



Health Insurance Exchanges

Facts tell us to rethink potential outcomes

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By Dave Racer, MLitt*

Disclaimer: Any opinions expressed in this article are not necessarily those of any of the organizations with which the author may be affiliated.

Fear: This paper evaluates facts to guide decisions about establishing state-based health insurance exchanges as required by the Affordable Care Act (ACA) of 2010. Various leaders and individuals charged with enactment of Exchanges are often heard saying, "We do not want a federal exchange imposed on us." A variation would be: "It is better that we put our own state's mark on this, than live with the federal exchange." Building and maintaining government-run insurance exchanges is a major change in insurance distribution, and it is a great concern that fear seems to be the only justification.

Fear appears to be driving market-oriented interest groups, political leaders, and fierce opponents of government-run health care to support state-based Exchanges. Their premise is that since the federal law requires exchanges, even though privately they strongly oppose the idea, they must help design them, to protect their own interests. This is a fear-driven motive, not a fact-driven policy.

Dozens of entities see an opportunity in designing and operating Exchanges as a way to access tax dollars to grow their revenue. Single payer advocates see the Exchange as a step toward their ultimate goal of a government-run health care system.

Fear, then, drives rationalization of long-held convictions. But such a major change in insurance distribution should be driven by facts, not fear.

This paper lays out serious facts that should cause policymakers to hesitate in creating state Exchanges.

1. We already have exchanges: they are called health insurance agents.
2. We already have online insurance purchasing portals in the private market.

3. Exchanges will not reduce the cost of health insurance but instead, will increase it.
4. Exchanges' primary outcome will be to increase dependency on government.
5. Politicians gain power and influence, and the people lose. Exchanges mean endless political tinkering.
6. Exchange insurance subsidies weaken families by creating dependence on government.
7. Exchanges result in an insatiable appetite for tax dollars that will push the United States' economy toward the brink of collapse.

The Exchange Model Undressed

The Affordable Care Act's model for state Exchanges is the [Massachusetts Commonwealth Connector](#).

When considering the Connector as the Exchange model, it is imperative to understand that *the Connector is primarily a method used to distribute taxpayer money to insurance companies* on behalf of individuals that qualify for tax subsidies. The Pioneer Institute's 2011 study of the Connectorⁱ celebrates the fact that the Connector has reduced the Massachusetts' uninsured rate below three percent, but downplays that 85 percent of individually covered recipients receive tax-subsidized coverage: 85 percent!ⁱⁱ

Consider the idea that the federal government wants to "give" up to \$50 million to each state to create an Exchange structure: but this is the tip of the tax iceberg. The Affordable Care Act gives the power to the Secretary of Health and Human Services to tap a limitless amount of money to plan and establish Exchanges. Limitless.ⁱⁱⁱ As some members of Congress realized this outrage, House voted to repeal this section of the ACA (see HR 1213), but the Senate and President Obama refused to follow the lead of the House.

There is no end point for subsidizing insurance premiums in the Exchanges. "In 2006, Massachusetts' officials projected the annual cost of servicing the Connector enrollees at \$88 million. Today, the cost reaches \$4 billion, and is underfunded by \$294 million."^{iv}

A Massachusetts Connector observer asked in 2011, "How difficult can it be to distribute nearly a billion dollars of government money to insurance companies?"^v

The 45 government employees that run the Connector have average salaries in excess of \$100,000 a year.^{vi} Yet these highly paid and skilled public servants have been unable to persuade more residents to enroll. The Connector is failing in its mission to enroll *non-subsidized individuals and small groups*. Rather than accept this as a market signal, the Connector Directors turned to more aggressive marketing. It used a state-funded direct mailing in an attempt to expand its reach to small businesses, putting it in direct competition with the professional health insurance agents that serve employers.

Georgetown University confirmed the predominance of tax-subsidized coverage. In response, our Connector observer commented: "The Georgetown paper observes as follows (paraphrasing): the Connector hasn't proved to be a solution for *unsubsidized* lives where the Connector is no better off than any other small, medium or large purchaser of insurance (or healthcare) from the insurance market."^{vii}

Sounding the alarm about the cost of Exchange insurance premiums, Georgetown observed, "But for those who are unsubsidized, such as small business purchasers, Exchanges will likely struggle to provide a product that is more affordable than what is available in the outside market."^{viii}

One of the most ironic facts about which Georgetown and many others have observed is that the Connector increases, not decreases, the cost of health insurance.

