The Heritage Foundation
LEADERSHIP FOR AMERICA

# BACKGROUNDER

No. 2846 | SEPTEMBER 26, 2013

## Obamacare's Insurance Exchanges: "Private Coverage" in Name Only

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**Abstract**
*Obamacare's national system of health insurance exchanges is set to open for enrollment on October 1, 2013. A health insurance exchange is essentially a mechanism that enables people to choose among different health insurance options. Yet, the declared purposes—and resulting effects—of the Obamacare exchanges are very different from those of consumer-oriented approaches. Consumer-choice health insurance exchanges facilitate defined-contribution financing of health insurance. They increase not only the number, but also the variety, of health plan choices. The objective is not merely to increase supplier competition, but also to make suppliers more responsive to the preferences of individual consumers. A different type of exchange operates on a government "procurement model." A good example is a state that contracts with selected managed care plans to insure Medicaid enrollees. In those cases, while a private insurer may provide the coverage, the covered individuals have little or no say in the decision. The Obamacare health insurance exchange system, though often sold as a mechanism to provide consumer choice and competition, is, in fact, a vehicle for the detailed federal regulation of insurance. Americans can expect less choice and less competition. Given the extreme degree of that regulation, private health plans will soon become "private" in name only.*

### Key Points

- Enrollment in Obamacare's national system of health insurance exchanges is scheduled to open on October 1, 2013. While the exchanges are presented as a variant of the consumer-choice model, the resemblance is largely superficial.
- The primary goal of the Obamacare exchanges is to establish federal control over state health insurance markets by enforcing new federal insurance rules and requiring federal standardization of health benefits.
- Federal control is reinforced through coercion—the imposition of individual and employer mandates, with tax penalties, to buy federally standardized health plans.
- In a normal market, the dynamics of consumer choice and competition are virtually impossible for any central power to monitor, let alone control; there is no system of central government planning like that embodied in Obamacare.
- Under Obamacare, Americans will have less choice and less competition. Given the level of federal regulation, private health plans will soon be "private" in name only.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2846**
Produced by the Center for Health Policy Studies

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Let's be clear about the fact that nobody has proposed anything close to a government takeover of health care.

*—President Barack Obama, August 20, 2009*

Millions of Americans are expected to enroll in Obamacare's national system of health insurance exchanges.[1] And, for those seeking—or forced—to buy health insurance through these exchanges, the coverage will be "private" in name only.

Broadly defined, a health insurance exchange is a mechanism that enables people to choose among different health insurance options. Yet, the declared purposes—and resulting effects—of the Obamacare health insurance exchanges are very different from those of consumer-oriented approaches.[2]

Consumer-choice health insurance exchanges facilitate defined-contribution financing of employer-sponsored health insurance. They increase not only the number, but also the variety of health plan choices available to workers. The objective is not merely to increase supplier competition, but also to make suppliers more responsive to the preferences of individual consumers. Another, closely related, objective is to encourage supplier innovation in developing and offering new product designs that respond directly to many, varied, and changing consumer preferences.[3]

A different type of exchange operates on a government "procurement model." A good example is a state that contracts with selected managed care plans to insure Medicaid enrollees. In those cases, while a private insurer may provide the coverage, the covered individuals often have little or no say in the decision. They are in a position similar to that of soldiers who are issued standard uniforms that the military purchased in bulk from a vendor, or the standardized apartments that low-income people live in when they reside in government housing projects.

**Obama's Procurement Model.** While the Obamacare exchanges are often presented to the public as a variant of the consumer-choice model, their design differs to such a degree that the resemblance is largely superficial. More important, the Obamacare exchanges are intended to be the administrative mechanism for achieving a very different objective: The primary end of the exchanges is to implement new federal insurance market rules that standardize private insurance plans. The primary means to achieve this end is coercion: individual and employer mandates.

In a real market, suppliers of goods and services can freely enter and exit; their market share is exclusively, or almost exclusively, determined by real consumer choices. The new health law, as enforced by federal regulators, will instead determine which health plans are or are not permissible; which factors insurance companies must take into account in setting premiums; which health insurance benefits, services, and medical procedures must be covered; which levels of cost sharing and deductibles are permissible; which medical-loss ratios (what can and cannot be spent on administration and marketing) are required; and which levels of insurance coverage are acceptable. Premium levels reflect not just the crippled interaction of politically constrained supply and circumscribed demand, but also the fallible political judgments of public officials. The law thus controls what consumers can buy and what suppliers of insurance can sell.

While the massive statute specifies many of these conditions, constraints, and standards imposed on the market, an even greater number are developed administratively and enforced through regulations, which, of course, are subject to change. In administering this massive system, the Secretary of the Department of Health and Human Services (HHS) exercises sweeping regulatory power. Indeed, Obamacare makes the HHS Secretary one of the

1. For 2014 coverage in the exchanges, enrollment begins on October 1, 2013, and ends on March 31, 2014.
2. As Tom Miller, Senior Fellow at the American Enterprise Institute, says: "The ACA version of health benefits exchanges is a classic example of a limited, but potentially good, idea mutating into a politically driven gateway to over-regulation, income redistribution and greater control by the federal government over health care decisions." See Tom Miller, "Making Effective Connections: With or Without Health Benefit Exchanges," in Tom Miller, ed., *When Obamacare Fails: The Playbook for Market-Based Reform* (Washington, DC: American Enterprise Institute, 2013), p. 1.
3. In the private sector, there are already about 100 private health insurance exchanges. Under these emerging arrangements, employers would be able to give employees financial assistance in the form of a "defined contribution" with which they can purchase the coverage of their choice from among differing plans offered by competing insurers.

most powerful officials in the nation, with authority to decide what Americans will and will not have in their health insurance coverage.

