early 2010,[14] with an average rate hike of 20%. At the same time as these insurance policies went up in price, the proportion of their beneficiaries' care which insurance

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[11] *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act*, Department of Health and Human Services, Department of Treasury, and Department of Labor, issued May 13, 2010.
[12] U.S. Senate Committee on Commerce, Science, and Transportation, *Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers*, April 15, 2010, downloaded on 12/28/10 from http://commerce.senate.gov/public/?a=Files.Serve&File_id=be0fd052-4ca6-4c12-9fb1-a5e4a09c0667.
[13] *Simplifying Consumer Choices*, CONSUMERS UNION, June 2009, downloaded on 12/28/10 from http://www.prescriptionforchange.org/pdf/SimplifyingHealthInsuranceChoices-CU-FINAL-June2009.pdf.
[14] *Survey of People who Purchase Their Own Insurance*, KAISER FAMILY FOUNDATION June 2010, downloaded on 11/29/2010 from http://www.kff.org/kaiserpolls/upload/8077-R.pdf.

covered actually shrank. The percentage of families with a high deductible (over $2,000) on the individual market increased from 41 percent to 59 percent over a recent four-year period.[15] The result of these trends is that consumers are not only finding coverage increasingly unaffordable, but getting less and less coverage for their money when they do purchase it.

The New Law's Solution

The new law takes aim at these problems by establishing reformed health insurance marketplaces for individuals and small businesses, called "exchanges." Intended to provide an easy-to-use mechanism for purchasing private health insurance, the exchange will allow consumers to compare plans and prices, and to get up-to-date and relevant information. The exchanges will offer four tiers of plans (bronze, silver, gold, and platinum), based on the percentage of a person's projected health care costs that plans in each tier will cover. This standardization of plan choice will simplify the often confusing array of choices in the individual market and should facilitate improved choice and competition. The law also allows states to take bolder steps to standardize plan choices further.

Exchanges are also designed to mirror the functions of the human resources department of a large employer, by offering individuals and small businesses the help they need to navigate the insurance market and by actively negotiating with insurers to lower the cost and improve the quality of coverage. The CBO has estimated that, by 2019, roughly 24 million people will be purchasing coverage directly through the state exchanges, with an additional 5 million small business employees also covered through the exchange.[16] These millions are expected to include a healthier pool of enrollees than today's individual market, helping drive prices downward.

Because of this increased bargaining power and competition, insurance companies will have stronger incentives to cut wasteful administrative costs and to focus on prevention so their customers stay healthy. Furthermore, cost and quality ratings will be applied to all plans in the exchange, making it easy for consumers to recognize and avoid insurance companies who do not offer cost-effective and patient-centered plans.

All told, the effects of these provisions on value in the individual market should be substantial. The most comprehensive projection of the exchanges' impact on the price and quality of coverage on the individual market is a letter from the Congressional Budget Office to Senator Evan Bayh from November 2009.[17] According to that letter, by

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[15] *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits,* AMERICAN HEALTH INSURANCE PLANS CENTER FOR POLICY AND RESEARCH, 2007.

[16] Congressional Budget Office, *Selected Publications Related to Health Care Legislation, 2009-2010*, December 23, 2010, downloaded on 12/28/10 from http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf.

[17] Please note that the November 30th letter to Senator Bayh estimates the impact of exchanges under an earlier version of the Patient Protection and Affordable Care Act introduced in the Senate on November 18th, not the amended version signed into law on March 23rd. But the relevant provisions in the final enacted law remained similar to the November 18th version.

2016, the healthier enrollee population and the new efficiencies available in the exchanges will bring down costs on the individual market for equivalent insurance policies by 14-20%.[18,19]

The CBO also projects that new health insurance affordability tax credits, included in the law, will also have an impact on affordability of coverage on the exchanges. Under the provision establishing these credits, qualified consumers who do not receive a qualifying offer of coverage through their employer and who earn less than 400% of the federal poverty level (that is, $44,000 a year as a single person or $88,000 for a family of four) will receive a credit based on their income, which can only be used for plans offered on the exchange. An estimated 28.6 million Americans will be eligible to receive these tax credits in 2014.[20]