If insurance premiums will increase as a result of Exchanges, why should policymakers support it? The only answer is fear; fear that the federal government will make it worse than if a state controls it. Choosing the lesser of two evils is not a justification to establish a state Exchange.

Driving taxes up

Increased premium cost – and increased taxpayer subsidies – bodes ill for covered individuals and the taxpayers

that will underwrite their cost. While one state, like Massachusetts, may be able to receive federal government financing for shortfalls, it will be impossible for the other 49 states to receive the same level of subsidy. It is most likely that state taxpayers will eventually be forced to provide significant tax revenue to underwrite their state's Exchange insurance premium subsidies.

Massachusetts' law subsidizes premium for individuals with incomes up to 300 percent above the Federal Poverty Guideline (FPG). The Affordable Care Act of 2010 (ACA) sets the qualification guideline at *400 percent* of FPG – as many as 62 percent of the population. (See Table 1.) This means that starting in 2014, as many as 163.5 million Americans younger than age 65 technically will qualify for taxpayer subsidies to help them purchase health insurance in an Exchange, 28.7 percent more than 300 percent of FPG.^{ix}

Does any state, much less Massachusetts, really wish to increase the number of individuals receiving tax-subsidized insurance by 28.7 percent? Is there a *rational* state lawmaker that really believes the federal government can afford these subsidies? If so, they must respond to this finding: "A new study from the Senate Finance and House Energy and Commerce Committees found that as a result of ObamaCare, budget-strapped states face at least \$118 billion in unfunded mandates during the first 10 years after the law takes effect."^x

Tax Premium Subsidies			
Poverty level – Family of 4 - \$22,350 ^{viii}			
% of FPG	Family Income	Total Under Age 65	% of Total Population
200%	\$44,700	82.3 M	31%
300%	\$67,050	127 M	48%
400%	\$89,400	163.5 M	62%

Younger than age 65
Table 1

The actual number of enrollees in Exchange health plans, however, could threaten the taxpayers that subsidize coverage. "In May 2010, former Congressional Budget Office (CBO) Director Douglas Holtz-Eakin concluded that employers would drop coverage for about 35 million Americans because of ObamaCare. A month later, in June 2010, the National Center for Policy Analysis (NCPA) pegged the number between 87 million to 117 million. And last November, Allisa Meade, a McKinsey analyst, told health-insurance company executives that 80 million to 100 million people might lose their employer-provided health insurance."^{xi}

Lawmakers should carefully consider the threats to state and federal government budgets if they must support tens of millions of new enrollees.

The private market is already creating answers

Exchange proponents hope that government-run Exchanges will increase health insurance enrollment; they may be right, but at what cost? To increase enrollment, the Connector has had to simplify it, but Connector officials fail to emphasize the increased cost of insurance premiums it has created.

To increase enrollment in the Connector, the Board reduced the number of consumer choices from 24 health plans to seven. By contrast, in Minnesota, as in other states, [a non-government insurance "exchange"](#) leads to more than 135 choices. One should ask which of these models produces more competition: Seven choices in the Connector or 135 choices in a private insurance "exchange?" Which of these will result in lower insurance premiums: 135 choices or seven choices?

The National Conference of State Legislatures (NCSL) reported that in 2006, prior to the launch of the Connector, Massachusetts' health insurance premium for family coverage ranked seventh highest among states. Minnesota ranked 14th highest. By 2009, Massachusetts shot to the highest cost of family coverage among the states, while Minnesota fell to 18th.^{xii}

From 2006 to 2009, the average health insurance premium in Massachusetts – the Connector state – increased 18.6 percent compared to Minnesota's increase of 8.9 percent. The NCSL shows the average premium across the United States increased (2006 to 2009) 10.7 percent, far less than the 18.6 percent in the Connector state.^{xiii}

The Connector has not, nor can any government Exchange, reduce insurance premiums or health care spending, and that does not appear to be their purpose. Their purpose appears to be to *subsidize* insurance premiums, not reduce them – to increase dependency on government and reduce self-dependency.