The effect will be *less* competition and *less* product variation relative to the current conditions in the states' already flawed health insurance markets. Indeed, to the extent that the Obamacare design produces more individual choice, it will be as an unintended side effect of employers dropping group coverage. In order to minimize the cost of the new federal subsidies for Obamacare exchange coverage, the law penalizes employers with 50 or more workers who do not provide group coverage. Thus, Obamacare's authors seem to believe that employer shift from defined-benefit to defined-contribution health coverage is a "bug," not a feature, of their intricate statutory design. Regardless of their intentions, the law is completely contrary to a true consumer-choice approach.

The fundamental difference in these two applications of the health insurance exchange concept will become increasingly apparent to Americans over the next several years thanks to one of Obamacare's important—though unintended and unanticipated—side effects. While Obamacare is using government-run exchanges to standardize coverage and reduce choice and competition in the individual and small group health insurance markets, large employers are reacting by instead turning to *private* health insurance exchanges to offer their employees *more* choice, variety, and competition in health insurance benefits. Indeed, the new private exchanges are designed to implement the original objective of the exchange concept—creating a defined-contribution structure for employer-sponsored health benefits—and closely adhere to the original consumer-choice design for exchanges.

## The Design

Under Obamacare, centrally supervised health insurance exchanges are the platform for offering federally compliant health plans and new federal subsidies.[4] The national system of exchanges is also the main mechanism for implementing tight federal regulation of commercial health insurance in all 50 states.

Americans enrolled in the exchanges will be on the receiving end of decisions by employers and government officials over which they will have little or no control. Any individual who is a U.S. citizen or lawful resident and who does not otherwise qualify for health insurance coverage under a government program or employer-sponsored plan may enroll in coverage sold through the exchanges. Those whose household incomes are between 100 percent and 400 percent of the federal poverty level (single individuals with incomes between $11,490 and $45,960; families with incomes between $23,550 and $94,200) will also qualify for new federal subsidies toward the cost of insurance purchased through the exchanges. Because businesses with 49 or fewer workers are exempt from the health law's requirement that employers provide coverage, most individuals who work for small businesses, along with their dependents, will likely be forced to go into the exchanges for their coverage. Employees of large businesses may eventually end up in the exchanges as well, depending on whether state officials, under the terms and conditions of Obamacare, decide to include them in 2017.

**The State Role.** According to Obamacare, by January 1, 2014, state officials "shall" have established such an exchange in their state.[5] If a state cannot or will not comply with this requirement, the Secretary of HHS is legally required to intervene and set up a federal exchange for that state, thus establishing direct supervision of insurance markets within the state's borders.[6]

Clearly, the law's sponsors optimistically envisioned that state officials would do the heavy lifting and set up the statutorily required exchanges. HHS gave states a deadline of December 14, 2012, to declare their intentions. Only 17 states and the District of Columbia have declared their intentions to operate their own exchanges. A total of 26 states cannot or will not set up an Obamacare-compliant state-based exchange, leaving that responsibility

4. For more on the exchanges and their impact, see Robert E. Moffit, "Obamacare and Federal Health Exchanges: Undermining State Flexibility," Heritage Foundation *WebMemo* No. 3104, January 18, 2011, http://www.heritage.org/research/reports/2011/01/obamacare-and-federal-health-exchanges-undermining-state-flexibility.
5. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1311.
6. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1321 (c)(1).

entirely to the federal government. Thus, HHS will be responsible for performing all or most (through "partnership" agreements) of the exchange functions in 34 of the 50 states next year.

**Public Utilities.** Next year, Americans must enroll in a health plan offering "minimum essential coverage" or incur tax penalties.[7] The law defines minimum essential coverage to include public programs (such as Medicare and Medicaid), employer-sponsored plans that meet the tests of "minimum value" and "affordability," and federally "qualified" individual and group health insurance policies that meet new benefit standards and regulations. The latter are the only health insurance plans that will "qualify" for participation in the exchanges.

All individual and small group health insurance policies sold inside or outside the exchanges, as noted, must abide by new federal standards that include insurance rating and enrollment rules (guaranteed issue and community rating) and rules governing mandatory benefits, permissible cost sharing, and coverage levels. Those plans are also subject to federal rules governing medical loss ratios, annual dollar caps, and premium rate reviews.

Compliant health plans sold through the exchanges will be the only ones that qualify for federal taxpayer subsidies to offset enrollees' premium costs. These plans are the end products of bureaucratic fiat, not consumer demand. Sara Rosenbaum, a professor of law at George Washington University and a champion of the law, says that because of the health law and its attendant regulations, Americans' insurance will undergo a profound transformation. It will, she says, take on "certain characteristics of a public utility."[8] In other words: *Americans will have private coverage in name only.*

Beyond HHS regulatory standards, exchange officials are to monitor and restrict plans' premium increases. Officials will also have the power to decide whether a health plan's participation is "in the interests" of the "qualified" individuals and employers in the state.[9] The wants and needs of individuals and employers are beside the point. By law and regulation, then, government officials can mandate *fewer* health plan choices for Americans, but not *more*.

In sum, the exchange system will be the vehicle for federal regulation and control of health insurance in every state in the union. The exchange system will be the engine for expansion of Medicaid and the channel for new taxpayer premium subsidies for "qualified" insurance that meets federal approval. It will also serve as the platform for the federal government to sponsor at least two national health plans (administered by the U.S. Office of Personnel Management) to compete against all other "qualified" plans in the country. It will be the central mechanism for control over the financing and delivery of most Americans' health care. Furthermore, the law's new taxes on insurance premiums, drugs, and medical devices will ensure that Americans, regardless of their state of residence, will pay even higher health premiums and heavier taxes.

