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A State Lawmaker's Guide to Health Insurance Exchanges

Edmund F. Haislmaier

Abstract: *Health insurance exchanges are a good idea—if they are used to implement patient-centered and market-based health reforms that enhance choices and value for customers. The exchanges prescribed by Obamacare will have the opposite effect. Given the considerable uncertainty surrounding if, when, or how the exchange provisions of Obamacare will be implemented, governors and state policymakers opposed to the sweeping federal legislation have difficult decisions to make. While state lawmakers, like everyone else, would prefer to have more certainty, the reality is that they cannot expect it any time soon. They must focus on finding ways to better manage the new uncertainty that Obamacare has injected into the health care system. Pending further changes at the federal level, state lawmakers must determine the best approach in their respective states for advancing their own positive "counter reforms," and decide whether they will also try to block federal interference by creating a limited, "defensive" Obamacare exchange—and they must do so now. Heritage Foundation health policy expert Edmund F. Haislmaier provides a hands-on guide for state lawmakers.*

Governors and state legislators opposed to the misnamed Patient Protection and Affordable Care Act (PPACA) face a dilemma. Trying to shoehorn patient-centered, market-based reforms into the bureaucratic architecture of Obamacare's health insurance exchanges is not a viable strategy, neither practically nor politically. But refusing to create an Obamacare state exchange, while politically appealing, would leave state health insurance markets vulnerable to

Talking Points

- The best strategy for state lawmakers who oppose the Patient Protection and Affordable Care Act is to adopt their own reforms—separate from, and independent of, Obamacare's exchange design.
- State policymakers should augment their "counter reform" with defensive measures that minimize federal interference while the ultimate fate of Obamacare is debated in Congress and litigated in federal courts.
- A defined-contribution health-insurance market can create more consumer-oriented competition—attractive for state lawmakers concerned that Obamacare's new federal insurance regulations will result in insurer consolidation that further reduces choice and competition.
- Offering health benefits on a defined-contribution basis can give state and local governments better budget control, and give workers greater choice and portability of coverage.
- State lawmakers need to determine *now* the best approach for their own positive "counter reforms" while protecting their constituents from the adverse effects of this deeply flawed and misguided federal legislation.

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(202) 546-4400 • heritage.org

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even more federal interference and disruption over the next two years.

The best strategy for state lawmakers is to adopt their own reforms—separate from, and independent of, Obamacare's exchange design. State policymakers should then consider augmenting their "counter reform" initiatives with defensive measures designed to minimize federal interference, while the ultimate fate of Obamacare is debated in Congress and litigated in federal courts. Taking such an approach will give state lawmakers a strategy that has both offensive and defensive components.

Enacting their own reforms enables states to take the lead in advancing the kinds of patient-centered, pro-market reforms that should replace Obamacare; offers Americans concrete examples of a positive, alternative vision of real health reform; and reinforces congressional efforts to repeal this deeply flawed and misguided federal legislation.

Given the uncertain environment, state lawmakers need strategies that support the goal of repealing Obamacare at the federal level, and that also promote alternative reforms that will shield their states from the PPACA's destabilizing effects until repeal is achieved.

In particular, state initiatives that create a "defined-contribution" market for employer-sponsored health coverage and that streamline state health insurance regulations will promote increased choice, competition, and value—in stark contrast to Obamacare's design that further restricts choice and competition while increasing costs. Such moves will also restore state health insurance exchanges to their original purpose as non-regulatory, administrative mechanisms for implementing a competitive, patient-centered, market-based health system within the constraint of current federal tax law, which provides greater tax relief for employer-sponsored coverage than for individually purchased coverage. This is in stark contrast to Obamacare's perversion of exchanges into a bureaucratic tool for implementing sweeping new federal regulations.

At the same time, state lawmakers can also take a defensive approach to Obamacare's exchanges in their states so as to preserve state control and limit federal interference.

Understanding Obamacare's Exchange Provisions

The Patient Protection and Affordable Care Act provides for the establishment of health insurance exchanges in every state that conform to federal standards and requirements,[1] authorizes the Secretary of Health and Human Services (HHS) to provide grants to states to create exchanges,[2] and specifies that the Secretary is to establish and run exchanges in states that do not, or cannot, do so by January 1, 2014 (with the Secretary further required to make such determinations by January 1, 2013).[3]

The PPACA specifies two types of health insurance exchanges: the American Health Benefit (AHB) and the Small Business Health Options Program (SHOP). The legislation contains various requirements for the structure, functions, and operations of AHB exchanges, but provides no specifications for SHOP exchanges. Instead, the PPACA simply states that SHOP exchanges are "to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State."[4] Thus, the relevant "exchange" provisions are really only those that relate to the AHB exchanges.