Exchange proponents also point to the ability of Exchanges to aggregate tens of thousands of people under the same health plan, or into the same insurance risk

pools. Proponents claim this will save money: This theory is sound, and *it is why private, commercial insurance companies have been doing it for decades*. There is nothing new about this, except that in using the Exchange, the federal government will dictate the kinds of health plans it deems best, and then clamp down on insurance companies as they try to charge premiums adequate enough to pay the claims.

Exchange subsidies provide a perverse incentive for couples to remain unmarried. It does this by mandating a marriage penalty on many couples and families.

Exchange subsidies are based on income, marital, and dependent status. The ACA included insurance subsidies to buy down the high cost of insurance (even greater in Exchanges), but under its provisions, in some cases couples will pay as much as an additional \$10,000 per year for health insurance as compared to those who remain unmarried.

The federal government plans to subsidize the premiums of individuals with adjusted family incomes less than 400% of the Federal Poverty Guideline (FPG). For 2011 the FPG is \$10,890 for a one-person family and \$14,710 for a two-person family.^{xiv}

Allen Quist, a Minnesota college professor, former legislator, and researcher studied the anti-marriage provision of the ACA. He learned that two persons living together while married would qualify for subsidies with incomes up to \$58,840 per year – \$14,710 x 400%. The same two cohabitating/unmarried persons living together would qualify with total income of \$87,120 – \$10,890 x 400% times 2. This means that two people who remain unmarried and living together will be able to earn \$28,289 more yearly income and still qualify for federal insurance subsidies as compared to the same two people who decide to marry.

In addition to the subsidies, however, cohabitating and married couples also see a wide difference in the premiums they must pay.

The Heritage Foundation reported that the difference in health insurance costs for married couples in that \$28,289 window could be as much as an additional \$10,000 per year.^{xv} There is a distinct likelihood that, as

couples come to understand this discrimination, they may choose not to marry. If already married, couples may find it makes financial sense to divorce, and thereby increase their government benefit.

The present health insurance payment system does not discriminate against married persons: the new system does.

The Exchange, as a tool of the ACA, demonstrates an anti-marriage bias. Not only will its financial obligations threaten our economy, its negative impact on marriage could threaten family and community stability.

Lastly, the Exchanges' primary effect on marital dynamics will be increased dependency on government. As a result of its marriage penalty, spouses will be less dependent on each other, and more dependent on government. Children, likewise, even as they remain in the household, will find themselves depending on government for their health insurance, not on their families.

Exchanges do not promote the same options enjoyed by federal employees

Some members of Congress promote the Exchange suggesting it offers private employees the same model as government employees have through the Federal Employee Health Benefit plan (FEHB).

The FEHB plan relies on a defined contribution model (others call it a voucher). The government gives its employees a defined per-month amount that the employee can use to purchase their health insurance.

The FEHB plan offers health insurance options to which the federal employee can apply their voucher. Any premium cost above the voucher amount, the employee must pay. Congress believes that private employers and employees would relish the same opportunity they enjoy as federal government beneficiaries.

The Connector staff, in its never-ending attempt to entice more people to enroll, modeled a program after the FEHB plan. "[Private] employers would offer employees a fixed 'voucher' and allow them to choose any plan or carrier [in the Connector]. This was a failure and was discontinued."^{xvi}

Why did the Connector's private employer voucher system fail?

Government employers pay much more for health insurance than private employers pay for their employees. The Employee Benefit Research Institute (EBRI) found in 2008 that the employee health benefits paid by governments cost 235 percent more than those paid for by private employers. In other words, private employers insure 2.35 employees at the same cost as the government insures one.^{xvii} Perhaps just as startling are the differences in overall employee compensation. Government employees enjoy a 151 percent more generous compensation package than the private sector employees that pay the taxes to support them.^{xviii}

The government employee premium subsidy for FEHB plans is large enough to cover most of the cost of a family health insurance policy. Private employers cannot afford to subsidize family health insurance to the same extent as the federal government does in the FEHB plan. A Connector FEHB-type voucher plan might work if it provided more limited benefits and only attempted to cover individual employees, but fails as it tries to make family coverage affordable.

Private Market Exchanges Already Exist

Professional health insurance agents and private market vendors already operate fully-functional health insurance "Exchanges." This begs the question of why taxpayers should spend billions to create government Exchanges?