## State-Based Vehicles for Federal Regulation

As of January 1, 2014, each state exchange will facilitate the purchase of a "qualified" health plan for individuals and small businesses.[10] If states cannot or will not set up these exchanges, as noted, HHS will step in, create, and run an exchange within the states' borders.[11]

The law further provides that states can set up more than one exchange, and can enter into an agreement with other states to set up an interstate or multistate exchange. States are also required to set up a "small business health options program" (SHOP) to facilitate the purchase of "qualified" coverage for small businesses and their workers and the workers' families. At the time of enactment, supporters argued that the whole point of the SHOP exchange

7. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1501.
8. Sara Rosenbaum, "A 'Broader Regulatory Scheme'—The Constitutionality of Health Reform," *The New England Journal of Medicine*, Vol. 363, No. 20 (November 2010), pp. 1881–1883, http://healthpolicyandreform.nejm.org?p=12896&query=TOC (accessed September 12, 2013).
9. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1311(e)(1)(B).
10. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1311.
11. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1321 (c)(1). The Secretary is authorized to determine whether a state can meet the deadline, meeting all applicable federal rules and regulations, by January 1, 2013.

is to give these people a range of health plan choices.[12] Yet, the Obama Administration decided that it was administratively impossible to set up the federal SHOP exchanges in time to allow small business employees to purchase more than one plan, and delayed the program's implementation for one year.[13]

**Fake Flexibility.** Legally, states can only pursue a different course of insurance market reform if they secure a waiver from HHS.[14] But they cannot obtain such HHS waivers until 2017, three years *after* the statutory requirement to establish a state-based health insurance exchange is in force.[15] Even if states secure such a waiver, their market reforms must still meet the new federal insurance standards and the same levels of insurance coverage that would have been achieved had the states established HHS-approved exchanges. State capacities for showcasing new, imaginative, or innovative insurance market designs will be crippled.

Federal officials, and their academic allies, claim that the law allows states a wide degree of flexibility. In reality, the Obama Administration's idea of flexibility means that state officials will have limited leeway in how they are to comply with Washington's policy objectives.[16] Furthermore, the so-called flexibility is in only *one* direction. States have the flexibility to be *more* restrictive, but not *less* restrictive. As Henry Aaron and Kevin Lucia observe in *The New England Journal of Medicine*, "Exchanges can set additional standards for the quality of care paid for by plans, bar plans that do not meet quality or price standards, and selectively contract with those that do. In addition, to strengthen the position of exchanges within the health insurance markets, states may bar the sale of insurance to individuals and small businesses outside of the exchanges or require that the same plans be sold inside and outside them."[17]

The law also allows exchange officials to restrict plan choices even more, by making their exchange an "active purchaser" of coverage, under which the state establishes a bidding process for insurers to compete for the right to offer coverage through the exchange. In administering the federal exchanges, HHS officials have also taken on the role of an "active purchaser" of health insurance. In the states with "federally facilitated" exchanges, HHS will control the "markets" and bar participation by health plans with rates that federal officials decide are not competitive.[18] In other words, HHS officials will be negotiating rates in at least 26 very different health insurance markets in which they have little or no experience. The "active purchaser" option is simply a variant of the old-fashioned "procurement model," and is thus completely contrary to the consumer-choice model.

12. "The promise of affordable health insurance for small businesses was portrayed as a major advantage of the new health care law, mentioned often by White House officials and Democratic leaders in Congress as they fought opponents of the legislation." Robert Pear, "Small Firms' Offer of Plan Choices Under Health Law Delayed," *The New York Times*, April 1, 2013, http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html (accessed September 12, 2013).
13. Joe Klein, "Obamacare Incompetence," *Time*, April 2, 2013, http://swampland.time.com/2013/04/02/obamacare-incompetence/print/ (accessed September 12, 2013).
14. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1332 (2010). A waiver can extend for five years, but a state can reapply to the HHS Secretary for an extension.
15. Jennifer Staman, "Legal Analysis of Section 1311(e)(1)(B) of the Patient Protection and Affordable Care Act and State Sponsored Public Health Plans," memorandum to Senator John Cornyn (R–TX), Congressional Research Service, September 24, 2010, p. 6.
16. "The new statute envisions and permits varied approaches to applying federal rules and regulations. We expect federalism-related tensions over reform to center around the ways in which the administration interprets and implements the law; the ways in which interpretations are received and applied by states, plans, providers, purchasers, and patients; the extent of state variation in the law's application and enforcement that the federal government sanctions; and the way in which the federal government uses its backup authority when states fail to meet basic standards." Christopher C. Jennings and Katherine J. Hayes, "Health Insurance Reform and the Tensions of Federalism," *The New England Journal of Medicine*, Vol. 362 (May 2010), pp. 2244–2246, http://healthcarereform.nejm.org/?p=3436&query=TOC (accessed September 12, 2013).
17. Henry J. Aaron and Kevin W. Lucia, "Only the Beginning—What's Next at the Health Insurance Exchanges?" *The New England Journal of Medicine*, September 4, 2013.
18. This is a noteworthy reversal of HHS's original position, which was to allow "open markets." Phil Galewitz, "Sebelius: Administration Is Negotiating Rates in Federal Exchanges," *Kaiser Health News*, June 24, 2013, http://capsules.kaiserhealthnews.org/index.php/2013/06/sebeliius-administration-is-negotiating-rates-in-federal-exchanges (accessed September 12, 2013).

States are also allowed to impose rating rules on plans that are even more restrictive than the federal standards. However, states cannot permit new and different health insurance coverage options in the exchange that differ from the federal standards for "qualified plans," though the establishment of a government monopoly *is* an option. Vermont, for example, is establishing a single-payer system: "Although the development of a state exchange is a massive task, Vermont administrators believe that their exchange will serve as a foundation for a streamlined system for single payer reform."[19] Yet under Obamacare, it would be impossible for a conservative state to pursue a *less* regulatory market-based reform agenda.

