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Obamacare and Federal Health Exchanges: Undermining State Flexibility

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With enactment of the Patient Protection and Affordable Care Act (PPACA),[1] states "shall" establish a health insurance exchange in accordance with federal rules and guidelines. If a state chooses not to establish an exchange, the federal government will step in and set up such an exchange for that state.[2]

Summary. Under Section 1311, the Secretary of Health and Human Services (HHS) is to make grants to state officials so that they can establish an American Health Benefit Exchange in each state. The Secretary is authorized to determine the grant amount and to renew it for a state that is "making progress" in implementing the federal insurance rules and meeting "other such benchmarks as the Secretary may establish." States are to establish a Small Business Health Options Program for employees of small businesses but may use a single exchange for both populations. With the Secretary's approval, states may also establish multi-state exchanges. Under Section 1321(c)(1), the Secretary is required to establish and run an exchange in states that do not (or cannot) do so by January 1, 2014.[3]

The exchanges are to facilitate the purchase of a "qualified" health plan. Under Section 1311(d)(4), the states are to set up the exchanges to meet the minimum functions defined in law, subject to the Secretary's regulation. This includes:

- Certification of health plans as "qualified plans" to be offered in the exchange;
- Marketing rules for health plans;
- A requirement that a plan has a sufficient number of providers in addition to a network of "essential community providers" to serve low-income persons;
- A requirement that a health plan meet federally approved quality standards;
- Implementation of a health plan "quality improvement" strategy as defined by federal officials;
- Use of a "uniform enrollment form" for qualified individuals and employers;
- Use of a standard format for the presentation of health benefit and plan options;
- Provision of appropriate information to enrollees or prospective enrollees in the exchange;
- Development of a rating system for health plans on the basis of quality and price;
- Development of a consumer satisfaction survey to determine the "level of patient satisfaction" with health plans offered through the exchange;
- Preparation of a template for Internet use for plan comparisons and federal subsidies for coverage; and
- Provision of "open enrollment procedures" in accordance with the Secretary's determinations.

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State officials must establish the exchange in their state as either a government agency or a "nonprofit" entity, and they may not allow any health plan to compete within the exchange that is not a "qualified" health plan as defined by federal law and regulation. While the Secretary will define the level of the benefits that must be included in a "qualified" health plan, state officials may add (but not subtract) health benefits. State officials are also authorized to exclude a health plan if they determine that its premiums are too high.

Under Section 1321, the Secretary is given broad authority to issue rules and set standards governing the creation and operation of the exchanges. States creating such an exchange are to implement these federal rules and standards and may not make rules that conflict with those rules and standards. Under Section 1332, states can apply to the Secretary for a waiver to pursue insurance market innovations.

Impact. These exchanges bear little relation to the market-based mechanisms promoted by conservative analysts and state officials to facilitate a defined contribution for health care financing, individual purchase among a wide variety of private health plans, and personal ownership and portability of private health coverage.[4] In sharp contrast, for the President and Congress, an exchange is a mechanism to expand enrollment in public programs—like Medicaid and the Children's Health Insurance Program (CHIP)—to administer the costly new taxpayer subsidy program and to standardize and regulate consumer choice of private health insurance.[5] The law has serious consequences.

It Directly Assaults the States' Traditional Authority to Regulate Health Insurance. The nature and scope of these statutory provisions invite close constitutional scrutiny precisely because they apparently commandeer state officials as agents of federal health policy and regulation. Under the Constitution, as the U.S. Supreme Court has strongly affirmed, Congress can exercise no such authority over state officials.[6]

It Imposes Unknown Insurance Costs on Consumers and Administrative Costs on States. It is impossible to forecast the premium increases that will ensue from federal benefit-setting for the "qualified" health plans that alone are to be permitted to compete in the exchanges. It is also difficult to determine the new administrative and transactional costs imposed on state taxpayers for compliance with a large number of new federal rules and mandates.

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
3. The Secretary is authorized to make a determination on or before January 1, 2013, that the state is not going to have an exchange in operation by January 1, 2014, or has not taken the necessary actions to comply with federal standards for the operation of the exchange or the required insurance market reforms.
4. "Health insurance can best serve you and your family if it is always there, regardless of your employer or employment status. This can be attained by creating a health insurance 'exchange' for individuals and businesses to buy and sell the right insurance for them. This exchange would increase the odds of you getting your preferred plan and reduce administrative overhead that adds unnecessary cost." Newt Gingrich, "Jindal's Health Care Plan a National Model," *Ouachita Citizen*, October 18, 2007, at *http://www.ouachitacitizen.com/news.php?id=1415* (January 12, 2011).
5. In his original presentation, President Barack Obama described the exchange as a "watchdog" agency that would enforce federal insurance rules and new regulations governing the delivery of health care. Remarkably, the President on March 30, 2010, claimed—incorrectly—on *ABC News* that the idea of the health exchange in the legislation originated at The Heritage Foundation. On this controversy, see Robert E. Moffit, "This Isn't Our Law," *The Washington Post*, April 19, 2010, p. A15.
6. See, for example, *Jay Printz v. United States*, 521 U.S. 898 (1997).

