

PROGNOSIS



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Introduction

In 2010 and 2012, we released three reports detailing the impact of President Obama's health care law, the Patient Protection and Affordable Care Act (ACA, "Obamacare"). These three reports we released not as senators, but as physicians who care for patients, predicted dire consequences for individuals and families affected by Obamacare.

Now that most of the law is being implemented, Americans are feeling the very real and disastrous repercussions of it. Millions of Americans are losing their insurance policies, despite repeated promises from President Obama that "if you like your plan, you can keep it."¹ Millions more are seeing health care costs skyrocket, are being forced into Medicaid, are footing the bill for this massive government expansion, and are experiencing even less work opportunity due to this law.



President Obama and his Administration have tried to downplay the destructive consequences of the law by making it appear as if Obamacare's woes are due to a rocky start of a website or minor wrinkles in the law that need to be ironed out with administrative "fixes."

Despite the President's rhetoric, the negative impacts of Obamacare are not due to minor imperfections in the law. The millions of dropped plans and increasing health care premiums are the direct and predictable result of Obamacare's policies—which rely on mandates and tax increases rather than market-oriented options to expand coverage.

This report checks up on the warnings we made in 2010 and 2012 about the health care law and reviews the status of the predictions we made. Our current reality shows that the warnings we made are being realized across the country. The impacts of Obamacare were foreseeable and preventable. Now, President Obama's Administration is scrambling to mitigate these negative consequences through administrative actions and delays. However, the flawed policies within the health care law cannot be fixed through administrative adjustments or delays.

As physicians, we support real health reform that lowers costs and increases access to high quality health care. Many of the policies within the ACA increase costs and lower the quality of health care. Despite President Obama's efforts to delay the negative impacts of the law, Americans are already feeling its effect—and the majority of Americans continue to disapprove of the law.

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U.S. Senator

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Prognosis: Outlook Not So Good

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Report 1—Bad Medicine

Original Diagnosis: millions of Americans could lose their health insurance plans

We warned, “Americans were repeatedly promised the new health law would allow anyone who wanted to keep their current health plan to do so. However as the new law is being implemented, millions of Americans are in danger of losing their current health insurance.”²

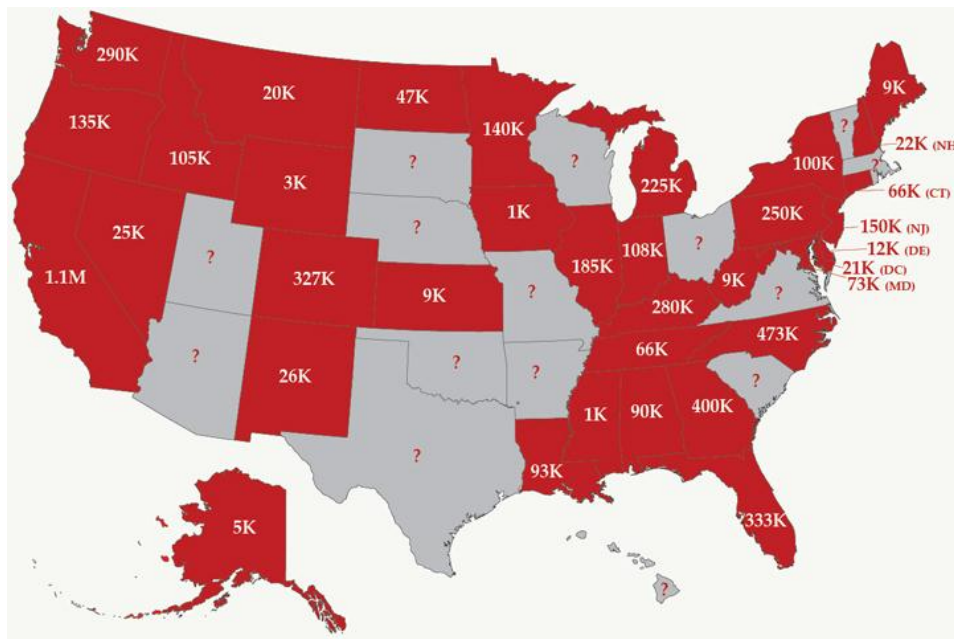
Prognosis: original diagnosis confirmed, and outlook may worsen with time

Our original diagnosis focused on the number of Americans who would lose their health insurance plans due to businesses dropping employer-sponsored plans, and seniors that would lose Medicare Advantage plans due to Medicare cuts. However, the number of Americans that have lost their health insurance due to the Obamacare regulations limiting grandfathered plans is worse than we imagined. Enforcement of the employer mandate has been delayed, which has pushed back some of the impact the mandate will have on individuals losing their original health insurance plans.