**Verboten Variances.** The Patient Protection and Affordable Care Act also specifies what state officials cannot do. Under the law, states can only establish the exchange as a government agency or a "nonprofit" entity. While the HHS Secretary can define the benefits and even the benefit levels that Americans must have in a "qualified" health plan in a state's health insurance exchange, state officials' power over benefits is also circumscribed. State officials must also enforce federal rules on the categorical number or level of benefits in those health plans offered in the exchange. They can add state benefit mandates for plans in the exchanges, at additional cost to state taxpayers, but they cannot subtract federal benefit mandates. If state citizens want to purchase leaner coverage or enroll in a different or less expensive plan, their personal wishes are as irrelevant as such plans are illegal.

State officials cannot legally allow a health plan or option, no matter how innovative, to be offered in the health insurance exchange if it fails to meet any HHS insurance rules, regardless of whether a state resident would like to purchase such a plan, or a state legislature would like to make such a plan available to its citizens. Under the Affordable Care Act, state officials cannot substitute state rules for federal rules in the state exchanges. In other words, *the state exchanges are state exchanges in name only.*

**Central Control.** In establishing and supervising the exchanges, Washington is assuming mind-numbing administrative responsibilities. Again, as Henry Aaron, a senior fellow at the Brookings Institution and a champion of the new law, says, "Nothing approaching the complexity of this 'roll out' has ever taken place in U.S. peace time history."[20]

The HHS Secretary, as noted, has extraordinary authority to supervise the establishment of state exchanges and maintain control over their operations. In doling out federal funds to create the exchanges, the Secretary can determine how much money to give a state, and can renew that grant if, in her judgment, the state is "making progress" in carrying out HHS rules for health insurance plans and exchange operations. The Secretary can also renew the grant if the state is meeting, according to the law, "other such benchmarks as the Secretary may establish."[21] Under this broad grant of administrative powers, the HHS Secretary has thus far made grants totaling more than $3.2 billion.[22]

The law outlines a hefty list of "minimum" functions that state officials must carry out if they are to comply with Washington's version of an exchange. (See text box.) But state officials can only do that in accordance with the HHS Secretary's regulatory authority.

**Fat Rulebook.** On March 23 and 27, 2012, HHS issued its first set of health insurance exchange regulations.[23] These rules cover how the exchanges will be governed and how they will operate. They prescribe how exchanges will make insurance-subsidy and Medicaid-eligibility determinations; how the "navigator" programs (consumer advocacy and enrollment entities) in the states will be implemented; which factors for premium variation in the exchanges will be permissible; and how the exchanges determine whether individuals will receive taxpayer subsidies for insurance plans in the exchange.

HHS has also issued rules governing the establishment and operation of the Consumer Operated and Oriented Plans (CO-OP). These member-run,

19. Laura K. Grubb, "Lessons from Vermont's Health Care Reform," *The New England Journal of Medicine*, Vol. 368 (April 2013), pp. 1276–1277, http://www.nejm.org/doi/full/10.1056/NEJMp1212974?af=currentIssue (accessed September 12, 2013).
20. Henry J. Aaron, "Health Reform: The Political Storms Are Far from Over," The Brookings Institution, December 27, 2012, http://www.brookings.edu/blogs/up-front/posts/2012/12/27-health-reform-aaron (accessed September 12, 2013).
21. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1311.
22. Center on Budget and Policy Priorities, "Status of State Health Insurance Exchange Implementation," March 29, 2013, p. 5.
23. As of June 2013, HHS had issued 778 pages of regulations and 234 pages of guidance concerning the exchanges.

## Exchange Functions

Exchange officials must:

- Certify health plans as "qualified plans" to be offered in the exchange.
- Establish marketing rules for health plans.
- Enforce the federal requirement that a plan has a sufficient number of providers.
- Enforce the federal requirement that each health plan contracts with designated "essential community providers" to serve low-income persons.
- Enforce the federal requirement that each health plan meet federally approved quality standards.
- Implement a health plan "quality improvement" strategy.
- Implement and fund a "navigator" program to facilitate enrollment in the exchanges.
- Implement a "uniform enrollment form" for qualified individuals and employers.
- Implement a "standard format" for the presentation of health benefit and plan options.
- Provide "appropriate information" to enrollees or prospective enrollees in the exchange.
- Develop and apply a health plan rating system that encompasses health care quality and price.
- Develop and use a consumer satisfaction survey to determine the "level of patient satisfaction" with health plans offered through the exchange.
- Create a template for plan comparisons on the Internet.
- Identify and enroll eligible persons in Medicaid.
- Administer federal taxpayer subsidies for coverage.
- Establish "open enrollment" procedures for health plans.

nonprofit insurance cooperatives were created by the Affordable Care Act as an alternative to private insurance and cannot legally be run by private insurers.[24]

On November 20, 2012, HHS issued rules on the "essential health benefits" that must be offered by qualified plans in the exchanges, specifying that each state is to identify, from a selected list of options, a "benchmark" plan that includes the 10 statutory categories of health benefits.[25] The federal benefit requirements, combined with federal insurance rules, will ensure higher premiums. It will affect the citizens of different states in different ways.

Other rules govern the health insurance risk-adjustment and reinsurance programs to stabilize health insurance within the states. Under federal rules, if the states cannot create an acceptable risk-adjustment mechanism or establish an acceptable reinsurance program, HHS will step in and do it for them.

**Higher Premiums.** President Obama has repeatedly promised Americans lower insurance premiums, but the law's new benefit mandates and insurance rules make insurance more expensive. A kitchen-table issue for most Americans will thus be the impact of the national health law on their premium costs for health insurance. Because Americans will generally be required to purchase more expensive coverage, their insurance premium costs in 2014 will be higher than premium costs in 2013.[26]

While hard data will soon take the guesswork out of next year's premium cost increases, employers and employees in heavily regulated states already realize that the law will cause health insurance costs to jump. In Massachusetts, premiums will increase for roughly 54 percent of individuals and employees of small businesses in the state,[27] prompting Bay State legislators to seek a waiver from the Administration. In New York, the Freelancers Union, which provides health insurance to uninsured sole proprietors, says that the law will undercut its innovative plan design and

24. Congress and the Obama Administration agreed to cut $1.9 billion from the funding of loans for these plans to offset the cost of the Medicare physician payment "fix."

