

POLICYBRIEF



Insurance Exchanges in Kentucky and the Health Care Reform Bill



By
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Recently, the creation of health insurance exchanges in Kentucky has come to the forefront. The Patient Protection and Affordable Care Act (PPACA) – often called “Obamacare” – mandates that each state have one.

The Beshear administration announced its intention to begin setting up an exchange if the Supreme Court upholds the constitutionality of PPACA. This policy brief discusses the nature of the health insurance exchanges as well as other major aspects of PPACA.

There are a multitude of problems with the exchanges and with PPACA and the approach it takes to health care reform. Many are described below. Unfortunately, the approach is one filled with mandates, requirements and restrictions that limit the types and prices of health insurance that you may buy, and which will lead to many adverse consequences.

However, it is clear that significant aspects of the pre-PPACA health care system are in need

of reform. Often people without jobs – or who are in low-paying jobs – have no health insurance and there are many individuals with low incomes and serious health conditions that have difficulty with their health care expenses. An alternative approach to health care reform is briefly outlined below that addresses these issues while avoiding the numerous pitfalls of PPACA. It is based on consumer- and market-directed health care, augmented with special assistance programs for the truly needy.

At this writing, it is not known which parts of PPACA may or may not be upheld as constitutional. Presenting the arguments on this issue is not the subject of this brief. Regardless of how the Supreme Court rules, it is important to understand the significance of the difficulties

that PPACA will cause and fruitfulness of the alternative approach.

Health Insurance Exchanges

PPACA mandates that each state have a health insurance exchange that may be operated by the federal government or state governments. Exchanges essentially are a website where consumers can find individual health insurance plans and prices that are available to them.

Federal funding is available to states for setting up an exchange, which are intended primarily for individuals and families that do not have insurance through their employer or small businesses that do not self insure. In-and-of itself, this sounds like a good idea.

However, such options already exist in the private sector. A Google search quickly reveals many websites where comparison shopping for individual health insurance policies can be done.

Government-operated exchanges often are portrayed as a market-friendly alternative. However, this is very misleading as the PPACA overlays the exchange with a whole new set of rules that plans and consumers must comply with.

An important new rule regarding “minimum loss ratios” will limit the availability of “consumer-directed” health plans. These are plans that have full coverage for catastrophic and other major medical expenses, but are paired with higher deductibles and health savings account.

Such plans are viewed by many as an important path to bring more efficiency into health care provision since they require that consumers pay every day, anticipated expenses out of their own pockets while insurance is reserved for significant medical expenses. These policies make a great deal of sense. High-deductible plans induce more careful utilization of normal medical services and also lower health insurance premiums greatly.¹ As a comparison, auto insurance covers major accidents but not oil changes.

Under PPACA, the minimum loss ratio rule requires a certain percentage of insurance

claims payouts relative to total premiums collected. High deductible plans have lower premiums but not proportionately lower administrative costs. Thus, insurers are unlikely to offer these plans.

It’s ironic that a health care reform law that purports to encourage efficiency in health care provision is discouraging the use of one of the most important paths to efficiency.

Another set of insurance rules imposed by PPACA affects the pricing of insurance policies offered on exchanges. Normally, insurance premiums are set according to the risk of the individual or group. Under PPACA, there are severe limits to this because of mandated use of community rating of insurance. Basically, this requires that, aside from certain things such as age and tobacco use, the premium is the same for everyone. Additionally, everyone is guaranteed coverage regardless of pre-existing health conditions.

