A State Obamacare Exchange: Arkansas's Worst Option

By Dan Greenberg and Marc Kilmer
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Once again, Arkansas policymakers are debating whether our state or our federal government should establish and manage a health insurance marketplace (popularly called an "exchange"). In a recent presentation to the Health Reform Legislative Task Force, Governor Asa Hutchinson asked "Why are we building a state exchange, rather than relying upon the continued partnership with the federal exchange?" No real answer has been forthcoming: notably, the advocates of transforming Arkansas's federal exchange[1] to a state exchange have provided slogans, not substance, when asked to explain the basis of that recommendation. In fact, establishing a state Obamacare exchange would create huge problems for Arkansas:

- From a *tax* perspective, a state exchange would impose a 378 percent tax increase on Arkansans who purchase insurance through it.
- From a *budget* perspective, the establishment of a state exchange appears to be a gateway to new health care fees and new burdens on the Arkansas state budget.
- From a *practical* perspective, states that have established state exchanges have experienced extraordinary practical difficulties. Indeed, several states have recently abandoned their state-run exchanges for a federal exchange.
- From a *policy* perspective, a state-run exchange produces little or no meaningful increase in local or state control.
- From a *political* perspective, voters do not want Arkansas policymakers to set up such an exchange.
- From a *legal* perspective, establishing a state exchange may violate federal law and invite legal action.

In short, establishing a state exchange would cause problems for Arkansas consumers and burden state taxpayers for decades to come. To put it bluntly, a state exchange is bad for Arkansas.

The Choice Policymakers Face

Currently, Arkansas is moving toward a state-run health insurance exchange. In 2013, Governor Mike Beebe signed legislation that created the path towards a

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state exchange.[2] The state would have taken over its operation on July 1, 2015; however, earlier this year the General Assembly reshuffled the deck by passing Act 398. This legislation prohibited Arkansas from moving to a state-run exchange until the Supreme Court ruled in *King v. Burwell*, a case in which plaintiffs challenged the legality of subsidies to people who buy their health insurance through a federal exchange. Earlier this summer, the Supreme Court ruled in *King* that under the ACA, individuals who buy insurance in federal exchanges, as well as in state exchanges, are entitled to federal subsidies.

Given that ruling, the Arkansas Health Insurance Marketplace (AHIM), the nonprofit establishing a state-run exchange, can now continue its work. But the transition is not inevitable. Theoretically, state policymakers could step in and ensure that the federal government continues to manage Arkansas's exchange.

The Heritage Foundation sums up the situation that Arkansas faces in the post-*King* world:

> The main purpose of the ACA's government-run exchanges is to administer the law's absurdly complicated coverage subsidies. By ruling in the *King* case that those subsidies may be paid through the federally run exchange (Healthcare.gov), the Supreme Court effectively eliminated any remaining rationale for states to establish and operate their own ACA exchanges.[3]

Few (if any) benefits would therefore accrue from setting up a state exchange. However, as described below, there would be many drawbacks to doing so.

A State Exchange Will Trigger A Tax Increase

If the state moves to a state exchange, many more Arkansans will find their insurance policies subject to a new fee or tax. This change is described in the grant proposal submitted by AHIM in October 2014:

> AHIM has decided to recommend an initial assessment or user fee of 3 percent to be applied against all Qualified Health Plans (QHPs) sold in the Marketplace in Plan Year 2016. Subject to [Centers for Medicare and Medicaid Services] approval, this fee would replace the current 3.5 percent assessment being charged by the federal

government on all Arkansas QHP premiums, except Private Option premiums.[4]

In plain English, the state would charge a fee on every plan sold through the insurance exchange, including private-option plans. That would be a massive expansion of the fee's reach. The grant proposal estimates that 280,000 plans would be subject to this state fee by 2019. Currently, the only plans subject to the federal fee are those of 52,784 Arkansans who purchased health insurance through the federal exchange.[5]

AHIM estimates that in 2019 the new fee would raise $41.3 million from state policyholders. According to AHIM, in 2015 the average premium was $4,680.[6] If 52,784 Arkansans paid the 3.5 percent federal fee on these premiums, that would produce revenue of $8.6 million. Even though current enrollees would face a lower fee, the higher number of enrollees subject to the fee through a state exchange would increase the revenue extracted from Arkansans by 378 percent. Because Obamacare makes the purchase of health insurance compulsory, it is reasonable to view this revenue hike as a tax increase.

