

Contract, Clarity, and a Return to Sovereignty

How to Stop Federal Coercion – Including ObamaCare – and Enact Free Market Reform

For three years, policy experts, citizen groups, and politicians have argued for multiple approaches to either blunting the effects of ObamaCare or abolishing it altogether. The Affordable Care Act is a massive and unwarranted governmental intrusion that's already begun to stunt economic growth, make medical care more expensive, and endanger Americans' privacy. But as catastrophic as ObamaCare is, it's not the root cause of the rise in health care costs and the decline of quality care. Rather, the root cause is interference in the health care market from government at all levels. Policymakers and citizens must avoid the mistake of believing the state's health care market was fine until the Affordable Care Act passed Congress in 2009. It wasn't. Indeed, pre-ObamaCare, South Carolina's health care market was shackled by federal regulations and distorted by federal subsidies. A bill seeking simply to restore the status quo would do nothing to stop the failed government-managed system that produced the mess we're in now.

The only way to stop ObamaCare – and federally mandated health care under any other name – is to turn down the dollars and free South Carolina from the mandates that come with those dollars. And the only way to restore quality and affordability to the health care system is to remove the barriers to a free market health care system in South Carolina.

The wrong goal

Before asking what should be done about ObamaCare, we must ask what our goal is. The goal is access to the highest quality health care system in the nation, and that goal can only be achieved by restoring the doctor-patient relationship – a relationship based on transactions in which mutually agreed upon fees are paid by the patient to the doctor for services rendered. But the Affordable Care Act, despite its name, wasn't even designed to achieve better and more affordable medical care; it was designed to provide more people with health *insurance* by putting the federal government in charge of the health insurance market. But the very reason why medical care has become so expensive is because health insurance is a third party that comes between buyer (patient) and seller (health care professionals); health care coverage has been elevated from a product of insurance against catastrophic problems to that of an all-encompassing system by which all one's health care needs are managed. Indeed, it's been [estimated](#) that nine out of every ten dollars spent on health care are paid by third parties: either government or insurance providers.

And yet, owing ultimately to a host of government regulations – chiefly insurance mandates – that is exactly the kind of system the American health care market had become. The Affordable Care Act simply sought to put the federal government in charge of that system, making a bad system more costly, more complicated, and more inefficient.

Genuine health care reform must, therefore, address our health care system's fundamental misdirection. The effort to make the Affordable Care Act null or illegal doesn't do that. Nor do

other proposals that purport to use money tied to ObamaCare in supposedly better ways – for example, by [supplying hospitals](#) with increased amounts of federal cash to deal with uncompensated care, or by using the money to create a more “responsible” [program](#) to insure low-income South Carolinians.

It’s important to acknowledge, too, that ObamaCare is, from a fiscal standpoint, utterly irresponsible. The “money” is borrowed: Fully \$1.79 billion of the money South Carolina received this year from Washington DC was financed by debt. The most conservative estimate available found that South Carolina receives \$1.92 in federal spending for every dollar we send to the federal government.

But the Affordable Care Act isn’t sound policy – far from it. And as long as we accept its mistaken premise – the premise that the goal of health care reform is to use governmental power to make sure everyone has health insurance – we’ll continue to make a bad system worse. And as long as that flawed goal involves the acceptance of more and more federal money, South Carolina elected officials will keep pursuing it.

[The right goal](#)

In order to effect genuine, long-term health care reform that benefits both consumers and taxpayers – in order to make the South Carolina health care market a truly free market – we have to first grasp the underlying problem. That problem is this: The federal government hasn’t usurped South Carolina’s authority to run our own agencies and programs in our own way; our elected officials have given it away.

In order to get federal money, state officials must first implement or promise to implement federal priorities. If state officials want [federal highway funds](#), for example, they must abide by federal officials’ dictates, frequently by diverting funds from maintenance projects to expansions. Similarly, in taking stimulus funds in 2009 and 2010 South Carolina lawmakers [willingly expanded](#) eligibility requirements for unemployment benefits and Medicaid. And in order to get No Child Left Behind funds, South Carolina had to enact major changes to the way schools assess student performance; and in order to get a waiver from NCLB requirements, state officials had to [sign on to Common Core](#). In every case, federal money came with mandates, and policymakers in Columbia dutifully changed state policies accordingly – despite the fact that none of these policy changes were voted on or debated in the legislature in any significant way.

In the case of health care, South Carolina is allowing the federal government to decide that the way to reform our health care system is to give government officials vast powers over the private health insurance market. If South Carolinians are persuaded that this is the wrong way to achieve better and affordable health care, they have no choice but to turn down ObamaCare funding.

