



## WHAT'S WRONG WITH HEALTH INSURANCE EXCHANGES...

By Rita E. Numerof, Ph.D. • May 2012

The purpose of this paper is to describe why the health insurance exchanges defined in PPACA won't work, won't increase access to affordable health care, and won't do anything to improve health outcomes or increase value. The solution to affordable coverage isn't to be found in these new bureaucracies, but rather in reducing barriers to competition and consumer choice and removing regulations that make coverage unaffordable today.

This paper explains the problems states will face if they go down the path of creating health insurance exchanges. A subsequent paper will offer recommendations on a framework for finding the right solution for states' unique needs.

### INTRODUCTION

There is little argument that changes are needed in our health sector to improve access to affordable health care and coverage. The debate continues over how to accomplish those goals and determine the right policy solutions.

The Patient Protection and Affordable Care Act (PPACA)<sup>1</sup> primarily addresses access to coverage through health insurance reform, but it does so at great cost and complexity.

The answer offered by PPACA to expanding the number of people who have access to health coverage is to mandate that the uninsured and everyone else obtain coverage, either through an employer-offered program, Medicaid, or policies from a limited range of subsidized and heavily regulated health plans offered via health insurance exchanges. The exchanges must be created, managed, and funded by each state or, in the event states do not comply, by the federal government.

Although the goal of extending health coverage to more of the population is important, the solution PPACA offers is fundamentally flawed. The requirements outlined in PPACA will result in the creation of administrative behemoths that will limit individual choice and drive up costs.

State legislators are required to make decisions to comply with fast-approaching PPACA deadlines. The Department of Health and Human Services (HHS) is acting on the assumption PPACA will be upheld by the U.S. Supreme Court and continues to emphasize readiness for the mandated launch of exchanges on January 1, 2014.

HHS announced in late May that states have until November 16 — just 10 days after the presidential election — to provide the federal government with details on how they will run their online exchanges.

HHS is expected to conduct a readiness assessment in late 2012 and announce the results in January 2013. HHS is then empowered to establish an exchange on behalf

---

<sup>1</sup> In this paper, we will use "PPACA" to refer to the *Patient Protection and Affordable Care Act, Health Care and Education Reconciliation Act of 2010*, and subsequent regulations issued.

of states that are too far behind.<sup>2</sup> This plan, however, may be derailed by a provision in PPACA that only residents enrolled “through an Exchange established by the State” would be eligible for federal premium subsidies.<sup>3</sup>

Given the intricacies of developing a state exchange, it is difficult to believe that many states will meet the 2014 deadline. As of May 1, 2012, the Center on Budget and Policy Priorities reported that only ten states and the District of Columbia have enacted bills into law establishing exchanges; another three states also have authority to create a state exchange. The Center also reported that Louisiana and Arkansas have decided not to establish a state run exchange, and seventeen other states are awaiting the outcome of the Supreme Court decision regarding constitutionality of the law before moving forward with their efforts.

### **OVERVIEW: CREATING ACCESS TO AFFORDABLE HEALTH COVERAGE**

There is a general consensus that the high cost of health care and insurance in the United States is a barrier to access, especially for the uninsured. Who among us could afford to pay full list price for every drug, office visit, or procedure? It is also agreed that if individuals would make good personal health choices, the cost of care would decrease dramatically over the long-term. The challenge is aligning economic incentives, focusing accountability, and giving people the power to make better health choices, thus driving change in the system.

<sup>2</sup> For that transition period, HHS has proposed partnerships in which states would perform certain functions. State funding for the entire effort would still be required.

<sup>3</sup> PPACA Section 1401’s revision to the IRS tax code. In the draft regulations issued by the IRS in August 2011, this distinction was not acknowledged, but members of Congress have contended that the IRS regulations cannot introduce changes or adjustments to the law.

