Policy Brief
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What Flexibility?

Debunking the Myth of the Free-Market Health Exchange

By Andrea Sepenzis

A vast number of new federal healthcare regulations are introduced in the Patient Protection and Affordable Care Act (ACA), most of which will be enforced through state or federally run health exchanges. The harmless public face of these health exchanges is a web-based "marketplace," in which the uninsured and small businesses can shop for health insurance plans selected for sale by the government. Behind agency doors, however, these exchanges will act as the primary regulator of the insurance industry within states, approving or rejecting health plans, overseeing new rate and coverage requirements, doling out health insurance subsidies, and enrolling consumers in whichever government program they are eligible for.

As originally introduced by the US House of Representatives, ACA would have established a national health exchange, in which federally approved plans would be offered to consumers nationwide. The law was altered to allow states to establish their own exchanges in the US Senate, in light of concerns about the capacity of the federal government to regulate the insurance market in each state without local knowledge. As the law reads now, each state must either establish its own exchange by 2014 or allow the federal government to do so in its place.

While this looks like a compromise for federalism, states shouldn't be fooled: very little flexibility in structure – and almost no flexibility in regulatory policy – is available within "state" exchanges under the requirements of ACA. For the dubious pleasure of administrating and funding their own exchange, states can enjoy such "flexibilities" as website design, call center hours, board membership eligibility guidelines, and the choice of whether to incorporate with an existing state agency or fund and empower a nonprofit with the same service requirements.

States can also choose whether to make their exchanges a "clearinghouse," in which every health plan that meets ACA's stringent regulatory requirements for insurance plans will be offered, or they may interfere even *more* in the market by adding further participation requirements of their own. In the latter case, the state exchange will operate as an "active purchaser" that "negotiates" directly with insurers by offering deals to insurance companies to enter the market in their states.

Suffice it to say, no room for free market experimentation exists between those two equally intervention-heavy options. Whichever type of exchange they choose, states will have no flexibility to accept or reject specific ACA market "reforms" like guaranteed issue, community rating, and minimum coverage requirements, the pervasive effects of which are outlined below.

In plain terms, since the federal government doesn't have the resources to regulate the health care market directly in each state, they've chosen to compel states to regulate their markets the way the federal government has decided they ought to. The "flexibility" that states have been told they will enjoy if they choose to set up an exchange is a carrot hiding a stick.

While states are not technically required to set up a health exchange of their own, they are encouraged to do so by generous federal establishment grants and the knowledge that, if they decline to establish one, the federal government will set up an exchange for them.

Certain policymakers seem convinced that so long as the health exchange is technically "run" by the state, they'll be able to convince South Carolinians that it isn't an Affordable Care Act exchange, or design the state exchange to have minimal effects on the market. This claim is patently false. There is no true flexibility within the federal law for states to run or operate exchanges "their own way." While policymakers may hope that they'll retain some control over the health insurance market in their states by setting up state exchanges, in point of fact, they'll only take on all of the regulatory and administrative burdens imposed by ACA, while tying their political fortunes to the most deeply unpopular piece of legislation in recent memory.

The best thing South Carolina can do now is shift our energy and focus to genuine health reform, by pursuing better health outcomes and cost controls, and not the bureaucratic shuffle of epic proportions proposed in the Affordable Care Act. Little energy has been focused on this goal so far, however, because a myth has been perpetuated among policymakers that genuine health reform can be accomplished with the "right" kind of exchange.

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The unfortunate truth is that there is no "right" kind of exchange. The model's first test run in Massachusetts ("Romneycare") has been an unmitigated disaster, with a rapid, unexpected rise in premiums across the state, failure to provide much-promised universal coverage, and reported 30-45 day wait times for appointments with primary care physicians. The Beacon Hill Institute reports that the state of Massachusetts created over 18,000 fewer jobs in 2010 than it would have had the law not been enacted, in addition to suffering investment losses of twenty to thirty million dollars. Even Governor Romney himself has stated publicly that he would order the US Director of Health and Human Services to issue a waiver exempting all fifty states from ACA's requirements, should he be elected President.

Even the arguably more free-market friendly health exchange in Utah has suffered since its inception, with participants enrolling far below expected totals. As of this June, only 2,793 individuals participated in Utah's health exchange, including 112 small businesses – lackluster numbers, considering that the exchange was established in 2009. Despite some initial enthusiasm, enrollment had dwindled to 13 businesses at the end of that year. Contrary to the expectations of the health exchange planners, insurance plans offered inside of Utah's exchange ended up being more expensive than those offered outside of it. Instead of admitting failure, the state simply mandated that plans inside the exchange be offered at the same price as those outside of it, essentially transferring the premium increase of the exchange-specific policies onto the entire private health insurance market of Utah. And that's the "free-market" version.