Under Obamacare, the AHB exchanges are designed to implement the federal regulation and standardization of private health insurance, administer a new program of federal health care subsidies for tens of millions of Americans, and enroll millions of additional Americans in state Medicaid programs.

The problem is that state lawmakers have no certainty about when, how, or even whether the PPACA's exchange provisions will go into effect. The

1. PL 111-148 § 1321(c)(1).
2. PL 111-148 § 1311.
3. PL 111-148 § 1321(c)(1).
4. PL 111-148 § 1311(b)(1)(B).

Obama Administration faces significant technical challenges in merely implementing this complex legislation. At the same time, a majority of the public remains opposed to Obamacare, more than half the states are challenging its constitutionality in federal courts, and either the current Congress or the next one could repeal, alter, delay, or defund all or parts of it. Given this uncertain environment, state lawmakers need strategies that support the goal of repealing Obamacare at the federal level, and that also promote alternative reforms that will shield their states from the PPACA's destabilizing effects until repeal is eventually achieved.

Consumer-Centered Exchanges vs. Obamacare Exchanges

The first point to understand is that the entire design for health insurance exchanges in the PPACA is a perversion of the core concept of what is an otherwise sound approach to improving health insurance markets.

The true purpose of a state health insurance exchange is to act as a purely administrative mechanism for implementing a defined-contribution health insurance alternative for employer-sponsored coverage. Allowing employers to offer health benefits on a defined-contribution basis gives workers the ability to choose the coverage that best suits them and their families from a wide menu of options, creates new incentives for insurers and medical providers to compete for customers, and encourages greater diversity and experimentation in health plan design and benefits.

By enacting a defined-contribution health insurance option for employment-based coverage, states can create a more consumer-driven health care market while continuing to let workers benefit from the favorable federal tax treatment of employer-sponsored health benefits. Of course, such an approach would not be necessary if Congress were to enact health care tax reforms that provide the same tax treatment regardless of whether coverage is purchased directly or through an employer—reforms that have long been advocated by numerous health policy experts. Since Obamacare does not include tax reforms and it is uncertain if or when Congress might undertake them, state-level defined-contribution options for employer-sponsored coverage are still the most effective way to advance patient-centered, market-based health reform.

Within that construct, the function of a state health insurance exchange is simply to serve as a common mechanism for administering the transactions entailed in buyers and sellers offering and choosing coverage and paying and collecting premiums—much like a stock exchange provides a common administrative mechanism for transactions associated with buying and selling securities. Thus, an exchange gives employers, no matter how small, the opportunity to offer their workers health benefits in a market characterized by consumer choice from among numerous and varied plan options.

As with a stock exchange, a properly designed state health insurance exchange does not exercise regulatory powers. Rather, any regulatory functions remain the province of applicable government agencies—security regulators, in the case of stocks; insurance regulators, in the case of health insurance. Indeed, such an administrative—not regulatory—purpose is what the term "exchange" was originally intended to convey.

What Congress did in the PPACA, however, was to merely keep the word "exchange," while designating the purpose as something very different. Rather than serving as a mechanism for expanding health insurance choice, variety, and competition, and for spurring plans and providers to innovate and offer customers better value, Obamacare exchanges will impose new regulations, administer new subsidies, standardize coverage, and restrict consumer choice and insurer competition more than it is already. Thus, in the PPACA Congress has perverted the exchange concept into a bureaucratic tool for federal subsidization, standardization, and micromanagement of health insurance coverage by the Department of Health and Human Services.

It is important to recognize that it is Obamacare's perversion of exchanges, not the original concept itself, that is the problem. What matters is not the label on the box, but the contents. Consequently, the PPACA's misappropriation of the term "health insurance exchange" should not deter state lawmakers from pursuing their own defined-contribution, market-based reforms that employ state exchanges to perform purely administrative functions. If state

lawmakers want to further clarify this important distinction, they can use another term—such as "clearinghouse" or "administrator"—to distinguish their approach from the one in Obamacare.

Why States Should Enact their Own Health Insurance Reforms

State lawmakers should pursue reforms of the health insurance market *now*, independently of the PPACA, not only to increase access to coverage and provide incentives for better value in the near term, but also as a longer-term hedge against the uncertainties surrounding the timing of the eventual disposition of the federally mandated exchange provisions, related insurance market regulations, and the new federal subsidy program that the Obamacare exchanges are to administer.

