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Interstate Health Insurance Compacts versus PPACA Exchanges on the Roadmap to Health Care Freedom in Wyoming

by Regina Meena

EXECUTIVE SUMMARY

This paper provides a comparison between Interstate Health Insurance Compacts and the Insurance Exchanges authorized under the Patient Protection and Affordable Care Act. Last year, Wyoming enacted legislation authorizing the sale of Wyoming health insurance by out-of-state insurers through compacts, which are legal agreements between two or more states that, when approved by the U.S. Congress, have the power of federal law. Exchanges are online portals, run by a government agency or nonprofit entity, that match individuals with affordable health insurance plans. If states do not implement exchanges by 2014, the federal government is empowered to establish them within a state or region.

The insurance compact model would create larger markets through a move to individual purchase of private health plans. They would reconcile health insurance with other interstate offerings such as auto and property insurance, and would create larger risk pools and thus more offerings for both low - and high-risk individuals. Opening the market in this way will also create competition among insurers in these larger pools. The obstacles to compacts are the special interests seeking to prevent competition.

Though they may be run by states, exchanges will be under the authority of Health and Human Services, which will have the authority to determine minimum health insurance requirements and place strict limits on provider premiums. There are various uncertainties regarding implementation, including how to determine eligibility, how to verify eligibility, and how to integrate exchanges with other welfare programs. Most importantly, however, is the cost: exchanges are currently designed to provide Medicaid subsidies to families at 400% of the Federal Poverty Level, adding to an already financially unstable system.

Both Massachusetts and Utah have attempted to implement state-based exchanges, and neither have delivered on their goals to lower costs or increase the number of insured.

Moving forward, Wyoming should pursue compacts with other states, incorporate existing industry mechanisms that have proven effective in regulating other insurance products, work to encourage the U.S. Congress to eliminate interstate trade barriers entirely, and refuse to further implement PPACA exchanges while implementing compacts.

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INTRODUCTION

This paper provides a comparison between two health insurance delivery models, Interstate Health Insurance Compacts and the Exchanges authorized under the Patient Protection and Affordable Care Act (PPACA). Each model is built upon essential components whose collective arrangement proposes to lower health care costs, increase access to health services and increase the number of citizens covered by health insurance. A comparison of the most important components allows the reader to consider which model will most likely deliver the proposed results and why it is important in health care reform.

INTERSTATE HEALTH INSURANCE COMPACTS

Last year, Wyoming enacted legislation authorizing the sale of Wyoming health insurance by out-of-state insurers through interstate compacts. Enrolled Act No. 61 "recognizes the need of individuals seeking medical and surgical health insurance coverage in this state to have the opportunity to choose among competitive medical and surgical health insurance plans that are affordable and flexible."[1] Compacts are legal agreements between two or more states, by which each state voluntarily gives up sovereignty to the compact. Because they bind the states, courts have found that interstate compacts trump conflicting statutes passed by the member state, as long as the states belong to the compact in question.[2] Sixteen states have considered laws to allow interstate health insurance since 2007, with 13 proposing this law during the 2009 and 2010 sessions.[3]

The interstate health insurance compact model would create larger markets through a move to individual purchase of private health plans. Individual purchase means plans are bought directly from an insurance company instead of purchasing them through group (employer) offerings. This is how we currently purchase other insurance products like auto, property, and life insurance. These individual markets create larger risk pools among several states, a distinct advantage over Wyoming's small risk pools. Larger risk pools also increase access to both care and insurance for high-cost individuals traditionally covered by small groups, who are twice as likely to end up uninsured as high cost individuals covered in larger individual markets. The reason for this is that larger risk pools capture critical market share which, preliminary research shows, is 2.5 million to 4 million people depending on services offered in the plan.[4] Critical market share is the essential number of people paying into a plan, creating a solvent fund for payment of medical services offered through that plan.

Compacts have the flexibility to allow for vouchers for high risk, or low-income purchasers. Vouchers are government-subsidized payments that can be exchanged for specific goods or services. They allow low-income purchasers to buy private insurance policies of their choice and leave government-run health programs. Compacts could contain large group plans that are governed by the Employee Retirement Income Security Act

(ERISA) and exempt from state regulation and Association Group Insurance (such as the popular American Automobile Association), which are different from Association Health Plans like Medicare Advantage. The recently revised National Association of Insurance Commissioners' Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act recognizes association group insurance.[5]

Compacts also create competition. When insurance companies compete to see who can manage their plans best, consumers have an affordable product. Competition in other states has proven promising: according to Michael Kananen, a Montana insurance broker who also sells policies in other states, "I can sell a plan in Wyoming for $400 per month, and sell the same plan in Wisconsin for $150."