A State Exchange Will Create New State Budget Expenses

AHIM is seeking such a large increase in revenue because, nationwide, state exchanges have proven costly to establish and operate. States that complied with the ACA and established their health insurance exchanges before January 1, 2014, were eligible for federal grants. But as Heather Howard, director of the State Health Reform Assistance Network at Princeton University, points out, that is no longer the case: "There is no new money now to build new infrastructure, and there are no grants available to fix these systems if they're struggling."[7] Arkansas has received some grants to move to a state-run exchange, but further federal money is unlikely.

Even if the state did receive more federal grants, a state-run exchange would blow a hole in Arkansas's state budget; a federal exchange, in contrast, requires the federal government to pick up the tab. As analyst Elizabeth Stelle has noted, "Creating a state exchange – or even a hybrid exchange – would be costly. Annual operating budgets for state exchanges, according to *The Washington Post*, are $28 to $32 million, not including start-up costs which the federal government may not provide."[8] Some states spent well over $100 million to set up their exchanges. Maryland, for instance, spent $170 million, but had to scrap its exchange because it failed to work.[9]

According to the *Washington Post,* the Government Accountability Office found that "Six states running their own exchanges cited lack of adequate funding as a major challenge in a survey."[10] In California, for instance, the state exchange is struggling financially because of low enrollment. As Lanhee Chen of the Hoover Institution has noted, "They expected to bring in $242 million in revenues, but they are going to fall far short of that number, and it is unlikely they will remain sustainable in the long run without federal funding, which goes away next year."[11]

In July of 2014, Arkansas state exchange director Cheryl Smith Gardner informed state legislators that she planned to request federal grants of $91 million to $133 million to set up Arkansas's state exchange;[12] if Arkansas establishes a state exchange, a sizable portion of this original cost will be imposed on state taxpayers every year, given the required continuing eligibility verification for each Obamacare participant and the salaries, benefits, and routine expenses that come with operating an exchange. And considering Arkansas's record of expensive and embarrassing failures in determining eligibility, there is reason for concern about Arkansas's efficiency in performing these tasks in the future.[13]

Many states are trying to address their financial difficulties by imposing fees on the insurance plans sold through them. Of course, these fees are passed on to consumers, raising the cost of the supposedly "affordable" policies (and thus raising subsidy amounts). These states include Kentucky, Colorado, and Maryland, along with the District of Columbia. In fact, a majority of the state exchanges charge a percentage fee based on the plan's cost. Other states are looking at imposing such a fee to help recoup costs.[14]

Proponents of a state exchange in Arkansas have argued that a federal exchange is undesirable because of the fees that exchange could impose. Given the prevalence of this practice in the financing of state exchanges, this argument is difficult to take seriously. Some states, such as Kentucky, even apply the fee to policies sold outside the exchange. As noted above, AHIM proposes a massive tax increase on Arkansans purchasing insurance through the state exchange.

The Practical Problems A State Exchange Will Create

Besides the budget issues, there are also numerous practical problems that come with a state exchange. As the *New York Times* reports, some state officials regret their move to a state exchange:

> "There may be a little bit of buyers' remorse going on in some state capitals right now," said Sabrina Corlette, the director of the Center on Health Insurance Reforms at Georgetown University. She said states underestimated the difficulty and expense of building and maintaining state marketplaces. Now, she said, many officials are asking: "What did we get ourselves into?"[15]

Arkansas would likely experience the same problems. Indeed, earlier this year the *Washington Post* provided a portrait of widespread implementation failures and previously unanticipated costs in state exchanges nationwide: "Nearly half of the 17 insurance marketplaces set up by the states and the District under President Obama's health law are struggling financially."[16]

In Hawaii, for instance, "the exchange has been plagued by low enrollment numbers and technological issues, making it noncompliant with the federal requirements outlined in the Affordable Care Act."[17] These problems persist, despite Hawaii's consumption of $205 million in federal grants.[18]

Hawaii, Nevada, Oregon, and New Mexico have switched from a state exchange to a federal exchange.[19] Minnesota and Vermont are considering doing the same. (Minnesota's technical failures are particularly dire: its exchange just reported a backlog of $180,000 re-enrollment failures.[20]) Massachusetts has had to completely redo its state exchange. Other states are having serious difficulty achieving the necessary funding to pay for exchanges that are more expensive and that enroll fewer individuals than anticipated. Maryland, which had to scrap its state exchange and start over after a catastrophic launch, will likely request a taxpayer bailout.