In particular, states should create a defined-contribution option for their employer-sponsored health insurance market. Lawmakers should also review their state's existing benefit mandates and insurance rating rules to determine if those laws should be changed to make coverage more affordable. Beyond the near-term benefit of reducing premiums, such state reforms will also serve as a hedge against the uncertainty of the PPACA's effects while the fight over its repeal plays out in Congress and federal courts. Enacting their own "counter reforms" can better position states against the negative effects of Obamacare in several ways:

- **Expanding or Preserving Health Insurance Choice and Competition.** One advantage of a defined-contribution market for employer-sponsored coverage is that it offers insurers a more level competitive playing field. In a properly structured defined-contribution market all insurers—whether they are large or small, new entrants or longstanding players, selling new or traditional coverage designs—can offer their plans on the same terms on a single "menu" to a large number of potential customers. Thus, competition among plans and insurers is more appropriately focused on those aspects that matter most to individual consumers—plan design, value, and customer service.

  The ability of a defined-contribution market to create more level and consumer-oriented insurer competition is likely to be particularly attractive to states whose lawmakers are already concerned about inadequate choice and competition in their existing markets. It will also be attractive to state lawmakers justifiably concerned that the PPACA's new federal insurance regulations will result in insurer consolidation that further reduces choice and competition in their state. A number of those regulations have already taken effect, such as several new federal benefit mandates, new "minimum loss ratio" regulations (which specify how insurers are to spend premium dollars), and new federal premium rate reviews. These regulations will increase health insurance costs and lead some insurers to exit the market.

  In addition, states with smaller populations or a single dominant carrier can collaborate with one or more neighboring states to create a regional defined-contribution market to provide more choice and competition for their employers and residents. States can implement such an approach through "cross-licensing" or "reciprocity" agreements and shared administrative duties without federal approval for a formal "interstate compact," though such a compact might be an option.

States with smaller populations or a single dominant carrier can collaborate with neighboring states to create a regional defined-contribution market to provide more choice and competition for their employers and residents.

- **Putting Countervailing Pressure on Federal Officials.** Reducing state insurance benefit mandates or reforming rating rules not only makes coverage more affordable now, but will also make it politically more difficult for the federal government to later impose costly coverage requirements through the PPACA's "essential benefits" regulations and restrictive rating rules, which will sharply increase premiums for younger adults (both of which are also scheduled to take effect in 2014).[5]
- **Creating an Alternative Market.** Creating a defined-contribution market also provides states with the infrastructure for organizing and offering alternative, "non-qualified" coverage and

health care financing arrangements for individuals and employers who refuse to comply with the PPACA's mandates to buy coverage, should Congress fail to repeal those mandates before 2014, when they are scheduled to go into effect. Such alternative products would be subject to state regulation, but designed to be exempt from federal regulation.

Advantages of Defined Contributions

In a traditional "defined-benefit" program the payer (an employer or government) determines the form of coverage (such as a PPO, HMO, or high-deductible plan with an HSA), specifies the benefits offered, determines the share of premium that enrollees pay, and sets the schedule of patient co-payments. Thus, in a defined-benefit program it is the payer who makes the key decisions and it is the payer who bears most of the risk for the cost of those decisions.

By contrast, in a defined-contribution program, the payer offers the enrollee a contribution to help fund the cost of the insurance—pre-tax compensation to workers if the payer is an employer, or a subsidy if the payer is a government. Each enrollee then chooses the coverage he prefers from a menu of plans—with different plan designs, benefits, and cost-sharing—offered by competing insurers, and pays for the coverage with whatever mix of contributions he receives from employers and government (along with the enrollee's own funds, if the available contribution from the payer does not cover the full cost of an individual's chosen plan). A defined-contribution option for health benefits offers a number of advantages:

- Because it reduces the effort and risk to employers associated with offering health benefits, it creates a way for more firms, particularly smaller ones, to offer coverage.
- Because workers can choose coverage from a varied menu of plans, it increases the likelihood that more workers will be able to find a plan that they like and can afford.
- It provides a practical way for employers to offer part-time or seasonal workers prorated coverage contributions, with the reasonable expectation that those workers can obtain coverage by combining the employer's contribution with funds from other sources.
- It creates positive new incentives for health plan providers to collaborate with medical providers so that both get more business by offering consumers and patients better service at lower prices. When individuals and families choose their own coverage, they tend to prefer plans that offer better value—better care at lower prices—over plans that rely on crude cost-control strategies, such as limiting patient access to providers or simply paying doctors and hospitals less, regardless of performance.
- Over time, as more employers elect the defined-contribution option, portability of health benefits—with workers keeping their coverage when they change employers—becomes possible for more individuals and families.
- The same infrastructure can be used by states and local governments to provide health benefits to their own workers on a defined-contribution basis, and to "mainstream" recipients of public assistance by using Medicaid and Children's Health Insurance Program (CHIP) funding to provide them with better-quality private coverage.