Some might regard these requirements as important benefits of the PPACA-regulated exchanges. However, there are some unfortunate consequences of this regulation:

- Mandating the same price for everyone regardless of health status (aside from the above noted exceptions) means that the less healthy will obtain insurance for lower premiums. But this also means that those in good health will overpay for their insurance, so this group clearly does not benefit. In effect, these rules are equivalent to levying a tax on health insurance for healthy people to fund a health insurance subsidy for those in poor health. While we might agree that it is appropriate to help the truly needy who are in poor health, why put the burden of doing so just on the health insurance premiums of others?
- Such mandated pricing puts insurance companies at odds with their customers. For healthy customers, insurance is overpriced. Individuals in this group will seek less insurance since while insurers would like more of these customers. For the unhealthy, insurance

¹ See Haviland, Marquis, McDevvit and Sood (2012) for recent research on the savings from these types of plans <http://content.healthaffairs.org/content/31/5/1009.abstract>.

is underpriced, so these individuals seek insurance and more coverage – because it is underpriced – while insurers desire fewer of these customers and would prefer to limit their coverage. Why set up a system where insurance companies do better by avoiding the very customers that the reform allegedly wants to help?

- The essentially uniform pricing of insurance regardless of risk works against providing incentives to adopt healthy behaviors. Many of the biggest health issues today – such as obesity, diabetes and heart disease – are related to diet and exercise behavior. Disallowing individual rating of health insurance premiums leaves no scope for lower premiums as an incentive for healthy behavior. Bad health habits are, in effect, rewarded.

There are much better ways to assist those truly in need of health care assistance rather than follow the path of PPACA into exchanges fraught with perverse incentives.

Individual and Employer Mandates

A controversial aspect of PPACA – and one raising constitutionality issues – is the mandate that individuals obtain health insurance, either through an employer or other group, through a government program or via purchase of an individual policy on an exchange.

However, not just any health insurance plan will do. As noted above, a sensible and inexpensive option for many people would be a high-deductible, catastrophic-coverage plan. Yet, due to the rule noted above regarding minimum loss ratios, it will be infeasible for insurers to offer these plans.

Additionally, PPACA mandates that plans must have “minimum essential coverage” that includes things such as mental health and substance abuse treatments, wellness services, dental and vision care for children, birth control, and a number of other items. While each of these has some value, they add to the cost of the policy and individuals are given no choice as to whether the additional coverage is worth the cost.

Employers, except for very small businesses, are required to provide insurance for their employees or pay a penalty if they do not. Of course, employee benefits are another cost of employing workers. Employers are concerned about the overall cost of hiring workers, including wages and benefits. When the cost of benefits rises, competitive pressures on employers put a downward pressure on wages. Thus, in general, mandating more benefits means that workers forgo wage and salary increases. As above, the mandated benefits come at a cost, but the affected workers are given no choice as to whether they are worth the cost.

Another aspect of the individual mandate is that individuals may be awarded a subsidy to help them purchase an insurance plan if their income is low enough. However, the subsidy does not completely phase out until the individual or family income is 400 percent of the poverty level. For a family of four, this is approximately \$88,000. This certainly reaches well beyond the scope of providing assistance to low-income persons.

Also, for many low-to-moderate-income workers, the penalty that the employer pays for dropping insurance coverage is small relative to the subsidy that the worker can obtain to buy insurance on the exchange. Thus, there is an opportunity for the employer to increase profit and still keep the employee whole by dropping coverage and providing cash toward the employee’s purchase of the subsidized insurance.

This is a significant concern. It seems likely that many employers will take this route. This means that a larger than expected number of individuals will be receiving federally subsidized health insurance. This creates another large and growing entitlement-like expenditure program at a time when we already are overburdened with others.

Paying for it

A major government expenditure for PPACA is the subsidies to individuals for purchasing health insurance on exchanges. Another major expenditure is the expansion of eligibility for Medicaid. Eligibility is to be expanded to all people up to 133 percent of the poverty level.

² The official budget scoring can be found at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>.

Medicaid is one of the entitlement programs already under great fiscal stress. This adds even more to that stress.

These expenditures, and other smaller ones, were projected by the Congressional Budget Office (CBO) to cost roughly \$1 trillion during the 2010-2019 budget years.²

There are several items projected to “pay for” this \$1 trillion over this time period, including an assortment of tax increases, including: increases in some payroll and income taxes; taxes on high-cost health insurance plans, prescription drugs, medical devices and on insurers themselves; and penalties on the uninsured. This seems to be an odd mix of taxes, particularly the health care-related taxes. It is counterproductive to tax the thing that one is trying to make more affordable.