States have ensured portability and competition in other lines of insurance through compacts. By moving from group-sponsored health insurance to individual purchase of health insurance, coverage follows the insured from state to state and employer to employer without interruption. There are already mechanisms in place that serve as a central point of electronic filing for insurance products, which promotes uniformity of national product standards and provides strong consumer protections. Consumer protection and state enforcement of insurance contracts is the key. This would prevent individuals from committing fraud and insurers from breaching their contracts. Adding health insurance oversight to the responsibilities of the already-existing Interstate Insurance Product Regulation Commission would ensure consumer protection and facilitate interstate portability.[6]

The compacts are not without their obstacles. Uncertainty surrounding whether or not states are willing to establish compacts while PPACA requires the establishment of exchanges has slowed the process, even though compacts are explicitly allowed by the Act beginning in 2016. Some insurance companies and regulators will oppose competition because it threatens their monopoly position. They will, of course, paint competition as a threat to consumers, a race to the bottom in terms of the very least coverage or an inferior product. Hospitals and other special interest groups may oppose free market solutions because they believe the PPACA translates into increased income. The basic premise of PPACA is that increased insurance coverage means everyone will get a bigger piece of the health care pie. However, it is a mistake to believe that insurance coverage translates into increased revenue. This is no more evident than the lack of participation in the State of Wyoming employee wellness program. This program has not resulted in increased revenue to primary care providers as intended when the program was implemented.

Enacting compacts requires Congressional action. Regulating and taxing insurance is a duty of each state prescribed by the federal McCarran-Ferguson Act of 1945.[7] This act protects states from interstate competition and has lead to a vast collection of mandated services that many consumers do not want or need such as acupuncture, wigs and vitamins. The in-

herent problem with mandated services is that they must apply to a broad spectrum of the public and consequently are not age specific. Where there is no demand for services, provider revenues decrease and the price of premiums increase in direct response to cost distribution, contributing to our current situation. To remedy this, Congress may need to require each state to recognize the insurance licenses issued by the other states in order to protect free trade among the states, leaving the states to regulate health insurance.[8]

PPACA EXCHANGES

Exchanges under PPACA are online portals that would function as a clearinghouse to match individuals with affordable health insurance plans. They must be established as either a governmental agency or a nonprofit entity. Options include having the exchange located at an independent public agency or quasi-government agency with a board appointed for the daily facilitation of the exchange. Exchanges can be either interstate (limited to 1 or 2 states) or regional exchanges (among several neighboring states). The National Association of Insurance Commissioners has released its American Health Benefit Exchange Model Act, which lays out the basic structure of exchanges. The guide will help states meet PPACA qualification in order to get licensed. The Model Act suggests that funding for the exchanges be derived from charging fees to health carriers that offer their plans through the state exchange.[9] Exchanges will publish their costs on a website in order to establish transparency with consumers. States may have to go through producer or consulting licensing depending on how they establish their exchanges.[10] Producer licensing is for brokers and agents who sell, solicit or negotiate insurance. Consultant licensing is for individuals who offer advice, counsel, expert opinion and services to the insurance and financial services industries. Consultants are typically licensed brokers or agents. This means that the state will either function as a broker/agent and sell insurance policies, or function as a risk management consultant that provides regulatory and technical assistance to broker/agents and insurance companies participating in the exchange.

PPACA requires states to develop exchanges by 2014. If a state does not comply, the federal government is empowered to set up an exchange within the state. In addition, the Office of Personnel Management is authorized to ensure that each state exchange offers at least two multi-state insurance plans. These multi-state plans are supposed to resemble the Federal Employee Health Benefit Plan, but will operate separately from the plan and will have a separate risk pool.[11] Health and Human Services will have the authority to determine minimum health insurance requirements for most medical services and providers, as well as cost-sharing details for plans offered through the exchanges. Insurers will face strict limits on how they can price their premiums according to individual risk factors, and insurance companies operating outside of the exchanges could be subjected to the same regulations.

Although they are regarded as the most

innovative component of the PPACA, exchanges raise a number of concerns. First, exchanges are very expensive to operate. Even though states have received upwards of $1 million in planning grants, Information-Technology costs for setting up the exchange websites greatly exceed initial estimates. Second, and more importantly for consumers, income verification has proven difficult because eligibility is based on family income, a major problem for dual-income homes.[12] Being that the primary function of the exchange is to determine eligibility for the newly expanded Medicaid population and allocate premium subsidies, families will be subjected to frequent re-determinations of their income status every time their employment, family size or family composition changes. Finally, states are required to ensure that the exchanges cooperate with Medicaid, Workforce development and welfare program databases. States will have to pay for integrated risk management and data information systems. The costs, as a result of exponential growth over a period of years, will be horrendous.