Impact of Repeal

Repeal of these new exchanges would ensure that consumers must face an unreformed, inefficient individual market with costs that will be 14-20% higher for the same level of coverage. Consumers would continue to be confined to a disorderly individual market, with no standardization of plan choices, and little meaningful opportunity for meaningful choice and competition among plans. For those consumers who did purchase their insurance on the market, the repeal of the affordability tax Credits would put the cost of coverage that much farther out of reach for the 28.6 million Americans who are projected to benefit from them.[21]

Costs of Employer-Sponsored Coverage

The Problem:

Even if the problems of discrimination and efficiency in the individual market were to be addressed, health care consumers would be left confronting an underlying upward trend in costs. The national average employer-sponsored insurance premium (ESI) was $13,776 for a family in 2009, a 114% increase over premiums in the year 2000; on average, the employee had to contribute $3,997 of that amount.[22] These projected cost

[18] Congressional Budget Office, "Letter to the Honorable Senator Bayh," November 30, 2009.
[19] The same letter also notes that the average price for individual health insurance policies on the market will be higher 10-13% than it would be under the law prior to the enactment of the 2010 law. This increase in average prices, however, is not an indication of worse deals for consumers. The average price is higher because, as the letter states, "The average insurance policy in this market would cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits."
[20] *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit*, FAMILIES USA, September 2010, downloaded on 12/28/10 from http://www.familiesusa.org/resources/publications/reports/health-reform/premium-tax-credits-states.html.
[21] Ibid.
[22] *Employer Health Benefits 2010 Annual Survey (Summary of Findings)*, KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATION TRUST, November 2010.

increases will affect the 156.5 million Americans who are covered through their employer.[23]

The root causes of these unsustainable cost increases include the inflated prices of health care services,[24] underuse of primary care and prevention that can keep people healthy,[25] and over-utilization of more expensive acute care and emergency room services.[26]

The New Law's Solution

The new health care law will implement several strategies intended to begin correcting these inflationary trends, by creating payment incentives for hospitals and providers within Medicare to make delivery of care more cost-effective. The theory is that Medicare, which accounts for a full quarter of the nation's health care spending, has the market clout to drive new efficiencies in the delivery of care that will lead to lower costs in the private sector as well as in Medicare.

New value-based purchasing initiatives will peg payment rates to quality of care. Incentives will encourage hospitals to reduce avoidable readmissions and hospital-associated infections. Providers and hospitals will have payment incentives to work together through a new shared savings program intended to scale up the high-quality, low-cost health care made famous by providers like Geisinger Health in Pennsylvania or Intermountain Health in Utah. And finally, a new Center for Medicare and Medicaid Innovation has already been established to test and implement additional new payment innovations that reduce costs and improve quality.

Even groups skeptical of the Affordable Care Act as a whole have recognized that the potential for savings from these reforms is substantial. A report commissioned by the Business Roundtable, an association of the country's leading CEOs, found that these reforms could reduce the rate of growth in health care costs across the economy by 15-20% when fully implemented. For employers struggling to afford the rising cost of coverage, the report estimates that, by 2019, the total cost of insuring employees could fall by more than $3,000 a year per employee if these reforms are implemented properly.[27]

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[23] U.S. Census Bureau, *Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2009*, Current Population Survey, downloaded on 12/24/10 from *http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm.*

[24] Robert Berenson *et. al., Unchecked Provider Clout in California Foreshadows Challenges to Health Reform, Health Affairs*, February 2010.

[25] Peter Orszag, Director, Congressional Budget Office, "The Overuse, Underuse, and Misuse of Health Care," Statement before the Senate Finance Committee, July 18, 2008.

[26] Ibid.

[27] *Health Care Reform: Creating a Sustainable Health Care Market*, HEWITT ASSOCIATES, November, 2009.

Impact of Repeal

Were the law to be fully repealed, these savings would vanish. Employers and their workers would face an average increase of more than $3,000 per employee per year.[28]

Cost Burdens Facing Small Businesses

The Problem

Over recent years, the rising cost of health care has forced a tough choice upon many small business owners: cut or drop increasingly costly health coverage for their employees or close the doors of their businesses. Small businesses have found themselves with little purchasing power, paying on average 18% more on premiums than a large employer would for the same plan.[29] To date, the failure to tame health care cost inflation has left only 43.2% of small businesses offering coverage to their employees.[30]

The problem is expected to get worse. Small employers spent $429.8 billion nationally in 2009 on health care, and by 2019 those costs would be as much as $885.1 billion unless action is taken.[31]

The New Law's Solution

To address this problem over the short term, the new health care law establishes new small business tax credits. These credits, available for the 2010 tax year, will help employers meet the costs of covering employees, with a sliding scale ensuring that the greatest assistance goes to smaller businesses with lower-wage employees.[32] 4,015,300 businesses are eligible for some level of tax credit, and this year alone, 1,198,700 small businesses are eligible to receive the maximum tax credit, amounting to a full 35% of the average small group premium cost in their state.[33]

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[28] Ibid.