Creating a Defined-Contribution Option

The principal goal of a defined-contribution option is to empower consumers to become the ultimate decision makers about their own health care. Following are key design issues that state lawmakers will need to consider:

5. For further discussion of the effects of the PPACA's rating rules, see Edmund F. Haislmaier, "Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets," Heritage Foundation *WebMemo* No. 3111, January 20, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Insurance-Rating-Rules-Increasing-Costs-and-Destabilizing-Markets*. For further discussion of the PPACA's benefit mandates, see Edmund F. Haislmaier, "Obamacare and Insurance Benefit Mandates: Raising Premiums and Reducing Patient Choice," Heritage Foundation *WebMemo* No. 3110, January 20, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Insurance-Benefit-Mandates-Raising-Premiums-and-Reducing-Patient-Choice*.

1. Insurance plan standards. State lawmakers will need to ensure that all plans offered through the defined-contribution option qualify as employer-sponsored coverage under both state and federal tax laws so that premiums can be paid on a pre-tax basis.

If a state intends to use its defined-contribution alternative to provide coverage for Medicaid and CHIP enrollees on a "premium support" basis—as it should—state lawmakers will also need to ensure that at least some of the plans offered meet the federal "benchmark equivalent" standards for those programs.

A state's defined-contribution option should also operate on an "any willing plan" basis—meaning that the state's insurance department is instructed to approve any plan that meets the state's standards for the defined-contribution market.

2. Rating rules. State lawmakers must ensure that the same rules for rating and pricing policies apply to the new defined-contribution coverage as well as the traditional defined-benefit employer group coverage. The specific rules themselves are less important than the fact that the *same* rules must apply to both subsets of the employer insurance market, to avert potentially destabilizing selection behaviors by carriers or customers. As long as the rules are applied uniformly, lawmakers can allow insurers to vary premiums on the basis of factors, such as age, geography, and family status.

While the specific provisions are not as important as ensuring uniformity, there are some additional, practical considerations that state lawmakers will want to keep in mind when setting or modifying rating rules, particularly with respect to varying premiums by age and geography.

With respect to age-rating of premiums, the natural age variation in medical costs is about five to one—meaning that among adults, the oldest (non-Medicare) group consumes about five times as much medical care as the youngest group. Incomes also generally increase with age. Thus, if the state allows insurers to adjust plan prices to reflect the age of the enrollee, premiums will be lower for younger adults—who on average are healthier but have lower incomes—and higher for older adults—who generally consume more medical care but tend to have higher incomes. Letting premiums vary by age will be particularly important if the state intends to subsidize coverage for low-income individuals, since it means that any subsidies can be better targeted to a relatively small number of older, low-income individuals, with less need to subsidize coverage for a large number of lower-income, younger—and healthier—individuals, since the latter group will be able to buy coverage at cheaper rates.

With respect to geographic variations in premiums, lawmakers will want to consider whether any proposed variation reflects underlying differences in salary scales for health care workers, or simply differences in provider practice patterns. Allowing premium variations that reflect differences in local economies, such as wage rates and living costs, is appropriate. But permitting variations in rates that are attributable primarily to differences in provider practice patterns will serve mainly to protect higher-cost, less-efficient providers. For guidance on the extent to which geographic variation in premiums is appropriate, lawmakers should look to their state's economic data on wage rates and living costs, not to data on provider charges or practice patterns.

3. Structure and operations. The states will need to create health insurance exchanges—or a similar "clearinghouse" mechanism—to handle the administrative tasks associated with offering the defined-contribution option. Utah has pioneered a quick and low-cost design that relies on contracting private-sector vendors to provide the necessary information technology and related infrastructure, funded by modest user fees paid by participants. States can adopt a variant of this approach, customized to fit their own particular needs and circumstances.[6]

4. State and local employee plans. The same advantages offered by defined-contribution options for private-sector firms and their employees can also be made available to state and local governments and their workers. As with private employers, offering health benefits on a defined-contribution basis can give state and local governments better budget

control over compensation costs, while at the same time giving their workers greater choice and portability of coverage.

Indeed, America's largest and longest-running defined-contribution health benefit program is the Federal Employee Health Benefits Program (FEHBP), operated by the U.S. government's Office of Personnel Management (OPM) for approximately 9 million federal workers, retirees, and their dependents.

Another major advantage of providing health benefits to state and municipal workers through the defined-contribution option, is that those public-sector plans will serve as "anchor" clients—that is, large, stable employers with a large, stable pool of covered individuals—and thus make participation in the defined-contribution option more attractive to both insurers and private-sector employers.