In its initial analysis of the new law, the Congressional Budget Office confirmed that PPACA's unfunded mandates on the states would exceed the annual thresholds established by the Unfunded Mandates Reform Act of 1995.[7] As Urban Institute analyst Stan Dorn remarks, "States will need to structure an ongoing source of administrative funding that is stable and sufficient."[8]

It Imposes a "One-Size-Fits All" Approach That Ignores State Differences. Before enactment of PPACA, only two states had enacted health insurance exchanges: Massachusetts and Utah.[9] In their design and function and how they have been implemented, each is very different and serves very different policy objectives. They are also different from the exchanges required under PPACA. The federal law imposes a national uniformity on very different state health insurance markets. As health policy specialists Frank Micciche and Cindy Gillespie observe, "There is *no existing model* in the United States for a full scale PPACA exchange."[10]

Furthermore, leaving aside the federal requirement, insurance market reform should not be confined simply to creating a statewide health insurance exchange. States have very different demographic, regulatory, and budgetary challenges, and each state should be able to develop solutions that meet its specific needs.

It Undermines Choice and Competition and Guarantees Further Consolidation of the Health Insurance Markets. In a real health insurance market, there would be a wide variety of different plans, combinations, new products, and delivery programs where insurers and providers, directly accountable to consumers, respond rapidly within the context of a free market. PPACA creates a very different environment: "choice without complexity."

The exchange standardizes plans and benefits and will serve as a convenient platform for Office of Personnel Management–sponsored national health plans as well as new congressionally authorized (but nonprofit) "co-op" health plans to compete directly against private health plans. The law restricts personal "choice" and channels consumer demand to a limited set of strictly standardized and federally approved health insurance options. States can limit but not expand consumer options.

A New Direction. The top-down federal approach to health care reform assaults the traditional state role in insurance regulation, squashes innovation, and undermines real choice and competition. PPACA is thus a bad deal for states, reducing them to mere agents of federal health and insurance policy. They could not make full use of their comparative advantages in coping with very different insurance markets, mending the safety net care for the poorest and most vulnerable of their citizens with new policies, or undertaking imaginative reforms without getting a permission slip from Washington.

In continuing the national health care debate, Congress should rediscover the value of federalism.[11] Congress should enact an alternative that would provide states with new flexibility and authority to establish state-based health insurance market reforms designed by state officials that would reduce the number of the uninsured, improve the accessibility and affordability of health

7. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, p. 15.
8. Stan Dorn, "State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals," *Academy Health*, August 5, 2010, p. 23.
9. On the Massachusetts "connector," see Joshua Archambault, "Massachusetts Health Care Reform Has Left Small Business Behind: A Warning to the States," Heritage Foundation *Backgrounder* No. 2462, September 16, 2010, at *http://www.heritage.org/research/reports/2010/09/massachusetts-health-care-reform-has-left-small-business-behind-a-warning-to-the-states*; on the Utah exchange, 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*.
10. Frank Micciche and Cindy Gillespie, "Health Insurance Exchange Functions Under PPACA," Bureau of National Affairs, July 14, 2010, at *http://www.mckennalong.com/media/site_files/1288_Health%20Insurance%20Exchanges%20Functions%20Under%20PPACA_BNA.pdf* (January 12, 2011). Emphasis added.

insurance, and establish portability in coverage. The federal government could provide access to funding grants and technical assistance to help states meet measurable goals in reducing uninsured and non-emergency visits to hospital emergency departments while increasing transparency in the cost and quality of care delivery.[12] And states, instead of being passive recipients of Washington's regulatory edicts, could become genuine laboratories for innovative health insurance market reforms.

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11. On the urgency of this approach, see Robert E. Moffit, "Revitalizing Federalism: The High Road Back to Health Care Independence," Heritage Foundation *Backgrounder* No. 2432, June 30, 2010, at *http://www.heritage.org/Research/Reports/2010/06/Revitalizing-Federalism-The-High-Road-Back-to-Health-Care-Independence*; see also Thomas C. Feeney, "Preserving Freedom and Federalism: What's at Stake for Americans in the Health Care Debate," Heritage Foundation *Backgrounder* No. 2327, October 13, 2009, at *http://www.heritage.org/Research/Reports/2009/10/Preserving-Freedom-and-Federalism-Whats-at-Stake-for-Americans-in-the-Health-Care-Debate*.
12. For a discussion of this approach, see Stuart M. Butler and Nina Owcharenko, "The Baldwin–Price Health Bill: Bipartisan Encouragement for State Action on the Uninsured," Heritage Foundation *WebMemo* No. 1190, August 7, 2006, at *http://www.heritage.org/Research/Reports/2006/08/The-Baldwin-Price-Health-Bill-Bipartisan-Encouragement-for-State-Action-on-the-Uninsured.*