Despite South Carolina elected officials’ well-deserved reputation for being incapable of turning down federal money, it is possible to do. What’s required is a process whereby state officials could only give up state sovereignty for federal money *if* they first publicly detailed terms of the agreement, including the impact on citizens and businesses and the specific authority that would be transferred from our state to federal officials. In effect, state officials would have to treat the acceptance of federal money as a contract – a contract in which they would openly explain what they intend to give up and what the outcome must be in order for the contract to remain valid.

The reasoning behind an open contract is simple: Our state politicians have accepted huge federal subsidies – and the mandates and regulations that go with them – without understanding the full impact of those requirements on individuals and businesses. In many cases the unknown about ObamaCare has driven the decisions of business owners as much as what is known. South Carolina officials should not be permitted to obligate citizens to any mandate without a full public debate and a clear outline of the impact on the public. Imposing a contract-like relationship on the sovereignty-in-exchange-for-money transaction would bring that process into the clear light of day. And only when that happens can South Carolina begin to turn down federal money and reject the federal government’s misguided attempts to solve our problems through centralized power.

No quick solution

There is no state law that could ensure the rejection of the Affordable Care Act into perpetuity. Proposals to shift dollars and control from DC to state capitals fail to consider that state politicians are no better qualified to manage a centrally planned, government-controlled health care system than are federal politicians. States that want to stop ObamaCare will have to rely on state officials to push back. And legislation to make ObamaCare specifically illegal in South Carolina couldn’t protect citizens from the implementation of the programs themselves, nor from the whims of future legislators. In fact, South Carolina politicians have already failed to protect us from the effects of ObamaCare. Despite promises that our state would “say no” to the Affordable Care Act, the law is already being implemented in South Carolina. Many of the programs contained in the Affordable Care Act are already in place, and the federal dollars have either already been accepted or are being requested. For example:

- *Auto enrollment* . On October 4, 2012, the South Carolina Department of Health and Human Services (SCDHHS) announced its plan for “Express Lane” eligibility for Medicaid. According to a press release, children in families receiving benefits from the food stamps and TANF programs but not currently enrolled in Medicaid will be notified of their eligibility and automatically enrolled in Medicaid.
- *Presumptive eligibility*. Under Section 2202 of the Affordable Care Act, hospitals that participate in the Medicaid program can determine “presumptive eligibility” for individuals who attest to a simplified set of eligibility requirements for the following U.S. DHHS categories: pregnant women, family planning, former foster care children to age 26, breast and cervical cancer treatment infants and children under age 19, parents and caretaker relatives. SCDHHS will provide the necessary training to these hospitals. If all eligible but currently unenrolled citizens (an estimated 162,000 people) receive full eligibility, the impact to the state will be \$996.9 million from 2014-2020.
- *SCDHHS is changing our Medicaid eligibility formula*. A component to the Affordable Care Act’s Medicaid “reform” is a change to income eligibility methodology. The federal law mandates, and SCDHHS has established, a Modified Adjusted Gross Income (MAGI) methodology. This will eliminate income disregards (certain income that is usually not counted when determining eligibility) and convert current income to the MAGI income standard. This standard will only apply to certain Medicaid groups, and despite the elimination of those disregards – which would otherwise raise your total income and make you ineligible for Medicaid – the goal of the methodology is not to lower the income level eligibility. Therefore, although income may rise, coverage for certain Medicaid populations would not drop. (This is similar to the optional Affordable Care Act Medicaid expansion from 100 percent of the federal poverty line to 133 percent.)

- *Increasing Medicaid reimbursement to primary care doctors.* In the agency's FY 2014-15 budget, SCDHHS requested to continue the enhanced fee schedule mandated by the Affordable Care Act even after the fee schedule expires. The rationale is that a dramatic increase in Medicaid roles will make it difficult to recruit primary care providers.
- *South Carolina has already begun expanding Medicaid.* Last year, the state received \$187 million for the purpose. The state has requested an additional \$217 million from the federal government.

Not only is ObamaCare already being implemented legally, but its effects are already being felt practically. The mandates required by ObamaCare have already begun to take a toll on individuals and businesses. Individuals have seen their employer-provided health insurance premiums substantially increased or canceled, and doctors will be going off-grid to protect their patients' privacy. And businesses have begun to make decisions about hiring based on impending regulations and penalties rather than market demands.

What can we do?