Exchanges do little to prevent adverse selection. Adverse selection occurs to prevent people with high health care costs from enrolling in a certain plan. Government-provided health plans attract those with high health care costs because the costs normally covered by deductibles are now covered by state funds. Because insurers in exchanges will be limited in terms of how they can charge based on health risk factors, new rules may encourage plan providers to avoid investing in resources that help the sick such as disease management, support services or fitness programs. Squeezed by federally-required regulations, insurers will certainly compete to avoid the sick.[13] The risk-adjustment system leaves taxpayers bearing more of the costs than expected as insurers chisel their costs and services by "cherry picking" the best of the worst.

Still, the most uncertain of all costs is related to the number of people eligible. The exchanges use subsidies to expand Medicaid-provided health care coverage from the current Federal Poverty Level of 133% to 400%. In Wyoming, individuals at $14,400 per year up to a family of four making $88,200 will receive a portion of their health care and insurance premium costs covered by state taxpayers. Arriving at a hard number is difficult due to the fact that income levels change throughout the year and people who are currently eligible for Medicaid but do not participate remain unaccounted for. One thing is for certain: Medicaid program costs have proven financially uncontrollable no matter how many people participate.

THE MASSACHUSETTS AND UTAH EXCHANGES

Massachusetts Connector is an independent state agency that was established in 2006, and has served as the model for exchanges under PPACA. Recent studies of the Connector have found that its increasing costs make coverage unaffordable, that its regulations block competition, that its price controls create crowd-out, and that its profit ceilings run private insurance out of the market. Specifically, the guaranteed issue component (requiring acceptance of all enrollees) and

community rating component (requiring insurance companies to charge all customers the same premium), in combination with coverage mandates, have swelled costs. Added coverage mandates give employers incentives to drop health insurance because the cost to the employer and employee keep climbing. Premiums for policies sold through the exchange are up 11 percent for the lowest-costing plans since the program began.[14] Gaming of the system—where people buy insurance just when they need it then drop it—has also swelled costs.

Massachusetts taxpayers are taking a hit too. Subsidies for low-medium earners are extremely expensive because insurance plans are expensive and growing. Less than 10 percent of the newly insured are people who purchased health coverage in the exchange using their own money.[15] Many employees who are required to purchase insurance drop to part-time employment, then drop off employer plans, which adds to the tax payer costs.[16] In other words, the exchanges reward people for working less and earning less. Crowd-out occurs when private insurance currently held by the newly eligible population is dropped in favor of public health programs. As a result, taxpayers become burdened with the ever-expanding Medicaid population. Thus, the entire escalation in costs is paid by all taxpayers, not the people receiving care.

Employers are squeezed even harder. By merging the individual into the small group markets, costs were transferred to small employers, who are dropping coverage for their employees and exiting the exchange. They have little choice between paying the tax or paying the escalating subsidy.

Another study used Current Population Survey data for 2008 to examine the accuracy of uninsured estimates, self-reported health and crowd-out of private insurance under the Massachusetts exchange. Researchers found evidence that the program's impact on insurance coverage was likely overstated by 45 percent. Evidence documenting that more people were covered by insurance simply could not be validated. There was substantial crowd-out of private coverage among low-income adults and children, and that at least 60 percent fewer young adults are relocating to Massachusetts as a result of the law. Most significant is that "there has been no effort to estimate the cost of the private health insurance mandates that legislation would impose on individuals and employers. The costs may therefore be far greater than legislators and voters believe . . . ."[17]

Utah's exchange tries to create a free-market, one-stop shop for consumers and small businesses to purchase health coverage. It allows employees of small businesses to visit a website with insurance coverage options, and allows businesses to avoid administrating health benefits. Families can aggregate defined contributions from different employers, allowing a husband and wife to choose which employer they affiliate with, thereby satisfying federal regulation for group coverage. This premium aggregate model has not been tested yet; it went into effect in January 2011.

Originally launched in 2009 as a pilot,

Utah's exchange is re-launching this year. However, the results of the pilot are cause for great concern: of the original 136 businesses signed up for the pilot, only 13 remained at its close. The small number of employers is why the "premium aggregator" was never tested.[18] Also, Utah's exchange features modified guaranteed-issue policies. This means that the exchange must accept all applicants regardless of health status and must charge premiums within a range that is narrower than what actuaries determine as accurate. The original exchange had different risk-rating rules than the traditional small-group market, so when businesses applied for coverage, health plans figured their employees were less healthy than average to make up for the law's guaranteed issue rule. As a result, premiums within the exchange were 30 percent higher than standard.[19]

The re-launched exchange has the same risk-rating rules as the small-group market, and with significant costs. It needs a way to compensate insurers that attract a disproportionate number of unhealthy people. This occurs by transferring a share of premiums from the insurers who attracted a disproportionate number of healthy people. As in Medicare Advantage, and in the Swiss system of social insurance, insurers as a group are clever enough to design a risk system that shifts the costs to the taxpayers. This is precisely what is about to happen. Wyoming will need to scrutinize Utah's results.

