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Hold the Line: Protecting the States from ObamaCare

by The Honorable Arlene Wohlgemuth, Mario Loyola & John Davidson

Key Points

- ObamaCare presents the states with a painful choice: obey the federal government or suffer significant fiscal and regulatory penalties.
- ObamaCare requires states to set up insurance "exchanges" subject to federal approval, or the federal government comes in and sets up the exchange itself. States gain nothing from complying with this requirement.
- ObamaCare requires states to dramatically expand their Medicaid programs or lose the money for the expansion to other states. States cannot afford to comply with the long-term costs of this expansion.
- States should not allow themselves to be deputized into the enforcement of federal law. The federal government should be forced to pay for, implement, and be accountable for its own policies.

Introduction

It is unconstitutional for the federal government to command the states—the Supreme Court has been clear on that point. Yet the federal government can accomplish much the same "commandeering" of the states through the practice of "cooperative federalism:" the intermingling of finances and regulatory activities among the federal and state governments. These arrangements are supposed to be voluntary. But they force the state to choose between (a) obeying the federal government on matters of purely state prerogative, or (b) suffering a major financial or regulatory penalty.

The Patient Protection and Affordable Care Act (ACA) presents the states with two such choices. One part of the law allows states to choose between setting up health insurance "exchanges" in accordance with federal specifications, or letting the federal government come in and build the exchange itself. Another part of the law lets states choose between massively expanding their Medicaid rolls with billions in federal subsidies, or watching as billions of their own money are transferred to other states.

Both of these are painful choices for the states. But in both cases, the long-term costs of bending to the federal will are simply too great. The federal government should be forced to pay for, implement, and be accountable for its own policies. The states have challenges enough without being drawn deeper still into the dysfunction of the federal government.

The states should refuse to set up the ACA insurance exchanges and should also refuse to go along with the ACA's Medicaid expansion.

Health Insurance Exchanges under ObamaCare

The ACA represents a new era of federally-mandated health insurance regulation in the U.S., effectively taking regulatory control of the industry away from the states. The law does this primarily through health insurance exchanges. Whether the exchanges are created by states or by the federal government, they will be costly to create and maintain, will leave the states with no meaningful flexibility, and will face serious challenges in federal court.

In 2006, the Heritage Foundation began advancing the idea of statewide health insurance exchanges. The original idea was to create a vehicle for defined contributions by employers that would increase coverage, lower prices in the individual market, expand consumer choice, and allow portability.[1] This became the basis for the exchange in Massachusetts' 2006 health care law, which itself became the model for the ACA.

Both in Massachusetts and in the ACA, however, the exchange became something very different from the Heritage Foundation's originally pro-market and patient-centered concept. Far from being market-driven, both exchanges are in fact highly regulated. In Massachusetts, the requirements imposed on insurers have limited the number of plans offered on the exchange and driven up premiums. In 2011, state regulators approved 17 coverage requirements and 28 benefit mandates on all insurance plans offered through the exchange,[2] which has increased the cost of premiums, disproportionately affecting small businesses.[3] Last year, the average family premium in Massachusetts was $16,953—the

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highest in the country and nearly $2,000 more than the national average.[4]

The exchanges envisioned in the ACA are even more divorced from market principles. They have been described as portals (similar to Expedia) where a consumer can go online and shop from a "menu" of health insurance plans. But the ACA-approved exchanges will be highly regulated to serve an essentially administrative role: to determine eligibility for Medicaid and Medicare, or whether an individual qualifies for a federal subsidy to purchase private health insurance, and if so, the amount of the subsidy.

To do all this, the exchanges will have to collect detailed income tax information from the IRS and coordinate with other federal agencies such as the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS)—a huge and potentially impossible administrative task. In addition, the exchanges will monitor a massive amount of data about the plans sold on them. Price controls will limit the cost of individual premiums, which must not exceed 4.5 times the lowest cost premium plan in the exchange. The plans will be organized in four tiers from lowest premium cost to highest—bronze, silver, gold, and platinum. Each tier denotes a percentage of medical expenses covered under the plan, beginning with bronze at 60 percent and going up to platinum at 90 percent.

Cost

The exchanges envisioned in the ACA will be expensive to build and maintain, and yet there is no long-term funding mechanism for the exchanges in the law. Beginning in 2015, states must develop their own revenues sources to fund them—a requirement that has raised concerns about long-term costs. A fiscal analysis by the Nebraska Department of Insurance and the Department of Health and Human Services indicated that creating and operating an exchange would cost taxpayers in that state $646 million over the next seven years.[5] In Texas, with more than 10 times the population, costs would be far greater.