South Carolinians do have an alternative, however, and it's not dependent on merely wishing State House politicians would turn down federal money. The first step is to codify a system by which the acceptance of federal funds would take the form of a contract. *State officials would be required to make available, in an open and accessible document, exactly what authority they are transferring to the federal government in exchange for money, and what the money is intended to accomplish.*

In any business transaction, the buyer has a legitimate right to know what he is purchasing, what the product is supposed to do or accomplish, and who he can hold accountable if the product fails to meet expectations. In the case of a contract between a state and the federal government, our elected officials should be able to explain the transaction in these areas:

- *Cost to citizens' freedom.* Will taking the federal money result in a new tax or higher taxes? Will it make products cost more? Will certain products or actions now be illegal? Will new law enforcement be needed?
- *New restrictions on citizens and/or state authority.* For instance, the General Assembly passed a law that would prohibit individuals deemed "mental defectives" from owning a firearm. After the bill became law it came to light that the State Law Enforcement Division (SLED) recently received a \$900,000 grant from the federal Department of Justice to help improve South Carolina's use of the National Criminal Background Check System. In fact, SLED applied for the federal grant shortly after the legislature passed Act 22 barring "mental defectives" from gun ownership. A contract would have stated openly that by accepting this grant, South Carolina would need to change its law with regard to gun ownership. As it was, South Carolina citizens knew nothing about it.
- *New state, federal, and local taxpayer-financed positions created.* New programs require people to run them; taxpayers have a right to know how many new employees they'll be supporting as a result of the acceptance of funds.
- *New regulations and policy changes mandated.* A specific enumeration of accompanying new regulations made contingent on the acceptance of federal money should be included in all contracts.
- *The process by which businesses be notified of the new regulations.* Will the Department of Commerce, the Department of Revenue, and/or the Secretary of State's office notify affected businesses? How – by mail, phone calls, or email?

- *Duplication of private-sector services.* Businesses and/or non-tax funded nonprofits are put at a disadvantage when government is providing the same service since government has a guaranteed source of revenue. Taxpayers have a right to know, therefore, whether a federal grant will fund a service that competes against private-sector organizations.

In short: Only by codifying a process by which South Carolina policymakers would be required to explain and document the losses of sovereignty and freedom involved in the acceptance of federal funds will it even be possible to turn the money down. No longer would lawmakers be permitted to insert a \$500,000 or \$1 million federal grant into the state budget with no more description than an innocuous-sounding phrase like “Clean Energy Program.”

How Will We Accomplish It?

To accomplish this reform, lawmakers must be required to follow the [state budget law](#). That law – long ignored by lawmakers – requires House and Senate appropriations committees to meet in joint open sessions to discuss the initial budget document submitted by the governor. Such an open process would provide an excellent venue in which citizens could see exactly what federal monies their elected officials are proposing to take in exchange for changes in policy.

The law code [requires](#) that the governor submit an executive budget to the House and Senate appropriations committees five days after the first day of session. This budget must contain a “complete and itemized plan of all proposed expenditures” for each agency and department as well as estimated revenues. A recently passed [law](#) also requires agencies to submit requests for federal dollars to the governor; that information should be made available at this point. Legislative appropriations committees are then to consider the executive budget in joint open meetings, at which point the public has the opportunity to hear and be heard on the state spending plan. Roughly a third of the state budget comes from Washington. Taxpayers should be given an opportunity to learn why this money (*their* money) is being spent in South Carolina, and what mandates state officials had to cede in order to get it.

With the absence of federal coercion as a possibility, South Carolinians can then begin to tear down the barriers crippling the state’s health care market. Unfortunately, that cannot happen until state lawmakers begin actually to turn down federal dollars.

Among the ways to remove barriers to the free market are these:

- The state’s licensing requirements prevent many smaller insurance companies from offering coverage in the state. These licensing requirements should be dropped. More out-of-state insurance providers will create more of a competitive environment and bring down costs.
- South Carolina law maintains 30 different [insurance mandates](#). These mandates make it practically impossible for many smaller companies to compete in the insurance market, and the consequence is a “market” dominated by a handful of large providers – which, of course, drives up prices. All 30 mandates should be dropped; coverage should be determined by buyer and seller, not by Columbia lawmakers and bureaucrats.
- The [Certificate of Need program](#) should be dropped. This is a regulatory process in which various types of health care facilities must prove to the government that there is a need for their services in a given area before building a new facility or expanding an existing one. A report published by North Carolina’s Civitas Institute cites several studies showing that CON programs have been ineffective, and that their repeal hasn’t led to higher costs. Their

findings show that CON laws had no effect on total personal health expenditure per capita or on per capita spending on doctor's services, they haven't controlled overall health care spending or hospital costs, and there is scarce evidence that CON laws resulted in cost reductions – and indeed some evidence suggests the opposite.

These are only three reforms, but they would be a start. Implementing these and [other market reforms](#) will prove to be an intense process. But it's only by identifying and removing state-created barriers to a free market health care system – concomitantly with removing the federal mandates that keep us from enacting these changes – that we can regain the ability to create an accessible and high-quality market for medical care.