



## **HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES**

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July 2010

**ABSTRACT:** Health insurance exchanges are the centerpiece of the private health insurance reforms of the Patient Protection and Affordable Care Act of 2010 (ACA). If they function as planned, these exchanges will expand health insurance coverage, improve the quality of such coverage and perhaps of health care itself, and reduce costs. Previous attempts at creating health insurance exchanges, however, produced only mixed results. This report identifies the earlier attempts' problems, enumerates the key issues that are critical for overcoming those problems, analyzes in detail the ACA's provisions addressing these issues, and discusses further policy options.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new Commonwealth Fund publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1426.



## CONTENTS

About the Author .....	iv
Acknowledgments .....	iv
Executive Summary .....	v
Introduction .....	1
Key Issues that the Implementation of Exchanges Must Address .....	3
Adverse Selection .....	3
Numbers of Participants .....	9
Market Coverage and Structure .....	10
Choice Without Complexity .....	12
Transparency and Disclosure .....	14
Competition .....	15
Administrative Costs .....	17
Market or Regulator? .....	19
Administering Subsidies and Mandates .....	21
State, Regional, or National Exchanges? .....	22
Governance .....	24
Relationship with Employers .....	26
Cost Control .....	28
Summary and Conclusions .....	30
Notes .....	32

## LIST OF EXHIBITS

Exhibit 1	Exchange Implementation Timeline
Exhibit 2	Essential Benefit Package Requirements Under the Affordable Care Act
Exhibit 3	Premium Subsidies Under the Affordable Care Act
Exhibit 4	Cost-Sharing Subsidies and Limits Under the Affordable Care Act

## ABOUT THE AUTHOR

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## ACKNOWLEDGMENTS

The author wishes to thank Mark Hall and Kathy Swartz for their helpful comments on earlier drafts, and David Riemer, William Kramer, and Alain Enthoven for the benefit of their thoughts on exchanges.

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*Editorial support was provided by Steven J. Marcus.*

## EXECUTIVE SUMMARY

Health insurance exchanges are the centerpiece of the private health insurance reforms of the Affordable Care Act of 2010 (ACA). If they function as planned, these exchanges will expand health insurance coverage, improve the quality of such coverage and perhaps of health care itself, and reduce costs. Previous attempts at creating health insurance exchanges, however, enjoyed only mixed results. As part of successfully implementing the new exchanges, the U.S. Department of Health and Human Services (HHS) and the states must address issues that undermined the earlier attempts. These issues are:

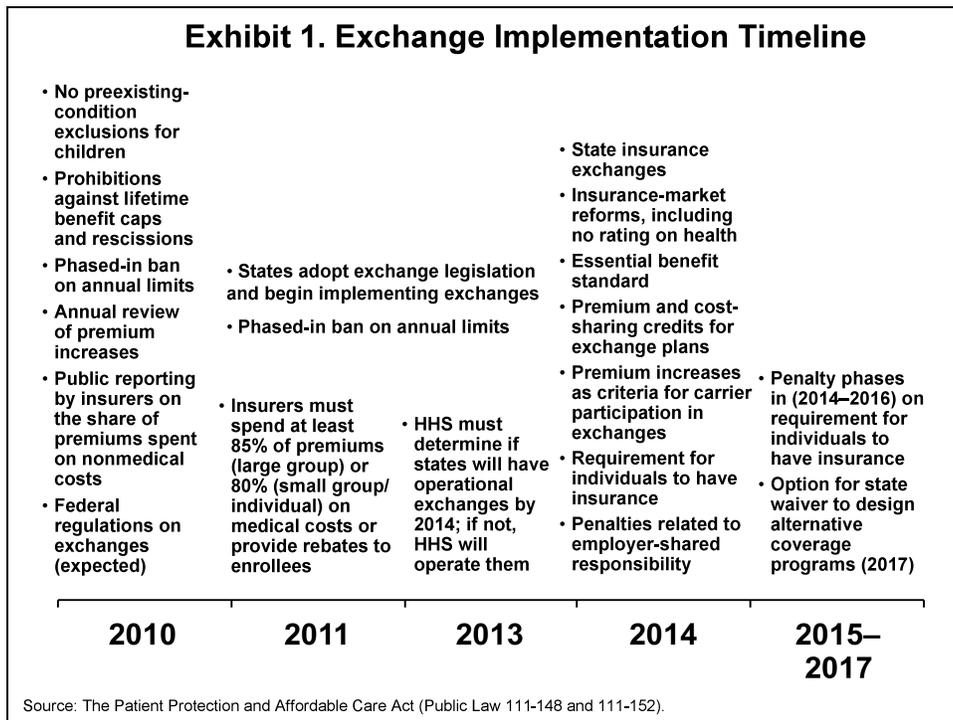
- *Adverse selection.* It is absolutely necessary that exchanges be protected against adverse selection (the disproportionate purchase of health insurance by the least healthy individuals)—especially because, under the ACA, small-group and nongroup insurance options remain available outside the exchanges. However, a number of provisions of the ACA level the playing field inside and outside the exchange, and weaken incentives for adverse selection. These protections can also be enhanced by the states.
- *Numbers of participants.* Exchanges that include large numbers of enrollees, as well as a high percentage of the total number of enrollees who are participating in the entire insurance market, offer greater market power, economies of scale, more stable risk pools, and stronger protection against adverse selection. The ACA offers opportunities for expanding risk pools, which should be fully exploited.
- *Market coverage and structure.* The ACA permits both the combination and separation of small-group and nongroup risk pools and exchanges. It also allows the creation of regional or subsidiary exchanges. The advantages and disadvantages of pursuing these options must be carefully weighed.
- *Choice without complexity.* The exchange model created by the ACA presents consumers with structured choices. An important implementation decision will be whether to further structure choices or, alternatively, to offer maximum choice and flexibility within the constraints of the ACA.
- *Transparency and disclosure.* The ACA contains numerous provisions designed to maximize transparency and disclosure. Putting these requirements into operation will be one of the Act's most important implementation tasks.

- *Competition.* The exchanges are intended to increase competition among insurers and focus that competition on value and price. A number of provisions of the ACA should help to facilitate this objective.
- *Administrative costs.* The ACA requires exchanges to fulfill a number of administrative functions that will add to their costs. Exchanges must find ways to reduce such internal costs, as well as the administrative costs to insurers and employers, if they are to offer better value to enrollees.
- *Market or regulator?* The ACA delegates to exchanges a number of regulatory responsibilities. Exchanges must certify health plans for participation and can exercise regulatory authority through this power. An important implementation choice will be whether exchanges should, on the one hand, maximize plan participation by minimizing certification requirements or, on the other hand, use their certification authority to limit exchange participation to high-value plans.
- *Administering subsidies and mandates.* The exchanges will play important roles in establishing insurance affordability, administering cost-sharing subsidies, and serving as a gateway to other public programs. It is particularly important that exchanges coordinate seamlessly with other public programs because participants will often move back and forth between an exchange, Medicaid, and the Children's Health Insurance Program (CHIP).
- *State, regional, or national exchanges?* Although the ACA favors the creation of state exchanges, it also confers authority to create a federal exchange as well as a multistate insurance program, and it provides for the possibility of regional exchanges. Important policy choices will need to be made concerning which avenues particular states should pursue and how the federal government should react to state action—or inaction.
- *Governance.* The ACA provides very little guidance as to how exchanges should be governed. HHS and the states must carefully consider how the entities that govern exchanges should be structured and how they relate to other state and to federal institutions.
- *Relationships with employers.* Although exchanges must be employer-friendly if they are to succeed, the ACA offers little guidance in this regard. Such relationships nevertheless need to be a major focus of implementation efforts.
- *Cost control.* Exchanges have been sold as a mechanism for moderating the growth of health insurance costs. Achieving this objective will only be possible if exchanges are implemented so as to maximize competition, choice, and participation and to minimize administrative cost and adverse selection.

# HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES

## INTRODUCTION

Health insurance exchanges are the centerpiece of the private health insurance reforms of the Patient Protection and Affordable Care Act of 2010 (ACA). It is expected that once state-level exchanges become fully operational in 2014 they will play a major role in the purchase and sale of health insurance (Exhibit 1). They will supervise insurance-plan marketing and competition in the small-group and nongroup markets; oversee the standardization of plan benefits and cost-sharing; bear some responsibility for restraining premium growth; and administer the distribution of tax credits for lower- and middle-income people who lack access to employer-sponsored coverage and who earn too much to be eligible for Medicaid. If the exchanges function as planned, they will expand coverage, improve the quality of health insurance coverage—perhaps even of health care itself—and reduce costs.



Over the next four years, federal and state implementation of the ACA will be centered on getting the health insurance exchanges up and running. It will be very important that the exchange implementation process be sound, and that we learn from

earlier mistakes and build on existing successes. Congress has from time to time implemented an innovation that one or more states have tried successfully—Medicare diagnostic-related groups payment is one such example. But while a few state-level exchanges have been quite successful, many others have failed. Thus, Congress has built its reform of private health insurance markets largely on what has to date been an experiment with decidedly mixed results.

The health insurance exchange is not a new idea. It is grounded in the concept of managed competition developed by economist Alain Enthoven and others in the late 1980s.<sup>1</sup> Exchanges have been around for nearly two decades in various guises—as purchasing cooperatives, health alliances, and connectors—among states and private entities. Health alliances also were at the center of the failed Clinton Health Security Act in the early 1990s.<sup>2</sup> The best of the exchange-like programs—including the Federal Employees Health Benefits Program (FEHBP), the California Public Employees Retirement System, the Dane County (Wisconsin) Public Employees Program, the Massachusetts Connector, and Connecticut Business and Industry Association’s Health Connections exchange—have enjoyed success in increasing choice of plans and moderating cost growth. Many efforts at creating exchanges, however—including exchanges in California, Texas, Florida, Colorado, North Carolina, and elsewhere—have failed, sometimes after enjoying some initial success.<sup>3</sup>

The theory behind exchanges appears to be sound. The large employer group health insurance market is generally viewed as successful because large groups can create sizeable and stable risk pools, minimize adverse selection (by covering all employees who do not opt out), deal with insurers from a position of bargaining strength or insure themselves, and keep administrative costs low. Also, large employers can offer their employees a choice of benefit plans, enabling them to pick the plan that best matches their needs and resources. An exchange, in theory at least, could offer these advantages to the small employer group and nongroup market, thereby stabilizing these markets, lowering transaction costs, increasing competition, and widening choice. For exchanges to succeed, however, they will have to avoid the pitfalls of earlier efforts that failed. The ACA goes to some length toward achieving this goal, though more will have to be done as implementation proceeds.

The burden of creating successful exchanges will first fall to the federal government. The U.S. Department of Health and Human Services (HHS)—in addition to drafting regulations and issuing guidance (in consultation with the National Association of Insurance Commissioners and other stakeholders) that help operationalize the

exchange concept—has the responsibility under the ACA to administer the subsidies granted to the states to help them begin exchange implementation, monitor that implementation, and establish a federal exchange alternative for states that elect not to implement their own exchanges or that fail to effectively do so. In the end, however, the ACA leaves the task of implementing the exchanges to the states, which will have the responsibility of actually making them work.