The exact cost of setting up and running an exchange is not yet known, with estimates between $10 million and $100 million per year.[6] In December, HHS announced it will impose a "monthly user fee" equal to 3.5 percent of the premium on all plans sold in a federally-facilitated exchange.[7] In Texas, the average annual premium for an individual with an employer-sponsored plan was $5,198 in 2011.[8] Calculating the user fee based on this average premium would mean $182 per year for every Texan who buys insurance through the exchange. As premiums rise, so will user fees for those who purchase insurance through the exchanges.

Given the technical complexity and unknown costs, there is good reason to think that the federal government will face significant difficulty establishing federally-facilitated exchanges in states that fail to set up their own. The deadline for states to inform HHS of their intention to establish an exchange was December 16, 2012. As of that date, only 15 states had indicated they would do so.

Flexibility

It is becoming increasingly clear that the structure and function of the exchanges will be dictated by HHS. For example, all plans sold on an exchange must cover certain Essential Health Benefits (EHBs) in 10 different areas of coverage, in order to be certified as a qualified health plan.[9] Initially, the administration intended to impose a uniform set of required benefits on all health insurance plans nationwide, but after criticism that its approach was too rigid, HHS announced that states would have more flexibility.[10]

Recent developments have proven otherwise. Nebraska Governor Dave Heineman submitted an EHB plan to HHS in October 2012 that called for a health savings option with high deductibles—$4,000 for individuals and $8,000 for families—that his administration considered to be a more affordable option for individuals and families not facing serious health challenges. But HHS disagreed, and rejected the plan.[11]

In short, the exchanges will not be controlled by states, but by HHS. The ACA explicitly states that, "an Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary [of HHS]."* Whether created by the federal government or by the states, exchanges will be little more than administrative offices making determinations on eligibility for standardized insurance products and the massive federal subsidies to support them.

Legal Challenges to the Exchanges

Because the ACA states that tax credits and penalties are to be administered only through state-created exchanges, some have argued that federal subsidies would be illegal if administered through federally-sponsored exchanges.[12] If so, Texas might be able to exempt its employers from penalties of up to $2,000 per worker by refusing to create an exchange. This issue is currently being contested by the State of Oklahoma in a major federal court challenge to the ACA.[13]

Governor Rick Perry has officially notified HHS Secretary Kathleen Sebelius that Texas will not set up a state-based health insurance exchange.[14] As a result, the ACA requires HHS to set up a "federally-facilitated" exchange. Though nobody wants to see the federal government establish a whole new bureaucracy in Texas, it is better than the alternative of letting Texas be deputized into federal service, with no flexibility to do anything different than what the federal exchange would do.

The federal government escapes an important limit on its power when it can deputize the states into doing its work for it. Hemming the federal government into implementing its own exchanges could help Washington realize that it cannot and does not want to do everything itself. That could give the states important bargaining leverage.

Medicaid Expansion under ObamaCare

The ACA requires states to expand their Medicaid programs to cover everyone earning up to 138 percent of the Federal Poverty Limit (FPL). As originally enacted, the law provided that states which refused to comply with this mandate could lose not just the large federal subsidies for the expansion, but also federal funds for their current Medicaid program, which accounts for about 60 percent of the average state's Medicaid program.[15]

Forcing states to dramatically expand Medicaid under the threat of losing all existing Medicaid funds, "is a gun to the head," wrote Chief Justice John Roberts, because it threatens to upset the "structural framework of dual sovereignty."

In its landmark June 2012 decision, *NFIB v. Sebelius*, the U.S. Supreme Court ruled that this part of the ACA amounted to coercion. Forcing states to dramatically expand Medicaid under the threat of losing all existing Medicaid funds, "is a gun to the head," wrote Chief Justice John Roberts, because it threatens to upset the "structural framework of dual sovereignty." While the ruling upheld the legality of other parts of the ACA such as the individual mandate, it opened up an opportunity for states to opt out of Medicaid expansion, which Texas signaled it would do weeks after the Court's decision.[16]

