

April 2011

State Insurance Exchanges: The Case Against Implementation

By Benjamin Domenech*

State policymakers face a complex task as they decide whether to implement President Barack Obama's health care law. For those in one of the 29 states currently mounting legal challenges to the law, the decision of how to proceed in the short-term is even more complex. They must decide whether to implement a series of burdensome regulations and vague requirements even as their representatives in the courts argue that key provisions of the law are unconstitutional.

State policymakers face a complex task as they decide whether to implement President Barack Obama's health care law.

The pressing decision for most states is whether to implement the health insurance exchanges required under Obama's law. Some state policymakers, told that if they do not set up their own state-specific exchanges, the federal government will establish one that bypasses their authority, have attempted to find a middle path between compliance and resistance, adding pro-market or anti-abortion provisions to improve their exchanges.

This *Policy Brief* explains that the middle path is treacherous: It offers no protection against future decisions by the federal bureaucracy, collaborates with an unconstitutional framework, and risks undercutting court cases across the country.

The *Brief* concludes that, in formulating their response to the exchange requirement, state officials should reject false offers of flexibility, recognize the weakness of federal threats, and responsibly refuse to implement Obama's law.

* Benjamin Domenech is a research fellow for The Heartland Institute and managing editor of *Health Care News*. A more complete bio appears on page 10.

Don't Rush to Develop Exchanges

President Obama's law mandated the creation of a statewide regulated insurance market, called an "exchange," in all 50 states. To comply, each state must submit its exchange for a federal audit and review by January 1, 2013.¹ The date is an intentionally political one: Each exchange must be approved by the Department of Health and Human Services, but only after the 2012 election, when Washington's position on health policy may have changed dramatically, and when the political fallout from a negative review of a state exchange would be very limited.

Any exchange created to pass muster with HHS Secretary Kathleen Sebelius and the current rules within Obama's law will be fundamentally flawed.

Some governors have pushed forward on developing these exchanges in advance of the 2013 deadline, despite the pending court cases and intervening election. Chief among these on the Republican side is Mississippi Gov. Haley Barbour,² whose current exchange proposal will mean 76 percent of

the people in his state will be eligible for health care subsidized by other taxpayers.

Although most Republican governors seem prepared to follow Barbour's lead, they would be wise to consider that any exchange created to pass muster with Health and Human Services Secretary Kathleen Sebelius and the current regime of rules within Obama's law will be fundamentally flawed.

Beyond the redistributionist subsidies, leveraged so effectively by Barbour, any exchange created under Obama's law will have to be designed to pass a series of tests that are fundamentally anti-market and anti-consumer, setting the stage for never-ending bureaucratic regulation. State policymakers are kidding themselves if they believe developing an exchange by the 2013 deadline will protect them from federal government interference.

Not Consumer-Friendly

An exchange created outside Obamacare's provisions could prove useful for some states, but this is not an option under the current law. While some organizations continue to push for the creation of exchanges, arguing that the potential exists for a more market-based option, the reality is that outcomes in Utah (the sole existing exchange other than Massachusetts' Commonwealth Connector) have thus far been less than stellar. Even granting that Utah's

¹ Title I, Subtitle D, Parts 2 and 3 of the Patient Protection and Affordable Care Act contain the timeline for exchanges.

² Benjamin Domenech, "Barbour Gets it Wrong on Obamacare Exchanges," *Washington Examiner*, February 21, 2011.
<http://washingtonexaminer.com/blogs/opinion-zone/2011/02/barbour-gets-it-wrong-obamacare-exchanges>

exchange was designed to be limited in scope, its poor performance shows that states may have to go through several iterations to structure an exchange that works for their citizens.

As John R. Graham of the Pacific Research Institute noted recently in a column in the *Richmond Times-Dispatch*:

Some claim that the Utah Health Exchange is a consumer-friendly model that can blunt the most harmful consequences of Obamacare. However, Utah's exchange has been a disappointment. Although 20 businesses enrolled on the first day of operations in August 2009, only 13 remained enrolled by the end of 2009. As a result, the exchange is being re-launched with new rules in 2011.

A "successful" exchange is very expensive to operate. Massachusetts' Commonwealth Connector spent more than \$26 million on vendors and contractors in 2009, and \$3.4 million on employee compensation. This is fully 3.5 percent of the money that businesses and enrollees paid into the exchange – on top of the bloated administrative costs that already burden our health insurance.