First, there is the exchange that has existed for decades: We know these as insurance agents, operating out of insurance agencies. Every professional health insurance agent is an exchange, with the ethical obligation to provide wise counsel for clients to help them purchase coverage most appropriate for them.

Some private market "exchanges" are built on already-functioning Internet portals. The [private market insurance exchange](#) mentioned above is a non-government solution to finding competitively-priced health insurance. This "exchange" portal allows any individual searching for health insurance to enter a few pieces of data, and then access more than 135 health plan choices. The individual can narrow down their choice, and then fill out or order an application, and soon after, receive the help

of a personal health insurance agent to complete the transaction: more importantly, to help the applicant make sure they have made a wise choice.

Private market “exchanges” resulted from entrepreneurs investing their own money, time, and creativity to meet a need. Although this paper offers no hard data, it seems certain that not a single private market “exchange” required a investment of \$50 million to get up and running. More likely, \$25,000 or less (.05% of what the government plans to spend to create a single state Exchange).

The reason the federal government plans to spend \$50 million to develop each state Exchange is because it must:

- 1) Test for subsidy eligibility;
- 2) Comply with tens of thousands of pages of new regulations;
- 3) Survive endless bureaucratic meetings and on-going review;
- 4) Link to dozens of federal and state government agencies; and
- 5) Employ a fast-but-futile search for immediate access to electronic medical records.

Private online insurance “exchanges” concern themselves with finding affordable coverage and plan options. Since the individual enrolling through them is not receiving a taxpayer subsidy, the plan choice is based on need, cost, and value.

The Eventual Federal Court Decision and the Exchange

Across the country, individuals and groups otherwise opposed to them but who are working toward establishing a state Exchange, insist on including a Sunset Provision in their new state laws. If the Supreme Court eventually overturns the ACA as unconstitutional, the state law would “sunset.”

Sunset language requires that the state Exchange must shut down if the Supreme Court finds the Affordable Care Act (ACA) to be unconstitutional, or if the federal government fails to meet its financial obligations to state Exchanges. Recent polling data suggests that millions of

Americans believe and even hope the Court overturns the entire ACA.

The Mandate: Root of the Court’s Decision (and the effect on the Exchange question)

The ACA requires that everyone must enroll in a health insurance plan – known as the individual mandate. Many Americans believe the Court will find the individual mandate to be unconstitutional.

It is hard for to imagine that the Court will sanction the rationale that grants Congress the power to tell individuals what they must buy, at a price they may not be able to afford and cannot directly negotiate, whether they wish to purchase it or not: Yet this is exactly the requirement of the ACA mandate. Court-watchers believe the individual mandate will be overturned as too great a reach of the federal government.

What about the rest of the ACA?

Nothing requires the Court to adopt the position that the entire law must be overturned because of the pivotal nature of the mandate. The public risk of not overturning the entire law is the threat that it could destroy private insurance (because of guarantee issue and forbidding of medical exclusions for pre-existing conditions on new insurance purchases). The insurance companies knew this risk when they endorsed the ACA at the start, but have counted on the mandate to drive millions of individuals to enroll in insurance plans. The Court, however, besides the mandate itself has far larger issues about which to be concerned, especially state’s rights.

Twenty-six states have engaged in a court battle to overturn all or parts of the ACA. One assertion the states make is termed “states’ rights,” drawn from the Tenth Amendment. “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”

This paper does not attempt to define states’ rights, but the argument is central to claims made by the 26 states in their lawsuits. ObamaCare’s defenders fight off the assertion of states’ rights: “We fought a Civil War over this, and settled it.” By this, people who believe the Court cannot overturn the ACA speak of the “Sovereign-

ty Clause,” which holds that federal law supersedes state law, when they are in conflict. It is easy to dismiss this argument when the basis of the assertion of the 26 states is that the new law is unconstitutional. No one would argue that states must abide by unconstitutional laws. But would the Court decide that the ACA in its entirety is unconstitutional simply because 26 states say so? That is less clear.

It is entirely possible, and the contingency upon which Americans must plan, that the Court will find precedent to let stand portions of the ACA even while over-turning the mandate. The Court may, for instance, specifically address the issue of the Exchange, and assert that the federal government has every right under the Commerce Clause to impose federal Exchanges on states. This is a very likely outcome.