This report, the first of a series on health insurance exchanges, examines 13 issues that must be resolved for the exchanges to succeed. In each of the subsections that follow we first describe the issue and then analyze in some detail how the ACA addresses it.

## **KEY ISSUES THAT THE IMPLEMENTATION OF EXCHANGES MUST ADDRESS**

### **Adverse Selection**

#### *The Issue*

The single most important reason why some exchanges have not succeeded in the past is that they became the victims of adverse selection—they were unable to capture a large enough share of the healthy participants in the insurance market.<sup>4</sup> In effect, these exchanges attempted to offer better coverage, or more affordable coverage, to too many individuals or groups with unfavorable risk profiles and were unable to attract enough healthy enrollees.<sup>5</sup>

Indeed, as long as small-group or nongroup coverage is easily available outside the exchange, the potential exists for healthy individuals and groups to find policies cheaper than those available through the exchange. A particular concern is the possibility that employer-sponsored groups can “self-insure” (thus escaping state regulation) as long as their employees are healthy, only to turn to the exchange once group members’ health deteriorates.

In this way, an exchange can essentially turn into a high-risk pool, with its coverage becoming unaffordable and its enrollees becoming very unattractive to insurers. The most successful exchanges have featured a large and diverse population (such as FEHBP), have barred outside competition, or have made available significant advantages only to individuals participating in the exchange (for example, in Massachusetts, premium subsidies are available only through the state’s Health Connector).<sup>6</sup>

#### *The ACA*

The ACA does not eliminate the potential for adverse selection, as it permits both an individual and group health insurance market to continue to exist outside the exchange.<sup>7</sup>

People cannot be restricted to insurance plans offered within the exchange. Lower-risk individuals in particular can go outside the exchange, without penalty, if they find less expensive coverage there.<sup>8</sup> The ACA also provides for “grandfathered” plans to exist outside the exchange.<sup>9</sup>

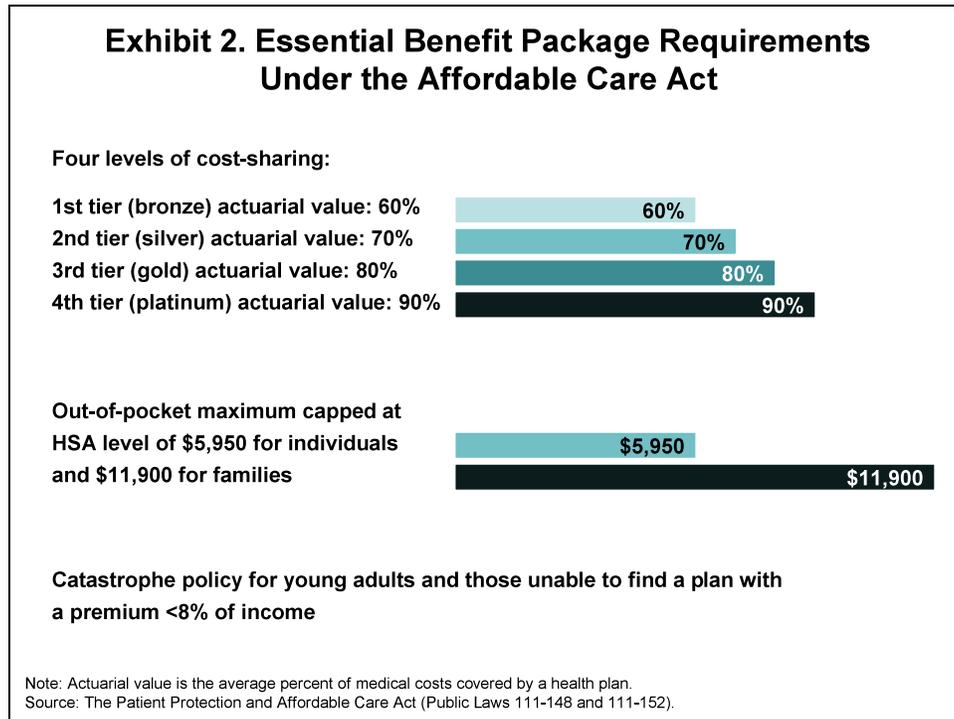
Many of the provisions of the ACA will, however, tend to discourage adverse selection against the exchange. First, the Internal Revenue Code, as amended by the ACA, requires individuals to have “minimum essential coverage.”<sup>10</sup> Individuals who do not have employer-based or public insurance will be required to purchase an insurance plan or pay a penalty. By encouraging individuals to at least purchase insurance somewhere, healthy individuals will be dissuaded from staying out of the insurance market altogether.

Second, most of the insurance reforms imposed by the ACA apply *both* within and outside the exchange. These provisions, which might encourage adverse selection if they applied only within the exchange, include:

- Banning lifetime or annual dollar limits on coverage;<sup>11</sup>
- Requiring plans to permit members’ participation in approved clinical trials (relative to the prevention, detection, or treatment of cancer or other life-threatening diseases) and to cover the routine patient costs of such participation;<sup>12</sup>
- Permitting premium variation based only on age (3:1), geographic region, individual or family coverage, or tobacco use (1.5:1); and prohibiting rating based on health status;<sup>13</sup>
- Guaranteeing the issuing and renewability of coverage;<sup>14</sup>
- Prohibiting preexisting-condition exclusions;<sup>15</sup> and
- Prohibiting waiting periods of longer than 90 days.<sup>16</sup>

Third, individual and small-group plans, both within and outside the exchange, must cover defined “essential health benefits” (Exhibit 2),<sup>17</sup> with a scope equal to that of the typical employer plan.<sup>18</sup> State benefit requirements also continue to apply outside as well as inside the exchange.<sup>19</sup> Beginning in 2014, out-of-pocket expenditures both inside and outside cannot exceed those allowed for high-deductible health plans linked to health savings accounts.<sup>20</sup> Deductibles in the small-group market cannot exceed \$2,000 for individuals and \$4,000 for families. Plans outside the exchange will be limited, therefore, in their ability to attract healthy individuals by offering higher cost-sharing or by excluding benefits that might be more attractive to high-cost individuals. Direct

marketing of insurance plans through the exchange, to the extent it occurs, also will reduce the ability of agents and brokers to engage in “street underwriting”—that is, to informally steer low-risk enrollees away from the exchange, and high-risk enrollees into the exchange, through marketing practices.<sup>21</sup>



Fourth, aside from their dealings with enrollees in grandfathered plans, health insurance issuers must treat all individual enrollees in their plans as a single pool and all enrollees in the small-group market as another single pool; or, if the state elects, treat members of both pools as one single pool.<sup>22</sup> Issuers of qualified health plans must agree to charge the same premium rate for a qualified health plan whether it is inside and outside the exchange.<sup>23</sup>

Fifth, the ACA includes three risk-adjustment programs—two transitional and one permanent—that should reduce adverse selection against the exchange.<sup>24</sup> If plans outside the exchange attract a significantly healthier population than plans within the exchange, the former group will need to compensate the latter. The first risk-adjustment program, a permanent one to be administered by the states,<sup>25</sup> covers health plans inside and outside the exchange, but not self-insured or grandfathered plans. In this program the state will assess plans and insurers with low-risk enrollees and make payments to plans and insurers with high-risk enrollees. Second, the bill includes a transitional reinsurance program to be implemented for 36 months (from 2014 to 2016) by the states under

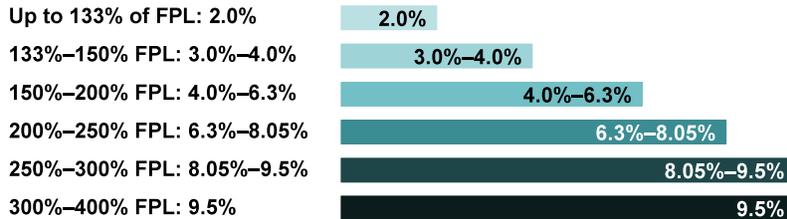
contracts with private reinsurers.<sup>26</sup> Finally, during the 2014–2016 period a risk-corridor program also would be available for qualified health plans in the individual and small-group market.<sup>27</sup>

The transitional reinsurance program is likely to prove very important for smoothing the introduction of the exchanges, which are likely to pick up most of the participants in the federal high-risk pool when it terminates at the end of 2014.<sup>28</sup> States may terminate their own high-risk pool programs, and companies may terminate or cut back on early-retirement coverage, as the exchanges become available. Because individual mandate penalties do not fully phase in until 2017, unhealthy individuals may be overrepresented in the exchanges for the first few years.<sup>29</sup> The reinsurance program will help to ease this transition. The permanent risk-adjustment program also will be essential, as it should deter risk selection against the exchange on a long-term basis.

Perhaps the most important protection that the exchanges will have from adverse selection, however, is that the ACA's premium-assistance credits and cost-sharing reduction payments will be accessible only to individuals enrolled in health plans through exchanges.<sup>30</sup> These subsidies, for households with incomes of up to 400 percent of the poverty level, are expected to cover 19 million Americans (Exhibit 3).<sup>31</sup> The subsidies become available once a family has spent a percentage of its income on health insurance premiums. For example, a qualifying family would only receive assistance once it had spent 9.5 percent of its household income. At this level, a young healthy family might find it less expensive to purchase the minimum essential coverage outside the exchange, as opposed to purchasing a subsidized plan within the exchange. At lower income levels, however, the subsidies are much more substantial. It is likely that most persons eligible for subsidies will remain within the exchange.

### Exhibit 3. Premium Subsidies Under the Affordable Care Act

Premium contributions are limited as a share of income to:



Note: FPL refers to the Federal Poverty Level.  
Source: The Patient Protection and Affordable Care Act (Public Laws 111-148 and 111-152).

Tax credits also will be available to small employers through the exchange, though only for the first two years that an employer offers insurance through the exchange.<sup>32</sup> This provision, it is hoped, will encourage employers to purchase health insurance for their employees through the exchange. Finally, the ACA requires states that mandate the coverage of certain benefits (which are not part of the federal essential benefits package) to cover the cost of those added benefits only if they are provided by qualified health plans. This also should encourage the purchase of qualified plans through the exchange.<sup>33</sup>

The provisions of the ACA, however, do not eliminate the possibility of adverse selection against the exchange. In the first place, only “qualified health plans” can be sold within the exchange. These qualified health plans must comply with all of the requirements in the ACA that apply to health plans generally, including covering essential benefits, but the exchange’s plans also must comply with additional requirements that might render them more expensive than plans outside the exchange. This, in turn, could make the non-exchange plans more attractive to healthier individuals,<sup>34</sup> and also could make the marketing of plans through the exchange less attractive to insurers, thereby contributing to adverse selection.