Cost

Texas is already facing difficulties funding its current Medicaid program. Expanding Medicaid would incur huge costs that the state can ill afford. In addition to backfilling a $4 billion hole in the current Medicaid budget, Texas forces a crushing long-term fiscal burden if it expands Medicaid. In 2011, state expenditures on Medicaid totaled $28 billion and accounted for one-quarter of the state budget. If Texas were to expand Medicaid, those figures would increase dramatically. A study by the Texas Public Policy Foundation found that the state would spend $7.3 billion more in 2020 than it would without the expansion and $15.9 billion more in 2040.[17] Other estimates place the cost of expansion for Texas at $10 billion by 2017.[18]

Since the Supreme Court ruling, some have urged Texas to reverse its position and embrace Medicaid expansion as a viable means for providing coverage to an estimated 1.5 million low-income, uninsured Texans. Proponents of expansion argue that it will cost Texas relatively little, because the federal government will initially pay for 100 percent of

* §1803, Patient Protection and Affordable Care Act.

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the cost of new enrollees and gradually roll back to cover 90 percent of the costs by 2020.

However, this does not take into account several key factors. The number of Texans eligible for Medicaid but not yet enrolled will number about 600,000 by 2014.[19] The ACA will not cover the costs of these "current eligibles," many of whom will enter Medicaid to satisfy the law's individual coverage mandate, further straining an already over-burdened system. The Texas Health and Human Services Commission estimates this enrollment increase will cost nearly $1 billion in the 2014-15 biennium and could cost up to $8.6 billion by 2023.[20]

Moreover, given the projected cost of expansion nationwide, estimated to be more than $1 trillion,[21] it is unlikely that the federal government will be able to continue to pay 90 percent of the costs of new Medicaid enrollees for long after 2020. Already, there are signs the administration will dial back its commitment to pay for 100 percent of the initial expansion. Late last year, the White House showed its hand by proposing a "blended rate" for Medicaid in its 2013 budget, backing off from the 100 percent commitment. The proposal was quickly retracted.

Even with some federal support, Texas would still have a substantial fiscal burden over the long term if it expanded Medicaid. The current trajectory of the program is unsustainable, and rising costs threaten to swallow an ever greater share of the state budget even without expansion.

Flexibility

Much like its claims about allowing states flexibility in setting up their exchanges, Washington has emphasized that states will also have flexibility in the Medicaid expansion. However, HHS's recent announcement that it would not allow states to pursue a partial or phased-in expansion—in fact, nothing less than extending eligibility to 138 percent FPL—shows that promises of flexibility are in fact empty rhetoric meant to mask a rigid approach to implementation. States that seek to expand Medicaid can expect no flexibility from HHS to enact measures designed to mitigate costs and ensure access to care.

Medicaid in Texas is already plagued by problems that only greater flexibility from the federal government can solve. Under the current rules, states have few options to control costs. The only significant measure available to them is to reduce reimbursement rates to providers, which has driven an increasing number of providers out of the program and left Medicaid enrollees with limited access to care. Currently, only about a third of Texas physicians will accept new Medicaid patients, down from 67 percent in 2000.[22] Expanding the state's Medicaid program would exacerbate this trend and leave enrollees with worse access to care than they already have.

Because Texas will need to prepare for a higher Medicaid enrollment even without expansion, it is imperative that state lawmakers retain as much control as possible over the program and maintain their resolve not to expand Medicaid—even in the face of pressure from county hospitals and other groups that stand to benefit from an expanded Medicaid population.

Conclusion

The protection against federal commandeering is one of the few shields that states retain against federal power. States give that shield away when they allow themselves to be deputized into implementing federal policy. One of the most effective ways to limit federal power is to force the federal government to pay for, implement, and be accountable for its own policies. It is precisely that limit that the federal government escapes when it deputizes state governments into doing its bidding.

Texas should refuse to set up a health insurance exchange of any kind, whether on its own or as part of a federal-state partnership, and it should also refuse to expand Medicaid. The state will not have meaningful control over the design or function of any ACA-approved exchange, and whatever discretion the federal government grants to states in crafting their exchanges will be merely cosmetic.

The same is true for Medicaid. Rather than further intermingling state and federal finances by expanding the program, Texas should take advantage of the opportunity afforded by the Supreme Court ruling in *NFIB v. Sebelius* to control the size of the program and insist on more flexibility.

The ACA was presented as a compromise between states and the federal government, and between market-based and government-centered reform. But as the details have rolled out over the past two years and much of the law has been filled in by extensive HHS regulations, it is clear that The ACA is no compromise, nor is it cooperation, but rather a thinly-veiled power grab by the federal government with the aim of using states to implement federal policy. Texas should not be taken in by promises of cooperation or flexibility. The law will afford the state neither. ✯

Endnotes

[1] Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," The Heritage Foundation (5 Oct. 2006).

