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POLICY INSIGHTS

State Health Insurance Exchanges Will Impose Federal Control

By Twila Brase*

The federal health care reform law of 2010 ("Obamacare") says States SHALL establish an "American Health Benefit Exchange." Certain currently operating Exchanges are initally presumed to meet the law's requirements. (§1321(e))

This federal requirement undermines State sovereignty, according to Thomas M. Christina, attorney at Ogletree Deakins and former Associate Deputy Attorney General during the Reagan Administration. He warns that Exchanges are:

- Central to the anti-market project
- Essential to eradicating private plans.
- Enforcement without federal fingerprints.
- Nationalization-in-fact

(PPT presentation, AEI, 12/6/2010)

Some State legislators believe a federally-approved Exchange established by the State will be better than a federally-imposed Exchange established by the Secretary of Health and Human Services (HHS). However, the federal law makes it clear that every Exchange must conform to federal requirements, including pending regulations. Thus, a "State Exchange" is actually an imposed Federal Exchange.

Key Points:

- All State-established American Health Benefit Exchanges are federal Exchanges that must comply with the requirements of the federal health care reform law of 2010 ("Obamacare").
- State-established Exchanges may not write rules that conflict with or prevent implementation of federal rules issued by HHS under the law.
- The Federal government (HHS) has authority to require "any measure or procedure" to be undertaken by an Exchange.
- The Exchange will engage in "police" functions, sending names and tax ID numbers to the IRS to impose penalties on those who are not insured.
- The Exchange will expand goverment dependency using tax credits and expanded Medicaid enrollment. To compel compliance, credits are available only if State establishes Exchange.

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The Exchange has also been portrayed as a simple "one-stop-shop" for buying health insurance. This report on the actual requirements of the federal law demonstrates that every American Health Benefit Exchange will impose federal control over all aspects of health care.

The following federal requirements include citations from the federal health care reform law of 2010, officially titled the Patient Protection and Affordable Care Act (PPACA - Public Laws 111-148 & 111-152):

Exchange Mandate:

- "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange…" (§1311(b))
- "An Exchange shall be a governmental agency or nonprofit entity that is established by a State. …" (§1311(d))
- "An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle. (§1311(k))

Exchange Options:

- An American Health Benefit Exchange may operate in more than one State if each State permits such operation and the Secretary of HHS approves such regional or interstate Exchange. (§1311(f))
- A State may establish one or more subsidiary American Health Benefit Exchanges if each Exchange serves a geographically distinct area and the area is of a certain federally designated size. (§1311(f))
- A State may contract the authority for operating an American Health Benefit Exchange to a U.S. corporation or the state Medicaid agency. (§1311(f)(3)(B))

Federal Requirements & Expected Costs:

- States that agree to establish an American Health Benefit Exchange "shall, not later than January 1, 2014, adopt and have in effect the Federal standards established by the Secretary or a state law or regulation that the Secretary determines implements the federal standards within the State." (§ 1321(b))
- Federal regulations pertaining to states meeting the requirements for federal standards will be issued regarding: (§1321(a))
    - The establishment and operation of Exchanges, including Exchanges specific to small businesses.
    - The offering of "qualified health plans" through the Exchange
    - The establishment of reinsurance and risk adjustment programs
    - *"such other requirements as the Secretary determines appropriate."*
- American Health Benefit Exchanges must be "self-sustaining beginning on January 1, 2015, including

allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations." (§1311(d)(5)) The cost of the Exchange in Massachusetts in 2009 was $26 million for vendors and $3.4 million for employee compensation. *("Don't Start a State Health Exchange," John Graham, Richmond Times Dispatch, February 13, 2011.)* Oregon expects annual operating expenses of around $36 million. *(Oregon Health Policy Board, December 2010)*

- Federal payments to stabilize insurance premiums as high-cost patients enter the Exchange begin in 2014 and end in 2016, leaving States responsible for all future costs related to adverse selection. (§1341(c))

Federalized Functions of American Health Benefit Exchange:

- **Purchase** - Facilitate the purchase of federally-qualified health plans.
- **Enroll** - Establish a federally-mandated Small Business Health Options Program (SHOP) to assist employers to facilitate enrollment of employees in federally-qualified health plans.
- **Other Functions** - Meet "the requirements of subsection (d)" in the federal law which include, but are not limited to (§1311(d)(4)):
    - Coverage - offer available federally-qualified health plan coverage to qualified individuals and employers (Bronze, Silver, Gold, or Platinum coverage).
    - Federally-Approved Benefits - offer the "essential health benefits" determined and required by the Secretary.
    - State-Only Costs - require the State to pay for the cost of any additional state-mandated insurance benefits.
    - Health Plan Certification - certification, recertification and decertification of health plans "consistent with guidelines developed by the Secretary."
    - Phone & Website - operate a toll-free telephone hotline and maintain an Internet website for enrollees and prospective enrollees to obtain standardized comparative information on qualified health plans.
    - Rate Health Plans - assign a rating to each health plan, "in accordance with the criteria developed by the Secretary…"
    - Federal Format - utilize a standardized format for presenting health benefits plan options.
    - Expanded Entitlement - inform individuals of eligibility for federally-funded programs including Medicaid and the Children's Health Insurance Program (CHIP).
    - Enroll - automatically enroll citizens in subsidy programs if found eligible. (§1311 and §2201)
    - Determine and Provide Tax Credit Eligibility – Apply premium tax credits to cost of coverage for qualifying individuals. (§1411)
    - Determine Exemptions from Mandate to Purchase Insurance - certify individuals as exempt from the individual requirement or from the penalty imposed for not purchasing health insurance as mandated by the federal law ("Individual Responsibility" - §1501).