[29] *The Economic Impact of Healthcare Reform on Small Business*, SMALL BUSINESS MAJORITY, June 11, 2009, downloaded on 1/3/10 from http://www.smallbusinessmajority.org/_pdf/SBM-economic_impact_061009.pdf,

[30] Agency for Healthcare Research and Quality, "Table II.A.2(2008) Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2008" *Medical Expenditure Panel Survey*, downloaded on 12/29/10 from http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiia2.htm.

[31] *The Dangers of Defeat*, FAMILIES USA, March 2010.

[32] *A Helping Hand for Small Businesses: Health Insurance Tax Credits*, FAMILIES USA AND SMALL BUSINESS MAJORITY, July, 2010.

[33] Ibid.

The impact of these credits is already being felt. A national study by Bernstein Research found that the percentage of the smallest employers (those with 3-9 employees) offering health insurance climbed from 46% in 2009 to 59% in 2010.[34]

But these tax credits are far from the only provision of the new federal health care law designed to alleviate small business' health care costs. In 2014, small employers can pool their buying power and purchase coverage through their state's exchanges. The pooling of their resources should help these businesses gain access to health plan options that are equal to the quality and value available to their larger competitors.

Alternatively, those small businesses that cannot afford to cover their workforce finally can be assured that their employees have affordable insurance options. Employees of any business that does not offer coverage will be eligible to purchase coverage through the exchange as individuals.

Impact of Repeal

If the new law is fully repealed, longer-term solutions like the exchange will not be available to small business owners. And more immediately, nationally more than four million small businesses will be denied tax credits that would cover as much as 35% of the average small business' health care costs.

Effects on Job Creation

The Problem

The problems with America's costly health care system are also affecting the country's job market. "Job lock," the phenomenon where workers choose to stay in their current job for fear of losing health coverage, has become a hindrance to job creation in the American economy, especially among the 66.1% of firms that are small businesses with twenty-four or less employees.[35] A 2009 study found that 1.6 million small business employees nationally are "locked" in their current jobs. For fear of losing health insurance, workers forgo opportunities to strike out on their own as small business owners or pursue new job opportunities with other employers. This phenomenon stifles the creation of new jobs and reduces worker mobility between 25% and 50%.[36] Nationally, job lock costs working families an estimated $3.7 billion in forgone wages per year.[37]

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[34] Janet Adamy, *Health Benefits Appear on the Rise*, WALL STREET JOURNAL, November 2, 2010, downloaded on 11/29/10 from http://online.wsj.com/article/SB10001424052702304879604575582642946850052.html.

[35] Agency for Healthcare Research and Quality, "Table II.A.1.a(2008) Percent of number of private-sector establishments by firm size and State: United States," *Medical Expenditure Panel Survey*, downloaded on 12/29/10 from http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiia1a.htm.

[36] *The Economic Impact*, SMALL BUSINESS MAJORITY.

[37] Council of Economic Advisers. *The Economic Case for Health Care Reform*. June 2009.

The New Law's Solution

As discussed above, the new health care law contains many provisions to help Americans obtain secure coverage regardless of who they work for, or if they are self-employed. First, the new ban on pre-existing condition denials will mean that those who wish to start a small business need not be held back by worries that changing jobs means losing coverage. The exchanges are designed to make it easier for individuals without affordable coverage from an employer to select and enroll in a plan on their own. And the health insurance affordability tax credits will help many afford coverage without an employer's help.

In addition to freeing workers from job lock, the law's steps to hold down the growth in employer health care costs, described above, should enable firms to devote more resources to expanding their business and hiring additional staff. A recent study shows that by reducing premiums in the small group market, an *additional* 2 to 4.5 million jobs will be created over the next ten years, nationally.[38] Although the new federal health care law may not be the solution to all of the job creation problems facing the American economy, curtailing job lock will mean more and better jobs and incomes.