5. Role of risk adjustment. States will also need to establish a risk-adjustment mechanism that enables insurers to manage any selection effects that result from consumers having a wider choice of plans in the defined-contribution market. Rather than viewing selection effects as an undesirable outcome to be suppressed, lawmakers should see them as a potentially positive phenomenon to be managed.

For example, the existence of an adequate risk-adjustment mechanism makes it possible for insurers to offer plans that specialize in collaborating with providers to provide better care for individuals with specific medical conditions. Even though current federal law for employer-sponsored plans prevents carriers from varying premiums based on enrollee health status, insurers should be more willing to offer coverage designs that are likely to attract less healthy individuals if they know that the extra cost of those enrollees can be spread—through the risk adjuster—across all policyholders in the market.

Because health insurance risk adjustment is a highly technical issue best handled by actuaries, state lawmakers should not attempt to design a risk-adjustment mechanism themselves.[7] Rather, they should focus on authorizing the creation of a risk-adjustment mechanism for their employer market within the following parameters:

- The state requires, as a condition of selling coverage in the state, that all carriers issuing employer-sponsored plans—on either a defined-benefit or defined-contribution basis—participate in the risk adjuster.
- The enabling legislation should specify that the risk-adjustment system will be collectively designed and operated by the participating insurers—without outside interference—under the regulatory supervision of the state's insurance department.
- While the state may provide funding for the start-up or administrative costs of the risk adjuster, the state will not provide any funding to the risk adjuster for claims costs. The risk adjuster is to function as a "closed loop" within which participating insurers adjust among themselves for selection effects, not as a "backdoor" subsidy to carriers for higher cost enrollees.
- If the state intends to also offer health benefits to state and municipal employees on a defined-contribution basis—as it should—then its current state and municipal plans should also be participating "insurers" in the risk adjuster. That way, lawmakers can allow those existing plans to continue to offer their coverage to state and municipal workers as options on a greatly expanded menu of coverage choices, without the risk of those plans being destabilized by selection effects.

6. For a further discussion of Utah's defined-contribution health reforms, see Gregg Girvan, "Utah's Defined-Contribution Option: Patient-Centered Health Care," Heritage Foundation *Backgrounder* No. 2445, July 30, 2010, at *http://www.heritage.org/Research/Reports/2010/07/Utahs-Defined-Contribution-Option-Patient-Centered-Health-Care*, and Gregg Girvan, "Consumer Power: Five Lessons from Utah's Heath Care Reform," Heritage Foundation *Backgrounder* No. 2453, August 19, 2010, at *http://www.heritage.org/Research/Reports/2010/08/Consumer-Power-5-Lessons-from-Utah-s-Heath-Care-Reform*.
7. For a further discussion of risk adjustment, see Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Backgrounder* No. 2166, July 28, 2008, at *http://www.heritage.org/Research/Reports/2008/07/State-Health-Care-Reform-A-Brief-Guide-to-Risk-Adjustment-in-ConsumerDriven-Health-Insurance-Markets*.

While the main purpose of the risk adjuster will be to facilitate greater individual choice in the defined-contribution market segment, it should also apply to the traditional defined-benefit employer-group market segment as well, for two reasons. First, doing so will minimize the possibility of selection effects between the two market segments. Second, it will help stabilize premiums in the traditional group coverage market, so that employers who offer defined-benefit coverage no longer face "experience rating" premium spikes when one employee incurs a major illness.

6. Role of agents and brokers. For businesses that decide to offer health benefits on a defined-contribution basis, insurance agents could not only help the business make the necessary arrangements, but could also counsel individual employees on making coverage choices that best suit their particular needs and preferences, and "service" their policies—such as by helping them should they experience a problem or seek to appeal a claim or coverage decision by their insurer. The availability of such advice from a trained and knowledgeable professional benefits the employer as well as its workers, since business owners generally feel uncomfortable giving their employees personal advice and are naturally wary of any possible legal ramifications.

The key change for insurance brokers is that in a defined-contribution market, they will act as "buyer's agents," instead of their more traditional role of "seller's agents." This is similar to the business model shift that has occurred in recent years with many real estate agents. State lawmakers can facilitate such a shift by providing for a per-enrollee, fee-based compensation structure for agents in which the broker is paid the same amount regardless of which plan the worker (client) chooses.

While some brokers welcome such a change, seeing it as a way to expand their client base and establish relationships with new customers who might also be interested in other products the brokers offer—such as life, disability, or property insurance—others have so far been resistant.