Neither the Massachusetts nor Utah exchanges have delivered on their goals to lower costs or increase the number of insured. They simply can't capture market share. As Michael Cannon concludes, "What we really need in order to give consumers more choice is federal tax reform that shifts control to consumers and away from employers."[20]

THE ROAD TO HEALTH CARE FREEDOM

The Wyoming Election Survey found that 68% of the public disapproved of the PPACA. It also found that 62% believe the law should be repealed as soon as possible.[21] This sentiment, combined with the pending Federal court challenges and Wyoming's pending Health Care Freedom Amendment,[22] makes it clear that all options and alternatives to the PPACA for reforming Wyoming's health care system must be part of the conversation. A thorough understanding of these alternatives is necessary to keep in lockstep with federal actions, thwart government takeover of our health care industry, and determine the right combination between the good we have now, the good we want and which model will get us there. Equal emphasis should be given to understanding what other states are doing to safeguard their sovereignty, whether it be opting out of Medicaid, refusing to implement PPACA, or pursuing compacts. For Wyoming to respond in a timely manner, it must have well-researched and developed alternatives. Choosing the right model will be the difference between health care freedom and encumbering future generations with unsustainable costs they don't deserve and services they don't want or need.

The best steps for Wyoming to take to move forward with effective, choice-driven health care are the following:

- Implement Enrolled Act No. 61 by pursuing compacts with the 13 states mentioned,[23] and create competition that will expand the individual market, spread risk, increase access to care and insurance, and lower consumer costs.

- Incorporate existing insurance industry mechanisms that have proven effective in regulating other insurance products (auto, life, property, etc.).

- Coordinate efforts with other states to encourage Congress to amend current law and allow interstate health insurance trade barriers to be eliminated.

- Refuse to further implement PPACA Exchanges pending a Supreme Court decision on the constitutionality of the individual mandate while concurrently creating private market models to replace government programs. Creating compacts would effectively displace the need for exchanges.

- Once the compact is established, join other states (e.g., Texas) and research the feasibility of opting out of Medicaid, identifying federal funding ripple effects and identifying strategies for controlled, managed decrease in dependency on federal funding.

SUMMARY

In exchanges, the federal government takes on the state's role of regulator, emerging as a monopoly provider; in compacts, the free market creates the exchange and facilitates competition for the best possible product. PPACA's effort to emulate free markets will not lead to health care reform; interstate insurance compacts will. Interstate insurance compacts can limit government interference in health care, leverage free market enterprise and put us on the road to health care freedom.

ENDNOTES

[1] H.B. 0128, 60th Leg., Budget Sess. (Wyo. 2010), *available at* http://legisweb.state.wy.us/2010/Enroll/HB0128.pdf. *See also* WYO. STAT. ANN. §§ 26-18-201–26-18-208 (2010).

[2] Ted Cruz and Mario Loyola, *Shield of Federalism: Interstate Compacts in Our Constitution*, POL'Y PERSPECTIVE (Tex. Pol'y Found., Austin, TX), Dec. 2010, *available at* http://www.texaspolicy.com/pdf/2010-12-PP21-InterstateCompacts-tcruz-mloyola.pdf.

[3] Those states are California, Colorado, Georgia, Indiana, Maine, Minnesota, New Hampshire, North Carolina, Oklahoma, Pennsylvania, South Carolina, Vermont and Wisconsin. Richard Cauchi and Katie Mason, *Out-of-state Health Insurance - Allowing the Purchase (State Implementation Report)*, NAT'L CONFERENCE STATE LEGISLATORS, http://www.ncsl.org/default.aspx?tabid=20015 (last visited March 21, 2011).

[4] Dr. Sven Larson's research is on file with the Wyoming Liberty Group.

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[13] *Id.*

[14] Tanner, *supra* note 11, at 12.

[15] Sarah McIntosh, *States Setting Up Exchanges Examine Massachusetts and Utah Versions*, HEALTH CARE NEWS (Dec. 21, 2010), http://www.heartland.org/healthpolicy-news.org/article/29032/States_Setting_Up_Exchanges_Examine_Massachusetts_and_Utah_Versions.html.

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[20] McIntosh, *supra* note 15.

[21] *See generally Wyoming Residents Disapprove of New Health Care Law*, U. WYO. (Dec. 21, 2010), http://www.uwyo.edu/uw/news/2010/12/wyoming-residents-disapprove-of-new-health-care-law.html. The Wyoming Liberty Group was provided with the detailed results of this survey, and maintains a copy on file.

[22] S.J. 0002, 61st Legis. (Wyo. 2011), *available at* http://legisweb.state.wy.us/2011/Enroll/SJ0002.pdf.

[23] *See supra* note 3 and accompanying text.

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