- IRS Data Transfer - send a list of individuals certified as "exempt," including their name and taxpayer ID number, to the Secretary of the Treasury (IRS).
- Employment Penalties - transfer to the IRS the name and taxpayer ID number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit (because the employer did not provide minimum essential coverage, or the employer provided it but it was determined to be unaffordable to the individual).
- Employee Insurance Status - Provide to employers the name of each employee who drops coverage under a qualified health plan during a plan year.
- New Government Workers - Establish the Navigator program as per federal standards issued by HHS. (§1311(i))
- Oversight - Annually report to, and submit to an annual audit by, the Secretary of HHS.

State Failure to Establish American Health Benefit Exchange:

- If a State does not establish an American Health Benefit Exchange as required by the federal law, will not have an Exchange operational by January 1, 2014, or has not taken actions the Secretary of HHS determines necessary to implement the federal requirements related to the Exchange (e.g. if the State is judged to be moving too slowly): "The Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements." (§ 1321(c))

- Tax credits are available only through a State-established American Health Benefit Exchange under Section 1311, not a Federally-established AHB Exchange under Section 1321. (§1401("SEC. 36B(b)(2)(A))

HHS Secretary's Responsibilities Include:

- "[P]rovide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that the Secretary determines is appropriate to reduce fraud and abuse and the Secretary has authority to implement under this title or any other Act." (§1313 (a)(5))
- Establish criteria for certifying plans as "qualified health plans" and develop a rating system of qualified health plans on the basis of relative quality and price. (§1311(c))
- Develop an enrollee satisfaction survey for American Health Benefit Exchanges to use, operate an Internet portal and help States develop Internet portals to direct citizens to health plans. (§1311(c))
- Establish initial open enrollment, annual open enrollment periods, special enrollment periods for health plans—and special monthly enrollment periods for American Indians. (§1311(c))
- HHS may investigate the affairs of an American Health Benefit Exchange, examine its properties and records and require periodic reports related to its activities. (§1313(a)(2))
- Conduct annual audits of American Health Benefit Exchanges. (§1313(a)(3))

Enforcement of Exchange Mandate:

- "Subsection 1321(c)(2) provides that section 2736(b) of the Public Health Services Act shall apply to enforcement of the requirements of subsection (a), and that the authority under that section is extended to nongroup health plans. 2736 is the current 42 U.S.C. 300gg-22, which provides that if HHS determines that a state has substantially failed to enforce a provision of the statute with respect to health insurance issuers, HHS shall enforce the law directly. Section 2736 further authorizes HHS to impose a civil penalty of up to $100 per day for each individual affected by a violation at section (b), subject to some exceptions." *[emphasis added]* (Source: *"Enact the Senate Bill, but Demand National Health Care Reform Implementation," O'Neill Institute for National and Global Health Law, accessed April 19, 2011*)

Individual Options:

- A "qualified individual" may enroll in any "qualified health plans" made available in an American Health Benefit Exchange. (§1312(a)(1)) If an employer chooses a level of coverage for employees in the Exchange (bronze, silver, gold, platinum), employees may choose any plan offered at that coverage level. (§1312(a)(2))
- Individuals may choose not to participate in the American Health Benefit Exchange (§1312(d)(3)), however, all individuals in State high-risk pools will be transferred into the Exchange. (§1101(g)) By law, no individual may be compelled to enroll in a qualified health plan or to participate in an Exchange. However, this may be difficult if the employer chooses the Exchange for employees or if the individual needs the premium tax credits offered only through the Exchange. (§1312(d)(3))
- Individuals may enroll in any "qualified health plan" in the American Health Benefit Exchange, but may not enroll in catastrophic coverage (indemnity insurance) if age 30 or older. (§1312(d)(3)) Individuals who do not have "minimum essential" coverage will be subject to penalties ("Shared Responsibility Payment") unless they are determined and certified by the Exchange to be exempt. (§1501)

"Pay for Compliance":

- The Secretary of HHS shall develop guidelines for health plans to implement a payment structure that provides increased reimbursement or other incentives to health plans that:
    - improve health outcomes through government reporting, case management, care coordination, chronic disease management, medication and care compliance initiatives, prevention of hospital readmissions, "appropriate use of best clinical practices, evidence based medicine, and health information technology," and the implementation of wellness and health promotion activities and activities "to reduce health and health care disparities." (§1311(g))
- The health plans shall report to the American Health Benefit Exchange the actions they have taken to implement the payment structure and its incentive-related activities. (§1311(g))

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