Evidence:

Despite President Obama and Democrats’ promises that “if you like your plan you can keep it,”³ more than 5 million people in 35 states have lost their current health insurance plans due to Obamacare.⁴

The Senate Republican Policy Committee generated the map below displaying the thousands of people per state who lost their original health insurance plans:



Employers are also choosing to drop coverage for part-time employees due to Obamacare. Target,⁵ Trader Joe’s, Forever 21, and Home Depot have all announced they will no longer offer health insurance for part-time employees.⁶

The Administration has allowed states to extend the deadline by which grandfathered plans must meet additional criteria through the 2017 plan year, so more cancellations may occur with time.

Original Diagnosis: the law's new mandates will increase health costs

We said, "Passage of the new health care law means millions of Americans will be forced to pay higher health insurance premiums and pay more for health care."⁷

Prognosis: original diagnosis confirmed, outlook shows increasing health costs

Evidence:

*"Of the 51 states studied, all experienced health insurance rate increases, with 44 of those states experiencing triple digit percentage increases in premiums for the lowest-priced coverage. Pre-ACA premiums average \$62.00 monthly, while post-ACA premiums average \$187.08 per month, a \$125.08, or 202 percent, increase."*⁸-Sam Cappellanti, American Action Forum

*"A study by Avalere Health found that 'consumers could face steep cost-sharing requirements—like co-payments, co-insurance and deductibles—layered on top of their monthly premiums ...furthermore, there is a risk that patients could forgo needed care when faced with high upfront deductibles.'"*⁹-Kyle Cheney, Politico

*"The ACA imposes an excise tax on insurance plans with an \$8 billion cost the CBO expects to be passed to the consumer in the form of premium increases...Over the next decade, the HIT is estimated to cost the average individual \$2,171 and family \$5,140 in additional premiums."*¹⁰-Sam Cappellanti, American Action Forum

According to a report by the Manhattan Institute, insurance rates for young men will increase 97 to 99 percent due to Obamacare.¹¹ Rates will increase by 55 to 62 percent for young women.¹²

A study by the American Action Forum found, "On average, a healthy 30 year old male nonsmoker will see his lowest cost insurance option increase 260 percent."¹³

In addition to increasing costs in the individual market, the ACA "is prompting companies to raise workers' premium contributions, steer them toward high-deductible plans and charge them more to cover family members."¹⁴



Original Diagnosis: 16 million Americans will be forced into a government program that denies care

We wrote, “The new law enrolls half of the uninsured into a system [Medicaid] that denies access to care and is financially stressing state budgets.”¹⁵

Prognosis: condition still developing

Our estimate of the number of people added to Medicaid is higher than the actual number of individuals determined to be newly eligible. However, not all states have expanded their Medicaid programs, which has affected the number of eligibility determinations, and the number may continue to rise.

Evidence:

According to HHS’ update on January 22, 2014, an additional 6.3 million people were determined to be newly eligible for Medicaid or CHIP between October 1, 2013, and December 31, 2013.¹⁶ However, “that tally does not include the 750,000 or so people who were determined eligible in Medicaid through the federally-run Obamacare exchange HealthCare.gov. Adding the two enrollment numbers together equals more than 7 million Medicaid-eligible determinations.”¹⁷

“About 13 percent of those who’ve signed up for new coverage in Washington State, where the state-run insurance exchange appears to be operating fairly well, have enrolled in private plans; the rest were added to the Medicaid rolls. In its first week-and-a-half of operation, Connecticut’s exchange enrolled about the same number of people in Medicaid as in private health plans. And in Kentucky, more than half of all new enrollees signed up for Medicaid.”¹⁸-Kate Pickert, TIME

“The Congressional Budget Office has estimated that some 7 million people will sign up for private health coverage through the federal and state insurance exchanges by the end of 2014 and about 9 million will be added to the Medicaid rolls during the same period.”¹⁹-Kate Pickert, TIME

A study by Sandra Decker, an economist for the National Center for Health Statistics at the Centers for Disease Control found, “Primary care doctors were 73 percent more likely to reject Medicaid patients relative to those who are privately insured, and specialists were 63 percent more likely to reject Medicaid patients...[and] the states with the worst Medicaid reimbursement rates also had the lowest rates of physician acceptance of new Medicaid patients.”²⁰

Original Diagnosis: short-term fixes threaten seniors' long-term access to care

In our first report, we pointed out the health care law purposely omitted any changes to the flawed Sustainable Growth Rate (SGR), as a gimmick to “lower the price tag of [the] bill and claim it would reduce the deficit.”²¹ The SGR affects 40 million seniors and 96,000 physicians who use Medicare, and most lawmakers agree the SGR needs to be replaced.

