



## Obamacare 2013: Now Playing At A State Capitol Near You

By Austin Hill - 10/14/2012

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If elected, Mitt Romney vows to “end” it.

If re-elected, Barack Obama says he’s “open to amending” it.

But regardless of who wins the presidency next month, conscientious voters need to know this: Obamacare is already costing taxpayers lots of money, and within the next few months it will cost millions of dollars more.

It’s bad enough that President Obama’s “if you like your Doctor, you can keep your Doctor” promise has proven false. And it’s bad enough that his promise to “bend the healthcare cost curve downward” has proven to be fictitious, as well (according to MIT Economist Jonathan Gruber prices for private insurance will likely increase 30% by 2016 – this, despite Gruber’s support of the President’s claims in 2009).

Now, state governments are spending taxpayer-funded time and resources figuring out how to comply with the federal mandates. The Obamacare law has imposed a deadline of November 16th, whereby the states must explain to the U.S. Department of Health and Human Services what they intend to do about the establishment of their respective “healthcare exchanges” - the government organized group of standardized health insurance plans from which citizens private citizens and organizations will be permitted to purchase health plans – and the states are deciding now how to proceed.

According to the law, each state can choose one of three options when it comes to setting up an exchange: A) the state can establish an exchange on its own; B) the state can let the federal government set up an exchange on the state’s behalf; or C) the state can choose a “hybrid” approach, and co-mingle both state and federal authorities and resources and produce an exchange together.

Back in August of this year, members of the U.S. House of Representatives heard testimony about the exchanges from Michael Cannon, Director of Health

Policy Studies at the Cato Institute. Cannon noted at the time that, given the way the Obamacare law is written, the sitting Secretary of Health and Human Services (whomever that happens to be at any given time) has broad authority to impose requirements and restrictions on a “state exchange,” regardless of whether the individual state government constructs the exchange or if the federal government does it for the state. In cases where a state seeks to set up an exchange, the federal government will ultimately determine which health insurance plans will be “allowed” to be bought and sold in that state, and what those health insurance plans will cover.

Cannon spelled-out this reality in no uncertain terms: “If what you want is a federally run health insurance exchange in your state – a government agency controlling the private health insurance market – if what you want is the federal government to control your state, the best thing you can do is establish an exchange” he told the congressional members. He also noted that once a state makes the overture towards creating an exchange, there is probably no turning back on that decision, legally speaking; the state at that point will have forfeited its sovereignty and will likely not regain it.

For states that don’t want a “federally run health insurance exchange,” Cannon had a fascinating suggestion: don’t do anything. “If the state does not establish an exchange then there might not be an exchange at all” Cannon noted. The reason for this is simply because Congress never approved any funding for the state health insurance exchanges, and given how politically unpopular Obamacare is today, Congress probably won’t approve any such funding for the foreseeable future.

Meanwhile, state government officials are consulting with outside “experts,” and each other, in hopes of determining how to proceed. Just last week, a task force selected by Idaho Governor Butch Otter met and heard over six hours of testimony from both private consultants, and officials from other states.

Bruce Greenstein, secretary of the Louisiana Department of Health and Hospitals, told the Idaho task force that Louisiana has chosen not to create its own exchange. “There is really no way to effectively estimate the state’s costs for creating an exchange and the provisions in the law are vague,” he said. His associate, Carol Steckel, added that “we view this law as a ‘one size fits all’ effort that cannibalizes the private insurance markets. It doesn’t work for us here in Louisiana.”

Jonathan Hurst, a policy advisor to Texas Governor Rick Perry, described the insurance exchange mandate as a “logistical and administrative nightmare,” and noted that “90 percent of the rules that will govern these things have yet to be written” (the hastily drafted Obamacare law makes reference to “future rules” that haven’t been established yet). Hurst said that Texas is not pursuing a state exchange, noting that there are “too many risks and unknowns” in the law, and a

state that pursues an exchange today could be held liable for violating rules that will be established sometime later.

Perhaps most striking was the testimony heard in Idaho from representatives of KPMG, the global accounting and professional services firm. Hired by Idaho to research the costs of creating a state exchange, KPMG reported the price to be approximately \$77 million to design and implement the exchange, with recurring operational costs estimated to be \$10 million annually.

When asked by one of the Idaho task force members what the state would get in return for this estimated \$77 million expenditure, KPMG representative Andrew Gottschalk was vague: "It's hard to explain exactly what you get...It's hardware, it's software, there's infrastructure, there's people and staffing" he stated. "There would likely be a call center. It's all kinds of things... there's a lot of stuff....but it's hard to be specific."

But there are two things we can be specific about. As states spend taxpayer dollars crafting programs and plans, the cost of healthcare continues rise.

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