This cash flow explains why information technology vendors and consultants, health insurers who believe that they can dominate an exchange to the detriment of smaller competitors, and brokers who hope to get paid by government to serve as "navigators" in the exchanges, are investing heavily in lobbying states to establish exchanges.³

Graham also has argued⁴ that if the exchanges are created, it is likely a temporary approval from the Obama administration would be followed by mandates pushing aside any market-friendly reforms.

The reality is that control over the exchanges will reside in Washington, not in the states – forming "a federal exchange with a veneer of state flexibility."

And market-friendly reforms are not the only provisions likely to be swept aside: With the support of Gov. Bob McDonnell, Virginia recently joined several other states in passing a requirement banning the coverage of abortions by insurance plans operating within the exchange. Under Obama's law, however, such state laws are meaningless. HHS Secretary Sebelius, who controls the approval of state exchanges and directs the subsidies that flow through them, ultimately will decide whether Virginia's health plans may cover abortions.

³ John R. Graham, "Don't Start a State Health Exchange," *Richmond Times Dispatch*, February 13, 2011. <http://www2.timesdispatch.com/news/commentary/2011/feb/13/tdcomm01-dont-start-a-state-health-exchange-ar-837636/>

⁴ John R. Graham, "Health Exchanges a Bad Idea for Wisconsin," *JSONline*, January 20, 2011. <http://www.jsonline.com/news/opinion/114312939.html>

The administration's silence to date with respect to provisions like Virginia's should not be interpreted as acceptance. California Gov. Arnold Schwarzenegger signed in the fall of 2010 an exchange without pro-market provisions or anti-abortion requirements; HHS has not yet rendered a public opinion on whether its approach will pass muster. The administration has no incentive to approve state exchanges any time soon; it can simply wait until after the 2012 election to reveal its hand on state-developed exchanges.

High Administrative Costs to States

It is likely most estimates of state costs for running these exchanges are on the low side. As further study is given to Obamacare's system of subsidized care, a picture is emerging of an administrative nightmare that virtually ensures gaps in coverage for millions of Americans and additional costs for states.

Citizens will move back and forth between Medicaid and the state exchanges, increasing the administrative costs for states.

A study published in *Health Affairs* by two respected health policy experts – Harvard Professor Benjamin Sommers and George Washington University Professor Sara Rosenbaum – found Obama's system will force millions of adults and their families to move back and forth between Medicaid and

state exchanges over periods of just a few months.⁵

“The income-sensitive approach to subsidizing health insurance creates issues for people near the eligibility cutoff,” explained Sommers. “Because there's no minimum enrollment period, eligibility and subsidy levels will change as income rises and falls—disrupting both coverage and care while potentially increasing administrative costs.”⁶

Sommers and Rosenbaum estimate more than “35 percent of adults with family incomes below 200 percent of the federal poverty level will experience a change in eligibility within six months, and 50 percent will experience a change within one year.”⁷

Obama's plan expands subsidies to cover persons with incomes up to 400 percent of the federal poverty level (FPL), creating a nationalized subsidy regime under which, according to the

⁵ Benjamin Sommers and Sara Rosenbaum, “Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges,” *Health Affairs*, Vol. 30, No. 2 (February 2011), pp. 228-236. <http://content.healthaffairs.org/content/30/2/228.abstract>

⁶ Chris Fleming, “Frequent Churning Predicted Between Medicaid and Exchanges,” Health Affairs Blog, February 4, 2011. <http://healthaffairs.org/blog/2011/02/04/frequent-churning-predicted-between-medicaid-and-exchanges/>

⁷ Ibid.

nonpartisan Washington think tank e21, “a family of four earning just below \$88,000 [400 percent of FPL] will receive about \$5,000 in annual subsidies to purchase insurance in 2016. Once that threshold is crossed, the subsidy immediately drops to zero.”⁸

This handout-based approach makes pursuing a raise or finding a better job a very bad choice for low- and middle-income households. It gives families a powerful disincentive to pursue advancement and risk losing their subsidies. Any exchange created under Obamacare will be unable to avoid this subsidy problem.

False Offers of Flexibility

Mindful that some states are hesitant about setting up an exchange, Secretary Sebelius and other representatives of the administration in Washington are taking time to stress their willingness to be “flexible” in their regulations of the states. Yet as Twila Brase noted in a recent policy paper for the Citizen’s Council for Health Freedom, the reality is that control over the exchanges will reside in Washington, not in the states – forming “a federal exchange with a veneer of state flexibility”:

A small amendment to Obamacare proposed by Sens. Ron Wyden (D-OR) and Scott Brown (R-MA) is an example of false flexibility.