Prognosis: original diagnosis confirmed

Evidence:

In the almost four years since the passage of Obamacare in March 2010, there have been nine short-term patches to the SGR. The bill was essentially playing tricks with seniors' care. These short-term fixes threaten seniors' access to quality health care, as doctors face continuous uncertainty about Medicare reimbursement rates.

Time Covered	Legislation
Mar. 1-Mar. 31, 2010	Temporary Extension Act (P.L. 111-144)
Apr. 1-May 31, 2010	Continuing Extension Act (P.L. 111-157)
June 1-Nov. 30, 2010	Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (P.L. 111-192)
Dec. 1-Dec. 31, 2010.	Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286)
2011	Medicare and Medicaid Extenders Act (P.L. 111-309)
Jan. 1-Feb. 29, 2012	Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78)
March 1-Dec. 31, 2012	Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)
2013	American Taxpayer Relief Act (P.L. 112-240)
Jan. 1-March 31, 2014	Bipartisan Budget Act of 2013 (P.L. 113-67)

In addition, the ACA threatens seniors in other prominent ways, including cutting Medicare Advantage (MA) by more than \$300 billion.²² American Action Forum has highlighted how the cuts to Medicare Advantage have already resulted in 10,000 seniors in Iowa receiving cancellation notices, and 50,000 seniors in New Jersey have received cancellations.²³ The “upcoming open enrollment period is expected to have 142 fewer MA plans than last year, representing a 5.3 percent decrease,” according to a report by Avalere Health.²⁴ The report also finds the South and Midwest regions of the country, traditionally rural, will be the hardest hit by plan reductions.²⁵

United Healthcare is reducing its network by 10-15 percent in response to the MA cuts.²⁶ Robert Zirkelbach of American's Health Insurance Plans was quoted by CNN saying, “Washington can't cut and tax the Medicare Advantage program this much and not expect seniors in the program to be harmed. And that's exactly what we're starting to see.”²⁷

After United Healthcare dropped Arthur Vogelmann, a gastroenterologist, from their network, he told the Washington Post, “It is an outrage. I have patients in their 80s and 90s who have been with me 20 years, and I'm having to tell them that their insurer won't pay for them to see me anymore. The worst thing is I can't even tell them why.”²⁸

In February 2014, CMS proposed a rule that would cut Medicare Advantage payment rates by several percentage points on average, in part because of mandates in the Affordable Care Act.²⁹

Original Diagnosis: patients with pre-existing conditions still face care restrictions

In 2010, we warned, “The new law gives the Secretary of Health and Human Services the authority to stop taking new applications from patients [for the Pre-Existing Condition Insurance Plan]. According to reports, it appears that Secretary Sebelius will have to start rejecting application from thousands of Americans with preexisting conditions as early as 2011.”³⁰

Prognosis: original diagnosis confirmed

Evidence:

The ACA created a program called the Pre-Existing Condition Insurance Plan (PCIP) to temporarily cover individuals with pre-existing conditions. However, this program failed to provide coverage for many individuals with pre-existing conditions. National enrollment in the plan was lower than expected, but greatly exceeded estimated costs.³¹ Due to high costs, in February 2013, the program stopped allowing individuals to enroll in the program.³² The federal government also required state-administered PCIPs to stop enrolling new applicants on March 2, 2013.³³

The Helping Sick Americans Act Now Act (H.R. 1549) was introduced in the House of Representatives to provide additional funding for PCIP to allow individuals to continue enrolling in the program until January 1, 2014, when the program was scheduled to expire. H.R. 1549 would have also eliminated the requirement in the ACA that an individual had to be uninsured for at least six months in order to qualify for PCIP. Unfortunately, Congress failed to take action to ensure those with pre-existing conditions could access affordable health insurance.