The other major source of projected revenue is cuts in Medicare reimbursement rates. Medicare is another of the entitlement programs that has major funding problems. Clearly, long-term budgetary issues with Medicare are important to deal with. However, simply cutting reimbursement rates does not address the underlying problem. It simply makes health care providers less willing to serve the Medicare population, causing more difficulty for seniors to find medical care. Given the ill-advised nature of this type of cut and the political clout of seniors, this avenue of cost reduction is unlikely to materialize.

Also, as noted above, the CBO’s cost projection is for 2010-2019. Most of these expenditures do not begin until 2014, so spending over the 10-year horizon after the program really starts will be much higher than the \$1 trillion projection.

In sum, PPACA creates an entitlement spending program of its own, adds to the entitlement crises regarding Medicaid spending and does nothing to address the issues regarding Medicare.

The PPACA bill is long and complicated, so there are many details left out of this summary. Nevertheless, the above provides an overview of many of the important concerns.

An Alternative Path

Fortunately, there is an alternative path to addressing the problems in our health care sector without encountering the chaotic consequences of PPACA. This path has two steps. Step one is to encourage and embrace

market competition and consumer-directed health care to keep costs low, quality high and increase access. This step, in and of itself, will enable many to acquire affordable and high-quality insurance and health care. Even with this accomplished, there likely will remain a group of individuals who are truly needy, due to low earning capacity or precarious health conditions. Step two is to devise a targeted program focused on aid to this group.

Step one involves ideas such as the following:

- Interstate purchase of health insurance ought to be allowed to embrace the lower prices and better service that increased competition brings.
- Insurance regulations mandating “laundry lists” of services that must be covered should be eliminated. These drive up the price of insurance and prevent consumers from acquiring the coverage that suits them best.
- States should examine their scope-of-practice laws and modify them to remove onerous restrictions on practitioners such as physician assistants and nurse practitioners.
- Burdensome certificate-of-need laws can be repealed that prevent hospital and clinics from opening and expanding. More facilities would increase competition and reduce costs to health care consumers.
- A major roadblock to a vigorous, competitive individual-based health insurance market is the income tax code. Employer-provided plans are tax exempt while individual plans are not. Making both tax exempt would encourage more individual plans, creating a market that’s deeper, more competitive and with a wider variety of plans available.

Individual-based health insurance is preferred to employer-based plans for many reasons. For example, people do not lose their insurance when they lose their job. Also, they can buy a plan more suited for their individual needs instead of being limited by an employer’s options.

A wide variety of plans would emerge, including the high-deductible, low-premium

one that is likely to attract many. The individual market also features plans that have guaranteed renewability at group-average rates so those who get sick are not denied future coverage. Plans may emerge that tie premiums to health and wellness activities, thereby encouraging healthy behavior.

Once step one is accomplished, affordability and portability problems for many people will be resolved. Yet there still will be the truly unfortunate in our midst who will struggle with health care and its cost. Programs for assistance in purchasing health insurance can be devised for this group, with the assistance based on income and health status.

What to do about the Kentucky Exchange

The above analysis indicates that health care reform ought to take an entirely different path than PPACA. But this leaves us with the question of what Kentucky ought to do now regarding its exchange.

There are many good reasons to do nothing and turn the task over, if needed, to the federal government.

States really do not have much flexibility in setting up their exchanges. In nearly all aspects, the state is merely carrying out the dictates of the federal government. Once past the initial stages of federal support, the state is responsible for the expenses of operating the exchange. It also will be responsible for enforcing the perverse and counterproductive incentives embedded in the rules for exchanges.

The state will take the blame for difficulties high-risk consumers will have in getting coverage, for people dropped from employer coverage onto the exchange and for the healthy who are forced to buy overpriced insurance.

Better to leave the federal government with the expense and headaches of its own creation.

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