Proponents claim that if the State does not create their own exchange, the federal government will impose a federal exchange. However, the “state” exchange becomes a de facto federal exchange. It is the Administration’s preferred and expected exchange – the one they don’t have to set up, has to comply with Obamacare and its rules, and is established by its opponents.⁹

The administration’s approach to state innovation waivers allowed under the law provides insight into what this White House means by flexibility. In recent remarks to the nation’s governors, President Obama responded to calls for flexibility from the states by endorsing the concept behind a small amendment proposed by Sens. Ron Wyden (D-OR) and Scott Brown (R-MA). Wyden-Brown would tweak Obama’s law by moving up an existing waiver, with respect to the individual mandate to purchase insurance, from 2017 to 2014.

This is an example of false flexibility. Under current law, Secretary Sebelius is directed to grant

⁸ Obamacarewatch: Exchange & Premium Subsidies.
<http://www.obamacarewatch.org/primer/exchanges-and-premium-subsidies>

⁹ Twila Brase, “The Minnesota [Health Insurance] Exchange Act – HF 497: Why Minnesotans Should Say “NO,” Citizens’ Council for Health Freedom, n.d.
http://www.cchfreedom.org/pdf/MN_Exchange_Act-WhyMNsShouldSayNO.pdf

waivers for states only if their alternative plans, among other requirements, “will provide coverage that is at least as comprehensive as the coverage defined in section 1302 (B) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services.” They must “provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide.” And they must “provide coverage to at least a comparable number of its residents as the provisions of this title would provide.”

Even if Wyden-Brown makes waivers available to states in 2014 rather than 2017, the burdensome anti-market coverage requirements are still there (a state’s alternative plan must be as or more comprehensive); the coverage and cost-sharing provisions on out-of-pocket spending are still there (preventing high-deductible HSA-based plans); and most damning of all, a state must still demonstrate that “at least a comparable number” of state residents will be provided coverage under its alternative plan.

“Flexibility” under Wyden-Brown brings to mind Henry Ford’s comment, “Any customer can have a car painted any color he wants so long as it is black.”

Wyden’s staff acknowledged in a March 2010 interview I conducted that “at least a comparable number” means states must demonstrate any alternate plan they develop covers at least as many people as would be covered under a plan wherein people are required to purchase coverage under penalty of law.

Additional commentary¹⁰ from liberal columnists exposed the limits of the Wyden-Brown flexibility plan. Writing for Kaiser Health News, Jonathan Cohn noted, “[Senator] Hatch ... and other critics of Obama’s proposal have a point: It wouldn’t allow them to enact the sorts of health care reforms they would prefer.”¹¹ And writing at the *Washington Post*, Ezra Klein admits, “conservatives can’t do any better – at least not under these rules.”¹²

What this “flexibility” would mean is that states could get an exemption approved by the secretary of HHS only if they prove they can cover at least as many people without an individual mandate while meeting all the other burdensome Obamacare requirements for coverage, and even then the choice to approve the waiver request would be at the discretion of HHS Secretary

¹⁰ Ben Smith, “On Call, Officials Stress Public Options in Health Care Shifts,” Politico, February 28, 2011. http://www.politico.com/blogs/bensmith/0211/On_call_officials_stress_public_options_in_health_care_shift.html.

¹¹ Jonathan Cohn, “A Message To Health Law Critics: It’s Not About A Lack Of Flexibility,” Kaiser Health News, March 1, 2011. <http://www.kaiserhealthnews.org/Columns/2011/March/030211cohn.aspx>.

¹² Ezra Klein, “What Is the Health Care Reform that Republicans Actually Want” The Washington Post, March 2, 2011. http://voices.washingtonpost.com/ezra-klein/2011/03/what_is_the_health-care_reform.html.

Kathleen Sebelius. This situation brings to mind Henry Ford’s comment, “Any customer can have a car painted any color he wants so long as it is black.”

Vermont and other states are considering enacting single-payer plans,¹³ which would be allowed under the waiver process. There is a lesson here for policymakers: Despite the administration’s promises of flexibility, the ability of states to experiment with truly competitive and innovative alternative plans—to move away from single-payer health care and toward consumer-driven solutions—remains tightly restricted by the law. The administration is likely to take a similar approach to any promised flexibility toward the implementation of exchanges.