[2] Massachusetts Health Connector, "Health Care Reform: Key Decisions" (27 Aug. 2010).

[3] Joshua D. Archambault, "Massachusetts Health Care Reform Has Left Small Businesses Behind: A Warning to the States," The Heritage Foundation (16 Sept. 2010).

[4] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2011 Medical Expenditure Panel Survey-Insurance Component.

[5] Office of Governor Dave Heineman, "Gov. Heineman on Federal Health Care Law: $646 Million State Exchange Too Costly" (15 Nov. 2012).

[6] Michael F. Cannon, "Obamacare Is Still Vulnerable," *National Review* (9 Nov. 2012).

[7] Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2014, *Federal Register*, Vol. 77, No. 236, pp. 73118-73218 (7 Dec. 2012).

[8] Kaiser Family Foundation: State Health Facts, "Texas: Employer-Based Health Premiums," Statehealthfacts.org (accessed Dec. 2012).

[9] Patient Protection and Affordable Care Act: HHS Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, *Federal Register*, Vol. 77, No. 227, pp. 70648-70653 (26 Nov. 2012).

[10] U.S. Department of Health and Human Services, "Essential Health Benefits: HHS Informational Bulletin," Healthcare.gov (Feb. 2012).

[11] Abby Goodnough, "Interest Groups Push to Fill Margin of Health Coverage," *New York Times* (5 Dec. 2012).

[12] Michael F. Cannon, "Obamacare Is Still Vulnerable," *National Review* (9 Nov. 2012).

[13] Motion to Lift Stay, *Oklahoma v. Sebelius*, CIV-11-030-RAW (E.D. Okla. July 2012).

[14] Letter to the Honorable Kathleen Sebelius, Secretary U.S. Department of Health and Human Services (15 Nov. 2012).

[15] Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline, Congressional Budget Office (Mar. 2012).

[16] Morgan Little, "Rick Perry announces Texas opting out of Medicaid Expansion," *Los Angeles Times* (9 July 2012).

[17] Jagadeesh Gokhale, "Final Notice: Medicaid Crisis, A Forecast of Texas' Medicaid Expenditures Growth," Texas Public Policy Foundation (Dec. 2010) 7.

[18] Thomas Suehs, "Presentation to the House Appropriations Subcommittee on Article II: Affordable Care Act," Texas Health and Human Services Commission (12 July 2012) 17.

[19] Jagadeesh Gokhale, "Final Notice: Medicaid Crisis, A Forecast of Texas' Medicaid Expenditures Growth," Texas Public Policy Foundation (Dec. 2010) 7.

[20] *Texas Medicaid and CHIP in Perspective*, Texas health and Human Services Commission(Jan. 2011) chap. 3, pg. 9.

[21] John Holahan, et al., "The Cost of Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Kaiser Family Foundation (Nov. 2012) 1.

[22] *TMA March 2012 Survey of Texas Physicians*, Texas Medical Association (9 July 2012).

About the Authors

The Honorable Arlene Wohlgemuth is Executive Director and director of the Foundation's Center for Health Care Policy. She served 10 years as a state representative for district 58. During the 77th legislative session, she served as chairman of Appropriations Article II Subcommittee (Health and Human Services), vice-chairman of Calendars, CBO for Human Services, and member of the Select Committee for Health Care Expenditures. Wohlgemuth authored HB 2292, the sweeping reform of Health and Human Services which improved service delivery for the recipients, saving taxpayers more than $3.7B during its first five years. The reforms consolidated 12 agencies into five and was the largest government reform bill ever passed in the state.

Wohlgemuth served as president of the Texas Conservative Coalition, chairman of the TCCRI Health and Human Services Task Force, and chairman of the TCCRI State Finance Task Force. She was twice named to Texas Monthly's "Ten Best" List.

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Loyola has written extensively for national and international publications, including features for *National Review* and *The Weekly Standard*, and op-eds in *The Wall Street Journal*. He has appeared on The Glenn Beck Show, CNN International, BBC Television, Radio America, and more. Together with Prof. Richard A. Epstein, Loyola wrote three amicus briefs for the U.S. Supreme Court in the Obamacare case, *NFIB v. Sebelius*.

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