Impact of Repeal

By eliminating provisions that address job lock and hold down employers' costs, repeal would hold back job creation. The resulting decrease in job creation could cost the economy between 2 million and 4.5 million jobs.

Funding for Community Health Centers

The Problem

Ninety-six million Americans live in what experts call medically underserved areas.[39] These areas that experience a shortage of access to healthcare, often facing possible "economic, cultural, or linguistic barriers,"[40] exist in suburbs, rural areas, and cities throughout the 50 states.

And this lack of access is costing consumers and taxpayers across our health care system. Residents of medically underserved areas are statistically less likely to get preventive care and more likely to have a chronic condition.[41] Too often the first care

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[38] *State-by-State Job Creation Estimates From Health Reform*, CENTER FOR AMERICAN PROGRESS, January 2010, 2010, downloaded on 1/4/11 from http://www.americanprogress.org/issues/2010/01/pdf/health_care_jobs.pdf.

[39] Sarah Rosenbaum, et al. "National Health Reform: How Will Medically Underserved Communities Fare," George Washington University, July 9, 2009, downloaded on 12/29/10 from http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_5046C2DE-5056-9D20-3D2A570F2CF3F8B0.pdf.

[40] Department of Health and Human Services, *Shortage Designations: HPSAs, MUAs, and MUPs*, May28, 2010, downloaded on 12/29/10 from http://bhpr.hrsa.gov/shortage.

they seek is at the nearest hospital's emergency room, rather than more cost-effective primary care, driving up rates for all consumers.

The New Law's Solution

A primary initiative of the new law is to improve access and quality of primary care for individuals and families who live in these areas—whether they are urban neighborhoods or rural town and communities—through significant new investments in Community Health Centers. These community clinics provide comprehensive medical services in underserved areas. The new health care law allocates $11 billion in new federal funding for these centers, most of which will be spent on giving them the capacity to treat 20 million new patients.[42]

Community health centers have been widely hailed across the political spectrum as models of health care delivery; not only do they provide care to 17 million people at 7,500 sites,[43] they are cost-effective and financially sustainable, as well.[44] As a result of focusing on coordinated delivery of the most effective primary care, per-patient costs are, on average, 41% lower than in other facilities.[45] That translates to overall savings to the health care system of $9.9 to $17.6 billion a year.[46]

These health centers contribute substantially to local economies. In 2005, existing community health centers injected $12.6 billion into local economic activity nationwide, and directly or indirectly created 143,000 jobs.[47]

Across the fifty states and the District of Columbia, 8,200 health centers will receive federal funding to either start new centers or expand existing ones.[48]

Impact of Repeal

In the event of repeal, however, communities across the country that would be served by the new and expanded health centers would see not only poorer health but rising costs and emergency room usage. These same communities would also be denied the economic benefit that 8,200 new or expanded health centers could be expected to bring.

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[42] *Health Centers and Health Care Reform: Health Center Funding Growth*, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, 2010.
[43] Agency for Health Care Policy Research, *Health Care in Urban and Rural Areas, Combined Years 2004-2006*, April 2009.
[44] Ibid.
[45] *The Primary Care Payoff*, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS AND THE ROBERT GRAHAM CENTER, August, 2007.
[46] *Access to Community Health Databook*, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, 2006.
[47] National Association of Community Health Centers, *The Primary Care Payoff*.
[48] We derived the 8200 number by downloading the reports on the state by state benefits for health reform from http://www.healthreform.gov.

EXAMINING THE ARGUMENTS FOR REPEAL

In the first part of this report, we have seen some of the negative consequences that repeal could bring. However, reform opponents contend that certain provisions in the law will harm consumers and taxpayers, and that their repeal would actually be of real benefit to the nation. These claims require a thorough examination.

The Minimum Coverage Requirement

The Affordable Care Act includes an individual responsibility provision, effective in 2014, which requires all residents to purchase qualifying insurance plans or pay a fine. If the cost of such insurance plan exceeds 8% of a person's income or if that individual secures a special hardship or religious waiver, he or she is exempt from the requirement.

Opponents have suggested that this requirement will burden consumers with costly insurance, and leave them at the mercy of abusive practices by private insurance companies from whom they must now purchase coverage. But the evidence suggests otherwise.

