NATIONAL CENTER FOR POLICY ANALYSIS

The Biggest Myths of ObamaCare

Issue Brief No. 144 by John R. Graham May 2014

Four years after its passage, ObamaCare has now been largely implemented, and millions have had their coverage disrupted. For years, the administration has propagated a number of myths about ObamaCare. Some have already crumbled, and others will fall as ObamaCare continues to change the American health system.

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Myth No. 1: If you like your health plan, you can keep it. Despite President Obama's promise that "If you like your plan, you can keep it," about 6 million people have already been notified by insurance companies that their policies are being canceled. That number will grow. Currently, about 19 million people have health coverage that they purchased in the individual market. Most of those plans do not comply with the requirements of the Affordable Care Act. One expert estimates that the law will cause more than 15 million people to lose their individual insurance by the end of 2014.[1] Most of these people have to get coverage from the deeply troubled ObamaCare exchanges.

Businesses were supposed to be allowed to keep their employee coverage. The term the government uses for this is "grandfathered." The truth is that few small business health plans will be "grandfathered."[2] For example, even small changes in deductibles and copayments or switching to another plan offered by the same carrier means losing this protection. Small firms keep premiums down primarily by changing insurers, but doing so will likely cause them to lose grandfathered status. The employer will have to find insurance that complies with dozens of costly new mandates, such as paying for so-called "preventive care" with no out-of-pocket cost to the employees.

- Under a mid-range estimate, two-thirds of small business employees will not be able to keep the plan they now have.[3]
- Under the worst-case scenario, as many as 80 percent will lose their plans.[4]
- By contrast, a self-insured, large company plan or union plan is free to change its third-party administrator (the firm hired to administer the benefits on behalf of the employer) as often as it likes and still keep its grandfathered status.[5]

However, a government memorandum predicts that more than half of all employees — and up to as many as two-thirds — with employer-provided health insurance will have to switch to more expensive, more regulated plans.[6] A survey of employers by a leading benefits consultant found that 90 percent of employers expect to lose their grandfathered status. A majority expect to do so before the employer mandate takes effect.[7] The

memorandum suggests that eventually all plans will lose grandfathered status.

Myth No. 2: If you like your doctor, you can keep your doctor. Many health plans sold in the exchanges offer very narrow networks with a limited choice of doctors.[8] For example, 70 percent of California physicians are not in CoveredCalifornia exchange plan networks.[9] If government estimates are correct, about 26 million uninsured people will eventually acquire health insurance.[10] If economic studies are correct, the newly insured will try to double their consumption of health care.[11] Yet, with no increase in the number of physicians, there is no realistic way to meet this demand.

The Association of American Medical Colleges predicts a shortfall of 21,000 primary care physicians by 2015. Before health care reform passed, the Health Resources and Services Administration estimated a shortage of 55,000 to 150,000 physicians by 2020. That number is undoubtedly higher today.[12] Texas alone is predicting a shortage of 18,000 nurses by 2015.[13]

Myth No. 3: There is an "employer mandate" to offer affordable coverage. If an employer has fewer than 50 full-time workers, she is not required to offer health benefits. There is a mandate for larger employers to offer health benefits. However, they do not have to cover spouses or pay for dependents. Most importantly, they have an incentive to offer benefits that will be unaffordable to many workers.

One option is to refuse to provide health insurance and pay a $2,000 fine per employee. Because this is much less than what most companies spend on employee health benefits, many employers will stop offering health insurance and send their employees to the exchanges.

Furthermore, half of all employees work for an employer who is self-insured (meaning the company pays the medical bills and hires a third-party administrator to administer the plan). A self-insured company can avoid the fine with a health plan that only covers the cost of preventive care, *with no annual or lifetime limit.* However, because this insurance will not satisfy the full requirements of the law, employees may go to the exchange and get subsidized insurance. If they do, the employer will be liable for a $3,000 fine per employee. An employer could avoid the fine by offering to "top up" the limited benefits and requiring employees to pay up to 9.5 percent of their annual wages in premiums and the full cost for their spouses and children.

The table shows an example of a $50,000-a-year employee who is asked to pay 9.5 percent of his or her annual gross wage for individual coverage ($4,720) and the full cost of family coverage ($10,000). Under the law, this is deemed "affordable" and satisfies the employer mandate, even though few workers would willingly spend nearly one-third of their take-home pay on health insurance — unless they expect some whopping medical bills. If an employee turns down this offer, he will not be entitled to subsidies if he buys coverage in an ObamaCare exchange.

Myth No. 4: Health reform will lower the cost of health insurance by $2,500 a year for the average family. Because of ObamaCare's mandates and regulations, coverage will be more expensive for everyone outside a small portion of older, low-income adults who can obtain highly subsidized coverage in the exchanges.