Individuals who were covered by federal or state-administered PCIP programs were given a special extension allowed individuals with PCIP coverage to keep their coverage through March 2014 but must sign up for a new health plan by March 15, 2014.³⁴

In addition, an article by the National Journal highlights individuals with HIV might still face discriminatory practices to discourage those with pre-existing conditions from signing up for insurance.³⁵ Specifically, the AIDS Foundation of Chicago wrote the Secretary of the Department of Health and Human Services, Kathleen Sebelius, that companies are not offering coverage for single-tablet regimens (STRs) which are the most commonly used drugs by HIV patients.³⁶

Original Diagnosis: the individual mandate will fail with Internal Revenue Service (IRS) as the enforcer, and costs will increase

We said without “the usual tax-like penalties for noncompliance,” the “relatively low-cost penalties and anemic enforcement [of the individual mandate] will create an incentive for millions of Americans to game the system and only buy health insurance when they are sick...All this means that while IRS may still harass millions of Americans, the individual mandate will largely be ineffective in broadening the risk pool.”³⁷

Prognosis: still developing, outlook is not promising

It is too early to determine whether or not the individual mandate will work since it only went into effect this January, but the early evidence shows the IRS may be unable to enforce the tax.

Evidence:

“The Internal Revenue Service probably will bark at you if you fail to obtain health insurance next year, but the agency won’t have much bite. On this issue, Congress pulled the watchdog’s teeth...experts predict the government will have a tough time forcing people to pay up...[because] Congress banned the IRS from using any of its usual techniques to force people to pay the penalty for failing to obtain health insurance.”³⁸ -Tony Leys, USA Today

“The Affordable Care Act (ACA) contains an extensive array of tax law changes that will present a continuing source of challenge for the IRS in coming years.”³⁹ -J. Russell George, Inspector General for Tax Administration

“The IRS estimates that at least 42 provisions will either add to or amend the tax code and at least eight will require the IRS to build new processes that do not exist within the current tax administration system. In addition, the IRS must create new or revise existing tax forms, instructions, and publications; revise internal operating procedures; and reprogram major computer systems used for processing tax returns.”⁴⁰ -Treasury Inspector General for Tax Administration

“Adding fuel to the fire, last week reports surfaced that ‘an unnamed health care provider in California is suing the IRS ... alleging that they improperly seized some 60 million medical records of 10 million Americans, including medical records of all California state judges.’ These allegations raise further concerns that the American people simply cannot trust the IRS to manage its health care law responsibilities.”⁴¹ -Senate Republican Policy Committee, Scott Gottlieb, Forbes

In a memorandum to the Secretary of the Treasury on November 8, 2013, the Treasury Inspector General for Tax Administration (TIGTA) indicated implementing the ACA includes “the largest set of tax law changes in more than 20 years,” and they are a top management and performance challenge for the Internal Revenue Service (IRS).⁴²

In order to monitor compliance with the individual and employer mandates, as well as verify subsidy amounts, “the IRS and HHS are now building the largest personal information database the government has ever attempted. Known as the Federal Data Services Hub, the project is taking the IRS's own records (for income and employment status) and centralizing them with information from Social Security (identity), Homeland

Security (citizenship), Justice (criminal history), HHS (enrollment in entitlement programs and certain medical claims data) and state governments (residency).”⁴³

A study released by the American Action Forum also found “the individual mandate penalty may never be substantial enough an incentive to get young adults to buy into the ObamaCare exchanges. The study found that after accounting for cost-sharing and subsidies in 2014, it would still be cheaper for 86 percent of young adults to forgo coverage and to pay the individual mandate instead.”⁴⁴

It appears most young adults are finding this to be true, as only 24 percent of individuals who have selected a health insurance plan through a state or federal marketplace are between the ages of 18 and 34.⁴⁵ President Obama’s Administration had originally hoped about 39 percent of individuals in the exchanges would be in this age group, in order to ensure a diverse mix of enrollees to keep prices from spiraling upward.⁴⁶ However, if enough young people do not sign up, and most Obamacare enrollees are older, sicker, and use more health care, next year’s premiums may skyrocket. And if Obamacare is bleeding money, taxpayer expenses will be higher than expected too.

Original Diagnosis: new IRS tax would harm small businesses

In 2010, we said Section 9006 of the health care law “is a burdensome tax provision that could overwhelm small businesses with additional paperwork and increase their administrative costs dramatically...[and] does nothing to improve health care in America.”⁴⁷

Prognosis: original diagnosis confirmed- tax repealed



Evidence:

In 2011, the Senate voted 87-12 to repeal this provision of the health care law, and the House passed a repeal of this section by a bipartisan vote of 314-112.⁴⁸ The repeal was then signed into law by President Obama, and marked the first successful congressional effort to repeal a portion of Obamacare. The White House remarked in response to Congress’ repeal it “was pleased Congress had acted to correct a flaw that placed an unnecessary bookkeeping burden on small businesses.”⁴⁹

Recognizing the harmful effects this new tax would have on small businesses, Congress acted to repeal this provision before it went into effect.