California's state exchange, Covered California, did not serve users well, according to the Hoover Institution's Chen:

> Covered California required Californians who wanted to buy subsidized coverage to complete their enrollments by telephone, even where a Web-based option was available. This added layer of bureaucracy is demonstrative of why Obamacare is driving up costs in our health care system and ultimately making it more difficult for people to get access to quality, affordable health coverage.[21]

Because of these difficulties, California is considering other options. According to the director of that state's exchange, "I think you are going to see

much more of a hybrid across the nation."[22] In other words, more states will be looking at adopting the type of federal exchange that Arkansas is in the process of abandoning.

Last month, the General Accounting Office released a draft report looking at state exchanges. According to one account, it found problems in many states:

> Of the 14 state-based marketplaces, for example, only eight were "fully operational" and operating without service interruptions" as of February 2015. The other six were categorized as partially operational, meaning that although there was some functionality they "did not work as intended and may have required manual processes to supplement automated functionality" – workarounds such as using paper copies or human data entry.[23]

In an article for *Forbes*, health care expert Grace-Marie Turner described the various problems that plagued the Oregon health insurance exchange. Then she pointed out a salient fact that Arkansas lawmakers should consider:

> While Oregon clearly tried to do too much, it had nearly four years to get its exchange up and running. States considering setting up their own exchanges would have months, not years, to get it done. This is not a turnkey operation, no matter what armies of management consultants surely are telling officials in the 37 states in efforts to win huge contracts going forward.[24]

In light of these problems, Congress is increasingly likely to change the rules in the future in response to the concerns of the states and their exchanges. Because of the widespread failure of state exchanges and the trend towards federal exchanges, the problems that states will face in the future will almost certainly be easier to address through a federal exchange. The argument that state exchanges have advantages in innovation is a snare: the reform designs that Congress adopts in the future appear increasingly likely to focus on federal exchanges, and thus the possibility of a unique state-exchange design could create more bugs than features. For instance, Congress is likely to move away from Obamacare's one-size-fits-all rules and make changes permitting consumers to buy insurance through existing private channels, such as eHealthInsurance.com. As long as the federal government makes Obamacare rules, the flexibility that state-exchange boosters brag about might create unintended consequences that could place state-exchange states at a significant disadvantage relative to federal-exchange states.

The Myth of State Control

Contrary to the sloganeering of state-exchange advocates, a state exchange would not increase state policymakers' control over insurance providers or create better customer service. The federal government would control either a state or federal exchange. Obamacare empowers the secretary of Health and Human Services to impose "such … requirements as the Secretary determines appropriate" on state exchanges;[25] it specifies that states "may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary";[26] it grants the secretary ultimate authority to reject or approve a state exchange.[27]

The Cato Institute's Michael Cannon points out how the federal government can enforce this control:

> The law allows the federal government to commandeer any state-run Exchange that falls short of full compliance with federal dictates. An Obama administration missive explains that the new law "authorizes [the federal government] to ensure that States with Exchanges are substantially enforcing the Federal standards… and to set up Exchanges in States that elect not to do so *or are not substantially enforcing related provisions.*" [The emphasis is Cannon's.][28]

In effect, the federal government sets the rules for the exchange and leaves the states "free" to carry out these rules. The states have little flexibility in how they design or manage an exchange. Arkansas could do little to innovate, given the strictures laid out by the federal government in its Obamacare regulations. Notably, although state-exchange advocates such as Gardner have claimed that Arkansas could transition back to a federal exchange if Arkansas policymakers wanted to, those policymakers should bear in mind that the federal government possesses something like a veto power that can be exercised so as to bar conversion back to a federal exchange. If Arkansas (or, indeed, any state-exchange state) wants to end its state exchange, it must not only formally notify the federal department of Health and Human Services of its intention to do so at least a year in advance, but must also "coordinate with HHS on a transition plan to be developed jointly between HHS and the state."[29] That is, existing regulations seem to grant HHS holdout power that could stymie the conversion from a state to a federal exchange.