Health insurers may market qualified health plans both inside and outside the exchange, and they must sell gold- and silver-level coverage through the exchange before

they can sell other levels of coverage there. Insurers, however, do not need to participate in the exchange if they choose not to. They can remain outside the exchange, selling bronze-level high-cost-sharing plans to healthy enrollees or catastrophic plans to people under 30 or to persons who cannot find affordable policies.<sup>35</sup> This leaves open the possibility for healthy individuals or small employers to purchase minimum coverage outside the exchange, thereby threatening significant adverse selection against it. Self-insured plans are subject to even less rigorous requirements under the ACA, and they might offer coverage that is substantially less protective, and less costly, than exchange coverage.<sup>36</sup> Some adverse selection against the exchange, therefore, is likely.

Although the ACA does not allow the federal government to require individuals or employees to purchase insurance through the exchange, it doesn't preclude the states from imposing additional requirements to discourage adverse selection. The ACA only preempts state laws that would "prevent the application" of the ACA, and state laws limiting or tightly regulating the sale of insurance outside the exchange would not violate this principle.<sup>37</sup> The only federal constraint on state regulation of the health insurance market is that they cannot, because of the Employee Retirement Income Security Act (ERISA), regulate self-insured plans.

States could, for example, adopt laws that: prohibit insurers from selling insurance outside the exchange; require insurers that sell insurance outside the exchange to sell only qualified health plans; or require insurers that sell insurance outside the exchange to comply with all of the requirements applicable to plans sold inside the exchange.<sup>38</sup> But states may want to: prohibit insurers that participate in the exchange from establishing separate affiliates to sell only outside the exchange; prohibit insurers from selling only bronze or catastrophic coverage outside the exchange; or prohibit insurers from using marketing practices or benefit structures intended to attract healthy applicants to plans outside the exchange while discouraging unhealthy applicants. Insurance regulators can monitor grandfathered plans carefully to make sure that they are not "lemon dropping"—that is, encouraging high-cost enrollees to move to the exchange. States that have entered into an interstate compact could require plans (as permitted under the ACA, section 1333) to sell interstate policies only through the exchange.<sup>39</sup> States also could prohibit brokers from collecting higher commissions for plans sold outside the exchange, thereby discouraging them from steering business elsewhere.<sup>40</sup>

## Numbers of Participants

### *The Issue*

Earlier exchanges were troubled by their inability to attain a large enough pool of participants. This was problematic for several reasons. First, if an exchange can offer only a small number of enrollees, it is unlikely to attract enough health insurance plans. Moreover, the insurers it does attract are unlikely to give the exchange a better deal, or perhaps even as good a deal, as what they offer directly. Insurers already active in a particular market generally prefer to sell a single plan to a group, thereby capturing all of its enrollees, rather than to compete with other insurers for individual enrollees. And insurers not already selling their products in that market are unlikely to enter it without being offered the possibility of an attractive customer base. Either way, the exchange has to offer insurers a pool sufficiently large that it cannot be ignored.<sup>41</sup>

Second, an exchange must achieve a significant size to be able to create economies of scale and limit administrative costs. Any exchange will have certain fixed expenses, such as personnel, IT, publication, legal, rent, and utilities. Spreading these expenses over a larger population will reduce the costs imposed on each participant.<sup>42</sup>

Third, insurers are unlikely to market through an exchange unless they can be assured of enough enrollees to offer a credible insurance-risk pool. Small insurance pools, being potentially volatile and susceptible to destabilization by large claims, are problematic for insurers. According to one expert view, a risk pool of at least 100,000 covered lives would probably be necessary to be viable.<sup>43</sup> An exchange should have a large enough enrollee base to offer several competing insurers credible risk pools. If insurers cover a number of lives outside of the exchange, however, the size of the pool offered by the exchange may be less important. Moreover, once risk-status underwriting is eliminated, a universal insurance-purchase mandate goes into effect, and reinsurance and risk adjustment are implemented, the risk faced by a single plan will be considerably diminished, at which point credibility will be less of an issue.

Finally, an exchange must be able to offer a large enough group of enrollees to permit insurers to obtain favorable discounts from providers.<sup>44</sup> Virtually all health insurance plans today are network plans, and providers do not give an insurer discounts unless they believe that the insurer can deliver a significant share of an insurance market. An insurer might currently be able to obtain provider discounts in a new market by signing a major employer in the area, but in an exchange the insurer will have to attract enrollees on an individual basis. In the case of exchanges, size does matter.

It is important to note that the percentage of a market captured by an exchange is at least as critical as the absolute number of enrollees—at least, above some minimal number. An exchange that contains 20 percent to 25 percent of the privately insured participants in a small state is less vulnerable to adverse selection and likely to possess more market clout than an exchange with more enrollees but a smaller market share in a larger state.<sup>45</sup> This is another reason for maximizing participation by employers in the exchange.

### *The ACA*

As noted earlier, the ACA's subsidy and mandate provisions should encourage large numbers of individuals to purchase insurance through the exchanges. The small-employer tax credit also will create an incentive for very small employers to purchase insurance for their employees through the exchange, although the credit is only available for two years after the exchanges go on line.<sup>46</sup>

By contrast, large employers (employing more than 100 people) are initially not allowed to purchase insurance for their employees through the exchange; and until 2016, states can restrict exchange participation to employers with 50 or fewer employees.<sup>47</sup> Beginning in 2017, however, states may open their exchanges to employment groups in excess of 100 employees.<sup>48</sup>

As large employer-sponsored groups currently cover 133 million people while small groups covers only 43 million and the nongroup market insures only 17 million, opening up the exchanges to larger groups as soon as possible may be vital to their ultimate success.<sup>49</sup> On the other hand, the pursuit of larger employers will have to be done with care, lest only employers with less-healthy-than-average employees enter the exchanges while employers with healthier enrollees remain self-insured or experience-rated. States also should consider providing state and local government employee coverage through the exchanges, as this could dramatically expand the size of the participant pool.<sup>50</sup> Even prior to 2017, states could establish state and local government exchanges that parallel the ACA exchanges and contract with the same insurers. This would immediately increase market share, and after 2017 the two types of exchanges could be merged.<sup>51</sup>

## **Market Coverage and Structure**

### *The Issue*

Should there be separate risk pools for individuals and small firms or only one risk pool for both? On the one hand, a single risk pool would be larger and less volatile. On the

other, the risk profiles of group and nongroup pools have heretofore been quite different in many states, and a risk pool combining both could contribute to market instability or regulatory complexity.<sup>52</sup>

Whether or not a state should maintain separate individual and small-group exchanges is a related question. A separate SHOP (Small Business Health Options Program) exchange could focus on servicing the needs of small businesses, for example, offering consolidated billing for employee premiums. But a combined exchange could potentially offer enrollees more choices if insurers were required to participate in both markets.

Another related issue is the geographic coverage area of the exchange. If a small state offers too small a participant pool to be viable, a regional exchange involving several states may be indicated. Conversely, some states may be so large that a single exchange would be unwieldy. Plan pricing also may need to vary within an exchange so as to take account of variations in the price of health care within different parts of a state or region. In most states, it will make sense to allow HMOs to participate in exchanges that cover only local or regional areas rather than the entire exchange, as this allows for the maximization of enrollee choices and competition.<sup>53</sup> Care may need to be taken, however, to avoid the redlining of areas with lower-income enrollees or racial minorities. Finally, special issues may arise where metropolitan areas span two or more states, or where an individual may live in one state and be employed in another.<sup>54</sup>

### *The ACA*

The ACA requires insurers to pool all of their individual members in one risk pool and all of their small-employer group members in another, but the law also gives states the prerogative to combine risk pools.<sup>55</sup> Whether or not a state chooses to do so will depend on the factors discussed above. The ACA also allows states to operate separate individual and small-business exchanges, or to merge the two into a single exchange.<sup>56</sup> Although there may be sound reasons for maintaining a separate small-business (SHOP) exchange (see below), combining the exchanges may be necessary, at least in smaller states, to create a large enough market to attract insurers and to reduce the administrative-cost load. The ACA also offers the possibility of subsidiary exchanges within a state, and of regional exchanges, which are discussed further below.<sup>57</sup> In sum, the ACA offers a menu of options by which states may address their particular needs, though the making of sound choices will require considerable thought.

## **Choice Without Complexity**

### *The Issue*

One of the major selling points of exchanges is that they have the potential to widen the choice of health plans.<sup>58</sup> Surveys consistently show that a wider choice of plans results in greater enrollee satisfaction.<sup>59</sup> In fact, whatever else can be said about the exchange experience to date, exchanges do have a good track record of increasing the choices available to individual enrollees, particularly in the small-group market. Choices can be offered among different insurers, premium levels, benefit packages, cost-sharing options, and provider networks. Insurers also can offer innovative approaches to plan design or service provision, such as accountable-care organizations, medical homes, or value-based cost-sharing.

Too much or the wrong kind of choice can be counterproductive, however, by making insurance shopping more complex.<sup>60</sup> Choice is optimized if it focuses the enrollee's attention on the salient features of the health plans. By contrast, when choice is unstructured it can become overwhelming, resulting in choices that are largely random and may not serve the individual's actual interests. Because exchanges offer the possibility of standardizing plan choices,<sup>61</sup> they can concentrate selection on key features such as price or cost-sharing requirements. They also can eliminate "fine print" exclusions or exceptions that are usually ignored in the selection process but that can have a devastating effect when a rare and unanticipated condition occurs. Above all, exchanges can offer convenient, fast, and responsive service to consumers, which improves their experience in purchasing and dealing with insurers rather than frustrating or alienating them.

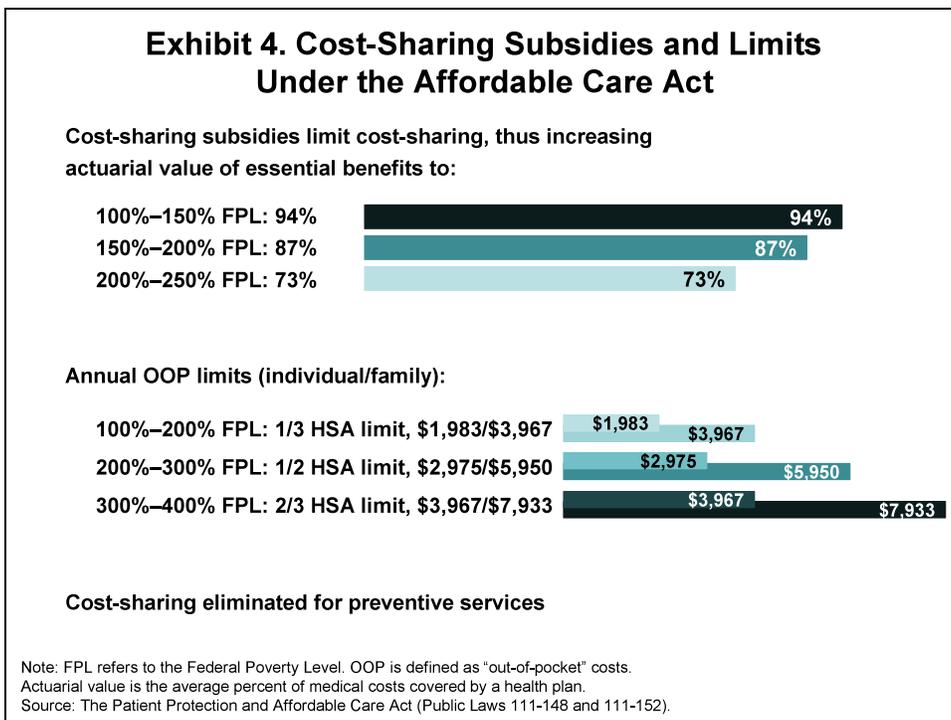
### *The ACA*

If the premium subsidies described above create a large enough market so that insurers find operating through exchanges to be an attractive proposition, despite the additional requirements involved, exchanges will be able to offer a range of health plan options to their enrollees.