- A new tax on health insurance is likely to cost the families of employees of small businesses more than $500 a year in higher premiums.[14]
- A 40 percent tax on the extra coverage provided by expensive "Cadillac" plans will apply to about one-third of all private health insurance plans by 2019, but, because the tax threshold is not indexed to medical inflation, it will eventually reach every health plan.
- Scores of other items will be taxed, ranging from tanning salons to the sale of appreciated capital assets (including homes), in extreme cases.[15]

Some benefits have hidden costs:

- Health insurers are raising premiums for everyone in order to charge people with pre-existing conditions less than the expected cost of their care. Some young people, for example, have seen a doubling or tripling of their premiums.[16]
- Insurers are also trying to cover the higher costs of sicker enrollees with higher deductibles and narrow networks that cover only some of the doctors and hospitals in areas where people live.
- In order for employers to provide health insurance (or more generous insurance) to their employees, they will have to reduce what they pay in wages and in other benefits.
- The Congressional Budget Office estimates that 2

million fewer workers will be employed in 2017 and 2.5 million fewer in 2024 than would have been employed in the absence of ObamaCare. Also, total compensation will be 1 percent lower.[17]

Myth No. 5: There is an "individual mandate" that ensures everyone has health coverage. As originally written, the Affordable Care Act required most legal residents of the United States to have qualifying coverage or pay a fine. There were narrowly defined exemptions for some religious groups, prisoners, those whose incomes were so low that they did not have to file a tax return and those who would have to pay over 8 percent of household income to buy health insurance. For 2014, the fine was only supposed to be $95 per adult or $285 per family, or 1 percent of household income, whichever is greater. By 2016, the fine is scheduled to go up to $695 per adult or $2,085 per family, or 2.5 percent of income.

However, the individual mandate was effectively deferred until at least 2016 when the Obama administration's Department of Health & Human Services allowed people to decide for themselves if they qualify for a "hardship exemption." An individual can claim a hardship exemption if she attests that "you received a notice that your current health plan is being cancelled, and you consider the other options available unaffordable."[18]

Because this exemption was created to reduce the political liability of fining people before the November 2016 election, the individual mandate is highly unlikely ever to be imposed. After all, there is an election every two years. Thus, fewer healthy people and more sick people will continue to sign up for coverage, and premiums will continue to rise.

Myth No. 6: Individuals cannot be denied individual coverage due to pre-existing conditions. This was only true if they applied for ObamaCare coverage before March 31, 2014. If they missed that deadline, they cannot get coverage at all until November 15, 2014, unless they experience a life-qualifying event, such as getting married or having a child. In the individual market, prior to ObamaCare, people could apply whenever they wanted to.

Myth No. 7: Health insurers no longer can cancel a policy after an insured individual gets sick. This has been illegal for decades. If an insurer canceled a policy, it had to offer coverage under another policy without underwriting. Before ObamaCare, a health insurer could only rescind a policy if the insured had misrepresented her health status on her application. If the insurer did so illegally, it was called "post-claims underwriting," and insurers that did it were punished severely under state law. In 2008, for example, HealthNet announced an agreement with the California Insurance Commissioner to reinstate 926 policies, pay $3.6 million in penalties and reimburse $14 million in outstanding medical claims.[19]

On the contrary, ObamaCare has caused many cancellations. For example, as a contractual condition of selling health plans in the CoveredCalifornia exchange, insurers were required to cancel existing policies and force those already covered into the exchange.

On November 14, 2013, the U.S. Department of Health and Human Services sent a letter to state insurance commissioners giving them the discretion to allow individuals to keep their prior coverage for one more year.[20] Nearly three-fourths of states agreed to allow insurers to reinstate canceled health plans. However, it appears that most insurers were not able to do so. Indeed, the practice has been specifically barred in a handful of states, including Washington, Indiana and the District of Columbia.[21]

Myth No. 8: Medicare has been strengthened. Reduced Medicare spending, amounting to $715 billion over the next 10 years, will pay for more than half the cost of health reform:[22]

- Cuts to hospital services total $260 billion.
- Cuts to Medicare Advantage Plans total $156 billion.
- Cuts to skilled nursing, hospice, home health and other services add up to $155 billion.

Calculating Affordable Coverage

	Employee's Premium	Cost of Insurance
Employee's Coverage	$4,720*	$5,000
Remaining Family Coverage	$10,000	$10,000
	$14,720	$15,000

*9.5% of $50,000

Source: National Center for Policy Analysis

- Hospitals that treat a disproportionate share of indigent patients will lose $56 billion.

The elderly and disabled will incur significantly higher costs:

- In general, the Medicare spending cuts exceed the new benefits by a factor of more than 10 to 1.[23]
- As a result, one of every two people expected to participate in Medicare Advantage over the next 10 years (7.5 million of 14 million) will lose their coverage entirely. According to Medicare's chief actuary, they will be tossed back into Medicare, with the option to buy another Advantage plan or a supplement. Those who retain their Advantage coverage will face steep benefit cuts or hefty premium increases, or both.[24]
- Additionally, indirect costs, including new taxes on drugs and medical devices, will apply to items that are disproportionately used by seniors and the disabled.

To make matters worse, Medicare's chief actuary believes the planned cuts in fees may cause some doctors to retire and force some hospitals out of business.[25]

Conclusion. Favorable media coverage of the 8 million people who have enrolled in health insurance via exchanges has allowed the administration and its allies to revive discredited claims about ObamaCare's benefits. The numbers touted by the administration disguise the fact that many of these people lost previous coverage in the period prior to open enrollment, and people are no longer free to acquire the health insurance they want. The real costs of ObamaCare will continue to burden Americans, despite the apparent success of the first open enrollment. We need an alternative.

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References and sources can be found in the online version at www.ncpa.org/pub/ib144.

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