Gardner has also claimed that Arkansas needs a state-run exchange to pursue Medicaid reform.[30] But because the law governing Medicaid is the Social Security

Act, not the Affordable Care Act, it is difficult to see why this would be true. Arkansas can pursue changes to Medicaid under Section 1115 of the Social Security Act regardless of whether it has a federal or state exchange. It is true that under the ACA, the state can submit a single innovation waiver that would coordinate Medicaid activity with a state exchange, but this does not preclude stand-alone Medicaid reform.

Furthermore, the notion that our state cannot control the performance of Arkansas insurance providers under a federal exchange is groundless. Arkansas policymakers can always exercise their power to determine if insurance providers are in good standing, a judgment that dictates whether they can keep their licenses to do business in the state.

A State Exchange Is Unpopular

Although voters are probably unfamiliar with all these arguments against a state exchange, they nonetheless realize it is a bad idea. According to a recent poll by the Foundation for Government Accountability, 50 percent of voters (and over 75 percent of Republican voters) say they would be less likely to reelect legislators who move to set up state health insurance exchanges. Only 27 percent of voters say they would be more likely to reelect legislators who choose a state exchange.[31]

Policymakers who are attentive to public opinion about health care reform (or, to put it another way, about Obamacare) will find that, in this instance, the public is in sync with healthy public policy.

Creating a State Exchange after 2014 May Be Illegal

With respect to federal law, there is a live question whether our state can legally switch to a state-run exchange after missing the black-letter statutory deadline. Section 1321 of the ACA gave each state until January 1, 2014, to establish a state exchange.[32] Obviously, that deadline has passed.

Nonetheless, because Arkansas officials took certain actions that could lead to the future establishment of a state exchange, defenders of a transition could argue that the state has complied with the law. And given our courts' recent history of assigning more weight to what they understand as the law's purpose than to the law's text,[33] these arguments might be successful. But this issue is far from clear. The text seems to indicate that Arkansas cannot establish a state exchange after January 1, 2014 – period. By definition, when the government spends money in a

manner inconsistent with the law, this is an illegal exaction. Given Obamacare's rock-bottom political reputation in Arkansas, an arguably illegal switch from a federal to a state exchange invites an illegal-exaction lawsuit.

Conclusion

The establishment of a state exchange in Arkansas would demonstrate a rejection of conservative principles of governance; it would take place against a backdrop of state-exchange failures across the nation. As other states grapple with implementation difficulties and cost overruns, it makes little sense for Arkansas to invite such problems into our state. A state-run exchange would provide little advantage for Arkansas, but it would create a variety of terrible consequences for Arkansas's consumers and taxpayers.

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[1] Although Arkansas's exchange is sometimes described as a "hybrid" exchange, our exchange has historically been understood as a federal exchange. The relevant federal statute, Section 1321(c)(1) of the ACA, only anticipates two kinds of exchanges: state and federal.

[2] Act 1500 of 2013.

[3] Edmund Haislmaier and Nina Owcharenko, "States Should Start Planning Now for the Post-ACA World," The Heritage Foundation, July 23, 2015. http://www.heritage.org/research/reports/2015/07/states-should-start-planning-now-for-the-post-aca-world

[4] "Arkansas Health Insurance Marketplace Level Two Establishment Grant Project Narrative," AHIM, October 15, 2014, p. 48.

[5] "March 31, 2015 Effectuated Enrollment Snapshot," CMS, June 2, 2015. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html

[6] "Arkansas Health Insurance Marketplace Level Two Establishment Grant Project Narrative," p. 48.

[7] Margot Sanger-Katz, "Obamacare Ruling May Have Just Killed State-Based Exchanges," *New York Times*, June 25, 2015. http://www.nytimes.com/2015/06/26/upshot/obamacare-ruling-may-have-just-killed-state-based-exchanges.html

[8] Elizabeth Stelle, "State Health Care Exchange: A Disastrous Contingency Plan," Commonwealth Foundation, May 8, 2015. http://www.commonwealthfoundation.org/policyblog/detail/state-health-care-exchange-a-dangerous-contingency-plan.