The ACA distinguishes among four levels of coverage based on "actuarial value" (the average percent of medical costs covered by a health plan), with an additional catastrophic policy (Exhibit 2).<sup>62</sup> The bronze-level plan has to provide benefits equivalent to 60 percent of the actuarial value, with the silver level at 70 percent, the gold level at 80 percent, and the platinum level at 90 percent.<sup>63</sup> Catastrophic policies are available only for persons under age 30 or those who cannot otherwise find affordable coverage or would suffer a hardship in buying other coverage.<sup>64</sup> Qualified health plans must agree to

offer at least one plan at the silver level and at least one at the gold.<sup>65</sup> Nothing in the law prohibits states from requiring plans within (or outside) the exchange from standardizing plans even more—for example, by offering only a limited number of deductible options or requiring copayments instead of coinsurance. Indeed, a state could establish a standard plan at each tier to give consumers a benchmark for analysis.<sup>66</sup> Greater standardization might not only aid consumer choice but also deter the structuring of benefit and cost-sharing packages for risk-selection purposes.<sup>67</sup>

Individuals may choose any qualified health plan offered through the exchange,<sup>68</sup> with premium-affordability credits keyed to the cost of the second-lowest-cost silver plan. Nothing in the legislation prohibits a subsidized individual from choosing a more generous plan (other than a catastrophic plan) and paying the difference in cost, or from choosing a less generous plan and paying less.<sup>69</sup> However, the cost-sharing reduction subsidies are available only to a person who chooses a silver-tier plan, as the subsidies are intended to raise the actuarial value of a silver-level plan to a higher level (Exhibit 4).<sup>70</sup> Therefore, it is expected that most subsidized enrollees will choose silver-level plans. If an employer contributes to insurance purchased through the exchange, the employee may enroll in any qualified health plan in the tier of coverage chosen by his or her employer.<sup>71</sup> In this way, the ACA will expand but also channel choices.



## Transparency and Disclosure

### *The Issue*

Choice is meaningful only if it is informed. One of the potential benefits of exchanges is that they can require participating health plans to fully disclose their terms and conditions, in a comparable form and in plain language, so that enrollees can actually understand what alternatives are available.<sup>72</sup> In this way, they may form realistic expectations regarding their coverage. Exchanges also can facilitate communication with linguistic or cultural minorities. And exchanges can and should offer reliable and objective ratings of the quality and efficiency of available plans.

### *The ACA*

The ACA contains a host of transparency and disclosure requirements that should significantly expand the amount of information available to health insurance consumers. Section 1001 (which creates §2715 of the Public Health Services Act) requires the HHS secretary, in consultation with the National Association of Insurance Commissioners and others, to develop standards which group health plans (including self-insured plans and grandfathered plans) and health insurance issuers (both inside and outside the exchange) must follow in providing summaries of benefits and coverage explanations.<sup>73</sup> Each plan must provide its summary of benefits and coverage explanation to enrollees, who are entitled to 60 days notice of modification of plan terms, as well as to applicants. These requirements preempt any state standards that require less disclosure.

The legislation imposes separate disclosure requirements on plans seeking to sell their policies through an exchange. These include disclosures of: claims-payment policies and practices; financial information; data on enrollment and disenrollment and on claims denials and rating practices; information on cost-sharing for out-of-network coverage and on enrollees' rights; and "other information as determined appropriate" by HHS.<sup>74</sup> Because plans sold outside an exchange must provide these disclosures to state insurance commissioners and to HHS, which must then release the information to the public), this requirement should not be a deterrent to exchange participation.<sup>75</sup> Exchange plans are further required to provide additional information on cost-sharing with respect to specific services from specific providers, if an enrollee requests it.

Additional disclosure provisions elsewhere in the ACA require:

- Health insurance issuers and HHS to post on their Web sites justifications for seemingly unreasonable premium increases.<sup>76</sup>

- HHS to establish a Web portal on which comparative information will be posted about insurers. This information will include medical loss ratio (the percentage of premiums paid out in claims and quality improvement expenses), eligibility, availability, premium rates, and cost-sharing, consistent with the standards described above.<sup>77</sup>
- Group health plans and insurance issuers to report to HHS and to enrollees information regarding programs to improve health outcomes, reduce hospital readmissions, implement patient safety and error-reduction programs, and promote prevention and wellness. Insurers must also report the proportion of their total premium revenue spent on clinical services, as well as their non-claim costs (excluding taxes and fees). HHS is required to post these reports on a Web site.<sup>78</sup>

The ACA requires exchanges to rate plans based on quality and price, to make this information available to the public in a standardized way so that consumers may compare plans,<sup>79</sup> and to periodically survey exchange plan-member satisfaction.<sup>80</sup> Exchange-based plans also must provide information on the availability of in- and out-of-network providers.<sup>81</sup>

## **Competition**

### *The Issue*

Efficient competition occurs when consumers may choose from a range of available plan options. But there is considerable evidence that local insurance markets are highly concentrated in many parts of the United States—that is, too few choices are available there. One hope for the exchanges is that they will lure new entrants into concentrated markets, thereby increasing the competitiveness of the local insurance industry. To the extent that exchanges make insurance markets more competitive and choices more focused on price, value, and quality, they will increase market efficiency and reduce costs. They also may make it more possible for local and regional integrated health plans to compete with large carriers, as occurred with the Dane County exchange in Wisconsin.

### *The ACA*

The offer of subsidies to lower- and middle-income Americans and to small employers who purchase health insurance through the exchange should attract sizeable numbers of insurance purchasers. The individual mandate, and the penalties imposed on businesses whose employees receive premium subsidies when their employers fail to provide them with adequate insurance coverage, also will drive individuals and employers to the exchange. The interaction of subsidies and mandates should create an attractive market

for insurers, thereby increasing the number of insurers competing for exchange business. Guaranteed issue and renewal requirements, the prohibition against health-status underwriting, the requirement that all plans cover essential benefits, the risk-reallocation mechanisms found in the legislation, and the classification of plans by tiers should all focus competition among plans on price and on value. Disclosure and transparency requirements also should assist consumers in identifying plans that actually provide good value for the money spent.

The ACA creates several other options intended to expand competition. Exchanges may offer interstate plans, as well as plans offered by cooperatives and “qualified direct primary care medical home plans.”<sup>82</sup> They also may offer multistate plans that would be available in every state through the Office of Personnel Management.<sup>83</sup> It is not clear, however, that these options will in fact expand competition.

States can already enter into interstate compacts. They exist only for the sale of life insurance and not for health insurance, however.<sup>84</sup> States have been reluctant to cede any regulatory control and, moreover, are concerned about a race to the bottom in regulation. The interstate sale of insurance also creates an opportunity for adverse selection, as healthy individuals may sign up for low-cost low-value insurance policies from lightly regulated states, leaving behind a higher-cost risk pool in their home state.

Cooperatives are already legal as well, but virtually none have been created in recent years because of the difficulties of entering new insurance markets and of forming cooperative enterprises. They are unlikely to become widespread under the new law.

Finally, the most likely candidates for multistate plans (the Blue plans) already exist in most states and are not likely to compete aggressively against themselves. New multistate plans will face barriers that are at least as great as those that new local or regional plans face, most notably in establishing brand allegiance and convincing providers to join networks and give discounts to a new entrant with a small market share.

Note as well that the ACA does not prohibit states from creating a public plan to bring additional competition into a market, as long as the plan otherwise meets the requirements necessary to be a qualified health plan. All of the above options, however, could encourage competition among plans, which should in turn bring down the cost of health insurance and improve its value. At least, that is the theory and hope.

## **Administrative Costs**

### *The Issue*

Exchanges could perform a host of administrative functions, such as processing applications (for coverage and subsidies), billing enrollees, doing financial reconciliation, paying commissions, developing and maintaining Web sites, performing marketing and outreach, and providing broker and human resources training.<sup>85</sup> One of the attractive features of exchanges is that they have the potential to cut the administrative costs of offering health insurance as they perform these functions and thereby increase the proportion of insurance premiums actually spent on health care. Because they can offer centralized enrollment, exchanges should be able to cut marketing and enrollment costs. Brokerage commissions can amount to 10 percent or more of the cost of individual insurance policies in the first year, but they could be sharply reduced by a well-functioning exchange.<sup>86</sup> The elimination of risk-based underwriting should cut the cost of issuing policies. And by creating greater transparency, exchanges could make insurers' administrative costs more visible, thus creating pressure to lower them.

Exchanges also can take over some of the administration and maintenance of insurance policies currently handled by employers—a possibility that offers savings to employers who would otherwise have to handle these functions themselves or contract them out. By creating a larger risk pool, exchanges also can reduce the risk premium that insurers must charge to cover smaller and more volatile pools. By affording continuity of coverage when employees change jobs, exchanges can reduce insurer marketing costs.<sup>87</sup> And exchanges can take over some of the tasks currently carried out by insurers, such as collecting premiums, thereby reducing premium costs.

Most exchanges to date have not been able to reduce administrative costs significantly, however.<sup>88</sup> Indeed, some have increased rather than reduced costs, as they have simply added their own administrative costs without reducing the costs of either employers or insurers.<sup>89</sup> Moreover, it often has proven difficult to realize savings that in theory should be available. Attempts to eliminate brokerage commissions, for example, have simply led brokers to steer clients away from exchanges.<sup>90</sup> If an exchange provides only a small share of an insurer's business, the insurer will maintain, and often duplicate, administrative functions rather than cede them to the exchange.<sup>91</sup> Unless such administrative-cost issues are resolved, exchanges may have a difficult time competing with insurers marketing policies outside the exchange.

### *The ACA*

It is not at all clear that the ACA exchanges will significantly reduce administrative costs, as they have many responsibilities and will not be inexpensive. The administrative costs of the Massachusetts Health Connector run to about 3 percent of insurance premiums, and it is unlikely that the ACA exchanges will cost much less.<sup>92</sup> Initially, the federal government will provide grants to the states to set up the exchanges.<sup>93</sup> These will terminate as of 2015, by which time the exchanges are supposed to be self-supporting through fees imposed on participating insurers.<sup>94</sup> Administrative cost savings must be sufficient to cover these fees if exchange plans are to cost less overall.