Report 2—Grim Diagnosis

Original Diagnosis: the “employer mandate” will lower incomes and result in hundreds of thousands of jobs being lost

We said, “The employer provision will lower wages and lead to less jobs because workers, not businesses, ultimately feel the impact of taxes and fines.”⁵⁰ We also predicted Obamacare would result in the loss of hundreds of thousands of jobs being lost, including jobs in the health care industry, and there is a “huge number of future jobs and future workers that will be effectively sidelined because of the health reform legislation.”⁵¹

Prognosis: still developing, as the mandate has been delayed several times

Evidence:

Since our report, the Administration has chosen twice to unilaterally delay enforcement of the employer mandate.⁵² This is a clear indication even the law’s most vocal proponents can see the negative impact the mandate may have on Americans. While the delay of the employer mandate may temporarily help some businesses, it does not eliminate this fundamentally flawed policy. The delays also increase the uncertainty businesses face as they try to comply with the health care law. As Thomas Donohue, President of the United States Chamber of Commerce stated, “This short-term fix also creates new problems for companies by moving the goal posts of the mandate modestly when what we really need is a time-out.”⁵³

“[Bureau of Labor Statistics] data show that the workweek in low-wage sectors sank to a record low in July [2013]—just before the Obama administration delayed enforcement of the employer mandate until 2015...In the interest of an informed debate, [Investor’s Business Daily] compiled a list of job actions with strong proof that ObamaCare’s employer mandate is behind cuts to work hours or staffing levels.”⁵⁴ -Jed Graham, Investor’s Business Daily

“Obamacare supporters have long argued that the law will not have a negative impact on jobs. President Barack Obama’s latest delay of the employer mandate contains a clear admission that it will.”⁵⁵ -Lanhee J. Chen, Bloomberg

“Forty-one percent of the businesses surveyed have frozen hiring because of the health-care law known as Obamacare. And almost one-fifth—19 percent— answered “yes” when asked if they had ‘reduced the number of employees you have in your business as a specific result of the Affordable Care Act.’ The poll was taken by 603 owners whose businesses have under \$20 million in annual sales. Another 38 percent of the small business owners said they ‘have pulled back on their plans to grow their business’ because of Obamacare.”⁵⁶ -Dan Mangan, CNBC

“More than one in ten firms surveyed by Mercer, a consultancy—and one in five retail and hospitality companies—say they will cut workers’ hours because of Obamacare.”⁵⁷ -The Economist

“Health care companies shed 6,000 positions in December, the first down month since July 2003, according to the government’s monthly jobs report. This comes after a yearlong slowdown in hiring. The hardest hit areas were nursing homes, which jettisoned 3,900 jobs, and home health care, which lost 3,700 positions. Hospitals got rid of 2,400 jobs, while physicians’ offices reduced staff by 1,200.”⁵⁸ -Tami Luhby, CNN Money

“Faltering economic growth at home and abroad and concern that President Barack Obama’s signature health care law will drive up business costs are behind the wariness about taking on full-time staff, executives at staffing and payroll firms say.”⁵⁹ – Lucia Mutikani, Reuters

“Executives at several staffing firms told Reuters that the law, which requires employers with 50 or more full-time workers to provide healthcare coverage or incur penalties, was a frequently cited factor in requests for part-time workers. A decision to delay the mandate until 2015 has not made much of a difference in hiring decisions, they added.”⁶⁰ – Lucia Mutikani, Reuters

In a report on current economic conditions released in October 2013, the Federal Reserve noted, “Many contacts [in the labor markets] also commented on reluctance to expand due to uncertainty surrounding the Affordable Care Act; some employers cut hours or employees.”⁶¹ In addition, the Congressional Budget Office (CBO) recently estimated Obamacare would lead to a reduction in “the number of full-time-equivalent workers of about 2.0 million in 2017, rising to about 2.5 million in 2024.”⁶² The decline is due in part to reduced employer demand for labor, CBO found.⁶³

As of January 31, 2014, Investor’s Business Daily counted 401 separate employers who have announced they are cutting hours or reducing workers.⁶⁴

The University of California-Berkley’s Labor Center also studied the impact of the employer mandate at firms of over 100 people. The analysis found approximately 2.3 million Americans could be subjected to work reductions because of the health care law’s employer mandate.⁶⁵

The simple fact is the employer mandate creates three bad choices for businesses. They can either offer government approved insurance that many simply will not be able to afford, pay a tax penalty, or get their number of full-time employees below fifty by either cutting hours or not hiring new workers. None of these choices will help businesses grow or increase the amount they can afford to pay their employees. When the President sold the American people his health reform policy, he failed to mention that many would be making less because of his law.