Of course, neither the Massachusetts nor Utah exchange would fit into ACA's requirements, even if either of them worked as intended. As the law is currently written, ACA does not empower states to decide which policy reforms will best combat the problems in their insurance markets. Instead of allowing them to choose which health care reform strategies are appropriate for their unique circumstances, the law insists that states adopt whatever "one size fits all" approach to market intervention that the federal government has decided is best. Even if this were constitutional, it would still be bad policy: state insurance markets differ widely, and no single set of policies could have the same kind of effect on all of them. Control of the "structure and governance" of exchanges, as described by

the US Department of Health and Human Services, is totally insignificant in light of the regulatory policies that state exchanges will be required to enforce on the federal government's behalf.

Below are brief descriptions of what market "reforms" ACA requires states to implement for plans within exchanges, regardless of whether the state's exchange is locally or federally run. With the exception of minimum coverage mandates, even private health plans offered outside of exchanges will be subject to these policies, an unprecedented regulatory intervention in the private health insurance market.

- **Community Rating:** Community rating is a standard for health insurance premium pricing that dictates that every member of a plan – regardless of their health status or risk level – pay the same premium. Future premiums will differ only according to geography and whether the plan is for an individual or family. This vastly increases the cost of health insurance for young and middle-aged healthy individuals, leading many of them to drop out of the market altogether in a process called adverse selection: the young and healthy who enroll in plans will be paying for far more heath coverage than they need in order to subsidize the costs of providing care for higher-risk plan enrollees. It's worth questioning why we need yet another distribution program from the young to the old, especially when the ones that currently exist are headed for financial catastrophe.
- **Risk Adjustment:** One of the most far-reaching interventions into the private market under ACA, risk adjustment penalizes plans that have proportionately low-risk enrollees (like the young and healthy) by transferring money from them to plans that have high-risk enrollees. This "reform" acts in concert with community rating to force every health insurance company to operate off a single model: one that covers the expenses of high-risk plan members with the premiums of low-risk plan members.
- **Medical Loss Ratio:** This "reform" mandates that 80-85 percent of premium payments in health plans be spent directly on health care costs. While well-intentioned, insurers point out that this kind of interference in their operational budgets could divert spending from important services like fraud and abuse prevention and consumer information systems. This type of command-and-control intervention into the operation of private companies flies in the face of any concept of free enterprise or administrative innovation, and sets a very dangerous precedent for the future regulation of other industries.
- **Guaranteed Issue:** Guaranteed issue mandates that insurers accept every employer and individual that applies for coverage, regardless of their health status. While health insurance should be accessible to all, guaranteed issue prevents health insurers from targeting specific segments of the market by tailoring plans to the needs of individual consumers. It also incentivizes consumers to wait to purchase health care until they become sick, since no insurer can deny coverage for pre-existing conditions.
- **Minimum Coverage Mandate:** Though these regulations have yet to be released in full, the US Secretary of Health and Human Services will decide what coverage elements must be included in health insurance plans, and pass those dictates down to the states. States can only escape this mandate by applying for a waiver, which is granted at the Secretary's discretion.

Community rating and guaranteed issue gut the ability of insurers to manage risk and remain solvent without government subsidies. Most experts, including the Congressional Budget Office, agree that the new group rating and risk adjustment requirements in ACA will increase the overall cost of health care premiums. These policies in conjunction with higher premiums will create a series of perverse incentives for both consumers and insurers, in which insurance companies chase after federal subsidy dollars instead of consumer satisfaction, and consumers have to choose government plans to enjoy an affordable premium rate.

The federal government will attempt to "shield" consumers from these premium increases by providing direct subsidies to those making up to 400 percent of the federal poverty level, which will be passed out through exchanges. As we've previously written, this range includes nearly 60 percent of South Carolina's entire population. Regardless of how high premiums rise, the amount of money a consumer pays for health insurance will be limited to a certain percentage of his or her income, with tax dollars covering the rest. In order to be eligible to receive these subsidies, exchange participants will have to select from among plans approved for sale by the government.

These subsidy "incentives" will naturally cause many employers to cease to offer coverage for those employees that are eligible for them. Why would an employer spend its money providing affordable health coverage when the government is required to do so by law? Whatever fines those employers might face for not insuring their employees will be dwarfed by the higher premium costs inherent in the new market model, making it a perfectly rational (if unethical) decision for them to cease to offer coverage plans for their employees. Other employers will simply increase the employee share of premiums.