Among their responsibilities, exchanges are required to “facilitate” the enrollment of individuals and employees of small businesses in qualified health plans.<sup>95</sup> Exchanges also are charged with enrolling individuals eligible for Medicaid, the Children's Health Insurance Program (CHIP), and other available state or local public programs.<sup>96</sup> They are supposed to contract with “navigators”—organizations that help to inform the public about the availability of qualified health plans and financial assistance, as well as help to enroll individuals into qualified plans.<sup>97</sup> Exchanges will have a substantial role in creating, collecting, managing, and distributing information about participating plans.<sup>98</sup> And exchanges also will have regulatory responsibilities (see below), which will require resources.

The exchanges will not eliminate brokerage commissions, a major expense in the current insurance market. Under the ACA, agents and brokers may still help individuals and small groups to enroll in qualified health plans and to apply for premium tax credits and cost-sharing reductions.<sup>99</sup> Although the exchanges will provide a great deal of comparative information about health plans, insurers will in all likelihood continue to advertise their products. The ACA also seems to require that individuals be given the option of paying their premiums directly to insurers rather than through the exchange, and the law provides that federal premium-assistance credits and cost-sharing reduction payments be made directly to insurers.<sup>100</sup> Nowhere does the ACA require exchanges themselves to enroll individuals or the employees of small employers into health plans. Insurers therefore may still bear the cost of enrolling individuals and of collecting and accounting for premiums. Exchanges are not precluded from offering these services as well, but they may end up duplicating what insurers offer.

Insurers should face reduced underwriting costs as health-status underwriting is eliminated. But because they will still be able to underwrite based on age, geographic location, and tobacco use, and also may offer premium reductions for enrollees who

participate in wellness programs, these costs will not disappear. Also, the disclosure and transparency requirements will likely impose increased costs on insurers. Finally, the ACA encourages insurers to engage in health care quality-improvement programs, which are not costless.<sup>101</sup> All in all, insurers will continue to bear considerable administrative expenses.

On the other hand, the ACA offers opportunities to reduce administrative costs. The fact that exchanges will exist in every state makes it likely that certain types of national vendors, offering exchanges services such as Web site design and maintenance, enrollment and payment processing, and customer service-call centers, will offer their services. Exchanges may be able to reduce administrative costs by purchasing these services and even engage in joint purchasing arrangements to further reduce costs.<sup>102</sup>

The medical loss ratio provisions of the ACA might encourage health plans to use the exchanges. Under these provisions, insurers that spend less than 80 percent of their premium income on payment for clinical services, or on activities that improve quality of care, will be required to rebate the difference to their enrollees. But federal and state regulatory fees are excluded from the denominator before the ratio is calculated. If exchange fees are considered to be regulatory fees (and they probably should not be), they will be subtracted from plan administrative costs (and from premiums), increasing the medical loss ratio.<sup>103</sup>

## **Market or Regulator?**

### *The Issue*

The fundamental idea of a health insurance exchange is that it is supposed to create a well-functioning and efficient market for insurance products. To achieve this goal, an exchange must take on some regulatory functions. Exchanges can require insurers to provide standardized disclosure of policy terms, guaranteed issue of policies, uniform open-enrollment periods, and minimum essential-benefit packages with cost-sharing in standardized tiers. Exchanges also can require insurers to provide data that may then be disclosed to consumers. Exchanges can limit participation to insurers that comply with exchange requirements. And exchanges can negotiate premiums with insurers or, as a condition of being able to sell through the exchange, require them to conform to premium limitations or other requirements.<sup>104</sup> Indeed, most successful exchanges to date, including FEHBP and the California Public Employees' Retirement System (CalPers) have negotiated with insurers, although usually not very aggressively.<sup>105</sup>

### *The ACA*

The primary role of exchanges under the ACA is to create a market; but, as noted above, exchanges also have significant regulatory responsibilities. Exchanges may offer only qualified health plans,<sup>106</sup> and premium-assistance tax credits can be used only to purchase such plans.<sup>107</sup> One of the functions of exchanges, therefore, is to certify health plans as qualified.

An exchange may certify as qualified only those health plans that meet the requirements of the ACA—that is, if the exchange “determines that making available such health plan through such Exchange is in the interests of the qualified individuals and qualified employers in the State or States in which such Exchange operates.”<sup>108</sup> An exchange cannot exclude a plan because it is a fee-for-service plan or because it “provides treatments necessary to prevent patients’ deaths in circumstances the Exchange determines are inappropriate or too costly.”<sup>109</sup> An exchange cannot impose premium cost controls, but it must require that plans seeking certification submit and post on their Web sites information justifying a premium increase prior to implementing it. The exchange also must take excessive or unjustified premium increases into account in determining whether to make a health plan available through the exchange.<sup>110</sup>

One of the most important policy choices to be made in implementing exchanges is whether to pursue this regulatory role aggressively or minimally. On the one hand, exchanges could allow every insurer in the state or region to participate, as long as it minimally complied with statutory requirements. On the other hand, exchanges could limit participation to a few high-value plans, either by applying restrictive certification requirements, using a bidding process, or negotiating with plans. Maximizing participation might increase competition and innovation, while asserting regulatory authority or using a bidding or negotiation process might increase value and consumer protection. Both HHS (in the drafting of regulations) and the states (in implementing the exchanges) will need to take positions on this issue.

Finally, it must be noted that the new regulatory responsibilities created by the ACA are not all assigned to the exchanges. The new requirements that the statute imposes on insurers generally will be enforced by state insurance departments or by HHS, if a state declines to enforce them.<sup>111</sup> And the state or federal government, independent of the exchanges, will run the risk-adjustment and reinsurance programs.<sup>112</sup> The ACA provides funding for state insurance-consumer-assistance offices or ombudsman programs. Exchanges do have some regulatory responsibilities under the

ACA, but the primary responsibility for regulating health insurance will be located elsewhere.

## **Administering Subsidies and Mandates**

### *The Issue*

One valuable role that exchanges can play is to administer subsidies that assist lower- and middle-income people in purchasing insurance. The Massachusetts Connector has been successful in large part because it provides subsidies to individuals lacking access to employer-sponsored or public insurance; in that way they can purchase insurance through the exchange. Exchanges are ideally situated to administer these subsidies, as eligibility can be determined during the enrollment process, and the subsidies can be sent directly to the insurance plan chosen by each person. The subsidy determination process is likely to work most smoothly if it is joined with the Medicaid and CHIP eligibility-determination process (as is done in Massachusetts), particularly because families are likely to move frequently between Medicaid, CHIP, and the exchanges as their income rises and falls. Ideally, plans that participate in Medicaid and CHIP, as well as in the exchange market, should be available, so that enrollees can move among programs without having to change plans. Exchanges also could play a role in enforcing mandates to purchase insurance, at least by identifying individuals who are in compliance and by assisting those not in compliance but who wish to comply.

### *The ACA*

Under the ACA, applications for premium-assistance credits and cost-sharing reduction payments are handled through the exchanges.<sup>113</sup> For its part, HHS is responsible for establishing a system to assure that if individuals apply to an exchange and are found eligible for premium subsidies and cost-sharing reductions, or eligible for the state basic health programs established by ACA Section 1331, Medicaid, or CHIP, they will be enrolled.<sup>114</sup> HHS also is supposed to develop and provide to the states a single streamlined form that can be filed online, in person, or by telephone—with the exchange or with the state—and that can be used to apply for all state health-subsidy programs.<sup>115</sup> The exchange can contract out program-eligibility determination to the state Medicaid agency,<sup>116</sup> but basic responsibility for processing premium-subsidy applications is assigned to HHS, which will determine eligibility after verifying information with the Internal Revenue Service and the Department of Homeland Security.<sup>117</sup> Centralizing enrollment in subsidies through the exchanges, however, should greatly simplify the process of providing subsidies. Similarly, the standardization of cost-sharing will facilitate the administering of cost-sharing reduction subsidies.

The exchange plays a minor role in the administration of the individual mandate, certifying that a person is exempt from the mandate when no affordable qualified health plan is available to that individual through the exchange or because he or she meets other mandate exemptions.<sup>118</sup> The exchange plays no role in the enforcement of the mandate, which is handled by the Internal Revenue Service.

### **State, Regional, or National Exchanges?**

#### *The Issue*

To date, insurance exchanges have been created at the state or local level, with one notable federal-level exception—FEHBP. In addition, federal Part C and D Medicare programs have exchange-like features. As we have learned with Medicaid, the Health Insurance Portability and Accountability Act (HIPAA), and other programs, state implementation of federally directed programs is at best awkward and at worst ineffectual,<sup>119</sup> but a national exchange could have implemented a uniform national program to solve a national problem. A national exchange could have potentially created larger insurance markets and risk pools. It could have lowered administrative costs by achieving economies of scale—for example, reducing the variances in state insurance mandates and requirements and simplifying regulatory tasks.<sup>120</sup> It also could have solved the problem of how to deal with markets that span state boundaries, such as the New York metropolitan area, where an individual may work in one state and live in another.

There also are arguments for locating the exchange at the state level. Foremost is that for more than a century states have had primary responsibility for regulating insurance sold within their borders. Although the ACA will establish federal requirements that all health insurers will have to meet, some states have stricter limits that are not affected by the ACA and that insurers in those states will need to meet even after ACA is fully implemented. For example, although the ACA limits age rating to 3 to 1, Massachusetts limits it to 2 to 1, and New York prohibits it altogether.<sup>121</sup>

State-level exchanges also would provide opportunities for experimentation with a variety of models and for learning from them. For example, some states have been involved in forming and operating purchasing cooperatives (although, on the whole, that experience has not been positive, as noted above), while others run their public-employee health-benefit programs through an exchange. Another argument for state exchanges is that many health insurers, particularly HMOs, sell in state or local markets and would not expand if there were a national exchange. State exchanges also could adapt to the special circumstances of their state, for example, by ranking plans based on their handling of chronic diseases that are unusually prevalent in the area.<sup>122</sup> And there is the widely held

belief that having control of social programs at the state or local level makes them more responsive to individuals' concerns.

Regional exchanges might offer some of the benefits both of national and state exchanges. Such regional entities could leave the states largely in control but give smaller states the options of sharing administrative costs, creating larger markets, and having access to bigger insurance pools. They could also address the question of how to offer insurance efficiently in metropolitan markets that span state lines. On the other hand, regional exchanges would present difficulties if markets or regulatory environments varied significantly from state to state within the region. They also would have to relate to more than one insurance department, which would undoubtedly cause political complications. Finally, risk adjustment in regional exchanges would be problematic.

#### *The ACA*

The ACA leaves implementation responsibility primarily with the states,<sup>123</sup> though the HHS secretary will be responsible for issuing regulations to set standards for the operation of the exchanges.<sup>124</sup> In addition, HHS will promulgate regulations for implementing the ACA insurance reforms, the provision of qualified health plans through the exchanges, the establishment of reinsurance and risk-adjustment mechanisms, and other regulatory requirements.<sup>125</sup> States may elect to adopt, no later than January 1, 2014, these federal standards into their own laws or to adopt state standards that HHS finds to be equivalent.<sup>126</sup> HHS also will provide grants to the states to assist with implementation, which will, it is hoped, be targeted to assure that states are proceeding seriously and complying fully with federal regulations and policies.