Few Consequences for Resistance

While some governors are proceeding with the creation of exchanges under Obama’s law, others – such as Louisiana Gov. Bobby Jindal and Florida Gov. Rick Scott – are defying the federally imposed regulation. It is no coincidence that Jindal and Scott are the two governors most experienced in health care policy – the former was a state secretary of health in Louisiana before he was 30, while the latter once headed one of the largest private health care providers in the world. They are joined by Georgia’s Nathan Deal, Texas’s Rick Perry, and New Mexico’s Susana Martinez (as of this writing) as governors who have announced their opposition or vetoed the exchange bills sent to their desks.

These governors recognize that the consequences for resisting the insurance exchange requirement are few, while the consequences for collaboration could be profoundly negative. Any exchange established under Obamacare is virtually guaranteed to become an anti-market force, designed to please the bureaucrats more than the people.

The consequences for resisting the insurance exchange requirement are few, while the consequences for collaboration could be profoundly negative.

As Louisiana Health and Hospitals Secretary Bruce Greenstein said when announcing the rejection of Washington’s taxpayer-funded grant for the purposes of exchange implementation, state officials there are not willing to take the blame for the inevitable future premium hikes under Obamacare: “Envision an exchange which, if we were to run it, has the governor’s name on the top of the letterhead”¹⁴ every time a premium increase is announced.

¹³ Michael F. Cannon, “Obama Offers States ‘Flexibility’ to Adopt Single-Payer instead of ObamaCare,” Cato @ Liberty, February 28, 2011. <http://www.cato-at-liberty.org/obama-offers-states-flexibility-to-adopt-single-payer-instead-of-obamacare/>.

¹⁴ Jan Moller, “Louisiana to opt out of health insurance exchanges in federal law,” Times-Picayune, March 23, 2011. http://www.nola.com/politics/index.ssf/2011/03/louisiana_to_opt_out_of_health.html

One of the strongest challenges to Obamacare advancing through the courts is that the individual mandate is unconstitutional.

In February and March 2011, I spoke with several state health officials, not one of whom expressed a belief their exchanges would be able to function in the absence of an individual mandate. One of the strongest challenges to Obamacare advancing through the courts is that the individual mandate is

unconstitutional. Establishing exchanges that depend on Obamacare's success in the courts hands an argument to those who support the law and plays into the hands of Secretary Sebelius. As Graham noted in the *Atlanta Journal Constitution*:

Appealing to conservative sentiments, lobbyists also warn that if states don't establish their own exchanges by January 2013, the federal government will do it for them. This is highly unlikely. U.S. Secretary of Health & Human Services Kathleen Sebelius already has missed many deadlines prescribed by the legislation.

The greater risk is that Georgia would establish an exchange that it believes blunts the worst effects of the federal takeover. Given the Affordable Care Act's unpopularity, Sebelius is likely to approve exchanges for the short term, making the act appear less harmful than it really is.¹⁵

As Michael Cannon wrote in his Kaiser Health News column:

Choosing the right course of action is simple for governors who believe ObamaCare is unconstitutional. Every governor takes an oath to support the U.S. Constitution. Implementing a law they believe to be unconstitutional would violate that oath. At a minimum, then, governors who believe ObamaCare is unconstitutional have a solemn obligation not to implement it.¹⁶

Fortunately for the states, the timeframe for implementation, designed for political purposes to allow Secretary Sebelius maximum latitude, is a double-edged sword. States can proceed slowly and cautiously, even to the point of entirely rejecting the federal exchange structure, confident that the intervening election will very likely be preceded by a Supreme Court decision in the spring of 2012. That decision is likely to have a profound effect on how the exchanges would function should the individual mandate be found unconstitutional and will almost certainly result in further reforms.

¹⁵ John R. Graham, "Pro & Con: Should States Block Formation of Health Insurance Exchanges?" February 28, 2011, *Atlanta Journal Constitution*, <http://www.ajc.com/opinion/pro-con-should-states-856517.html>.

¹⁶ Michael F. Cannon, "All Governors Should Just Say No to ObamaCare," Kaiser Health News, February 22, 2011. <http://www.kaiserhealthnews.org/columns/2011/february/022211cannon.aspx?referrer=search>.

Conclusion

For reasons of principle and practicality, state elected officials should take only the bare minimum of steps legally necessary to investigate an exchange under Obamacare. If they determine that political pressure requires them to proceed, they should work to ensure the inclusion of a sunset provision to eliminate the exchange if Obamacare is repealed.

President Obama got one thing right: Americans deserve a better health care system.