However, another change resulting from the PPACA is likely to make more insurance agents consider shifting from representing carriers to representing buyers. Specifically, the PPACA's new "minimum loss ratio" regulations, which apply to all commercial major medical policies and took effect on January 1, 2011, will count commissions paid by carriers to agents against the share of the premium that insurers are allowed to retain to cover administrative costs and for profit. Thus, health insurers will have a strong, new incentive to reduce, or even eliminate, sales commissions to agents, since those payments will now directly reduce insurer profits.

In a defined-contribution market, agent compensation can take the form of a fee paid by the buyer, which is therefore separate from any minimum loss ratio calculation applied to insurer premium income.

In a defined-contribution market, however, agent compensation can take the form of a fee paid by the buyer, which is therefore separate from any minimum loss ratio calculation applied to insurer premium income. This also means that agents can offer their clients all the plan options available in the defined-contribution market, not just those from insurers with whom they currently have contracts. State insurance regulators can help facilitate this transition by providing licensed brokers with additional training, information, and comparison tools for the state's new defined-contribution market.

Preserving State Authority in the Face of Obamacare

Some state lawmakers may decide it is in the best interest of their state to simply refuse to implement an American Health Benefit exchange and instead focus solely on their own state-based reforms that counter Obamacare. That view is understandable, and consistent with the strong opposition to Obamacare among many of their constituents.

Others, however, may also want to shield their states from the legislation's harmful effects and minimize federal interference in addition to advancing their own counter reforms at the state level. Those state lawmakers can enact defensive measures that slow, block, or restrict federal implementation of Obamacare in their states—at least until such time as the legislation is either repealed by Congress or voided by the Supreme Court.

One such defensive component is for state lawmakers to protect the independence and integrity of their state insurance departments by refusing to accept (or returning, if already received) federal "premium review" grant funding. This funding was included in the PPACA in order to co-opt states into helping implement the legislation's new system of arbitrary and politically manipulated health-insurer rate regulation by HHS. State lawmakers need to reassure the citizens they represent that their state insurance departments will continue to apply appropriate financial requirements so that premiums are sufficient to cover claims costs, and will not acquiesce to the Administration's agenda of politicized rate regulation—which could threaten insurer solvency and potentially leave policyholders liable for unpaid claims.

Similarly, when it comes to the Obamacare AHB exchanges, state lawmakers should also consider taking a *defensive* strategy.

As noted, the PPACA effectively gives state governments a "right of first refusal" to design and operate AHB exchanges within federal guidelines. If a state does not exercise that right in a timely manner, the HHS Secretary is required to establish an exchange in that state. There are two important considerations that state lawmakers should take into account.

First, a state refusing to create an AHB exchange raises the prospect of HHS—or an organization picked by HHS—controlling access to the state's Medicaid program. That is because the legislation requires the AHB exchange to enroll any individuals it determines Medicaid-eligible in the state Medicaid program, instead of giving them the new federal coverage subsidies.[8] It also requires states to accept such individuals into their Medicaid programs without any further eligibility determination, leaving states unable to reject even erroneous eligibility determinations.[9] The combined result of those two provisions is effectively to transfer control over enrollment in state Medicaid programs to AHB exchanges beginning in 2014. From that point on, whoever controls the AHB exchange becomes the de facto gatekeeper for both the state's Medicaid program and the new federal subsidy system.

Second, depending on how it is implemented, an AHB exchange can also become a de facto health insurance regulator that is in competition, or conflict, with the state's insurance department. If a state creates the AHB exchange itself, state lawmakers can take steps to avoid or limit potentially duplicative or conflicting insurance market regulation. But if the state lets HHS create the AHB exchange, then, in order to meet the requirements of the PPACA with respect to participating insurance plans, the exchange will need to exercise the full range of insurance regulatory powers available to it under the legislation, since it will be unable to rely on the state's insurance department. Thus, a state that declines to set up an AHB exchange can expect the exchange established by HHS to act as a duplicative, and likely conflicting, insurance regulator, further disrupting the state's health insurance market.

Furthermore, the timing of this second risk is more immediate. While the Medicaid changes are not scheduled until 2014, a number of insurance regulations have already gone into effect. Thus, the sooner a state declares "non-compliance" with the PPACA, the sooner HHS will build an exchange in that state to act as a federal insurance regulator, and the sooner insurers will gravitate toward answering to HHS rather than to the state's insurance department.

The alternative to not creating an AHB exchange is for state lawmakers to establish a narrowly limited and closely controlled AHB exchange within the parameters of the federal legislation. Such a "defensive" approach lets state lawmakers who oppose Obamacare, or who are at least wary of its effects, avoid the risk of losing control over their Medicaid programs or insurance markets by letting HHS operate AHB exchanges in their states.

