For several months, I gave qualified support to the creation of a Minnesota health insurance Exchange in response to the requirements of the Affordable Care Act of 2010. During all that time, I never could say I thought the Exchange was a good idea: Three years ago, I contributed to killing the Exchange proposed by then Minnesota Gov. Tim Pawlenty. The only reason that, this time, I spoke in favor of a Minnesota Exchange – and in fact, helped lead the effort in Minnesota – was to protect the vital role played by insurance agents in the distribution of private market health insurance. After examining the facts, I confess that I should have resisted with all effort.

May, 2011
**Health Insurance Exchanges**

*Exchanging Independence for Dependency, and Bankrupting America*

By Dave Racer, MLitt*

Disclaimer: The facts, ideas, and opinions expressed in this article are not necessarily those of any of the organizations with which the author is affiliated.

Fear is the primary motivation any conservative lawmaker would support the Exchange. Fear drives professional health insurance agents as well, for as a group, they recognize its futility to solve problems, and yet know their careers are in jeopardy. Fear also drives industry groups such as Chambers of Commerce to support what they otherwise have long rejected.

Others see an opportunity in the Exchange 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 is rooted in a simple rationalization: the fear of the federal government imposing an Exchange on the states. Some Governors and state lawmakers (and many proponents) reason that if a state passes its own Exchange, it gives the state a chance to shape the Exchange to express the state’s unique approach to health insurance. I used to buy into this reasoning.

America’s Founding Fathers rallied around many powerful and profound ideas. “Resistance to tyranny is obedience to God” is one of the more profound. When the federal government imposes its will on states, and state’s residents, through an Exchange it is a form of tyranny, unless, of course, the Exchange is a good and necessary use of government power. It is not.

There are at least eight good reasons to states should oppose Exchanges, and many reasons to oppose them.

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 debate and a consolidation of power in Washington, D.C.

6. Exchange insurance subsidies weaken families, and are an attack on the institution of marriage.

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 way to distribute taxpayer money to insurance companies on behalf of individuals that qualify for tax subsidies.

The Connector – or any Exchange – is primarily a way to distribute taxpayer money to insurance companies on behalf of individuals that qualify for tax subsidies.

Study of the Connector,

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 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. Congress realized this outrage and as a result, the GOP-controlled House voted to repeal this section of the ACA (HR 1213), but the Democrat-controlled Senate and President Obama refused to cooperate.

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 under-funded by $294 million.iii

In a gross understatement, a Massachusetts Connector insider asked in 2011, “How difficult can it be to distribute nearly a billion dollars of government money to insurance companies?”iv

The 45 bureaucrats that run the Connector have average salaries in excess of $100,000 a year.ivi Yet these highly paid and skilled public servants cannot persuade more residents to enroll. Because the Connector is failing in its mission to enroll non-subsidized individuals and small groups, the Connector Directors have been aggressive in an attempt to expand its reach.

Georgetown University confirmed the predominance of tax-subsidized coverage. In response, our Connector insider 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 conclusions Georgetown and many others have drawn is that the Connector increases, not decreases, the cost of health insurance.

Ask yourself: If insurance premiums will increase as a result of Exchanges, why should you 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.

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!

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.

Consider this startling reality: 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

Table 1

<table>
<thead>
<tr>
<th>Poverty level – Family of 4 (2013)</th>
<th>$22,350vii</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of FPG</td>
<td>Family Income</td>
</tr>
<tr>
<td>200%</td>
<td>$44,700</td>
</tr>
<tr>
<td>300%</td>
<td>$67,050</td>
</tr>
<tr>
<td>400%</td>
<td>$89,400</td>
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Younger than age 65

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 state lawmaker or governor 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

Is there a single lawmaker or governor that believes Exchanges will result in a fiscally sustainable path?

The private market is already creating answers

There is no need for the Connector/Exchange (except to build dependency on government).

Exchange proponents hope that this new government agency will increase health insurance enrollment; they
may be right, but at what cost? To increase enrollment, the Connector has had to simplify it, but fails to highlight 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 is common in other states, a non-government insurance “exchange” leads to more than 135 choices. Ask yourself, which of these produces more competition: Seven choices or 135 choices? 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.