The ACA provides two other opportunities that some states may want to explore in order to maximize their flexibility. For plan years beginning in 2017, states may apply to HHS for a waiver of up to five years from the requirement that they establish an exchange (as well as from other requirements of the legislation). A state may be granted such a waiver if HHS determines that the alternative state program offers benefit coverage that is as comprehensive, cost-sharing that is as affordable, and coverage of as many people as the reforms found in the ACA would accomplish; and if HHS also determines that the program achieves these objectives without increasing the federal deficit.<sup>127</sup> In addition, the state must meet public-notice-and-comment and reporting requirements. Under a second option, states can, with HHS permission, create a "basic health plan" for people lacking affordable employer-sponsored coverage and who live in households under 200 percent of the poverty level. The state would receive a federal

payment of 95 percent of what would otherwise have been provided for premium tax credits and cost-sharing reduction payments.<sup>128</sup>

The ACA also creates two possibilities for exchanges beyond the state level. First, with the approval of HHS, states may participate in regional exchanges.<sup>129</sup> Second, if a state chooses not to establish an exchange or if HHS determines on or before January 1, 2013, that the state has failed to take the actions necessary to implement the requirements imposed by the reform law, HHS must establish an exchange itself in that locale or contract with a nonprofit entity to do so.<sup>130</sup> This exchange would simply be a federally operated state exchange, but it could also be a national exchange that would be available in all states lacking an ACA-compliant state equivalent.<sup>131</sup>

In all likelihood, the ACA will result in a mix of state, regional, and national exchanges.

## **Governance**

### *The Issue*

An exchange could be operated by a federal or state agency or by a private, probably nonprofit, entity. The latter could operate more flexibly, free from constraints such as state civil service and public-contracting requirements, open-records or open-meetings laws, and formal administrative-procedure requirements. In particular, a private or quasi-governmental entity could pay higher salaries (which might be necessary to attract the best talent) than those currently possible under civil service laws. A private entity might also prove more acceptable to employers and insurance brokers,<sup>132</sup> and it would be more insulated from the political infighting that often bedevils government.<sup>133</sup> On the other hand, a public entity might, precisely because of these constraints, be more accountable and accessible.

Exchanges will have to relate to a host of government agencies—state insurance commissioners and departments, the state consumer-protection or ombudsperson offices funded through the ACA, federal insurance regulators, state Medicaid agencies, government employee-benefit programs, the Center for Medicare and Medicaid Services, and others. Regional exchanges will in addition need to work out their relationships with their constituent states, and subsidiary exchanges within a state will need to interact amongst themselves and with their state's authorities. Political accountability will be particularly challenging for regional exchanges, which also may face difficult relationships with insurance regulators that have different regulatory policies for different states. An exchange could be folded into an existing state agency, such as the insurance

department, the state employee-benefits program, or the state Medicaid agency. But it will probably be advisable for exchanges to maintain their independence from state insurance regulators or Medicaid agencies while also maintaining good working relationships with them.

The exchange governing board will have to comply with both the federal and state laws establishing the exchange. It will presumably be composed of experts and might well represent the users of the exchange or the interest groups affected by it (consumers, employers, labor organizations, and providers, for example). Strict conflict-of-interest requirements, however, must govern relationships with insurers, who should not be represented on the board. Exchanges may well find it advisable to contract out some administrative services to specialized firms rather than try to provide all services in-house.<sup>134</sup> Finally, it is important that states give the governing board substantial discretion to deal with the issues that arise over time in structuring the exchange and the health plans that it offers.

### *The ACA*

The ACA says relatively little about exchange governance. It does say that exchanges are supposed to be governmental agencies or nonprofit entities established by a state,<sup>135</sup> which may elect to have separate or combined exchanges for individuals and small employers.<sup>136</sup> A state also may contract with an “eligible entity” (a private organization that has relevant experience but is not an insurer, related to an insurer, or a state Medicaid agency) to carry out some exchange responsibilities.<sup>137</sup> Exchanges are prohibited from using funds for certain purposes, such as staff retreats, promotional giveaways, excessive executive compensation, or lobbying,<sup>138</sup> and they must consult with specified stakeholders in carrying out their business and also publish their charges on the Internet.<sup>139</sup> ACA’s Section 1313 contains extensive reporting, auditing, and financial-integrity requirements for exchanges, as well as penalties for serious misconduct. The U.S. Government Accounting Office is required to conduct a continuing study of the exchanges that reviews their operation and administration and makes recommendations for improvements. Payments made by, through, or in connection with an exchange are subject to the federal civil False Claims Act.<sup>140</sup>

The ACA leaves unanswered, however, most of the important governance questions that one might want answered with respect to exchanges. These include how their governing boards are constituted and appointed; who can serve on the boards; whether state civil service law or contracting law applies; to what extent state administrative-procedure laws, judicial review, and open-meetings or open-records law

applies; and how exchanges relate to other state entities. HHS regulations may answer some of these still-open questions or simply leave the answers to the states.

## **Relationships with Employers**

### *The Issue*

One of the purposes of exchanges is to provide greater choice of health plans to employees of small firms. If this goal is realized, and if exchanges offer higher-value and perhaps even lower-cost insurance, participation in exchanges may prove attractive to such employers. They could in turn provide the exchanges with the larger and healthier pool of enrollees that enable them to succeed.

Exchanges will only work for small employers, however, if they offer convenience rather than administrative complexity. At least initially, exchanges will have to accept the higher costs of working closely with brokers, which small businesses rely on to advise them on insurance issues.<sup>141</sup> Exchanges also will need to create a mechanism whereby a small employer can write a single check to the exchange for all of its employees.<sup>142</sup> And to assure legal compliance, exchanges should conduct due diligence to check on the arrangements made for offering health plans to the small firm's employees. Among the due-diligence points to be checked are that the policies comply with ERISA and the Age Discrimination in Employment Act (such as the latter's prohibition against discriminating against older workers in premium contributions).

Exchanges will need to be able to efficiently handle the frequent insurance "adds" and "drops" that are common among small businesses with high turnover rates. Exchanges could also collect and aggregate contributions from multiple employers of part-time employees or from employers of different family members. And exchanges should be able to assist employers in applying for and collecting the small-employer tax credit. In sum, employers should be able to cede to the exchange most of the health insurance functions that would otherwise be handled by a human resources department or an external consultant.

### *The ACA*

The ACA sets out in some detail the size of the employers that may participate in the exchange but is less clear as to how exactly employer participation would work. A "SHOP exchange" is identified but not described in the legislation. It could possibly be intended as an exchange in which small employers themselves purchase group plans for their employees. This would seem to be consistent with section 1312(f)(2), which defines a qualified employer as an employer "that elects to make all full-time employees of such

employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange.”

Elsewhere, however, the ACA seems to countenance an arrangement under which small employers play a more passive role, simply contributing to the premiums used by their employees to purchase insurance as individuals. For example, the law states: “A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under 1302(d) [bronze, silver, gold, or platinum] to be made available to employees through an Exchange.”<sup>143</sup> The provision goes on to say that employees may choose any plan within the tier of coverage chosen by the employer.

The ACA specifies that individuals may pay their premiums directly to the insurer,<sup>144</sup> but it is not clear whether an employer may pay its own share of the premium to the exchange or must pay directly to the insurer. One thing that is clear under the ACA is that an employer may not set up a Section 125 (of the Internal Revenue Code) “cafeteria plan” that permits employees to purchase insurance through the exchange with their own earnings free of taxes.<sup>145</sup> An employer can only allow employees to pay premiums through the exchange with a Section 125 plan if the employer itself contributes something to the cost of the insurance (although employers may continue to use Section 125 plans to allow employees to pay for health insurance outside of the exchange).<sup>146</sup>

There is no employer mandate, as such, in the ACA. Employers can be penalized if their employees receive premium or cost-sharing subsidies, however.<sup>147</sup> Workers with health benefits through their job can obtain subsidies if their share of the premium for their employment-based policy exceeds 9.5 percent of their household income (or if the plan covers less than 60 percent of the total allowed costs of the plan’s benefits).<sup>148</sup> To avoid a penalty, employers that cover their employees through an exchange will have to pay at least the cost of each individual’s policy in excess of 9.5 percent of the household income.

The ACA prohibits health-status underwriting, but it permits age ratings up to a 3-to-1 ratio, ratings based on tobacco use up to a 1.5-to-1 ratio, and “wellness” rewards that could reduce premiums by up to 30 percent—and, if the HHS secretary permits, up to 50 percent.<sup>149</sup> Premiums for individuals who purchase through the exchange will therefore vary considerably, and employer contributions might vary accordingly. Another law, the Age Discrimination in Employment Act, prohibits employers with 20 or more employees from requiring older employees to pay a higher percentage of premiums than younger

employees. Thus employers will still have to vary their premium contributions at least to respond to age differences so that the percentage of premium paid by employees stays constant.<sup>150</sup>

It may well be that the task of making sure that the right premium is paid for each employee to each insurer can be handled by payroll-services firms. But if the exchange could offer employers a consolidated bill covering all employees, and itself take care of allocating the funds among insurers, this might make the exchange much more attractive to employers.

## **Cost Control**

### *The Issue*

One of the hopes of advocates is that exchanges will help control the growth of health care spending and insurance costs. Continued growth of this kind, especially at rates in excess of the rate of growth of the economy, is not sustainable in the long run. Moreover, continued growth in the disparity between private-sector health-care-provider payment rates and public-sector (predominantly Medicare and Medicaid) payment rates is probably unsustainable as well. Either private-sector payments will need to be decreased, public payments increased, or public-sector beneficiaries forced to accept reduced access to providers (who will choose to forgo participation in public programs in favor of higher private-sector payments). But regardless of what happens to public-sector prices, private-sector cost growth must be controlled.

Health insurance exchanges are one of the few mechanisms in the ACA that address the growth of private-sector health care spending. The intention is that they will increase competition among insurers and focus it on price. The exchanges also may exclude insurers that charge excessive premiums; it is hoped that insurers struggling to lower premiums will in turn drive harder bargains with providers, pressuring them to lower their prices and control utilization. Insurers also may adopt different strategies for paying providers, which might result in better coordination or even reduced utilization of care.<sup>151</sup>

For this approach to in fact reduce prices, however, several of the elements of a successful exchange, each of which has been described above, must work together:

- Adverse selection will have to be effectively curtailed.
- Exchanges will need to reduce administrative and premium costs.