[9] Aaron Davis and Mary Pat Flaherty, "Maryland Officials Were Warned for Year of Problems with Online Health Insurance Site," *Washington Post*, January 11, 2014. http://www.washingtonpost.com/local/maryland-news/maryland-officials-were-warned-for-a-year-of-problems-with-online-health-insurance-site/2014/01/11/f094ad94-6a98-11e3-8b5b-a77187b716a3_story.html

[10] Peter Suderman, "Government Watchdog: Billions in Funding for Obamacare's Exchanges Not Tracked Well, Many Functions Remain Incomplete," *Reason* Hit & Run Blog, July 20, 2015. http://reason.com/blog/2015/07/20/government-watchdog-funding-for-obamacar
[11] Loren Heal, "California Obamacare Exchange is Running out of Money," *Health Care News*, The Heartland Institute, June 15, 2015. http://news.heartland.org/newspaper-article/2015/06/17/california-obamacare-exchange-running-out-money
[12] Andy Davis, "State Creating Own Exchange Gets Price Tag," *Arkansas Democrat-Gazette,* August 30, 2014.
[13] Earlier this year, Arkansas Department of Human Services Director John Selig testified that the state's project to create a computerized enrollment and eligibility verification system for Medicaid, food stamps, and other programs has already cost roughly $100 million in taxpayer funds but is not yet functional. Selig estimated that its cost would be roughly $200 million. Despite repeated questions from legislators, Selig declined to name any state employees responsible for this debacle, instead stating that he was ultimately responsible for it. He explained that "I didn't want to spend a lot of money on additional vendors to manage this project. I think in hindsight that was probably wrong. That's on me. I was trying to save money, and I think I saved a dime and spent a dollar." Andy Davis, "System's Cost Up to $200M, Legislators Told," *Arkansas Democrat-Gazette,* May 29, 2015.
[14] Colleen McGuire, "How Much Are You Paying In State Health Exchange Fees?" Healthcare.com, May 15, 2015. https://blog.healthcare.com/health-insurance/how-much-are-you-paying-in-state-health-exchange-fees/.
[15] Sanger-Katz, "Obamacare Ruling."
[16] Lena Sun and Niraj Chokshi, "Almost Half of Obamacare Exchanges Face Financial Struggles in the Future," *Washington Post*, May 1, 2015. http://www.washingtonpost.com/national/health-science/almost-half-of-obamacare-exchanges-are-struggling-over-their-future/2015/05/01/f32eeea2-ea03-11e4-aae1-d642717d8afa_story.html.
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[18] Alexander Hendrie, "Hawaii's $205 Million Obamacare Exchange Implodes," Americans for Tax Reform, May 12, 2015. https://www.atr.org/hawaii-s-205-million-obamacare-exchange-implodes.
[19] Lauren Gill, "What Hawaii can learn from Nevada's switch to the federal health insurance exchange healthcare.gov," *Pacific Business News*, June 9, 2015. http://www.bizjournals.com/pacific/blog/2015/06/what-hawaii-can-learn-from-nevada-s-switch-to-the.html.
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[21] Heal, "California Obamacare Exchange."

[22] Alonzo-Saldivar, Ricardo, "High Costs Plague Some State-Run Health Insurance Marketplaces," ABC News, July 27, 2015. http://abcnews.go.com/US/wireStory/high-costs-plague-state-run-health-insurance-markets-32703846
[23] Suderman, "Government Watchdog."
[24] Grace-Marie Turner, "Oregon's Failed Obamacare Exchange is a Warning for Other States," *Forbes*, March 31, 2015. http://www.forbes.com/sites/gracemarieturner/2015/03/31/oregons-failed-obamacare-exchange-is-a-warning-for-other-states/3/.
[25] 42 USC § 18041 (a)(1)(D).
[26] 42 USC § 18031 (k).
[27] 42 USC § 18041 (c).
[28] Michael Cannon, "Should New Hampshire Create a Health Insurance Exchange?" Cato Institute, February 2, 2012. http://www.cato.org/publications/congressional-testimony/should-new-hampshire-create-health-insurance-exchange.
[29] 45 CFR 155.106.
[30] Taylor, Caleb, "Will Arkansas Establish a State O'Care Exchange?" The Arkansas Project, June 29, 2015. http://www.thearkansasproject.com/will-arkansas-establish-a-state-ocare-exchange/
[31] "After *King v. Burwell*: Voters' Opinions on Obamacare, Exchange Subsidies, and Needed Reforms," Foundation for Government Accountability, March 26, 2015. http://thefga.org/download/KvBMemoPoll-final.pdf.
[32] See Section 1321 of the ACA here: https://sites.google.com/site/healthreformnavigator/ppaca-sec-1321.
[33] See, e.g., *National Federation of Independent Business v. Sebelius,* 567 U.S. ___ (2012), *King v. Burwell*, 576 U.S. ____ (2015).