TEXAS PUBLIC POLICY FOUNDATION

PolicyPerspective

June 2017

Center for Tenth Amendment Action

Unity Through Federalism: Repealing Obamacare's Regulations and Providing an Opt-In for the States

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Key Points

- A review of just a handful of ObamaCare's regulations and mandates exposes their harmful impact on patients and providers.
- Even if it doesn't fully repeal ObamaCare, at a minimum Congress must repeal the onerous regulations and mandates that drive up premiums and deductibles to give America's faltering healthcare system a chance to recover.
- The Senate should reverse the half measures of the House's waiver approach by changing the optional, partial opt-out waiver into an optional opt-in trigger to free states from Obamacare's heavy-handed regulatory regime, unless they choose to stay in.
- This is the only remaining compromise worth considering that would significantly drive down premiums for patients, improve quality of care for consumers, and provide states with the opportunity to operate in freer market-oriented environments.

Synopsis

Reversing the House's state waiver approach is the only chance Congress has to salvage both its credibility and America's battered health care system.

Where Things Stand

The American Health Care Act (AHCA) passed the House of Representatives on May 4th after nearly two months of negotiations and policy disputes. Unfortunately, the AHCA has provided a poor benchmark for the Senate and fails to fulfill the promise to the American people to fully repeal Obamacare. Despite good faith efforts made by the House Freedom Caucus to remedy the significant policy problems with the bill, the AHCA still passed the House leaving significant parts of the Medicaid expansion intact, replacing one subsidy with another in the form of a new refundable tax credit, and maintaining almost all of Obamacare's federal insurance regulations and mandates.

After the AHCA initially failed to secure the necessary votes for passage, the House Freedom Caucus secured limited waivers for states to opt out of some of Obamacare's onerous regulations and mandates—namely the age-rating requirements, the continuous coverage penalty, and the essential health benefits mandate. However, many onerous regulations remain unable to be waived and the default setting for all 50 states remains the Obamacare regulatory scheme.

To date, not a single state has announced that it would accept or even desire the AHCA waiver. Recent analysis by the Congressional Budget Office suggests that some states will accept the partial waivers for a slight decrease in premiums in the out-years of the 10-year budget window (CBO, 6). However, even this prediction is dependent on the type of coverage and the extent to which states would waive specific provisions. The CBO was quick to admit that their prediction is based on significant guesswork and that at minimum roughly half of the American people reside in states that will not take the waiver at all. The incentive for state leaders to expend significant political capital for only a partial opt-out of some regulations remains to be seen.

If lawmakers are serious, or were ever serious, about fully repealing Obamacare and moving toward a free-market system that empowers patients, lowers costs, and provides greater choice for consumers, then the only remaining course of action worth considering is reversing the waiver process. The Senate should alter the AHCA approach from a proactive opt-out of Obamacare to a proactive

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opt-in to Obamacare, with the default federal setting being a full repeal of the insurance regulations and mandates.

It's All About the Cost Drivers

Since the implementation of Obamacare in 2013, Americans have seen their premiums skyrocket—doubling or tripling in the past four years depending on the state in which they live and/or work (ASPE). These regulations and mandates are tightly woven together. Despite the creation of the limited state waivers, Congress should not simply cherry-pick which insurance regulations can be repealed and which ones must remain in place. This would create a patchwork environment, still heavily regulated, for all 50 states and leave insurers and patients with yet more uncertainty (Jacobs).

This approach is not only bad policy if Congress is truly committed to improving care and lowering cost, but also reckless in that it would likely accelerate the current death spiral. Insurers are exiting the Obamacare exchanges by the droves—a result of these heavy-handed federal regulations dictating coverage mandates and resulting in unsustainable cost differentials. This is leading to even higher premiums and fewer options for patients. Congress must repeal all the federal regulations and mandates and let states innovate to avert catastrophe.

Among the significant cost-driving regulations that the AHCA waivers fail to incorporate are guaranteed issue, the under-26 mandate, a complete withdrawal from community rating, medical-loss ratio, and the preventive services mandate. An inspection of just a few of these regulations not included in the opt-out waiver quickly illustrates why they must be outright repealed at the federal level.

Guaranteed Issue and Community Rating: Guaranteed issue is one of the most consistently talked about regulations, commonly known as the "pre-existing condition" mandate. Section 1201 of Obamacare re-wrote several sections of the Public Health Service Act. The revised Section 2702 requires insurers to offer coverage to all applicants and prohibit insurers from altering their coverage decisions based on health status or condition.

Before Obamacare was implemented, consultants at the actuarial firm Milliman determined that premiums would rise anywhere between 20 to 45 percent due to the enrollment of a sicker population stemming from the pre-existing condition requirements (Durham, 8). This prediction came to pass as Blue Cross Blue Shield Association found that individual market enrollees incurred 19 percent higher costs than enrollees in employer plans in 2014 because of this adverse selection. In 2015, that gap between individual enrollees and those in employer plans widened to 22 percent (Blue Cross Blue Shield).