Ideally, state officials would choose not to implement an exchange at all. By enshrining taxpayer subsidies in law and empowering the White House to dictate their insurance markets, state policymakers will declare themselves collaborators in the establishment of what is likely to be deemed an unconstitutional health care regime.

If state policymakers wish to pursue a market-based exchange in the aftermath of a U.S. Supreme Court decision, that's another matter entirely. But such an exchange will be possible only outside the regulatory confines of Obamacare and its raft of taxpayer subsidies.

In declining to implement an exchange under Obamacare, state policy leaders should use this historic moment to make progress toward real and necessary reform. They should demand from Washington the reforms necessary to replace the president's one-size-fits-all, nationalized health care plan with one that empowers states and individuals to adapt, innovate, and succeed.

State policymakers also should use this opportunity to open a conversation with state residents about what kind of health care solution best fits their needs.¹⁷ State officials must decide what to do about health care should Obama's law be repealed in whole or in part and keep in mind the larger goal of improving the efficiency of the health care system. Rising Medicaid costs and other challenges currently facing states did not begin with Obama's law, and these problems will outlast any repeal or court decision rejecting Obamacare.

Rejecting Obama's law won't in itself solve the nation's health care problems. It is wise to resist fraudulent offers of flexibility and avoid creating entities that foster massive subsidies and heavier bureaucratic regulation of state insurance markets. But conversations about what comes next have to begin now.

President Obama got one thing right: Americans deserve a better health care system. By seizing this opportunity to present the case for real health policy reform, state officials can turn the shortcomings of Obamacare into lessons on why a consumer-focused, market-driven approach is the wisest course for the future of their state and their citizens.

¹⁷ See, for example, Joseph L. Bast, "Ten Principles of Health Care Policy," *Legislative Principles Series* No. 2, The Heartland Institute, 2007.

About the Author

Benjamin Domenech is a research fellow of The Heartland Institute and managing editor of *Health Care News*. Domenech joined The Heartland Institute in 2009 after several years working and writing on national health care and entitlement policy. He served as speechwriter to U.S. Health and Human Services Secretary Tommy Thompson, and then as chief speechwriter for U.S. Senator John Cornyn during the Medicare Part D debate on Capitol Hill.

In addition to his work with Heartland, Domenech is currently editor of *The City*, an academic journal of faith, politics, and culture, published by Houston Baptist University. He co-founded the popular conservative blog Redstate and worked as a book editor on multiple New York Times bestsellers. He regularly writes opinion columns for *The Washington Examiner* and RealClearWorld and is co-host of Coffee & Markets, an award-winning daily podcast.

Educated at the College of William & Mary and the University of Nebraska-Lincoln, in 2009 Domenech was chosen as a Journalism Fellow by the Peter Jennings Project for Journalists and the Constitution.

About The Heartland Institute

The Heartland Institute is a national nonprofit organization with offices in Chicago and Washington, DC. Founded in 1984, it began as a state-based free-market think tank but soon evolved into a regional and, since 1993, a national organization. It has policy advisors and supporters in all 50 states. Approximately 120 academics and professional economists participate in its peer review process, and more than 200 elected officials serve on its Legislative Forum. Heartland currently has a full-time staff of 35 and a 2011 budget of \$7 million.

Heartland contacts more elected officials, more often, than any other free-market think tank in the United States. According to a telephone survey of randomly selected state and local officials conducted in 2009, 85 percent of state legislators and 63 percent of local officials say they read and rely on Heartland publications. Heartland's full-time staff of government relations professionals interacts daily with hundreds of elected officials across the country, and its public relations and media specialists help shape public opinion by writing and placing dozens of letters to the editor and opinion editorials each week.

Some 120,000 of the nation's most influential people – including every state and national elected official – receive at least one Heartland publication every month. Heartland also operates PolicyBot, an online clearinghouse for the work of some 350 think tanks and advocacy groups.

For more information, visit our Web site at www.heartland.org, call 312/377-4000, or write to The Heartland Institute, 19 South LaSalle Street #903, Chicago, Illinois 60603.

© 2011 The Heartland Institute. This report does not necessarily reflect the opinions or views of the The Heartland Institute. Nothing in this report is intended to influence the passage of legislation. Additional copies are available for \$3.95 from The Heartland Institute, 19 South LaSalle Street #903, Chicago, IL 60603; phone 312/377-4000; fax 312/377-5000; email think@heartland.org; Web <http://www.heartland.org>.