Original Diagnosis: the law included a risky insurance scheme that would cost taxpayers

The Community Living Assistance Services and Supports program (CLASS), was originally envisioned to help individuals pay for the services that individuals need as part of their daily living. While we certainly acknowledge the importance of long-term care, we said, “The financial structure of the program is so shaky it could require a taxpayer-funded bailout while saddling taxpayers with mountains of debt.”⁶⁶

Prognosis: original diagnosis confirmed- CLASS repealed

Evidence:

“The measure, a piece of the 2010 health reform law, was supposed to create a new national, voluntary long-term care insurance system. But it was roundly criticized by Republicans and little support among Democrats. Most important, actuaries found that, without substantial changes, the program’s premiums would be far too expensive for most buyers and projected it would be financially unsustainable. As a result, more than a year ago, the Obama Administration refused to implement the program.”⁶⁷ -Howard Gleckman, Forbes

“The Congressional Budget Office originally scored the CLASS Act as saving \$70.2 billion over 10 years. After the administration suspended the program, however, the CBO said it would score a straight repeal as costing nothing.”⁶⁸ -Emily Ethridge, Roll Call

Approximately one year after we released our *Grim Diagnosis* report which detailed many of the flaws with the CLASS program, the Secretary of Health and Human Services was forced to concede that, “despite our best analytical efforts, I do not see a viable path forward for CLASS implementation at this time.”⁶⁹ Congress and the President finally recognized the fundamentally flawed nature of the CLASS program and voted for its repeal as part of the fiscal cliff legislation that passed Congress at the beginning of 2013.

Report 3—Warning: Side Effects

Original Diagnosis: the law includes hundreds of billions of dollars of tax hikes

Prognosis: original diagnosis confirmed

Evidence:

Three years after passage of the law, the Congressional Budget Office (CBO) calculated that the Affordable Care Act includes \$1 trillion in new taxes from 2013-2022.⁷⁰ The Committee on Ways and Means outlined each tax, and its expected revenue (from CBO and Joint Committee on Taxation (JCT) reports) in the following chart:



Provision	CBO Estimates of Tax Increases 2013-2022 ⁷¹
Additional 0.9 percent payroll tax on wages and self-employment income and new 3.8 percent tax on dividends, capital gains, and other investment income for taxpayers earning over \$200,000 (singles)/\$250,000 (married)	\$317.7 billion
“Cadillac tax” on high-cost plans	\$111.0 billion
Employer mandate	\$106.0 billion
Annual tax on health insurance providers	\$101.7 billion
Individual mandate	\$55.0 billion
Annual tax on drug manufacturers / importers	\$34.2 billion
2.3 percent excise tax on medical device manufacturers / importers	\$29.1 billion
Limit FSAs in cafeteria plans	\$24.0 billion
Raise 7.5 percent AGI floor on medical expense deduction to 10 percent	\$18.7 billion
Deny eligibility of “black liquor” for cellulosic biofuel producer credit	\$15.5 billion
Codify economic substance doctrine	\$5.3 billion
Increase penalty for nonqualified HSA distributions	\$4.5 billion
Impose limitations on the use of HSAs, FSAs, HRAs, and Archer MSAs to purchase over-the-counter medicines	\$4.0 billion
Impose fee on insured and self-insured health plans; patient-centered outcomes research trust fund	\$3.8 billion
Eliminate deduction for expenses allocable to Medicare Part D subsidy	\$3.1 billion
Impose 10 percent tax on tanning services	\$1.5 billion
Limit deduction for compensation to officers, employees, directors, and service providers of	\$0.8 billion

certain health insurance providers	
Modify section 833 treatment of certain health organizations	\$0.4 billion
Other revenue effects (CBO's estimates in "Associated Effects of Coverage Provision on Tax Revenues" and "Other Revenue Provisions" not otherwise accounted for)	\$222.01 billion
Additional requirements for section 501(c)(3) hospitals	Negligible
Employer W-2 reporting of value of health benefits	Negligible
1099 reporting for small businesses	Repealed by P.L. 112-9
TOTAL GROSS TAX INCREASE (BILLIONS OF DOLLARS)	\$1,058.3 billion