In other words, this one regulation has been one of the most onerous for patients and providers. It has resulted in higher costs, longer wait times, reduced access, and reduced quality of care while being couched in politically misleading terms to make it seem popular. A 2015 study performed by Avalere Health found that the narrow networks on the Obamacare exchanges, largely a result of guaranteed issue and community rating, have on average 34 percent fewer providers than average plans outside the exchanges, including 24 percent fewer hospitals and 42 percent fewer oncologists and cardiologists (Sloan and Carpenter).

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A recent study from the Cato Institute showed that public support for this regulation plummets once Americans realize what it does to the cost and quality of their health care (Ekins). If guaranteed issue remains the default standard at the federal level, then no one can say that Obamacare was truly repealed.

The negative impact of guaranteed issue is further ex-

acerbated when combined with the community rating mandate.

Community rating prevents insurers from using any criteria other than family size, geography, tobacco use, and age for varying premiums. In Section 1201 of Obamacare, a specific prohibition was put on any cost variation by age of greater than three to one. As people age, their health costs tend to increase, resulting in a natural variance of about five to one. In effect, community rating raised premiums for young individuals and lowered them slightly for older enrollees.

The same Milliman study found that premiums would increase for enrollees under age 35 by 19 to 35 percent as a result of community rating (Durham, 7). A different study by the Society of Actuaries estimated that costs would rise by 27 percent for individuals aged 21 to 29 with a very slight decrease of 3 percent for those aged 60 to 64 (Yamamoto). And a third study by Oliver Wyman determined premiums would increase by some 41 percent for those in their twenties, and by 31 percent for those in their thirties as a result of this mandate.

Preventive Services Mandate: Among the "early benefits" of the law taking effect six months after its enactment was a mandate for preventive care provided without cost-sharing. Included in this mandate are women's preventive health screenings which were later interpreted to include contraception. While the contraception requirements should be administratively withdrawn, there are other requirements that are not as easily overcome.

When the Obama Administration was implementing the requirements of this mandate, even they admitted that this one mandate would increase premiums by nearly 2 percent on average for enrollees in non-grandfathered plans (Coverage of Preventive Services, 41738).

The Under-26 Mandate: Commonly referred to as the "slacker mandate," this provision allows individuals to remain on their parent's health insurance plan until their 26th birthday. Some states had previously enacted similar requirements, but the federal mandate extended coverage to a higher age group and incorporated it into employer plans.

The Obama Administration estimated the cost of this mandate at $3.5 billion to $7 billion in 2011-13 with a commensurate increase in individual premiums of some 1.5 percent (Dependent Coverage of Children, 27127). There are other estimates though that suggest the impact is much higher than what the Obama Administration calculated, adding upwards of another 3 percent increase to individual premiums (Japsen). And a Mercatus Center study suggested that the Obama Administration had under-estimated several components within this mandate and were underselling the costs by roughly $1 billion per year (Conover and Ellig).

If Congress is to achieve even a modicum of their policy objectives in repealing Obamacare, reducing costs, and improving quality of care, the AHCA opt-out waiver process must be reversed.

Federalism and The Opt-In Solution

The passage of the McCarran-Ferguson Act in 1945 largely devolved insurance regulation to the states. While there were a few isolated mandates, such as mental health parity coverage, the federal government largely left health insurance in the hands of the states. The lone major exception to this approach was large group insurance provided by employers, which is regulated under the Employee Retirement Income Security Act (ERISA) under the guise of interstate commerce. Historically, Washington has left states' health insurance markets alone and this remained relatively unchanged until the passage of Obamacare in 2010, which inserted federal bureaucrats into state markets and insurance regulation in a major, and negative, way.

It's important to note that the pre-Obamacare environment was hardly a free market and retained myriad heavy-handed federal policies that regulated the supply-side of health care.

Nevertheless, if Congress is to achieve even a modicum of their policy objectives in repealing Obamacare, reducing costs, and improving quality of care, the AHCA opt-out waiver process must be reversed. Instead of placing the burden on states to opt out of Obamacare's regulations, states should be allowed to opt in to Obamacare. This would restore state sovereignty in a manner consistent with Tenth Amendment principles.

This a two-pronged approach is arguably the most consequential element of the current health care debate. First, Congress should eliminate all of Obamacare's Title I regulations and mandates at the federal level. Second, Congress should provide a proactive opt-in trigger that would allow states to put their citizens back into the Obamacare architecture should they so choose. While this trigger is inadvisable and a far cry from where Congress should be, which is fully repealing Obamacare, this approach is the most viable compromise remaining, given the dynamic where many members of Congress never intended to actually repeal Obamacare.

Directly eliminating the regulations and mandates as the federal standard would have an immediate impact on the rising cost of premiums and deductibles. It would provide greater certainty for providers, and patients would immediately see the benefits on their monthly statements.