25. Edmund F. Haislmaier and Alyene Senger, "Obamacare's Essential Benefits Regulation Creates Disparities Among States," Heritage Foundation *Issue Brief* No. 3907, April 10, 2013, http://thf_media.s3.amazonaws.com/2013/pdf/ib3907.pdf.

26. For an excellent discussion of this issue, see Chris Jacobs, "Interpreting Obamacare's Premium Estimates for 2014," Heritage Foundation *Issue Brief* No. 4046, September 13, 2013, http://report.heritage.org/ib4046.

27. Joshua Archambault, "ACA Premium Roller Coaster for Small Business Coming to Massachusetts," Pioneer Institute, June 17, 2013, p. 2.

increase its members' per person cost by an estimated $178 per month.[28] In Oregon, the estimated average monthly premium of $244 in the individual market in 2013 is expected to jump to $405 in 2014.[29]

California, which adopted an "active purchaser" model for its exchange, will also experience significant increases in health insurance premiums. For example, in 2014, 25-year-old Californians will be able to secure a special, low-cost "catastrophic" plan (an option exclusively available to people under the age of 30) estimated at $184 per month; but in 2013, the cheapest California health plan available to them costs $92 per month.[30]

Connecticut also provides an interesting example. Officials recognize that their "benchmark plan"—outlining the "essential benefits" that must be included in all other health plans in the state—is neither "competitive" nor "affordable" for tens of thousands of Connecticut residents expected to get their coverage in the Connecticut exchange.[31] Kevin Galvin, chair of the Small Business for Healthy Connecticut, says: "The Connecticut state insurance exchange and, to some extent, the federal government, we feel, have not done a good job keeping people informed as to what is coming. We feel there is a huge knowledge gap, and we feel there is going to be considerable rate-shock."[32] An Urban Institute study notes that there are also federal–state communications problems in other states.[33]

## Branch Offices for HHS Micromanagement

The language of the Affordable Care Act is maddeningly curious: It is simultaneously very broad and yet highly prescriptive. Regardless of whether the exchange is established by the state or federal government, the law specifies that the officials managing the exchange *must* do a lot of things. For example, exchange officials must determine whether an individual is a U.S. citizen and resident of the state to be eligible for enrollment in the exchange. If they find out that a person is eligible for Medicaid or the Children's Health Plan, rather than exchange coverage, they must notify the state Medicaid officials to ensure that person's enrollment in those government programs. The state, in turn, is required to enroll such individuals in its Medicaid program "without any further determination by the State" of their eligibility.[34] If an individual does not qualify for a public program but instead qualifies for exchange coverage, exchange officials must next determine whether or not that individual is eligible for a taxpayer subsidy to offset the premium costs of the "qualified" health plans offered in the exchange and calculate the amount of the income-related subsidy for that person.

**Adjusting Taxpayer Subsidies.** Taxpayer subsidies for insurance are transmitted directly to the "qualified" health plans, and are designed to limit the enrollee's premium payments (for the reference plan) to a share of the individual's income, ranging from 2 percent to 9.5 percent of income for persons

28. The union is seeking a state-designed exemption from the national law. Paul Howard and E. J. McMahon, "Escaping ObamaCare," *The New York Post*, June 12, 2013, http://nypost.com/2013/06/12/escaping-obamacare/ (accessed September 12, 2013).

29. David Hogberg, "Oregon's Coming Health Insurance Death Spiral," National Center for Public Policy Research *National Policy Analysis* No. 650, June 2013, http://www.nationalcenter.org/NPA650.html (accessed September 12, 2013).

30. Avik Roy, "Rate Shock: In California, Obamacare to Increase Individual Health Insurance Premiums by 64–146%," *Forbes*, May 30, 2013, http://www.forbes.com/sites/theapothecary/2013/05/30/rate-shock-in-california-obamacare-to-increase-individual-insurance-premiums-by-64-146/ (accessed September 12, 2013). The state program Covered California features a calculator on its website to predict 2014 individual premiums. Covered California, "Calculating Potential Insurance Costs in 2014," http://www.coveredca.com/calculating_the_cost.html (accessed September 12, 2013).

31. Josh Archambault, "Blue State ACA Blues: Connecticut's 'Benchmark Plan' Already Unaffordable," *Forbes*, March 26, 2013, http://www.forbes.com/sites/aroy/2013/03/26/blue-state-aca-blues-connecticuts-benchmark-plan-already-unaffordable/ (accessed September 13, 2013).

32. Caroline May, "Confused About Obamacare? There's Now an App for That," *The Daily Caller*, April 2, 2013, http://dailycaller.com/2013/04/02.condused-about-obamacare-theres-now-an-app-for-that/ (accessed September 13, 2013).

33. In two of three states, Urban Institute researchers found that state officials were reporting that they were not "receiving all of the information that they need in a sufficiently timely manner in order to prepare most effectively for reform." Linda J. Blumberg and Shanna Rifkin, "State Level Progress in Implementation of Federally-Facilitated Exchanges: Findings in Three Case Study States," The Urban Institute, June 2013, p. 2.