The strategy behind this approach is for state lawmakers to tailor the design of their state's AHB exchange to maximize state government control, restrict the potential for federal interference, minimize market disruptions, limit the associated

8. PL 111-148 § 1311(d)(4)(F).
9. New § 1943(b)(1)(B) of the Social Security Act, as added by PL 111-148 § 2201.

costs and risks to the state, and preserve the state's options for responding to potential future changes in federal law.

Structuring a "Defensive" AHB Exchange

For a state that elects to take a "defensive" approach, the best way to proceed is by disaggregating the functional components of the AHB exchange, determining the best solution for each function, and then networking the components into a whole, along the following lines:

1. Corporate form and governance. The state should set up a "shell" AHB exchange and "subcontract" its various functions to a combination of state agencies and private-sector vendors, based on relevant expertise. While the PPACA allows the exchange to be housed within a state government (either as a new agency or as a subset of an existing one), state lawmakers will likely prefer the alternative PPACA option of establishing their AHB exchange as a specially chartered, state-government-sponsored, independent entity—but without any regulatory powers.[10]

There are three reasons for doing so. First, regulatory powers are retained within the applicable agencies of state government—not delegated to a quasi-independent entity over which state lawmakers have limited control and which will be more inclined to take direction from federal officials. Second, the state government avoids directly managing or funding the exchange's purely administrative functions, with those tasks instead contracted to private-sector vendors and funded by user fees. Third, the state has more flexibility to set governance of the exchange by a board composed of whatever mix of public officials and stakeholder representatives it deems most appropriate.

2. Certification of insurers and health plans. Lawmakers should vest their state's insurance department with responsibility for determining which carriers and health plans "qualify" under state and federal law to be offered through the AHB exchange. They should then stipulate that the exchange is to accept, without modification, those determinations by the insurance department and fulfill its requirement under the PPACA to "certify" participating insurers and plans by simply forwarding the state insurance department's determinations to HHS.

Such an arrangement has several advantages. First, it preserves state authority and accountability with respect to insurance regulation. Second, it avoids the potential for duplication and confusion in market regulation. Third, it keeps insurance regulation in the hands of those with the most extensive technical expertise—existing state insurance regulators. Fourth, it enables the state to more effectively challenge or contest any HHS regulation or interpretation of the PPACA with which the state disagrees. Should such disputes arise, the state will be positioned to deploy in support of its case the data and technical expertise of its insurance department, augmented by the legal resources of the state's Attorney General, if necessary.

As a related measure, state insurance law should be amended to stipulate that the certification of carriers and plans to participate in the exchange is to be implemented by the state's insurance department on an "any willing plan" basis. Meaning, that any plan that meets the applicable federal and state standards in effect at that time—as determined by the state's insurance department—will be automatically certified as eligible to be offered in the exchange. Such a move ensures a level competitive playing field for insurers, avoids the problems that arise when governments try to pick winners and losers, and helps preserve maximum consumer choice in the market.

Lawmakers should also instruct their state insurance department to apply state insurance law until such time as federal law preempts state law, and not to make any preemptive regulatory changes to accommodate federal laws or regulations that have not yet taken effect. In addition to preserving state sovereignty, such an approach has the practical advantages of limiting confusion in the market and serving as a "hedge" against the possibility that one or more of Obamacare's new federal insurance requirements may be postponed, repealed, or significantly altered prior to their statutory effective dates.

3. Eligibility determination. State lawmakers

10. PL 111-148 § 1311(d)(1).

should require the exchange to subcontract eligibility determinations to the state's Medicaid program in order to maintain state control. This also gives state lawmakers an opportunity to review their current program eligibility determination process and make improvements. For example, states that currently allow local governments to make program eligibility determinations might want to use this opportunity to consolidate that function at the state level, so as to achieve more consistent and accurate decisions. Under Obamacare, it will be necessary to determine if individuals are eligible for Medicaid under either pre-PPACA rules or under the PPACA Medicaid expansion provisions—with different federal match rates for the two eligibility categories. Also, a much larger share of the state's population that does not qualify for Medicaid or CHIP will be eligible for the new federal subsidies through the exchange, so lawmakers will need to plan for increased funding and system upgrades as well.

4. Certification of agents and "navigators." As with certification of insurers and health plans, state lawmakers should require the exchange to simply accept the determinations of the state's existing professional licensure system when it comes to certifying agents or organizations as "navigators" who assist individuals with enrolling in the exchange and choosing a health plan. State lawmakers will at some point need to amend the applicable state licensure statute and compensation regulations as necessary to conform them to whatever standards HHS eventually issues to implement these provisions of the PPACA.

States will still be able to specify different licensure standards for agents selling health coverage outside of the exchange—if they so choose—though this would be a good opportunity for lawmakers to review those existing statutes and regulations to determine if other changes should be made to them as well.