Regarding costs, the minimum coverage requirement, counterintutively, plays an important role in containing the growth of consumers' insurance premiums. The reason for this is easily explainable. If insurance companies must take all comers, more unscrupulous people, often referred to as freeloaders, will wait until they are about to incur a large bill before enrolling, and drop their plan afterwards. Consequently, the number of people paying into the system at any given time remains small, yet they end up covering the costs, not only for their own care, but for those freeloaders as well.

Facing these increased costs, healthier people become even more likely to forgo insurance entirely, making the pool of insured people even more expensive to cover. Insurance experts call this a death spiral. States that have banned pre-existing condition denials without also including a coverage requirement such as New York and New Jersey have seen that spiral drive up insurance rates and destabilize the market.[49]

But the experience of Massachusetts in recent years, shows that the death spiral can be avoided if a minimum coverage requirement is instituted. After that state's 2006 health reforms required all residents to acquire coverage, average individual premiums fell 40%, at a time when premiums nationally were increasing by an average by 14%.[50]

Not every state will see such a rapid drop. Massachusetts had banned pre-existing conditions several years before and required that plans charge the same price to all customers regardless of health status, without successfully expanding coverage. So they were already on their own way to a death spiral and their premiums were quite high when the 2006 reform went into effect. But their experience does show that an individual

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[49] Leigh Wachenmein, *The Impact of Guaranteed Issue and Community Rating Reforms in Individual Insurance Market,* August 2007, downloaded on 12/15/10 at http://www.ahip.org/content/fileviewer.aspx?docid=20794&linkid=179392.

[50] The Milbank Quarterly, *Health Care Reform in Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate,* Vol. 88, No. 1, 2010 (pp. 54–80).

responsibility requirement can be crucial to containing costs, particularly if plans are no longer allowed to deny coverage based on pre-existing conditions.

Regarding insurance market abuses, the minimum coverage requirement does require almost all Americans to maintain coverage, and the majority will receive that coverage through either an employer or private insurers. However, in contrast to the challenges which consumers face in the marketplace today, the law establishes a framework of insurance regulation that should protect consumers from many of the abusive practices seen in today's marketplace.

As noted above, by 2014, when the minimum coverage provision goes into effect, discrimination based on gender or health history will be banned from coverage and pricing decisions. And beginning in 2011, insurers will have to abide by new protections that require plans to spend at least 80% of premiums on care, not administrative costs and company profits, and to provide public justification for unreasonable rate increases.

Furthermore, the new law takes steps to ensure that the minimum coverage requirement does not impose an undue burden on any individual consumer. The affordability tax credits could help up to 28.6 million Americans without employer-sponsored coverage to receive coverage in the exchange.[51] Those who are 30 or under or who cannot find coverage at a cost of less than 8% of their income can meet the minimum coverage requirement by purchasing the limited, lower-cost catastrophic health insurance plan. And finally, hardship and religious exemptions are available for those who qualify.

Upon examination, then, the minimum coverage requirement, rather than an onerous burden on consumers, appears consistent with goals of lower costs and strong consumer protections.

The Expansion of Medicaid

The new health care law calls for a substantial expansion of the Medicaid program. Prior to the 2010 federal health care law, Medicaid was responsible for providing health insurance to specific categories of low-income adults, families and children. The program has been administered by the states, but is funded through a combination of state and federal resources.

The new law requires all state Medicaid programs to cover all eligible citizens with incomes up to 133% of the Federal Poverty Level, as of 2014. For most states, this will result in a significant increase in the number of people covered by Medicaid. The federal government will provide all the funding necessary to implement this expansion for the first three years, phasing their contribution down to 90% of the cost of covering the new Medicaid population. But opponents of the law have claimed that this expansion of Medicaid will place an excessive burden to the states, who are already struggling with serious fiscal problems.

[51] *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit*, FAMILIES USA.

These critics are right to point out that the newly expanded Medicaid program represents a substantially new responsibility for states, for which they will have to plan and budget. But independent analysis from the nonpartisan Urban Institute finds, "increases in state spending are small…relative to what states would have spent if reform had not been enacted."[52] Of new spending in Medicaid, 95% will come from the federal government, and the states with the largest increases in Medicaid beneficiaries will see the highest level of federal resources. The new federal funding will inject $443.5 billion in Medicaid resources into the American economy. [53]

Changes to Medicare Advantage

The new health care law phases in a new competitive bidding system, which requires privately-run insurance options within Medicare (called Medicare Advantage plans, or MA plans) to compete for beneficiaries—without the excessive taxpayer subsidies that these plans have enjoyed over recent years.