34. Title XIX of the Social Security Act Section 1943, as added by Public Law 111–148, Section 2201.

between 100 percent and 400 percent of the federal poverty level (FPL). This means that exchange officials must verify each enrollee's household income each year and adjust the subsidy amount to reflect any changes in income from year to year. If, in any given year, a person's income increases, thus rendering the taxpayer subsidy excessive, that individual will have to pay back the excess amount when filing a tax return the following year.[35]

Mistakes in this process could be the occasion of some unpleasant family tax increases. While the insurance subsidies are income based, as noted, so are the caps on annual repayment of excess subsidies back to the IRS. For those who might find their income increased just above 400 percent of the federal poverty level (FPL), the repayments could be significant. Writing in *Health Affairs*, researchers noted that "if a family of four with two working spouses over age fifty-five received a year-end bonus that put the family income just over 400 percent of poverty, the spouses could be required to repay as much as $11,200 or 12 percent of the family's annual income."[36]

Once exchange officials determine that a person is eligible for a taxpayer subsidy, they must notify that person's employer and check whether that employer is providing "minimum essential coverage." There is another complication, however, concerning the relationship of employers and their employees to coverage in the exchange: Under the law, employers with 50 or more full-time employees that do not offer a health insurance plan incur a $2,000 tax penalty for every uncovered employee. And, employers who offer coverage also face a tax penalty of $3,000 for every full-time worker who gets a taxpayer subsidy in the exchange *if* the employer-sponsored coverage either does not meet the requirements for being considered "minimum essential coverage" or is deemed to be "unaffordable" for the employee.[37]

Because the employer-coverage requirement applies only to *full-time* employees, employers can reduce their exposure to mandate penalties by relying on more part-time workers. In fall 2012, the Internal Revenue Service (IRS) issued an 18-page guidance to help employers (and exchange officials) distinguish part-time from full-time employees.[38] Tracking the flows of information—relating to employment, income, and subsidy eligibility and exemptions from the individual mandate—will prove to be a daunting process. As health care economist Robert Graboyes observes, "Coordinating all these flows may constitute the single largest information technology project in computer history."[39]

In July, the Obama Administration announced a delay of the employer mandate's reporting and penalty assessment until 2015. This delay, in spite of the plain language of the statute, adds to the complexity of the law's implementation.[40] Employer reporting of the coverage status of employees was a factor in verifying coverage eligibility for the exchanges, as well as income eligibility for subsidies. It remains to be seen how this delay will affect enrollment in the exchanges, the provision of employment-based health insurance, or the troubling trend toward the growth of part-time, as opposed to full-time, employment.

Exchange officials must perform all of these tasks in obedience to rules and guidelines promulgated by the Secretary of HHS. Under the law, exchange officials must also set up procedures for the certification or decertification of health plans offered in the exchange, but only in accordance with HHS guidelines. Exchange officials must also set up and maintain toll-free telephone lines to assist citizens and maintain a website for consumer information—and that website must be in a format approved by federal officials. Meanwhile, HHS has created its own central website as well as a 24-hour-a-day call

35. Associated Press, "Millions Could Get Surprise Tax Bills Under Obamacare if They Don't Accurately Project Their Income," April 2, 2013.
36. Ken Jacobs, Dave Graham-Squire, Elise Gould, and Dylan Roby, "Large Repayments of Premium Subsidies May Be Owed to the IRS if Family Income Changes Are Not Promptly Reported," *Health Affairs*, Vol. 32, No. 9 (September 2013), p. 1539.
37. Employers who do not offer coverage are penalized $2,000 for every employee not covered by a "qualified" health plan.
38. Robert J. Samuelson, "Obamacare's Rhetoric vs. Its Reality," *The Washington Post*, October 21, 2012, http://articles.washingtonpost.com/2012-10-21/opinions/35500098_1_seasonal-workers-health-insurance-insurance-for-part-time-employees (accessed September 13, 2013).
39. Robert Graboyes, "SHOP Chopped: Opt Dropped," *NFIB Health Care Bulletin*, April 23, 2013.
40. The Patient Protection and Affordable Care Act, Public Law 111–148, Section 1514(d) requires employers to comply with the requirements of the mandate "beginning after December 31, 2013."

center that will be manned by 9,000 customer service representatives.[41]

Exchange officials must also assign ratings to health plans to measure how well plans perform; but, again, the ratings are to be based on criteria established by the Secretary of HHS. When exchange officials create a format for the presentation of health plan information for individuals or families or businesses, they can only do so in a fashion approved by federal officials. Uncertainty is inherent in this process, as federal rules and guidelines can and do frequently change.

Trying to meet statutory deadlines for issuing and overseeing this vast administrative enterprise has proved stressful even for the well-experienced micro-managerial class at HHS. As Henry Chao, Deputy Chief Information Officer at the Centers for Medicare and Medicaid Services (CMS), remarked, "The time for debating about the size of the text on the screen, or the color, or is it a world class user experience, that's what we used to talk about two years ago. Let's just make sure it's not a third world experience."[42]

**Collecting Personal Information.** In order to secure the different flows of information in and through the exchanges, HHS is also creating a "Federal Data Services Hub." The "Hub" will be the central mechanism for a vast information-sharing program.[43] It will connect HHS to the IRS, the Department of Homeland Security, the Department of Defense, the Social Security Administration, the Office of Personnel Management, and the state Medicaid programs.[44]

In its February 6, 2013, notice in the *Federal Register*, HHS detailed the information to include—"but may not be limited to"—a person's full name and address, the permanent residential address if different from the mailing address, the date of birth, Social Security number, taxpayer status, gender, ethnicity, residency, e-mail address, telephone number, citizenship or immigration status, status of enrollment in government health programs, incarceration status, Indian status, and enrollment in employer-sponsored coverage. The Hub will also include information on requests for exemptions from the individual mandate to purchase insurance (including membership in "a religious sect or health sharing ministry"), employer information, veterans status, "limited" health status information, household income, IRS tax return information, "financial information from other third party sources," and, of course, information on a person's enrollment in the exchange, their premium payments, and their payment history. For employers, the information to be collected and stored will include the name and address of the employer, the number of employees in the firm, the employers' identification number, and the list of "qualified" employees and their tax ID numbers.[45] Professor Steven Parente, a health economist at the University of Minnesota, says, "The Federal government is planning to quietly enact what could be the largest consolidation of personal data in the history of the republic."[46]

Michael Astrue, former General Counsel of HHS, claims that the Obama Administration's data security is inadequate, and warns that the program is vulnerable to serious violations of the Privacy Act.[47] Taxpayers can now add new privacy concerns, including identity theft, to their growing list of worries over Washington's most ambitious concentration of power.

