

Should Kansas Establish a Health Insurance Exchange?

By Beverly Gossage

The federal health care law, commonly called Obamacare, is unpopular, mercurial, expensive, unconstitutional, and a prime target for repeal. Regulations are still being written a year later. Over a thousand waivers and counting and HHS is missing its own deadlines. The worst part: Obamacare expects states to do much of the law's dirty work: establishing "Exchanges", described as the "lynchpin of the health care law". To persuade states to participate, the feds have used a hook (if you don't do it, we will) and a worm (how about some federal dollars). Kansas should not swallow this bait because there are always strings attached.

So what is an Exchange? There are plenty of private Exchanges currently available in the free market for health and auto insurance, such as ehealth insurance and getinsured.com. One can enter basic information: age, gender, zip code and receive pre-underwritten quotes on thousands of plan choices from multiple carriers. Hundreds of thousands of insurance owners have purchased policies through these sites. Others have used a local agent, at no additional charge, to navigate them through the online application process and assist them with any claims issues throughout the duration of the policy.

So why a government Exchange? The theory is that these Exchanges are a "clearinghouse" that dispenses government funds and administers government health programs. An individual enters personal data, including detailed income information and is routed to Medicaid, SCHIP, or private policy choices, depending on the applicant's eligibility. Employers can offer a defined contribution and their employees can select a policy from a smorgasbord of plan designs. It sounds efficient, consumer friendly, harmless. Not so fast. It is a vehicle to implement and entrench Obamacare in the states, to add to the Medicaid rolls, and to further regulate the health insurance industry, favoring the large carriers.

Here are some other consequences of an Exchange:

- 1) Currently it takes 90 days to process a Medicaid application to determine eligibility in Kansas. The Exchange will be **linked to the IRS** database which will determine your eligibility within seconds of entering your information (supposedly-- this feature is not yet developed). This federal system is slated to be ready when the Kansas KMed program launches in October 2013.
- 2) Exchanges add a **layer of bureaucracy** creating an "artificial, pseudo market" in which the government decides the type and number of plans, and which carriers to be offered in the Exchange, stifling innovative plan designs that are fostered in an open, free market.
- 3) **Higher premiums** are a result of the federal government determining which benefits are mandated and which regulations, such as guaranteed issue and community rating, must be included. Kansas currently does not require as many federal mandates as are expected to be

included in the federal plans and they are risk rated. The federal government can add mandated benefits at will. Added mandates and the above regulations mean higher premiums. An Exchange vendor warned the Exchange Steering Committee that the 18,000 plans that are currently offered on the open market do not meet the Obamacare requirements. He estimated that bringing private Kansas plans to federal compliance would raise rates 300% to 400%. An actuary in our Working Group concurred.

- 4) The government-run Exchange **chokes out the free market**. In Utah, for example, only 11 small companies totaling a little over 100 participants signed up for the Exchange in the first year. If Exchanges are so great, why didn't everyone run to the Exchange? Did Utah drop the Exchange as a failed experiment? No. They began to pass laws to "fix" the Exchange by adding more regulations to the free market, which is now viewed as the competition to their Exchange. The Kansas Working Groups decided that they must be proactive to make sure their Exchange is successful by forcing all the Exchange rules and regulations onto the "outside" market, virtually closing the free market and expanding the Exchange. So much for "if you like your policy, you can keep it."
- 5) The higher rates make health insurance unaffordable for more Kansans, but not to worry because the government will use federal dollars borrowed from China to **subsidize those premiums**. 62% of Kansans (below age 65) will be eligible for subsidies. But only if their plan is purchased through the Exchange.
- 6) In a recent Working Group meeting Kansas actuaries shared their ominous prediction: **even more of the young "invincibles" will be uninsured**. The carriers' concern is since the rates will be higher than these young adults expected and/or are paying now, even with the premium subsidy, there is a strong probability that they will forego a policy and pay the \$95 fine, leading to adverse selection. Example: my 27-year-old son pays a \$58 premium for his private policy, but the rate in an Exchange would be closer to \$240 for a similar plan due to expanded regulations and mandates. Suppose his subsidy in the Kansas Exchange is half the premium; his portion of the premium would be \$120. An insured young person paying his own premium, could remain insured, but paying twice what he was paying before Obamacare and costing the taxpayers \$1440 in subsidies plus the cost to operate the Exchange. OR he could choose to be uninsured and pay a fine of \$95 and wait to get insurance when he gets sick. This is madness. Go to <https://www.mahealthconnector.org/portal/site/connector/> and see what your rate could be.
- 7) Carriers are already discussing how to try to get costs down. Two Kansas carriers in a Working Group suggested one cost saving idea would be to **reduce the number of providers in a network**.
- 8) Exchanges are **very expensive to operate**. Massachusetts' Commonwealth Connector spent more than \$26.6 million on vendors and contractors in 2009, and \$3.4 million on employee compensation. This comprises 3.5 percent of the money that businesses and enrollees paid into