Opponents contend that this change will hurt seniors who receive their Medicare benefits from these Medicare Advantage plans. They assert that seniors who like their current coverage will be unable to keep it, and that the $118 billion decrease in Medicare Advantage spending over the next ten years will harm the beneficiaries.[54] Eleven million American seniors are currently covered via Medicare Advantage, and opponents argue that many of these seniors will lose benefits because of these policy changes.

But concerns about this change may be overblown, given the facts and history of the Medicare Advantage program. The proposition behind Medicare Advantage, originally named Medicare+Choice, was that providing Medicare private plans would save the government money.[55] However, over recent years, the program has cost $1,000, or 14%, more per beneficiary per year than the conventional Medicare program.[56]

Given the long-term funding concerns about Medicare, this added expense to the Medicare program would be problematic, even if all of that extra $1,000 per beneficiary was needed for seniors' care. But that is not the case. Private fee-for-service Medicare Advantage plans spent half of their overpayment on profits, marketing, and administrative costs.[57] The other half has been passed on to seniors in the form of

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[52] John Holahan and Irene Heady *Coverage and Spending in Health-Reform: National and State By State Results for Adults at or Below 133 FPL*, KAISER FAMILY FOUNDATION, downloaded on 11/28/10 from http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

[53] Ibid.

[54] Congressional Budget Office, "Letter to the Honorable Senator Harry Reid," March 11, 2010.

[55] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, *March 2000*.

[56] *Curbing Medicare Overpayments could Benefit Millions of low-income and minority Americans*, CENTER ON BUDGET AND POLICY PRIORITIES, February 19, 2009.

[57] Medicare Payment Advisory Commission, *Report to the Congress.*

auxiliary benefits like gym memberships or extra chiropractic appointments above and beyond the benefits that law requires all Medicare plans, public or private, to furnish.

Repeal would allow MA plans to continue to receive these subsidies and thereby provide these extra benefits to MA beneficiaries. But repeal would accomplish this by draining $118 billion from taxpayers and an already financially unstable Medicare program over the next ten years. In fact, there are early indications that these reforms of Medicare Advantage are paying off for MA beneficiaries. At a time when premiums are rising for most Americans, the Department of Health and Human Services reports that the new bidding system with MA plans has resulted in a 1% drop in premiums in the program.[58]

CONCLUSION AND RECOMMENDATIONS

The evidence suggests that the costs of outright repeal are substantial and many of the asserted benefits of repeal do not stand up under scrutiny. But this does not mean that Americans need accept the status quo. If those opposed to the new federal health care law and those who supported it were willing to get past their disagreements and work on real improvements to the law as it stands today, the opportunities for progress are substantial.

Each state could use the substantial authority it has under current law to design a health insurance exchange that is adapted to meet the needs of their consumers, and businesses. State and federal governments could also lead public and private sector insurers in a market-wide effort to ensure that new quality and cost reforms that were made to Medicare in the new law benefit consumers on the private market, as well. Such a multi-payer initiative could extend reforms that have been shown to reduce costs by improving quality to all consumers—whether they get coverage through Medicare, Medicaid, or private insurance. Examples of the reforms that such an initiative could promote include coordinated care teams and "medical homes," to enhance primary care and the management of chronic diseases to help patients prevent acute flare-ups of their conditions.

Policy-makers could even take some of the important steps which the federal law failed to take to address our health care issues:

- Accelerating greater administrative streamlining and reducing health care paperwork can lower costs for consumers, providers, and insurers;
- Limiting the worst marketing practices of the drug and medical device industries can deliver more affordable medical treatments;
- Encouraging state-level support for research into the best treatments, and integrating this new knowledge into health IT systems can reduce medical errors and help doctors;

[58] Robert Pear, *Medicare Advantage Premiums to Fall in 2011*, NEW YORK TIMES, Sept. 21, 2010, downloaded on 12/15/10 from http://www.nytimes.com/2010/09/22/health/policy/22medicare.html?ref=health_care_reform.

- Ending the practice of billing consumers directly when hospitals are dissatisfied with the out-of-network reimbursements paid by insurers will protect patients.

Outright repeal of the federal health care law simply is not prudent choice. But if our elected officials make the choice to work together, opportunities exist to make real progress. It is time that our elected leaders put aside the rancor of the recent health care debate in order to find what works best for consumers and businesses.