**Patrolling Providers.** The exchanges will not only be the vehicles for federal regulation of health

41. The phone number is 800-318-2596. See Robert Pear, "U.S. Unveils Health Care Web Site and Call Center," *The New York Times*, June 24, 2013, http://www.nytimes.com/2013/06/25/health/us-unveils-health-care-web-site-and-call-center.html?_r=0 (accessed September 13, 2013).
42. Avik Roy, "CMS on Obamacare's Health Insurance Exchanges: 'Let's Just Make Sure It's Not a Third-World Experience,' *Forbes*, March 22, 2013, http://www.forbes.com/sites/theapothecary/2013/03/22/cms-on-obamacares-health-insurance-exchanges-lets-just-make-sure-its-not-a-third-world-experience/ (accessed September 13, 2013).
43. The program is authorized by the Patient Protection and Affordable Care Act, Public Law 111–148, Section 1414.
44. John Merline, "Think NSA Spying is Bad? Here Comes Obamacare Hub," *Investor's Business Daily*, June 25, 2013, http://news.investors.com/062513-661264-obamacare-database-hub-creates-privacy-nightmare.htm (accessed September 13, 2013).
45. Privacy Act of 1974, *Federal Register*, Volume 78, No. 25 (February 6, 2013), http://www.gpo.gov/fdsys/pkg/FR-2013-02-06/html/2013-02666.htm (accessed September 13, 2013).
46. Cited in Merline, "Think NSA Spying is Bad?"
47. For a brief discussion of this problem, see Chris Jacobs, "How Obamacare Threatens Privacy in America," Heritage Foundation *Issue Brief* No. 4032, September 3, 2013, http://report.heritage.org/ib4032.

insurance, they will also enforce federal standards governing delivery of care. Through federally qualified health insurance, medical practice standards will apply to such items as quality reporting, effective case management, care coordination, and chronic disease management, as well as medication and care compliance. Exchanges will also enforce measures to "improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine and health information technology under the plan or coverage."

Exchanges will also enforce the requirement that "qualified" health plans have a "sufficient number of providers" as well as contracts with all "essential community providers." In turgid prose, HHS outlines the expected level of plan participation among "essential community providers" and the population to be served (where 30 percent of the population in the designated service area falls below 200 percent of the FPL, which is $22,980). Low-income and medically underserved individuals, including HIV and AIDs patients, and members of Indian tribes, are the focus, as well as those needing "women's health and reproductive health services." To assist in implementing this particular requirement, the CMS has even compiled a publicly accessible "Non-Exhaustive List of Essential Community Providers" with information on 17,367 such "essential community providers" throughout the country—567 of which are Planned Parenthood facilities.[48]

## The Next Taxpayer Money Pit

State exchanges are to administer federal taxpayer subsidies; that is clear from the plain language of the law. But Obama Administration officials insist that the "federal facilitated" exchanges run by HHS can also administer taxpayer subsidies. Yet, because the language of the statute does not explicitly authorize the payment of subsidies through federally administered exchanges, this issue, like others in Obamacare, is now being litigated in the federal courts.[49]

Regardless of how the lawsuit is decided, the Obamacare exchanges will become the latest vehicle for a huge increase in federal entitlement spending. The law offers new insurance subsidies to anyone who does not otherwise have coverage under an employer plan or a government program, and has a household income between 100 percent and 400 percent of the FPL. In 2013, that translates into annual incomes of between $11,490 and $45,960 for a single individual and between $23,550 and $94,200 for a family of four.

The health law could also become another source of health-related fraud: The Obama Administration has recently admitted that, absent the employer-reporting requirements, it is not prepared to verify eligibility of persons who allegedly qualify for insurance subsidies in the exchanges. Instead, the Administration will rely on persons to attest that they are eligible for these subsidies—an "honor system" for accessing public funds. While the House of Representatives has recently enacted a measure that would require verification before the distribution of insurance subsidies, health policy analysts favorable to the health care law think that worries about fraud are overblown.[50]

A big question is the size of exchange enrollment. The Congressional Budget Office (CBO) projects that the total number of persons enrolled in the exchanges in 2014 will be 7 million, and that 6 million of them will receive federal subsidies.[51] The CBO projects that by 2023 25 million people will be enrolled in the exchanges and that 21 million of them will receive federal subsidies. The CBO also estimates

48. CMS, "Non-Exhaustive List of Essential Community Providers (ECPs), https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq (accessed September 19, 2013).

49. On May 2, 2013, the case of *Halbig et al. v. Sebelius* was filed with the U.S. District Court for the District of Columbia. The plaintiffs charge that Congress specifically authorized the provision of subsidies for residents of the states that agreed to operate the exchanges. Congress provided no such subsidies for states that did not establish an exchange in accordance with the law. Therefore, the IRS administrative ruling exceeds the statutory authority. The Obama Administration officials view the suit as a "last ditch" effort to derail the law.

50. See, for example, Stan Dorn, "Verifying Eligibility for Affordable Care Act Subsidies: Access to Employer-Sponsored Insurance," *Health Affairs Blog*, September 16, 2013, http://healthaffairs.org/blog/2013/09/16/verifying-eligibility-for-affordable-care-act-subsidies-access-to-employer-sponsored-insurance/ (accessed September 23, 2013).