The opt-in trigger could be tailored and couched in similar legislative language as the opt-out waiver. Implementation of the trigger would vary, and there are several pathways for giving a state the option to readopt Obamacare's architecture for its population.

One way would be to require the governor and the state legislature of a state to send a declaration of intent to the Department of Health and Human Services (HHS) to maintain Obamacare's regulations and mandates for that particularly state.

While this trigger could be tailored as a declaration of intent, it could also be tailored as a certification. This would require HHS to act as a sort of inspection entity to determine if the state's insurer and regulatory market is healthy enough to maintain the federal regime.

Under a certification process, once HHS ascertained that the appropriate criteria had been met, then the state would receive approval to readopt the provisions within Title I of Obamacare, and insurers would be expected to craft their coverage mandates accordingly in the affected states.

The opt-in trigger has the benefit of automatically freeing up states and giving them an opportunity to operate in a freer market-oriented environment, while providing a pathway for states seeking greater regulatory control. Furthermore, this reverses the process being considered so that states get to make the decision to opt in to Obamacare, as opposed to being forced to opt out.

This approach would not resolve the negative policy impacts of the costly Medicaid expansion or the new proposed subsidy regime, both of which only further centralize control in Washington and add to our nation's $20 trillion debt (TPPF, 6). Nevertheless, the opt-in trigger would preserve the fiscal posture and care quality of non-expansion states, while potentially giving even expansion states the opportunity to pursue market reforms capable of improving both their care and cost outlook.

Summary

As the Senate wrestles with important questions on the Medicaid expansion, the new refundable tax credit subsidy, the new Patient and State Stability bailout fund to insurers, and what can make it past the Byrd rule, it must ultimately refocus the discussion on the insurance regulations and mandates.

The Senate must eliminate the insurance regulations and mandates at the federal level as part of any legislative effort. This repeals Obamacare's cost-driving architecture, provides some certainty for insurers, and immediate relief for patients. Perhaps most importantly, this approach respects the states and gives them a fighting chance to allow markets to flourish in a less regulated environment to provide the competition necessary to empower patients, lower costs, and increase the overall quality of care.

The opt-in trigger for states reverses the flawed waiver process in the House, sets the default federal setting at full repeal, and provides a pathway for states

to re-embrace Obamacare's approach to health care should they so choose.

While it is far preferable for Congress to simply repeal Obamacare, a sizeable number of lawmakers seem determined to maintain Obamacare despite the desires of the American people. This opt-in approach is the only remaining compromise worth considering that can still achieve some of the policy results that Congress has promised the American people for the past seven years. Anything less than this will be rightly seen as both a policy failure and a broken promise. ✯

Reference List

ASPE (Office of the Assistant Secretary for Planning and Evaluation). 2017. *Individual Market Premium Changes 2013-2017*. Department of Health and Human Services.

Blue Cross Blue Shield Association. 2016. "Newly Enrolled Members in the Individual Health Insurance Market after Health Care Reform: The Experience from 2014 and 2015." Blue Cross Blue Shield Association, March 20.

CBO (Congressional Budget Office). 2017. *Cost Estimate for H.R. 1628, The American Health Care Act*. Congressional Budget Office.

Conover, Christopher, and Jerry Ellig. 2012. *Beware the Rush to Presumption, Part A: Material Omissions in Regulatory Analyses for the Affordable Care Act's Interim Final Rules*. Mercatus Center.

Coverage of Preventive Services under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726 (July 19, 2010) (to be codified at 45 CFR Part 147; 26 CFR Part 54; 29 CFR Part 2590).

Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27,122 (May 13, 2010) (to be codified at 45 CFR Parts 144, 146, and 147; 26 CFR Parts 54 and 602; 29 CFR Part 2590).

Durham, Daniel. 2013. "Health Insurance Premiums Under the Affordable Care Act" (testimony before the House Energy and Commerce Committee, Subcommittee on Oversight and Investigations, May 20). U.S. House of Representatives Document Repository.

Ekins, Emily. 2017. "New Cato Survey: Large Majorities Support Key Obamacare Provisions, Unless They Cost Something." *Cato at Liberty*, March 2.

Jacobs, Christopher. 2017. "Americans Do Have 'Binary Choices' About Replacing Obamacare, But Not The Ones Paul Ryan Says." *Federalist*, April 4.

Japsen, Bruce. 2011. "Young Adults' Coverage May Cost Parents Even More." *New York Times Prescriptions Blog*, November 23.

Sloan, Chris, and Elizabeth Carpenter. 2015. "Exchange Plans Include 34 Percent Fewer Providers Than the Average for Commercial plans." *Avalere*, July 15.

TPPF (Texas Public Policy Foundation). 2017. "Memo to the Texas Congressional Delegation." May 1.

Yamamoto, Dale. 2013. Health Care Costs—From Birth to Death. Health Care Cost Institute.

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