- The exchange market must be large enough to attract multiple insurers.
- Exchanges must be attractive to employers.
- Qualified individuals and employees must have incentives to choose lower-cost plans, thereby driving competition. This objective could be realized by benchmarking premium subsidies and employer contributions to lower-cost plans, and by requiring enrollees to cover the cost of more expensive plans on their own.<sup>152</sup>
- Ultimately, the price and utilization of health care goods and services must be reduced.<sup>153</sup>

### *The ACA*

The provisions of the statute relating to a number of the elements of an effective cost-control program—including provisions relating to adverse selection, reducing administrative costs, relations with providers, and number of participants—have already been described in this report.

The ACA requires that premium subsidies be geared to the difference in cost between the percentage of gross adjusted household income that applies to the enrollee's income bracket and the cost of the second-lowest-cost silver plan in the exchange.<sup>154</sup> This requirement will create an incentive for individuals and families in the nongroup market to attend carefully to plan price when choosing a plan. Meanwhile, employers are not required by the ACA to limit their contributions. The excise tax on high-cost health plans, however, will probably drive down employer contributions over time, and the exchange structure may encourage employers to pay a more uniform and perhaps lower share of premiums.

Finally, section 1311(g) of the ACA encourages exchange plans to create market incentives for quality improvement. If these plans are required to spend significant resources on quality initiatives not required of non-exchange plans, this could make exchange plans less competitive. On the other hand, if quality-improvement strategies also coordinate care and reduce the use of unnecessary care, cost reductions could result, making exchange plans more attractive.

## SUMMARY AND CONCLUSIONS

This report's main findings are as follows:

- It is absolutely necessary that exchanges be protected against adverse selection. Provisions of the ACA should help, but if small-group and nongroup insurance plans are available outside the exchange, the possibility of adverse selection remains open.
- For a number of reasons—including greater market power, economies of scale, more stable risk pools, and stronger protection against adverse selection—exchanges function better with larger numbers of enrollees and a higher percentage of consumers participating in insurance markets through exchanges.
- The advantages and disadvantages of combining small-group and nongroup risk pools and exchanges, and of creating regional or subsidiary exchanges, must be carefully weighed.
- The exchange model created by the ACA offers consumers structured choices. An important implementation decision will be whether to further structure choices or, alternatively, to offer greater flexibility.
- The ACA contains many provisions designed to maximize transparency and disclosure. Operationalizing these requirements will be one of the most important tasks of implementing the ACA.
- The exchanges must increase competition among insurers and focus that competition on value and price.
- If they are to offer better value to enrollees, exchanges must find ways to reduce administrative costs to employers and insurers.
- The ACA delegates a number of regulatory responsibilities to exchanges, which must certify plans for exchange participation. An important implementation choice will be whether exchanges should, on the one hand, maximize plan participation by minimizing certification requirements; or, on the other hand, use their certification authority to limit exchange participation to high-value plans.
- The exchanges play important roles as advocates of insurance affordability, as administrators of cost-sharing reduction subsidies, and as gateways to other public programs.

- Although the ACA opts for creating state exchanges, it establishes federal fallback authority to create a federal exchange as well as a multistate insurance program. It also leaves open the possibility of regional exchanges.
- The ACA provides very little guidance on exchanges' governance. Important choices will need to be made as to how the entities that govern exchanges should be structured and how they should relate to other state and federal institutions.
- Exchanges must be employer-friendly if they are to succeed. Thus, while the ACA offers little guidance to exchanges on how to interact with employers, this relationship must be a major focus of implementation efforts.
- The exchange has been sold as a mechanism for moderating the growth of health insurance costs. Achieving this goal will be possible only if exchanges are implemented so as to maximize competition, choice, and participation and to minimize administrative cost and adverse selection.

In a second report, now being prepared, we will further analyze solutions to the problems that have stymied exchange efforts in the past and specific recommendations will be offered.

## NOTES

Abbreviated citations below refer to sections of the Patient Protection and Affordable Care Act of 2010 (ACA), unless otherwise identified. For example, citations to the Public Health Services Act (PHSA) are also included.

<sup>1</sup> A. Enthoven and R. Kronick, “A Consumer-Choice Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy,” *New England Journal of Medicine*, Jan. 5, 1989 320(1):29–37; and M. Hall, E. Wicks, and J. Lawlor, “HealthMarts, HIPCs, MEWAs and Association Health Plans (AHPs): A Guide for the Perplexed,” *Health Affairs*, Jan. 2001 20(1):142–53.

<sup>2</sup> W. Zelman, “The Rationale Behind the Clinton Health Care Reform Plan,” *Health Affairs*, Spring 1994 13(1):9–29; and H. Greely, “Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity,” *Health Matrix*, 1995 5:37–82.

<sup>3</sup> E. Wicks, [\*Health Insurance Purchasing Cooperatives\*](#) (New York: The Commonwealth Fund, Nov. 2002), 3; Rand Compare, *Effects of Purchasing Pool Options* (2009). Available at <http://www.randcompare.org/policy-options/purchasing-pools>; and C. McGarr, “A Texas-Sized Health Care Failure,” *New York Times*, Oct. 6, 2009.

<sup>4</sup> L. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, D.C.: Urban Institute, 2009), 3.

<sup>5</sup> E. Wicks and M. Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” *Milbank Quarterly*, 2000 78(4):511–46, at 526–27.

<sup>6</sup> A. Lischko, S. Bachman, and A. Vangeli, [\*The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions\*](#) (New York: The Commonwealth Fund, May 2009).

<sup>7</sup> § 1312(d).

<sup>8</sup> § 1312(d)(1), (3) and (4).

<sup>9</sup> § 1251(a).

<sup>10</sup> Internal Revenue Code § 5000A(a) and (f), added by the ACA § 1501(b).

<sup>11</sup> § PHSA 2711, added by the ACA § 1001. Prior to 2014, “restricted annual limits” are allowed. Also, limits will continue to be permitted on specific covered benefits that are not “essential benefits.”

<sup>12</sup> PHSA § 2709, added by the ACA § 10103.

<sup>13</sup> PHSA § 2701, added by the ACA § 1201.

<sup>14</sup> PHSA §§ 2702, 2703, and 2705, added by the ACA § 1201.

<sup>15</sup> PHSA §§ 2704 and 2705, amended by the ACA § 1201.

<sup>16</sup> PHSA § 2708, added by the ACA § 1201.

<sup>17</sup> § 1302(b)(1) and PHSA § 2707, added by the ACA § 1201.

<sup>18</sup> § 1302(b)(2).

<sup>19</sup> § 1312(d)(2).

<sup>20</sup> § 1302(c) and PHSA § 2707, added by the ACA § 1201.

<sup>21</sup> Blumberg and Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, at 2.

<sup>22</sup> § 1312(c).

<sup>23</sup> § 1301(a)(1)(C)(iii).

<sup>24</sup> M. Hall, “The Three Types of Reinsurance Created by Federal Health Reform,” *Health Affairs*, 2010 29(6):1168–72.

<sup>25</sup> § 1343.

<sup>26</sup> § 1341.

<sup>27</sup> § 1342.

<sup>28</sup> The risk pool is created by § 1101.

<sup>29</sup> The mandate penalties are imposed by § 5000A(c) of the Internal Revenue Code, added by § 1501 of the ACA.

<sup>30</sup> See § 36B(b)(2) of the Internal Revenue Code, added by the ACA § 1401 and § 1402(b)(1).

<sup>31</sup> Letter from D. Elmendorf (Congressional Budget Office) to N. Pelosi, March 20, 2010. Available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>, Table 4.

<sup>32</sup> § 1421.

<sup>33</sup> § 1311(d)(3)(B)(ii).

<sup>34</sup> See C. Peterson and B. Fernandez, *The ACA Requirements for Offering Insurance Inside Versus Outside an Exchange* (Washington, D.C.: Congressional Research Service, 2010). The ACA instructs HHS to adopt regulations establishing criteria for the exchanges to use in certifying qualified health plans. These criteria aim to assure that a certified plan will:

- Meet marketing requirements that prohibit marketing practices and benefit designs that have the effect of discouraging high risk enrollees;
- Ensure a sufficient number of in-network providers and supply information on the availability of providers both in- and out-of-network;
- Include essential community providers that serve low-income medically underserved individuals;
- Be accredited, based on HEDIS data and CAHPS patient-experience surveys, by an accreditation agency recognized by HHS;
- Implement a quality-improvement;
- Use a uniform enrollment form;
- Use the standard benefit form for presenting health benefit options;
- Provide information to enrollees and prospective enrollees on performance with respect to quality measures; and
- Implement activities to reduce disparities in health and in health care.

Beginning in 2015, qualified health plans may only contract with hospitals with more than 50 beds if the hospital has implemented a patient safety-evaluation system and comprehensive patient discharge program, in accordance with § 1311(h).

<sup>35</sup> § 1302(e).

<sup>36</sup> T. Jost, “How Does the Health Reform Legislation Affect Self-Insured Plans?” Available at <http://oneillhealthreform.wordpress.com/2010/03/31/how-does-the-health-reform-legislation-affect-self-insured-plans/>.

<sup>37</sup> § 1321(d).

<sup>38</sup> Complete elimination of the nongroup market outside the exchanges is problematic because the ACA prohibits undocumented aliens from purchasing insurance through the exchanges. M. Russo, L. Etherton, and L. McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform* (U.S. PIRG Education Fund, 2010), at 18.

<sup>39</sup> L. Blumberg and K. Pollitz, *Cross-State Risk Pooling Under Health Care Reform: An Analytic Review of the Provisions in the House and Senate Bill* (Washington, Urban Institute, 2010). Available at <http://www.urban.org/UploadedPDF/412124-cross-state-risk.pdf>.

<sup>40</sup> Russo, Etherton, and McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform*, at 19.

<sup>41</sup> Wicks, *Health Insurance Purchasing Cooperatives*, at 4; Wicks and Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” at 534.

<sup>42</sup> D. Riemer, personal communication, June 28, 2010. Exchanges can also achieve economies of scales with respect to some factors by engaging in joint purchasing of administrative services. W. Kramer, personal communication, June 28, 2010.

<sup>43</sup> A. Enthoven, W. Kramer, D. Riemer, and J. Minarik, *Making Exchanges Work in Health Reform* (Washington, D.C.: Committee for Economic Development 2009). Available at [http://www.ced.org/images/library/reports/health\\_care/exchangememohc09.pdf](http://www.ced.org/images/library/reports/health_care/exchangememohc09.pdf).

<sup>44</sup> Blumberg and Pollitz, *Cross-State Risk Pooling Under Health Care Reform: An Analytic Review of the Provisions in the House and Senate Bill*.

<sup>45</sup> A. Enthoven, W. Kramer, D. Riemer, and J. Minarik, *Making Exchanges Work in Health Reform*; Riemer, personal communication, June 28, 2010.

<sup>46</sup> § 1421.

<sup>47</sup> § 1304(b) and § 1312(f)(2).

<sup>48</sup> § 1312(f)(2).

<sup>49</sup> HHS, Regulation on Grandfathered Plans Under the Affordable Care Act, 2010, at 43–44.

<sup>50</sup> D. Riemer, personal communication, June 28, 2010.