51. CBO, "Health Insurance Exchanges," Baseline Projection, February 2013.

TABLE 1

## An Illustration of Discontinuing Employer Coverage in Response to Obamacare

*Figures are for a hypothetical family of four earning the median income.*

| | Employer Currently Provides Coverage | Employer Discontinues Coverage under Obamacare |
|---|---|---|
| **Employer Effects** | | |
| Cash Wages | $74,964 | $86,204 |
| Health Insurance | $14,100 | $0 |
| Payroll Tax (Employer Share) | $5,735 | $6,595 |
| Employer Penalty | $0 | $2,000 |
| Total Compensation Cost | $94,799 | $94,799 |
| **Worker Effects** | | |
| Cash Wages | $74,964 | $86,204 |
| Income Tax | –$6,182 | –$7,868 |
| Payroll Tax (Employee Share) | –$5,735 | –$6,595 |
| Health Insurance Premiums | $0 | –$8,189 |
| Obamacare Subsidy | $0 | $5,911 |
| Disposable Cash | $63,047 | $69,463 |

**Source:** Authors' calculations using income data from the U.S. Census, the Congressional Budget Office's premium estimate, and 2013 tax rates, standard deduction and personal exemption amounts. This example assumes that current cash wages equal the 2013 median income for a family of four and that the cost of coverage both before and after equals the CBO's projected national average family premium for a Silver plan. Taxes are calculated for a married couple with two children and one wage earner.

that the average subsidy per enrollee will jump from $5,510 in 2014 to $8,290 in 2023.[52] The CBO expects that by 2023 the total value for taxpayer subsidies in the exchanges will reach $169 billion annually, and that the total 10-year expenditure between 2013 and 2023 will be $1.2 trillion. In short, the exchanges will be the platform for massive federal spending. On a per capita basis, according to one recent estimate, the new taxpayer subsidies would be even larger than those for Medicaid.[53] Of course, the CBO's official projections, though sobering, could be far too modest. Much depends on how employers and employees react to the law's complex combination of mandates, penalties, and government subsidies. A one-year delay in the reporting and penalty requirements of the employer mandate, for example, is not likely to reverse employers' decisions after they have already cut hours or moved more of their workforce into part-time employment or have cut back on spousal health benefits. In any case, many independent analysts have long believed that the loss of employer coverage will be severely disruptive and result in larger enrollments in the exchanges, guaranteeing explosive costs for the taxpayers.[54]

The Affordable Care Act does not create a level playing field for health insurance. Rather, it leaves

52. Ibid.

53. Charles Blahous, "The Affordable Care Act Optional Medicaid Expansion: Considerations Facing State Governments," The Mercatus Center, March 5, 2013, p. 7, http://mercatus.org/publication/affordable-care-acts-optional-medicaid-expansion-considerations-facing-state-governments (accessed September 13, 2013).

54. For example, McKinsey and Company, a prominent Chicago-based consulting firm, projects that anywhere from 30 percent to 50 percent of employers will drop coverage after 2014. Douglas Holtz-Eakin, former director of the CBO, expects that as many as 35 million Americans would lose their employment-based coverage. Those most likely to lose coverage would be lower-income workers with incomes between 133 percent and 200 percent of the federal poverty level, or those persons with an annual income between roughly $15,282 and $22,980. See Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010.

intact the long-standing tax exclusion for employer-provided health insurance while establishing new, and more generous, subsidies for exchange coverage—but only individuals without employer coverage can get those new subsidies. In other words, it creates new inequities and distortions in the health insurance market. The result is that millions of middle-class Americans would actually have *higher* disposable incomes (after paying taxes and health insurance premiums) if their employers drop their current coverage and they instead enroll in subsidized exchange coverage. That will be true even after their employers pay the penalties for not offering coverage.

Table 1 illustrates these effects for a hypothetical median income family of four. As the calculations in Table 1 show, the employer could drop coverage, pay the fine, and give the remainder of what the employer currently spends on health insurance to the worker as higher cash wages, with no change in the employer's total compensation cost for that worker. While the employee would then have to pay somewhat higher taxes on his increased cash income, as well as pay part of the premium for the replacement exchange coverage, thanks to the increased income in addition to the Obamacare premium subsidy, the worker would still experience a net 10 percent increase in disposable cash income.

Given these incentives, millions of middle-income and lower-income Americans, regardless of their personal wishes, will likely be removed from their employer-sponsored coverage, and the costs to taxpayers of the Obamacare exchange subsidies could be much higher than the CBO projects.

## Conclusion

Over the past several months, the media have focused on exchange implementation: "bumps and glitches," defective software, inadequate personnel, or managerial mistakes. These are merely "process issues" endemic to central planning. Far more important is the substance of central planning: the frustration of personal choice and the inhibition of product innovation.

Obamacare consolidates health care decision making in the hands of government officials. When the major decision points are collapsed into one or two—in this case, Congress and the Secretary of HHS—the very words "choice" and "competition" become empty. Normal market dynamics are virtually impossible for any central power to monitor, let alone control; and, in a normal market, there is no such central government planning. With Obamacare, the result is a nominally "private" market sealed off to all but officially approved and standardized "private plans," and where independent decisions are outlawed or curtailed to such a degree that they are meaningless. So, ordinary Americans will have access to "insurance," but not the innovation, productivity, and personal satisfaction that a real market competition among insurers would routinely deliver to consumers.

In a real market for goods and services in virtually every sector of the economy, tens of millions of people make decisions every minute of the day, and there are likewise millions and millions of decision points in these ordinary market transactions. Decision making is diffused among millions of players. The result is an explosion of innovation, productivity, and personal satisfaction. A free market ensures the growth of what Adam Smith, the great British economist, identified as the wealth of the nation.

The Obamacare health insurance exchange system, though often presented as a mechanism to provide consumer choice and competition, is, in fact, a complex bureaucratic machinery for federal control. Americans can expect less choice and less competition. Given the extreme degree of that regulation, private health plans will soon become "private" in name only. Indeed, Professor Sara Rosenbaum of George Washington University, a strong advocate of the new health law, best described the impact of the law and its regulatory scheme: She stated it will transform American health insurance into a kind of "public utility." Rosenbaum is exactly right.

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