Original Diagnosis: the new insurance cooperatives will waste taxpayer dollars

We said, “Because CO-OPs will qualify for millions of taxpayer dollars in loans, those dollars may be jeopardized and ultimately lost if a new insurance cooperative failed. Unfortunately, the initial regulation about the new CO-OPs project many of the new CO-OPs will fail.”⁷²

Prognosis: original diagnosis confirmed, and conditions may worsen



Evidence:

“One co-op, however, has closed, another is struggling, and at least nine more have been projected to have financial problems, according to internal government reviews and a federal audit.”⁷³ -Jerry Markon, Washington Post

“Their failure would leave taxpayers potentially on the hook for nearly \$1 billion in defaulted loans and rob the marketplace of the kind of competition they were supposed to create. And if they become insolvent, policyholders in at least half the states where the co-ops operate could be stuck with medical bills.”⁷⁴ -Jerry Markon, Washington Post

“The Obama administration has estimated that more than a third of the nearly \$2 billion it has lent to co-ops will not be repaid.”⁷⁵ -Jerry Markon, Washington Post

“But limits on co-ops may make it hard for them to repay the \$2 billion in federal loans they have received, said Kev Coleman, head of data and research at HealthPocket, a company that compares and rates health insurance plans. “They have a series of challenges,” he said. “They don’t have existing brand awareness; they have a lot of administrative work to do to meet regulations; and they don’t have existing revenue.” Co-ops also lack the leverage to negotiate lower prices with health care providers that big insurance companies have, Coleman said.”⁷⁶ -Kev Coleman quoted in a USA Today article written by Kelly Kennedy

The co-op in Vermont “failed to meet Vermont’s insurance standards and has been denied a license to sell health insurance in Vermont.”⁷⁷ The Commissioner of the Vermont Department of Financial Regulation said “the CO-OP has not shown sufficient evidence that it will be able to sustain solvency, repay its federal loans and gain enrollment.”⁷⁸

The botched roll out of the federal and several state exchange websites has also hurt co-ops. For example, the Maryland exchange “barely worked the first few days after it opened Oct. 1. When it did, it left Evergreen [a Maryland based co-op] off the list of options.”⁷⁹ Although this problem was fixed, the website still had trouble and Evergreen was still “paying staff, renting offices and hiring doctors and has only until March under the health law’s open enrollment period to recruit most clients for 2014.”⁸⁰ For co-ops operating in states using the federal exchange, it may have been even more difficult for co-ops to recruit clients during the same enrollment period.

Original Diagnosis: the medical device tax will stifle innovation

In our third report, we wrote the medical device tax “will stifle medical innovation, limit American competitiveness, and trigger thousands of lay-offs.”⁸¹

Prognosis: original diagnosis confirmed

Evidence:

*“Some medical-device makers, such as Stryker (headquarters: Kalamazoo, Michigan) and Zimmer Holdings (job locations in Nevada, Minnesota, Ohio, and Pennsylvania), already have announced layoffs (1,000 and 450, respectively) as a result of the tax.”*⁸²-Quinn Hillyer, USA Today

*“Smith & Nephew eliminated nearly 100 jobs in Memphis and Andover, Mass., on Thursday, January 31, [2012] as the medical device company cuts expenses in an effort to offset tax hikes included in the Affordable Care Act.”*⁸³ –Michael Wadell, Memphis Daily News

*“Medical Device investing declined for the third consecutive quarter, falling 37 percent in dollars and 27 percent in deal volume with \$434 million going into 65 companies, experiencing the lowest dollar level of investment since 2004.”*⁸⁴-Price Waterhouse Coopers

*“Boston Scientific said [in January 2013] it will prune another 900 to 1,000 jobs from its global workforce as it tries to manage the effects of the new medical device tax.”*⁸⁵-James Walsh, StarTribune

*“Investment in med tech has just cratered. It’s at an all-time low,” said Shaye Mandle, executive vice president and chief operating officer of the trade group LifeScience Alley. He says there had been a drop in investment in recent years, but the tax “put a cherry on top” of that trend.”*⁸⁶-Russ Britt, Wall Street Journal