<sup>51</sup> D. Riemer, personal communication, June 28, 2010.

<sup>52</sup> D. Faulkner, A. Lischko, and D. Chollet, *Considering a Health Insurance Exchange: Lessons from the Rhode Island Experience* (Washington, D.C.: Robert Wood Johnson State Coverage Initiatives) 3, 4.

<sup>53</sup> D. Riemer, personal communication June 28, 2010.

<sup>54</sup> Greely, “Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity,” at 58–59.

<sup>55</sup> § 1312(c).

<sup>56</sup> § 1311(b)(2).

<sup>57</sup> § 1311(f)(1).

<sup>58</sup> Wicks and Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” at 519.

<sup>59</sup> P. Fronstin, “Choice of Health Plans: Findings from the 2009 EBRI/MGA Consumer Engagement in Health Survey,” *EBRI Notes*, 2009 32(2): 2–9, at 4.

<sup>60</sup> E. Wicks, “The Insurance Exchange in Health Reform: Essential Characteristics,” *Health Affairs Blog*, Oct. 14, 2009.

<sup>61</sup> J. Kingsdale and J. Bertko, “Health Insurance Exchanges Under Health Reform: Six Design Issues for the States,” *Health Affairs*, 2010 29(6):1158–63.

<sup>62</sup> § 1302(d)(1).

<sup>63</sup> § 1302(d). Employer contributions to a health savings account may be taken into account in determining the level of coverage for an employment-based plan.

<sup>64</sup> § 1302(e).

<sup>65</sup> § 1301(a)(1)(C)(2). Qualified health plans must also be offered, at each level, that covers only children under the age of 21. § 1302(f).

<sup>66</sup> Russo, Etherton, and McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform*, at 13.

<sup>67</sup> S. Lueck, *Designing Benefit Standards for a Health Insurance Exchange* (Washington, D.C.: Center on Budget and Policy Priorities, 2009), 2.

<sup>68</sup> § 1312(a).

<sup>69</sup> § 36B(c)(3)(A) of the Internal Revenue Code, added by § 1401 of the ACA.

<sup>70</sup> § 1402(b)(1).

<sup>71</sup> § 1312(a)(2).

<sup>72</sup> Blumberg and Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, at 6–7.

<sup>73</sup> The standards must provide for a summary of benefits that:

- Is in a standard format, not more than four pages long, with not smaller than 12-point type;
- Is culturally and linguistically appropriate and in easily understandable language;
- Uses uniform definitions of standard insurance and medical terms (to be developed by HHS);
- Includes a description of coverage, including cost-sharing;
- Lists exceptions, reductions, and limitations on coverage for all essential services and other benefits;
- Includes cost-sharing provisions and renewability and continuation of coverage terms;
- Includes a “coverage facts label” that illustrates common benefit scenarios, such as a pregnancy or serious chronic illness;
- States whether the plan provides minimum essential coverage (meeting the individual mandate’s requirements) and whether an employer plan provides not less than 60 percent of allowed benefits (and thus is adequate to keep employees from opting for the exchange instead of employer coverage); and
- Includes a statement that the coverage outline is just a summary and that the coverage document itself is the real contract, as well as a contact telephone number (to permit the asking of questions) and a Web address as to where the contract itself can be found. § 2715 of the PHSA, added by the ACA § 1001.

<sup>74</sup> §1311(e)(3).

<sup>75</sup> § 2715A of the PHSA, added by § 1001 of the ACA.

<sup>76</sup> §2794 of the PHSA, added by §1003 of the ACA.

<sup>77</sup> §1103.

<sup>78</sup> PHSA § 2717, added by § 1001 of the ACA.

<sup>79</sup> § 1311(c)(3).

<sup>80</sup> § 1311(c)(4) and § 1311(c)(1)(G).

<sup>81</sup> § 1311(c)(1)(B).

<sup>82</sup> § 1301(a)(2) and (3), §1322, and § 1333.

<sup>83</sup> § 1334.

<sup>84</sup> Blumberg and Pollitz, *Cross-State Risk Pooling Under Health Care Reform: An Analytic Review of the Provisions in the House and Senate Bill*.

<sup>85</sup> A. Lishko, *State Coverage Initiatives: Health Insurance Connectors and Exchanges: A Primer for State Officials* (Washington, D.C.: AcademyHealth, 2007), 5.

<sup>86</sup> In the Massachusetts Commonwealth Connector the commissions range from 1.5 to 3.3 percent of premiums. Blumberg and Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, at 4.

<sup>87</sup> Blumberg and Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, at 4.; K. Swartz, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do About It* (New York: Russell Sage, 2006).

<sup>88</sup> Rand Compare, *Effects of Purchasing Pool Options*.

<sup>89</sup> Wicks and Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” at 522–23

<sup>90</sup> Wicks and Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” at 538.

<sup>91</sup> R. Curtis and E. Neuschler, *What Health Insurance Exchanges or Choice Pools Can and Can't Do About Risks and Costs*. (Washington, D.C.: Institute for Health Policy Solutions, 2009), 7.

<sup>92</sup> J. Kingsdale, “Health Insurance Exchanges—Key Link in a Better-Value Chain,” *New England Journal of Medicine* online, 2010, available at <http://healthcarereform.nejm.org/?p=3438&query=home,2>.

<sup>93</sup> § 1311(a).

<sup>94</sup> § 1311(a)(4)(B).

<sup>95</sup> § 1311(b).

<sup>96</sup> § 1311(d)(4)(F) and § 1413.

<sup>97</sup> § 1311(i).

<sup>98</sup> § 1311(c)(3) and (e)(3).

<sup>99</sup> § 1312(e).

<sup>100</sup> § 1312(b), § 1402(c)(3), and § 1412(c)(2)(A).

<sup>101</sup> § 1311(g), (h); PHS § 2717, added by § 1001 of the ACA.

<sup>102</sup> W. Kramer, personal communication, June 28, 2010.

<sup>103</sup> For example, if a nongroup or small-group plan collected \$100 in premiums and spent \$73 on clinical services, \$3 on quality improvement expenses, and \$24 on nonclaims costs, it would, under the medical loss ratio provisions, owe its enrollees a \$4 rebate. If, however, it spent \$73 on clinical services, \$3 on quality, and \$20 on nonclaim costs, but paid \$4 to the exchange, and the exchange was treated as a regulatory fee, its medical loss ratio would be  $\$73 + \$3 / (\$100 - \$4)$ , or 79.1 percent, and it would owe a rebate of \$0.90.

<sup>104</sup> Russo, Etherton, and McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform*, at 16; Kingsdale and Bertko, “Health Insurance Exchanges Under Health Reform: Six Design Issues for the States,” at 1161.

<sup>105</sup> E. Wicks, *Implementing a Health Plan Purchasing Pool* (Washington, D.C.: Urban Institute, 2005), 5.

<sup>106</sup> § 1311(d)(2)(B).

<sup>107</sup> § 36B(c)(2)(A), added by the ACA §1401.

<sup>108</sup> § 1311(e)(1).

<sup>109</sup> § 1311(e)(1).

<sup>110</sup> § 1311(e)(2).

<sup>111</sup> § 1321(c).

<sup>112</sup> §§ 1321(c), 1341, 1342, and 1343.

<sup>113</sup> § 1411.

<sup>114</sup> § 1413.

<sup>115</sup> § 1413(b)(1).

<sup>116</sup> § 1413(b)(2), (d)(2).

<sup>117</sup> § 1411.

<sup>118</sup> § 1311(d)(4)(H).

<sup>119</sup> T. Jost, “Implementation of Health Care Reform—Federal Versus State Government” *New England Journal of Medicine*, Dec. 30, 2009. Available at <http://healthcarereform.nejm.org/?p=2628&query=home>. Under our constitutional system, the federal government cannot “commandeer” state government for its purposes. To secure state cooperation in implementing a program, the federal government must either use the carrot of federal funds (as with Medicaid) or the stick of threatening the implementation of a federal fallback program.

<sup>120</sup> Blumberg and Pollitz, *Cross-State Risk Pooling Under Health Care Reform: An Analytic Review of the Provisions in the House and Senate Bill*.

<sup>121</sup> *Ibid.*

<sup>122</sup> Russo, Etherton, and McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform*, at 14.

<sup>123</sup> T. Jost, “State Lawsuits Won’t Succeed in Overturning the Individual Mandate,” *Health Affairs*, 2010 29(6):1225–28.

<sup>124</sup> § 1321(a)(1)(A).

<sup>125</sup> § 1321(a)(1).

<sup>126</sup> § 1321(b) and § 1321(b).

<sup>127</sup> § 1332.

<sup>128</sup> § 1331.

<sup>129</sup> § 1311(f)(1).

<sup>130</sup> § 1321(c)(1). There is also a presumption that the Massachusetts Connector can continue to operate unless HHS concludes otherwise (§ 1321(e)).

<sup>131</sup> § 1321(c)(2), cross-referencing current 42 U.S.C. § 300gg-22(b), which will be renumbered under the bill.

<sup>132</sup> Wicks, *Health Insurance Purchasing Cooperatives*, at 6.

<sup>133</sup> Kingsdale and Bertko, “Health Insurance Exchanges Under Health Reform: Six Design Issues for the States,” at 1159.

<sup>134</sup> Wicks, *Health Insurance Purchasing Cooperatives*, at 10.

<sup>135</sup> § 1311(d)(1).

<sup>136</sup> § 1311(b)(2).

<sup>137</sup> § 1311(f)(3).

<sup>138</sup> § 1311(d)(5)(B).

<sup>139</sup> § 1311(d)(6).

<sup>140</sup> § 1313(a)(6).

<sup>141</sup> S. Long and M. S. Marquis, “Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?” *Health Affairs*, 2001 20(1):154–63, at 161.

<sup>142</sup> See *Health Insurance Exchange Study* (Minnesota Department of Health, Feb. 2008), 9. Available at [www.health.state.mn.us/divs/hpsc/hep/publications/legislative/exchangestudy.pdf](http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/exchangestudy.pdf).

<sup>143</sup> § 1312(a)(2)(A).

<sup>144</sup> § 1312(b).

<sup>145</sup> A. Monahan, *The Use of Section 125 Plans for Individual Insurance Following the Enactment of Federal Health Reform* (Minneapolis: SHARE, 2010).

<sup>146</sup> § 1515.

<sup>147</sup> §4980H of the Internal Revenue Code, added by the ACA § 1513.

<sup>148</sup> § 36B(c)(2)(C) of the Internal Revenue Code, added by the ACA §1401.

<sup>149</sup> PHSA§ 2701, added by the ACA§ 1201.

<sup>150</sup> 29 C.F.R. § 1625.10(d)(4)(ii).

<sup>151</sup> Wicks, *Health Insurance Purchasing Cooperatives*, at 4.

<sup>152</sup> D. Riemer, personal communication, June 1, 2010.

<sup>153</sup> Blumberg and Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, at 3.

<sup>154</sup> § 36B(b)(2)(B)(i) of the Internal Revenue Code, added by the ACA § 1401.