From 2006 to 2009, the average premium in Massachusetts – the Connector state – increased 18.6 percent compared to Minnesota’s increase of 8.9 percent. The NCLS 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.

The Connector has not, nor can any government Exchange, reduce insurance premiums or health care spending, and that is not their purpose. Their purpose is 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 applying a huge 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 available only through Exchanges. Under ACA 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.

Allen Quist, a Minnesota college professor (Quist is a former legislator, 1994 GOP-endorsed candidate for governor of Minnesota) and researcher found an anti-marriage provision lurking in the ACA. Quist 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. If the couple considering marriage is made aware of this huge additional cost, they may be less likely to marry. Some married couples may divorce to avoid the cost. Some couples will see themselves having to choose between staying married and not making their mortgage payments or divorcing and keeping their home from foreclosure.
The present health insurance payment system does not discriminate against married persons: the new system does, and the Exchange executes the process used to fund the discrimination.

The Exchange, as a tool of the ACA, is in effect, anti-marriage. The ACA’s financial obligations threaten our economy, its negative impact on marriage threatens our moral base. Marriage should be honored not penalized. Lastly, the Exchanges’ primary outcome 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.

**Won’t the Exchanges Simply Provide Americans with the Same Options Enjoyed by Federal Employees?**

Congress continues to promote the Exchange because they believe it offers private employees the same model as government employees have through the Federal Employee Health Benefit plan (FEHB).

The FEHB plan uses what is called a defined contribution model (others call it a voucher). Simply, 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.”

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. 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.

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.

Consider: 1) promoting the Exchange is based on fear, 2) the Connector did not reduce the cost of insurance, but increased it more rapidly, 3) the Connector’s claim to success is directly tied to providing taxpayer subsidized insurance, 4) Massachusetts cannot afford to subsidize Connector coverage without federal subsidies, and 5) the Connector demonstrated a FEHB plan does not work for private employers. This alone should be enough reason to oppose and resist Exchanges.

**Private Market Exchanges Already Exist**

Professional health insurance agents and private market vendors already operate fully-functional health insurance “Exchanges.” Why should we 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. It is almost certain that not a single private market “exchange” required an investment of $50 million to become functional. More likely, $25,000 or less (0.05% 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 ongoing review;
4) Link to dozens of federal and state government agencies;
5) Employ a fast-but-futile search for immediate access to electronic medical records, and
6) Execute a near endless list of ideas only a government would pursue.

(When Minnesota tried to create a web-portal for low-income individuals to access government health plans – HealthMatch – it canceled the program. After millions of wasted tax dollars, programmers could not contend with more than 16,000 decision points required to determine eligibility. To avoid this, the ACA eliminates eligibility asset tests, but relies solely on income.

Relying solely on income creates another enormous distortion. It allows high-asset individuals and couples to receive government subsidies while holding onto assets – perhaps amounting to millions of dollars. This, one would think, constitutes a form of fraud on the goodwill of the American taxpayer.)

Private companies that need to make money, rather than raise it through taxation, shun many of these reforms as wasteful, and just get on with the job of providing coverage.

The Eventual Federal Court Decision and the Exchange

State Exchange supporters rationalize by insisting that legislators include a Sunset Provision in their new state law. Once the Supreme Court overturns the ACA as unconstitutional, it is argued, the state law would “sunset.” This, too, is the wrong motive to support a state Exchange: the ground under this rationale is soft and more like quicksand.

Sunset language requires that a state Exchange must shut down if the Supreme Court finds the Affordable Care Act (ACA) to be unconstitutional, or if (or is it when) the federal government fails to meet its financial obligations to state Exchanges. Millions of Americans are crossing their fingers in the hope the Court overturns the entire ACA.

Of course, for the sake of the Republic, it would be best if the Court released its ruling prior to Election Day, 2012, to free American voters to make an informed decision about the next President and Congress.

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, perhaps most Americans believe the Court will find the individual mandate to be unconstitutional.

It is hard for us to imagine that the Court will find any rationale that grants Congress the power to tell us what we must buy, at a price we cannot negotiate, whether we wish to purchase it or not – the exact thing required by the ACA mandate. Court-watchers, then, believe the mandate will be history.