According to a survey by the Medical Device Manufacturers Association (MDMA) about 47 percent of medical device companies are reducing investments in research and development (R&D) by an average of 18 percent to pay for the tax.⁸⁷

Recognizing the devastating impact of the ACA’s medical device tax in stifling innovation, many Democrats are now supporting a repeal of the law’s 2.3 percent tax. On March 21, 2013, the Senate approved a non-binding amendment to the Senate budget resolution to repeal the 2.3 percent medical device tax. The amendment was approved by a vote of 79-20 with 34 Democrats supporting the repeal.⁸⁸

Following the budget amendment, Senator Klobuchar released a statement saying that she “will continue to work to get rid of this harmful tax so Minnesota’s medical device business can continue to create good jobs in our state and improve patients’ lives.”⁸⁹

In addition, legislation introduced in the House of Representatives (H.R. 523, Protect Medical Innovation Act of 2013) to repeal the medical device tax has 269 cosponsors, including 42 Democrats.

Congressman Franken, another Democratic supporter for repealing the medical device tax “told reporters the tax is hurting Minnesota companies and pushing jobs overseas.”⁹⁰

Original Diagnosis: findings from new taxpayer-funded research institute could be used to deny payment for patients' care

We said the Patient-Centered Outcomes Research Institute (PCORI) “could be used to deny patients access to care they need.”⁹¹ PCORI was created to conduct comparative effectiveness research (CER), which compares “the effectiveness of medical treatments head-to-head to obtain better information about what works best and costs the least.”⁹² While the research is not controversial, as doctors we expressed our concern the research could be used by the Department of Health and Human Services (HHS) to make coverage determinations for Medicare and Medicaid, resulting in the denial of coverage for life-saving treatments.

Prognosis: still developing

Our original diagnosis assumed PCORI would follow through with its mission to conduct comparative effectiveness research, and focus on the impact this research may have on payment decisions through Medicare and Medicaid. While we still have concerns with how CER research through PCORI could impact patient care, PCORI has largely strayed from its original mission.

Evidence:

The Center for American Progress (CAP) recently issued a report on PCORI. The report revealed, “PCORI hasn’t initiated a single CER study of medical devices and has launched only a few CER studies of drugs.”⁹³ It also indicated the entity dedicated only 37 percent of its funding for CER in its first four years.⁹⁴ Instead, 38 percent of PCORI’s funding “went toward communicating and disseminating research, improving health-care systems, addressing disparities and accelerating patient-centered outcomes research and methodical research,”⁹⁵ and “a full 25 percent of the budget has been dedicated to ‘communications tools and education initiatives.’”⁹⁶

Peter Orszag, the former Director of the Office of Management and Budget under President Obama, says the entity was intended to conduct CER “to find out, for example, whether spinal fusion surgery works better than the alternatives in relieving back pain, or whether proton beam therapy is worth the extra cost to treat prostate cancer.”⁹⁷ However, instead of CER, PCORI is funding studies that could easily be done by other federal agencies or non-profits. Of the 284 studies PCORI has funded, only 34 (12 percent) addressed topics the Institute of Medicine identified as top priority topics, leading Peter Orszag to call the entity “sluggish.”⁹⁸

In one example of a study funded by PCORI, an associate professor at New Mexico State University School of Nursing received funding “to increase the capacity of Mexican-American families residing in the Colonias of the Southern New Mexico border region to discover strategies to promote healthy eating and physical activity to reduce health disparities related to overweight and obesity issues.”⁹⁹

Concerns we are keeping under observation:

Of course, not all of our observations have completely come to fruition. Those we have kept for further observation include:

- Emergency room wait times and costs will increase¹⁰⁰
- Medical Loss Ratio (MLR) will increase costs for consumers¹⁰¹
President Obama's Administration recently loosened the MLR requirements "likely due to insurance company concerns that they have faced and will continue to face increased administrative costs for 2014 [and 2015] due to the technological problems and last-minute administrative changes."¹⁰²
- Washington's Medicaid mandates will send state costs skyrocketing¹⁰³

Our reports were also not an exhaustive list of the negative consequences of Obamacare. However, our original reports and this check-up highlight many of Obamacare's negative impacts were anticipated and preventable. Sadly, President Obama's Administration continues to push forward with the law, rather than recognizing its deeply rooted flaws. While President Obama and Democrats continue to drive this failed law, Americans can expect Obamacare's policies will continue to harm access to affordable health care and health insurance.

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