The fundamental problem with ACA and the health insurance market can be described in a simple analogy. While the reforms outlined above may "control" prices, they do absolutely nothing to control spiraling costs, which is the single biggest issue in the health care market. Let's imagine that the government "subsidized" and "regulated" consumer products this way:

The government sets the price of corn at $1 an ear, then refuses to allow any farmer to charge more than $1.10 for a head of corn without investing additional money in each ear. However, the fertilizer, farm equipment, and farm labor companies can continue to raise the prices they charge to farmers with impunity. Normally, this would increase the price of each ear of corn, since the farmer would have to spend more money to produce it. If corn became too expensive and people stopped purchasing it, both the equipment manufacturers and the farmer would have *every reason* to lower their respective prices. Under the new "reformed" system, the price of corn will stay absolutely fixed at $1, and the additional costs incurred by farmers when producing it will be "covered" by federal subsidies. If the price of each ear of corn is $2, the government will pay $1 for each ear purchased; if the price of corn is $3, the government will pay $2 for each ear, and so on. In this case, the government has controlled the "price" of corn, but done nothing about its cost – and that *cost* will ultimately be borne entirely by taxpayers.

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Let's move on to the fallacy of creating a state health care exchange that operates "our way." A number of policymakers (including those who claim to favor small government) appear to be under the impression that it's possible for states to create a "minimalistic" exchange, which adheres to federal guidelines without interfering too much in the market.

While state exchanges will enjoy some latitude in defining how their agencies relate to one another and work with existing health care institutions (like hospitals and insurance companies), the state does not have the authority to define the minimum requirements for a Qualified Health Plan, the cornerstone of ACA's intervention in the market. In essence, state exchanges will act as enforcers for the federal reform regulations described above, and their "flexibilities" will only be positive. States can add more regulations that Qualified Health Plans offered must meet to participate in the exchange, but they can't take any of the federal requirements away.

So that rules out the minimally regulatory option. But there isn't an option to provide minimal services within an exchange available to state lawmakers, either. Below are the minimal federal requirements that a state health exchange must perform to comply with ACA:

- Design and maintain a web portal that compares all Qualified Health Plans
- Staff and establish a call-in support center
- Certify and approve or deny Qualified Health Plans for participation
- Oversee the financial solvency of insurance companies
- Make "health quality assessments" of each Qualified Health Plan
- Determine eligibility for government programs and subsidies
- Enroll applicants in Qualified Health Plans or government programs

Contrary to common references to the "minimalistic" or "Utah model," any exchange that meets the above requirements could hardly be considered free-market, autonomous, or minimalistic.

Despite how close the 2014 deadline looms, the DHHS has not yet released all of its regulations regarding state exchanges, and more flexibility could certainly be added as states push back against these requirements. For now, however, it seems impossible to imagine how states could genuinely "experiment" within exchanges that are so heavily regulated by the federal government.

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The most important thing to understand about health exchanges is that the very concept of a "free-market" exchange is a contradiction. A free market is a market in which businesses tailor their products to the desires and budgets of their consumers: health insurance products offered within government-run health exchanges are built to the government's specifications alone.

Newly-released federal regulations encourage state exchanges to "maximize enrollment of eligible individuals into [Qualified Health Plans] to increase QHP participation and competition, which in turn increases consumer choice and purchasing." Quite to the contrary, actively recruiting consumers to enroll in government-run, heavily subsidized exchanges that only offer the products of favored insurers will hardly "increase competition." When the state picks winners and losers in the health insurance market, while offering generous subsidizes to consumers who enroll in their chosen health plans, the competitive deck is stacked so heavily in favor of government-favored health insurers that others may as well not enter the game.

Most private health insurance markets within states are already dominated by a single insurer in control of over 50 percent of market share. South Carolina's biggest insurer already controls over 65 percent of the entire market. If small insurance companies are prevented from offering flexible, competitively priced, consumer-oriented plans, the private market is highly unlikely to become more competitive. Community rating and guaranteed issue in particular make it impossible for insurers to target particular segments of the market, making the only solvent and profitable health insurer an insurer that can afford to insure all applicants. This insurer will almost always be the biggest insurer around, with the largest pool of consumers to distribute risk between. It doesn't take an economics degree to predict that, when the law is implemented, whatever insurer currently occupies that position within states will enjoy an even less competitive market to dominate.

Any hope of a truly competitive health insurance market rests on the ability of insurers to offer plans that are priced differently, offering different coverage, appealing to different segments of the market. "Minimum" coverage mandates, rate review, and community rating policies make that quite impossible, and any hope that insurance companies could offer more competitive policies outside of the state exchanges is thwarted by the requirement that within-exchange plans be offered at the same premium rate as those outside of it.

Under the Affordable Care Act's requirements and policy mandates, the federal government will interfere heavily in the operation and structure of health insurance companies, and provide subsidies that cause health insurance companies to compete for the government's business instead of yours. This is an unavoidable consequence of either a state or federally run exchange. Does that sound like a free market option to you?