NEED TO KNOW

AMERICANS FOR PROSPERITY FOUNDATION

HEALTH CARE EXCHANGES

EXCHANGES LOOK DIFFERENT UNDER THE PRESIDENT'S PLAN

At its core, a health care exchange is a market-based mechanism that can help consumers make informed decisions about purchasing health care insurance, all within an innovative and transparent system. They can also be a tool to drive down health care costs: when plans have to compete directly with each other to offer the best services at the lowest price, consumers are the winners in the end.

However, the Exchanges created under the President's new health care law (the Patient Protection and Affordable Care Act of 2010) are far from simple, innovative, or transparent. They also aren't likely to drive down costs because they don't encourage competition. Instead, these Exchanges heap layers of onerous rules, restrictions, and mandates on states and insurers. They empower bureaucrats at the federal Department of Health and Human Services (HHS), binding consumers' choices and taking more control away from states.

HOW ARE EXCHANGES CREATED AND CHANGED?

The President's health care law directs the states to create a health care exchange by January 1, 2014, or face a federal takeover of the Exchange. They promise states "flexibility" to design the Exchange as they see fit but a simple review of HHS requirements shows that "flexibility" is available in name only.

QUICK FACTS

- HHS published the first portion of its Exchange rules in July 2011, in two documents totaling 244 pages. The word "require" appears 628 times (1).
- Federal subsidies paid to states to operate Health Care Exchanges are expected to cost $140.1 billion by 2021 (2).

NOTABLE & QUOTABLE

"By federalizing the regulation of insurance and by mandating exactly how it will work, you make it more expensive and you reduce the competition among insurers for people's business."

- **Paul Ryan**, House Budget Committee

First, before states are even allowed to begin operation they must submit their exchange plan for review by HHS, and the Secretary has wide discretion to deny approval under a slew of federal requirements. Assuming a state does get approval, federal meddling doesn't end there. Once the Exchange is up and operating, if a state wants to change or restructure their Exchange (say to streamline operations and reduce costs), those efforts are contingent upon HHS approval as well. A whole list of "significant changes" to Exchange operations require HHS approval, including changes to the health plan enrollment process, changes to state laws or regulations affecting the exchange, or any "other changes to the Exchange Plan that would have an impact on the operation of the Exchange." Even states' "IT systems or functionality" will face heavy federal oversight. In sum, there is no doubt states will face significant federal micromanagement preventing them from running or reforming their exchanges as they see fit.

Also troubling is that HHS has put states on an extremely tight schedule and asked them to design these Exchanges at break-neck speed. However, HHS has offered only vague and incomplete guidance on the criteria states will be expected to follow. The law itself offers a general outline, but until HHS publishes final guidance to flesh out that outline many important questions remain unaddressed and state officials are left scratching their heads.

What happens if the state's Exchange isn't ready and approved by the deadline? The federal government has authority to take over and operate an Exchange on the state's behalf under their own (not yet specified) guidelines. States then have to wait at least 12 months and clear a number of bureaucratic hurdles before they can take back control of their own Health Care Exchange from the federal government.

With each new regulation and restriction added by the federal government, states' "flexibility" is undermined and the usefulness of the Exchanges are diminished.

HOW WILL THE EXCHANGES WORK?

The short answer is: we don't know. However, while there is still incomplete information, the President's health care law provides a general outline of how Exchanges are expected to operate.

Individuals who do not have affordable health care coverage provided by their employers (and who are not eligible for Medicare or Medicaid) will be able to purchase insurance from a "qualified health plan" sold on the Exchange in their state. All insurers must offer coverage for a set of minimum "essential benefits" in order to participate in a state's Exchange, but they can charge higher premiums if they offer more comprehensive coverage. If an individual's household income is below 400% of the Federal Poverty Level ($89,400 for a family of four in 2011), they are eligible for a special tax credit subsidy from the federal government to aid in the purchase of "minimum essential coverage."

Among the pieces of information still missing from HHS: a definition of "minimum essential coverage," what constitutes a "qualified health plan," and what "essential benefits" insurance companies must provide to participate. We're all still waiting to see if we can keep the coverage we have and like, as the president promised.

As HHS continues to release regulations detailing the operation of state and federally created Exchanges, hundreds more pages of onerous restrictions will appear, masquerading under the guise of "flexibility." With each new restriction, effectiveness is sapped from the Exchange.

HHS could have given the states real authority and flexibility to create Exchanges to meet the needs of their residents. They could have allowed states to take different and innovative approaches to find the most effective formula to balance costs and improve services for patients. And they could have relied upon transparency, consumer choice, and competition to drive efficiency and advances in health care. Instead, HHS has opted for centralized control, hundreds of pages of restrictions in rules and guidance documents, and a "government-knows-best"
approach that at best will condemn the health insurance industry to mediocrity in the coming decades.

Endnotes:
1. Department of Health and Human Services, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans (July 2011) (online at http://www.healthcare.gov/center/regulations/exchanges07112011a.pdf)
2. Congressional Budget Office, CBO's March 2011 Baseline: Health Insurance Exchanges (March 2011) (online at http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf)

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