Given All This, Should State Insurance Exchanges be Opposed or Promoted?

First, there is no evidence that Exchanges will reduce either the price of health insurance or the rate of health care spending. The only way the federal or state government can reduce health care spending is to restrict it. The only role Exchanges might play in the restriction (rationing) of health care is by making people dependent on government and afterward, receiving care after government rations it.

Second, to be successful, Exchanges must enroll millions of formerly uninsured individuals into health plans, but could add as many as 62 percent – or more – of the population in tax-subsidized insurance plans (See Table 1). Can Americans afford the taxes required to do this? Will individual, state, and national economies be able to finance this new welfare state? It could lead to bankrupting the country.

Third, once in place, the Exchanges will require endless political negotiations to fix flaws and increase its reach. Medicare and Medicaid offer proof enough, but the Connector provides a more contemporary example. The Connector board regularly discusses how to extend the Connector’s reach into private markets, draw thousands more into its plans, and increase its authority.

Each Massachusetts legislative session spends valuable time debating how to either expand or reign in the Con-

necting, just as Congress spends countless hours debating Medicare, Medicaid, and a host of health care programs. During a recent session, Massachusetts lawmakers debated limiting open enrollment into Connector insurance plans to one month per year, instead of 365 days per year. They attempted this to prohibit individuals, labeled “Jumpers” and “Dumpers,” from purchasing insurance when they became ill or injured, and dropping it afterward.

Once established so that individuals count them, any attempt to roll back Exchanges will result in the same type of political backlash common to attempts to fix Medicare or Medicaid. The impossibility to reform Medicare and Social Security is exactly why Congress and State Legislators should not be empowered to control private health insurance distribution through Exchanges.

Will the Exchange increase or decrease government’s appetite for taxes? The Exchanges, offering premium payment assistance for tens of millions will extract tens of billions more from taxpayers. More taxes to underwrite Exchange health plans will only hasten the day of the financial collapse of the United States.

But what about that federal Exchange threat

When Gov. Bobby Jindal of Louisiana told the federal government there would be no state Exchange as long as he was governor, he showed courage and common sense. Knowing the Exchange endgame and the threat to his state’s financial future, he wanted no part of building a permanent home for a federal health care system. Instead, it appears Louisiana will compete with it.

When (if) the federal government imposes an Exchange on a state, this does nothing to tie the hands of the private insurance industry to compete with it. The singular advantage held by the federal Exchange is its tax subsidies to pay down insurance premiums: these will not be available in private insurance markets. This is not a death blow to private insurance markets by any means.

Reliable studies indicate insurance premiums on Exchange products will be as much as \$2,100 greater than they otherwise would have been without the ACA.^{xix} Innovative private insurance products, sold by confident, aggressive health insurance agents, will be able to com-

pete with Exchange health plans. The result? Federal Exchanges will fail in their mission.

Why the facts suggest there are no good reasons to create state Exchanges

1. We already have exchanges: they are called health insurance agents.
2. We already have online insurance purchasing portals in the private market.
3. Exchanges will not reduce the cost of health insurance but instead, will increase it.
4. Exchanges' primary outcome will be to increase dependency on government.
5. Politicians gain power and influence, and the people lose. Exchanges mean endless political tinkering.
6. Exchange insurance subsidies weaken families by creating dependence on government.
7. Exchanges result in an insatiable appetite for tax dollars that will push the United States' economy toward the brink of collapse.

The Most Powerful, Strongest Way to Maintain State and Individual Sovereignty Despite Exchanges

The primary concern of lawmakers should be to protect a robust private insurance market. Any obstacle to affordable private insurance must be removed, and every effort must be devoted to redesigning how health care is paid by private, non-government means.

States should focus on creating a private health insurance market to compete with federally-imposed Exchange. States should work to remove obstacles to the growth of personal income so as to move thousands of people who might be eligible for Exchange premium subsidies into private, unsubsidized insurance plans.

Lawmakers must devise strategies to reduce government's over-regulation of health care that drives up its price. Reducing over-regulation will result in less costly health care and lower insurance premiums, while increasing the number of people owning insurance.

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