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. True enough, leaving the balance of the law in place while killing the mandate will probably destroy private health insurance (because of guarantee issue and forbidding of medical exclusions for pre-existing conditions on new insurance purchases), but the insurance companies knew this risk when they signed onto the ACA at the start. The Court, however, has far larger issues about which to be concerned, especially state’s rights.

The ACA defenders fight off the assertion of states’ rights inherent in the 26 state constitutional challenges. We hear this argument: “We fought a Civil War over this, and settled it.” By this, people who believe the Court cannot overturn the ACA speak of the “Sovereignty 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 for which states must plan, that the Court will find precedent to let stand most 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. Frankly, this is a very likely outcome.

Why, Given All This, State Exchanges Should Be Vigorously Opposed

First, no one claims the 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 play in the restriction (rationing) of health care is by making people dependent on government and afterward, receiving care at the whim of government. This is reason enough to oppose Exchanges.

Second, Exchanges will not work, unless the definition of success means enrolling 62 percent – or more – of the population in tax-subsidized health (See Table 1). Achieving that goal, however, is far beyond reality: Americans cannot afford the taxes required to do this. Individual, state, and national economies will not be able to finance this new welfare state. It will bankrupt the country. This is reason enough to stop it now.

Third, once in place, the Exchanges will require endless political debate. 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 it authority: This is the way of government agencies.

Each Massachusetts legislative session spends valuable time debating how to either expand or reign in the Connector, just as Congress spends countless hours debating Medicare, Medicaid, and a host of health care programs.

During a recent legislative 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 from purchasing insurance when they became ill or injured, and dropping it afterward – they call these “Jumpers” and “Dumpers.”

Imagine the political backlash against any elected official that would have the audacity to point out that his/her state Exchange is failing, and must be eliminated. Exchange defenders would loudly and aggressively accuse the governor or legislative leader attempting to repeal the Exchange as damning children, infirmed, low-income and seniors to life without health care. They would be wrong, but in the same manner as Medicare, politically it would make no difference.

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. Only the most naïve people believe a government program once launched can ever be reined in. It does not happen.
Fourth, will the Exchange increase or decrease government’s appetite for taxes? The answer is obvious. The Exchanges, offering premium payment assistance (i.e., welfare) for 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

Call out the private health insurance industry and demand they step up to deliver.

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.

Jindal’s public announcement about refusing the Exchange said, in effect, “Bring it on.” Louisiana does not fear the federal Exchange. Instead, Louisiana will compete with it. Bravo. Other governors should take notice.

Jindal may have seen the failure of nearly every other attempt by the federal government to usurp citizen and state authority: He knows the federal government can never get its act together without states doing the hard work of administering its programs. Canada’s national government relies on provinces to carry out its dictates, and it would be no different in the United States, unless our “provinces” (states) refuse now.

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

Exchange insurance products will be as much as $2,100 greater than they otherwise would have been without the ACA. Innovative private insurance products, sold by confident, aggressive health insurance agents, will be able to compete with Exchange health plans. The result? Federal Exchanges will forever fail in their mission. Someday, perhaps, a courageous Congress and President will lay them to rest.

Once again: Why 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 debate and a consolidation of power in Washington, D.C.
6. Exchange insurance subsidies weaken families, and are an attack on the institution of marriage.
7. Exchanges result in an insatiable appetite for tax dollars that will push the United States’ economy toward the brink of collapse.

Maintaining State and Individual Sovereignty Despite Exchanges

The primary concern of lawmakers should be to protect a robust private insurance market, not create a state Exchange. 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.

Let the federal government set up its Exchanges, then compete with them. Devise every possible scheme to make private market insurance a better value, easier to access and more desirable. 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.

The essential primary focus from now until November of 2012 is to elect new national and state leaders that promise to roll back the Affordable Care Act.
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3 Affordable Care Act of 2010. Section 1311(a).
5 Our sources for Connector information wish to remain anonymous.
7 vi See note v.
8 vii See note ii.
12 Ibid.
15 See note v.
17 Iv Ibid.
18 xv See note ix.