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An ObamaCare Appeal From the States

Twenty-one governors representing more than 115 million Americans have written to Kathleen Sebelius asking for more flexibility on health-care reform.

By MITCH DANIELS

Unless you're in favor of a fully nationalized health-care system, the president's health-care reform law is a massive mistake. It will amplify all the big drivers of overconsumption and excessive pricing: "Why not, it's free?" reimbursement; "The more I do, the more I get" provider payment; and all the defensive medicine the trial bar's ingenuity can generate.

All claims made for it were false. It will add trillions to the federal deficit. It will lead to a de facto government takeover of health care faster than most people realize, and as millions of Americans are added to the Medicaid rolls and millions more employees (including, watch for this, workers of bankrupt state governments) are dumped into the new exchanges.

Many of us governors are hoping for either a judicial or legislative rescue from this impending disaster, and recent court decisions suggest there's a chance of that. But we can't count on a miracle—that's only permitted in Washington policy making. We have no choice but to prepare for the very real possibility that the law takes effect in 2014.

For state governments, the bill presents huge new costs, as we are required to enroll 15 million to 20 million more people in our Medicaid systems. In Indiana, our independent actuaries have pegged the price to state taxpayers at \$2.6 billion to \$3 billion over the next 10 years. This is a huge burden for our state, and yet another incremental expenditure the law's authors declined to account for truthfully.

Perhaps worse, the law expects to conscript the states as its agents in its takeover of health care. It assumes that we will set up and operate its new insurance "exchanges" for it, using our current welfare apparatuses to do the numbingly complex work of figuring out who is eligible for its subsidies, how much each person or family is eligible for, redetermining this eligibility regularly, and more. Then, we are supposed to oversee all the insurance plans in the exchanges for compliance with Washington's dictates about terms and prices.



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The default option if any state declines to participate is for the federal government to operate an exchange directly. Which got me thinking: If the new law is not repealed by 2013, what could be done to reshape it in the direction of freedom and genuine cost control?

I have written to Kathleen Sebelius, secretary of Health and Services (HHS), saying that if her department wants Indiana to run its program for it, we will do so under the following conditions:

- We are given the flexibility to decide which insurers are permitted to offer their products.

- All the law's expensive benefit mandates are waived, so that our citizens aren't forced to buy benefits they don't need and have a range of choice that includes more affordable plans.
- The law's provisions discriminating against consumer-driven plans, such as health savings accounts, are waived.
- We are given the freedom to move Medicaid beneficiaries into the exchange, or to utilize new approaches to the traditional program, instead of herding hundreds of thousands more people into today's broken Medicaid system.
- Our state is reimbursed the true, full cost of the administrative burden to be imposed upon us, based on the estimate of an auditor independent of HHS.
- A trustworthy projection is commissioned, by a research organization independent of the department, of how many people are likely to wind up in the exchange, given the large incentives for employers to save money by off-loading their workers.

Obviously, this is a very different system than the one the legislation intends. Health care would be much more affordable, minus all the mandates, and plus the consumer consciousness that comes with health savings accounts and their kin. Customer choice would be dramatically enhanced by the state's ability to allow more insurers to participate and offer consumer-driven plans. Through greater flexibility in the management of Medicaid, the state might be able to reduce substantially the hidden tax increase that forced expansion of the program will impose.

Most fundamentally, the system we are proposing requires Washington to abandon most of the command-and-control aspects of the law as written. It steers away from nanny-state paternalism by assuming, recognizing and reinforcing the dignity of all our citizens and their right to make health care's highly personal decisions for themselves.

So why would Ms. Sebelius and HHS agree to this de facto rewrite of their treasured accomplishment? A glance at the recent fiasco of high-risk pools provides the answer. When a majority of states, including Indiana, declined to participate in setting up these pools, which cover those with high-cost, existing conditions, the task fell to HHS. As widely reported, it went poorly, with costs far above predictions and only a tiny fraction of the expected population signing up.

If the feds can't manage this little project, what should we expect if they attempt it on a scale hundreds of times larger and more complex? If it were only Indiana asking, I have no doubt that HHS would ignore us. But Indiana is not alone. So far, 21 states—including Pennsylvania, Texas and Louisiana—have signed the same letter. We represent more than 115 million Americans. Washington's attempt to set up eligibility and exchange bureaucracies in all these places would invite a first-rate operational catastrophe.

If there's to be a train wreck, we governors would rather be spectators than conductors. But if the federal government is willing to reroute the train to a different, more productive track, we are here to help.

Mr. Daniels, a Republican, is the governor of Indiana.