the Exchange – *on top of* already bloated insurance bureaucracies. There is more to be paid as they bring their Connector up to Obamacare code. At one of the Working Groups Gary Schneider, K-MED and Kansas Health Benefits Exchange Project Manager, estimated set up costs to be 30 million and an ongoing \$2 to \$6 a month per participant for administration and aggregator fees. Kansas Health Institute estimates that up to 325,000 Kansas could use the Exchange. You do the math. States counting on truckloads of federal grants to offset these costs need a reality check. Also, the new Congressional majority is committed to repealing Obamacare, and is determined to confiscate Secretary Sebelius' checkbook. Even if they are not successful, most of the federal funds are sunset over 1-3 years and the Exchange is expected to be self sustaining.

- 9) Exchanges must send annual **audits to the federal government** and be **self sustaining** by 2015. Computer Sciences Corp. reports, "(HHS) doesn't provide much guidance for this requirement, and given the fiscal uncertainty of state and local budgets, it seems unlikely that the federal funding will be replaced by public revenue from local sources." According to a notice published April 15 in the Federal Register, CMS will enforce federal standards and PPACA provisions for the Exchanges and will set up Exchanges in states that do not build their own. The CMS Center for Consumer Information and Insurance Oversight will build the database, which will be the primary tool to track information for oversight purposes.

As mentioned above, two states, Massachusetts and Utah, already have some form of a government-established Exchange. Though some changes must be made to the Massachusetts Connector to make it compliant with the seemingly never-ending, federal regulations trickling out of HHS, the Connector is *the* model for the Obamacare Exchanges. Many have documented problems with the Connector including Michael Tanner of Cato Institute who cites escalating premiums and program costs, 200,000 uninsured despite the mandate and government subsidies, lack of choice, and a provider shortage.

Commissioner Sandy Praeger pointed to the Utah Portal as more of a consumer-friendly model that can blunt the most harmful consequences of Obamacare. But even with all its tweaking of legislation and expanded public awareness campaign, the Portal has only grown to 80 small businesses and 2500 participants including dependents, hardly a resounding success. Praeger admitted that the Portal must change dramatically to be Obamacare certified.

Some suggest that the federal government gives Kansas flexibility to design an Exchange that increases consumer choice. Michael Cannon of Cato Institute warns, "In a February 24 letter to the nation's governors, Kathleen Sebelius (Secretary of Health and Human Services) extolled the four types of flexibility that Obamacare allows states in shaping their Exchanges: 1) States can restrict insurers from participating; 2) states can add even more benefit mandates than Obamacare requires; 3) come 2017, states can opt out of Obamacare by creating a single-payer health-care system; and 4) states can adopt their own "governance structure" and "operational philosophy." **In sum, states can impose harsher**

regulations than Obamacare requires and can choose who sits on their Exchange's board. That's it."
(emphasis added)

Kansas is one of 28 states, which are litigants along with the National Federation of Independent Businesses in a lawsuit against Obamacare. Governor Brownback voted against Obamacare as a Senator and has stated publicly that Kansas won the lawsuit in Florida and will not implement Obamacare unless the Supreme Court says we must. This type of leadership is what Kansans expected when they elected the popular senator to the governor's office. **The answer is NO. Kansas should not have an Exchange.**

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