While coverage through a health plan increases access to care, access to insurance can be limited because of high cost, complexity, pre-existing conditions, and other limitations. Those with mid- to high-incomes are more likely to be enrolled in employer-sponsored health plans, which pool risk and allow people to get a generous tax subsidy for their health insurance. Coverage through taxpayer-funded assistance programs (such as Medicaid and the Children’s Health Insurance Program, or CHIP) also increases access to care for those with low incomes, and Medicare provides access to care for those over 65 and for about 7.9 million people with disabilities.<sup>4</sup> Those who don’t qualify for assistance programs or who don’t have health plan coverage through their employers are often forced to do without coverage and hope for the best.

While there is general agreement that this problem must be solved, there is not agreement on the best way to increase coverage. PPACA’s solution is to combine an individual mandate with health insurance exchanges, forcing consumers to choose from a limited slate of homogenized health plans, with federal subsidies available to some to offset the high cost of the plans.

PPACA’s solution is fundamentally flawed and unsustainable: It will limit choice, create new bureaucracies, cost consumers and taxpayers more, and put additional burdens on the states.

There is an alternative — states can create market-based solutions that leverage the laws of supply and demand to enable greater access to more affordable health coverage options. We will address those options in a subsequent paper. In every other industry, advancing technology has generally resulted in lower costs and improved products and services. Except for unique services — cosmetic dermatology

<sup>4</sup> The Congressional Budget Office (CBO) has estimated enrollment in Medicaid programs will expand from nearly 68.7M in 2013 to 90.1M in 2017.

and Lasik eye surgery, for instance — health care does not operate this way. Until we create a true market-based approach in the health sector, we won't be able to crack rising costs in any meaningful way. Transparency, increased accountability, competition, and a market-based model for health care will be necessary to achieve the goal of better health outcomes at lower costs.

**WHY THE PPACA MODEL WON'T WORK**

What's wrong with the solution offered in PPACA? The delivery mechanisms central to the law are health insurance exchanges, so we begin our analysis there. The exchanges have been described as relatively benign “online marketplaces” to provide consumers choices of affordable health insurance.

But in reality, the exchanges are major new bureaucracies that would stifle competition, limit choices available to consumers, and burden states with an avalanche of new responsibilities to comply with federal directives.

The table below provides a summary of the numerous activities and responsibilities

required of PPACA's health insurance exchanges. The section that follows provides further context on some of the most onerous and problematic elements of PPACA's health insurance exchanges.

**Intensive data-gathering responsibilities**

PPACA health insurance exchanges are required to evaluate eligibility of individuals and families based on a combination of family size and household income. Once a household has enrolled in a plan, the exchange would provide documentation of their participation to related agencies (Medicaid, CHIP, etc.) and employers.

Specifically, a PPACA health insurance exchange would validate data and determine eligibility based on:

- U.S. citizenship or foreign residency status
- Current and future expected income
- Household size and family relationships
- Eligibility for Medicaid or other assistance programs
- Employment status and income earned with each employer

<b>Core Functions of PPACA Health Insurance Exchanges</b>	
<ul style="list-style-type: none"> <li>• Validate eligibility of prospective health plan enrollees for subsidies</li> <li>• Facilitate application for federal premium subsidies on behalf of plan enrollees and distribution of these funds to designated health plans</li> <li>• Assess and collect fines levied on employers related to insufficient coverage options</li> <li>• Facilitate enrollment of the uninsured in health plans, or Medicaid, CHIP, or other assistance programs</li> </ul>	<ul style="list-style-type: none"> <li>• Approve health plans for participation in the exchange (certify, recertify, or decertify as “qualified”)</li> <li>• Provide a technical platform (website) and customer service functions, including data on plans</li> <li>• Establish a “navigator” program to assist consumers</li> </ul>

- Health plan coverage options offered by employers, if available
- Premium costs and cost-sharing burdens of various “qualified” plans
- Detailed health histories

This list could be expanded as needed by states or by HHS. To make it possible for an exchange to access and evaluate all of these data points, new federal databases are to be created. States will have responsibilities and costs associated with contributing to these databases as well as costs associated with collecting, connecting, accessing, and storing data they have retrieved from them. These requirements will be expensive to implement, even though federal grants may be available to states to offset initial development costs.<sup>5</sup>

Sufficient staffing and resources will also be needed to receive, process, and evaluate documentation provided by enrollees where electronic data is not available. An appeals process likely will be necessary to evaluate and render judgment on complex situations. These expenses would be in addition to the website and customer support functions noted below.

### **New costs for employers and states**

All PPACA exchanges are required to perform the functions of a financial clearinghouse of sorts: for each enrollment (i.e., individual or family plan), the exchange must (a) estimate, track, and apply federal subsidies, and (b)

<sup>5</sup> Also, PPACA Section 1411 includes requirements on eligibility, and three sets of draft regulations were issued in mid-August 2011 that offer more details about a proposed federal data hub for verification and eligibility support: (1) CMS-2349-P, “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010,” 76 FR 51148, (2) CMS-9974-P, “Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers,” 76 FR 51202, and (3) REG-131491-10, “Health Insurance Premium Tax Credit,” 76 FR 50931.

assess, calculate, and track payment of fines levied on employers, on a monthly basis.<sup>6</sup> The exchange must collect documentation on health plans offered by all employers in the state and evaluate them annually to determine whether they offer comprehensive and affordable options.<sup>7</sup> If employees purchase coverage through the PPACA exchanges, fines for that employer are triggered, meaning states would have to match up enrollees and employers to determine the full amount of the fines to be assessed against the employer.

In addition to the costs to states, this function will be expensive for employers due to the burden of complying with new reporting requirements and providing more extensive health benefits. This function will also be expensive for states since most of them don’t have the staffing or expertise necessary to evaluate employer health plans. These provisions will likely impose even more cost and complexity in the management of populations with complicated income or employment histories.<sup>8</sup> None of these expenses relate to the actual delivery or evaluation of health care services, and they come at a time when employers and states can ill-afford additional cost burdens.

### **Regulating choices of insurance**

A key role of the states in implementing PPACA exchanges will be to review, certify, or

<sup>6</sup> Multiple sections relate to payments and fines; in particular, PPACA Section 1412 outlines an exchange’s responsibility to make determinations related to fines and subsidies.

<sup>7</sup> New databases are to be developed to validate key data in the form of a “federal hub” under the Insurance Affordability Program.

<sup>8</sup> A myriad of scenarios easily come to mind where enrollees might act in legitimate ways, but experience situations that would be complicated to validate (and therefore expensive). For example, suppose a family has two wage earners, and each wage earner changes jobs in a given year: there would be work histories to validate with four employers.

### Categories of Essential Health Benefits

Scope of benefits provided should be equal to those offered by a typical employer plan, and must include the following:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health, substance use, and behavioral health
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

exclude health plans that don't meet a set of qualifications, allowing only "qualified" plans to be offered to consumers. States would have to determine what counts as a "qualified" plan, and then review each health plan to certify, recertify, or decertify it. To perform this new function, the states would require additional staffing and other resources.<sup>9</sup> HHS, in its exchange guidance released in May 2012, indicated that states would be allowed to certify any health plan meeting the federal requirements, but most expect that states or the HHS will eventually limit the number of plans allowed to participate.

All "qualified" plans would have to offer the minimum standard of coverage as determined by the states, relying on HHS options for their Essential Health Benefits package (EHB).<sup>10</sup> The underlying assumption is that individuals and families can't make decisions for themselves about what health benefits would be optimal for them and that the government must do it for them.

On December 16, 2011, HHS announced that each state would select a baseline coverage

<sup>9</sup> PPACA Section 1301 includes provisions related to "qualified" health plans.

<sup>10</sup> PPACA Section 1302 lists the areas of coverage.

plan from which to define the EHB for their residents. Although the scope of the EHB is provided in the table above, states are still awaiting more specific coverage definitions and regulations.

In defining "essential benefits," HHS will authorize a minimum standard of coverage that must be equivalent to what comprehensive employer plans "typically" offer.<sup>11</sup> Unfortunately, some employer plans are considerably more comprehensive than others and very expensive (\$15,073 per family, on average), including elements of coverage that many consumers may not want or need.<sup>12</sup> If plans don't currently meet the EHB requirements, they must be upgraded, further increasing the current cost burden on some employers and employees.

<sup>11</sup> In July 2011, the Institute of Medicine recommended HHS define the EHB to reflect a "small employer benefit package." IOM (Institute of Medicine), 2011, *Essential Health Benefits: Balancing Coverage and Cost*, Washington, DC: The National Academies Press.

<sup>12</sup> Annual Kaiser Family Foundation survey of employer-offered health coverage for 2011 notes that the total average cost of coverage rose from \$13,770 in 2010 to \$15,073 for a family, and from \$5,049 to \$5,429 for an individual. Of the employers that offer coverage, most pay 50-70% of the total cost.

It's analogous to requiring that all families purchase a vehicle that seats five; is painted either black or blue; has DVD players, seat warmers, integrated cell phones; and fuel performance of at least 40 MPG! With such limited ways to differentiate, few manufacturers would be interested in offering products in such a market. From a consumer-choice perspective, these minimal options mean that most vehicles would offer the same features, many of which consumers wouldn't need or want. Some consumers wouldn't be able to find specialized features for which they would be willing to pay (e.g., seating for six or more, more cargo space, or a racecar-red exterior). To make vehicle ownership affordable, massive subsidies would be required. This scenario is patently ridiculous so why are we attempting this with health insurance?

By defining "essential benefits" in this manner, consumers will suffer in several ways. First, health plans would be expensive and be out of reach for low and middle income families, meaning a greater portion of the population will be dependent upon subsidized health coverage.<sup>13</sup> Second, since the minimum standard is expected to be so high, insurers will have limited flexibility in designing benefits, meaning consumers will have fewer plans from which to choose and many will be forced to purchase more coverage than they need. Finally, states that adopt minimums greater than those defined by HHS would have to fund the cost of those additional benefits. This would create an additional burden on state budgets.

The idea that state governments should regulate health plans is not new, but the requirements of the PPACA exchanges take

<sup>13</sup> PPACA includes provisions that would limit "qualified" plan deductibles, cost-sharing ratios, and premiums as a percentage of household income. The CBO has estimated that federal premium subsidies will total \$21 billion in 2014, and increase to \$118 billion by 2021.

this idea too far. The rules create additional burdens and limit choice. Why should consumers have to choose from a short list of very broad and expensive coverage options?

### **Some employers may stop offering coverage**

Perhaps unintentionally, PPACA's provisions may encourage some employers to stop offering health coverage. PPACA requires all employers that offer their employees insurance to meet a minimum level of coverage. Some current employer plans may not meet these qualification requirements, and employers would have to make a choice: increase their offering or drop coverage and encourage participation on the exchange. The penalty for employers who direct their employees to the exchange for insurance is expected to be much less expensive than expanding their current coverage.

Employers with 50 or more full-time employees that don't offer "qualified" coverage would be subject to fines of \$2,000 or \$3,000 per employee based on circumstances. In most circumstances, fines based on the first 30 employees would be waived. Compared to the average cost of offering coverage under today's standards, approximately \$3,800 per employee, the math favors not offering coverage. For example, an employer with 55 employees would have to choose between paying a \$75,000 fine (25 x \$3,000) or funding \$209,000 (55 x \$3,800) in health plan costs!

### **Costs for states would continue to grow**

PPACA health insurance exchanges will be expected to create websites to aggregate and standardize health plan information for consumers. Each exchange would also be required to provide a call center, toll-free number, and specific tools for consumers,

**Table 1. Illustrative Costs for State Exchanges\***

	Cost to Implement	Annual Operations	Estimated Population
Massachusetts (Connector)	\$25M	\$30M	190,000 Current
Massachusetts (PPACA exchange)	\$36M	\$45M	260,000 Proposed
Oregon	\$58M	\$40-50M	300,000 Proposed
Average NAIC Model	—	\$25M	800,000 Proposed
North Dakota	\$40M	\$5M	71,000 Proposed
Utah (Health Exchange)	\$600K	\$500K	5,000 Current
Wisconsin	\$38M	—	320,000 Proposed

Notes: The National Association of Insurance Commissioners (NAIC) has developed a guidance document with a detailed budget for an average exchange. The Utah Health Exchange is not a PPACA exchange, but provides a useful comparison; the population figure is through October 2011. Wisconsin does not plan to add new staff or allocate state funding for its exchange.

\* Massachusetts has received additional funding for a full PPACA health insurance exchange, with higher annual operating costs. Utah's low-cost exchange has enrolled only 1% of the uninsured, and would require significant funding if expanded to a full-fledged PPACA health insurance exchange. The figures for Oregon are the costs for 2014-2016, and the maximum population figure.

e.g. a cost calculator.<sup>14</sup> Given that PPACA is estimated to expand coverage to up to 30 million uninsured nationwide, a high-functioning website and call center with sufficient staffing will be a significant burden for any state: current estimates indicate roughly \$30 to \$40 million in development costs, plus \$25 to \$50 million in annual operating costs per state (see Table 1).

In addition to the significant expense of creating exchanges with online access, the online portal would pose challenges for the uninsured who do not have digital access. The “digital divide” is well documented, so the

exchanges will have to plan for higher than usual customer support needs.<sup>15</sup>

PPACA also assumes that a website with standardized presentation of information would always enable consumers to evaluate options and choose an appropriate health plan. However, if we take a lesson from the travel industry, simply having a website with great functionality doesn't guarantee that travelers will plan ahead to take advantage of lower rates or that they will take the shortest route.

<sup>14</sup> PPACA Section 1311 addresses websites and required tools.

<sup>15</sup> Studies of internet usage by the PEW Charitable Trust show significant gaps in broadband access, and usage of the internet, for lower income populations and for minorities. In 2010, 40% of households with incomes under \$30,000 had broadband access, compared to 87% of households with incomes over \$75,000.

As we have outlined above, the specific requirements of the PPACA exchanges are onerous and may present significant challenges to the goal of helping consumers gain access to health insurance coverage.

PPACA and PPACA health insurance exchanges are not the answer to creating access to affordable coverage. They are flawed and will accelerate health care spending. They will create more bureaucracy and place more burdens on states already strapped for cash. States should reject PPACA exchanges and instead begin planning for policy changes that will allow their insurance markets to operate more effectively and efficiently.

Many state health insurance markets are operating under laws and regulations that limit rather than increase affordable choices for consumers. States would be well advised to give the regulatory environment a thorough scrubbing, keeping what works, and discarding what doesn't. State governments can right-size regulations so the market can accomplish the desired outcomes of greater access to care through greater access to affordable insurance coverage.

## CONCLUSION

As we've demonstrated, state insurance exchanges as defined in PPACA will not accomplish the goals they were designed to address. Rather than focus on compliance with PPACA and assume its burdens, legislators should take inventory of the problems plaguing the health insurance markets in their states. Then they can confront the most critical issues of insurance coverage, care delivery, and payment reform to ensure that residents have access to affordable care and enjoy better health outcomes at lower cost.

**Rita E. Numerof, Ph.D., is president and co-founder of Numerof & Associates, Inc. (NAI), a strategy consulting firm that helps major companies navigate technological, regulatory, and competition-oriented transitions. She would like to thank Kimberly White, MBA and Daniel King, Ph.D. for their contributions to this piece.**

### ABOUT THE GALEN INSTITUTE

The Galen Institute is a non-profit public policy research organization devoted exclusively to advancing free-market ideas in health policy. We work to promote a more informed public debate over ideas that support innovation, individual freedom, consumer choice, and competition in the health sector.

[www.galen.org](http://www.galen.org) [twitter.com/GalenInstitute](https://twitter.com/GalenInstitute) [facebook.com/GalenInstitute](https://facebook.com/GalenInstitute)