5. Administrative functions. When it comes to the various administrative functions that Obamacare requires the exchange to perform—such as providing a Web site for enrollment, plan comparison and plan selection, toll-free telephone assistance, an online calculator for determining plan costs to enrollees, information transmission to the U.S. Treasury to calculate and pay enrollee subsidies—the best course of action is for the exchange to simply hire private-sector vendors to provide the necessary software and operational support.

If, at some point, either Congress rescinds funding or the Supreme Court voids Obamacare, then the vendors will stop their work. In the event that Obamacare is still in place when the exchanges are scheduled to begin operation, a state's enabling legislation should require the exchange to fund its subsequent ongoing operations with user fees. Because of the PPACA's minimum loss ratio regulations, the enabling legislation should further specify that the exchange is to charge such user fees to enrollees, not to participating insurers.

In contracting for these administrative and technical services, state lawmakers can either require the exchange to follow existing state government contracting procedures, or permit the exchange's governing board to adopt alternative procedures.

6. State legislature oversight. A state that takes this approach should also establish special oversight committees of its legislature to supervise the AHB exchange and the interactions between the exchange and relevant state government agencies and departments. The oversight committees should pay particularly close attention to the state's insurance department, its Medicaid and CHIP programs, and its tax and revenue department (which may be affected by the need to verify income in connection with eligibility determinations for Medicaid and the new federal subsidies).

States will want to vest this oversight responsibility with new special committees—one for each legislative chamber, or, a single bicameral special committee—because implementation will involve several executive branch agencies and the jurisdictions of more than one standing committee. State legislatures typically have standing insurance committees to handle insurance matters, as well as standing health committees with jurisdiction over the state's Medicaid and CHIP programs. Thus, the state's legislative leadership will want to ensure that a special exchange oversight committee includes both members with experience and expertise in insurance law and members with experience and expertise in Medicaid and CHIP. Leadership may

also want to ensure that members with experience and expertise in other areas, such as tax or appropriations, serve on the special oversight committee.

Furthermore, states whose legislatures meet in time-limited sessions will want to authorize any oversight committee as an "interim" committee so that it continues to function between the regular sessions of the legislature. Should an interim oversight committee identify issues that need immediate legislative attention, those states can use their established procedures for calling the full legislature back for a "special" session to consider any relevant legislation.

7. Sunset provision. The state's enabling legislation should also include a sunset provision that automatically terminates the state's AHB exchange should a Supreme Court ruling void the legislation or should subsequent federal legislation be enacted that repeals the authority granted to the Secretary of Health and Human Services to establish AHB exchanges in states that do not establish such exchanges on their own. Specifically, the sunset provision should be triggered by any future federal repeal or nullification of Section 1321(c) of Public Law 111-148.

Conclusion

State lawmakers now face important decisions about whether they will pursue their own health insurance market reforms—separate and different from Obamacare—and whether they will create defensive AHB exchanges to shield their states and minimize federal interference while they await the ultimate disposition of Obamacare by Congress or the Supreme Court. State lawmakers should understand that these decisions, while related, are in fact severable. They can opt to pursue their own reforms, create a defensive AHB exchange, do both, or do neither.

State lawmakers should pursue health insurance market reforms of their own design *now*, independent of the PPACA, not only to increase access to coverage and provide incentives for better value in the near term, but also as a longer-term hedge against the uncertainties surrounding the timing of the eventual disposition of Obamacare's exchange provisions, related insurance market regulations, and the new federal subsidy program that the exchanges are intended to administer.

While there are good reasons why some states may decide not to establish AHB exchanges, it is important that state lawmakers inclined toward that option carefully consider its implications for their state's Medicaid program and insurance market. State lawmakers who feel more comfortable with a strategy that protects their state as much as possible until Obamacare's fate is decided by Congress or the Supreme Court can instead pursue the alternative approach of adopting a limited, defensive AHB exchange design.

Given the considerable uncertainty surrounding if, when, or how the exchange provisions of the PPACA will be implemented, the wisest course for state lawmakers is to adopt responses that position their states for a range of possible outcomes. While state lawmakers, like everyone else, would obviously prefer to have more certainty regarding Obamacare, the reality is that they cannot expect to obtain such certainty any time soon. Consequently, they will instead need to focus in the near term on finding ways to better manage the new uncertainty that Obamacare has injected into the health care system. Pending further changes at the federal level, state lawmakers need to determine *now* the best approach in each of their respective states for advancing their own positive "counter reforms" while also protecting their constituents from the disruption and adverse effects of this deeply flawed and misguided federal legislation.

—Edmund F. Haislmaier is Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation.