



**HEALTH INSURANCE EXCHANGES  
IN HEALTH CARE REFORM:  
LEGAL AND POLICY ISSUES**

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**ABSTRACT:** The two health reform bills pending in Congress represent quite different understandings of what a health insurance exchange is, what it does, how it is organized, and how it functions. How those differences are resolved is likely to determine the extent to which the eventual exchanges accomplish their goals and whether they avoid the difficulties that have afflicted earlier attempts at creating and operating exchanges. This report describes design and function issues raised by exchanges, prior experience with exchanges, the provisions of the pending House and Senate bills that affect exchanges, and policy issues raised by the legislation.

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## EXECUTIVE SUMMARY

One of the least controversial features of the health care reform legislation currently before Congress is the health insurance exchange. The concept of the exchange has support across much of the political spectrum, and the final House and Senate bills both contain, and have always contained, an exchange. The apparent widespread agreement, however, conceals a deeper lack of consensus on how the exchange should be designed institutionally and how it should function. The absence of a vigorous debate about the exchange concept, moreover, has contributed to a lack of focus on the exact nature and function of an exchange.

A health insurance exchange is basically an organized market for the purchase of health insurance. The exchange is intended to play a number of roles in health care reform. First, it is expected to be the locus of “managed competition” among health insurance plans. It is hoped that this competition will make health insurance more affordable and thus more accessible. Second, the exchange is expected to create a sizable risk pool that will allow insurance risk to be more efficiently managed, reducing the incidence of adverse selection (by the insured—[see p. 27](#)) and the practice of risk selection (by insurers). Third, it is hoped that the exchange will reduce administrative costs by simplifying marketing and eliminating risk-based underwriting. Fourth, the exchange offers the possibility of making health insurance markets more transparent and of facilitating consumer choice among health insurance plans by providing more and better information about health insurance options. Fifth, the exchange may play a regulatory role, helping to make insurers more accountable. In particular, it could serve as a forum for reallocating risk among insurers and for guaranteeing that those insurers sell comprehensive health coverage with manageable cost-sharing, that they market their plans fairly, and that they respond properly to consumer claims and complaints. Sixth, the exchange will likely play a role in facilitating other key features of the health care reform legislation, such as the payment of premium credits or perhaps even the imposition of the individual or employer mandates.

Whether the exchange will effectively perform these functions, however, depends entirely on the institutions established to administer it; the functions, responsibilities, and authority it is afforded; its regulatory environment; and the structure of the markets in which it operates. We have, in fact, had a lot of experience with exchanges—also called purchasing cooperatives or health alliances—and much of that experience has been discouraging. In the past, exchanges have often had a difficult time attracting enough

members or insurers to function efficiently, and have become targets of adverse selection. They have rarely been able to achieve their promise of significantly reducing the cost of insurance premiums or increasing access to health care. With this in mind, Congress needs to be careful in its policy choices in order to optimize the chance of success.

This paper first examines the role of the exchange in a reformed health care system, explores our experience with exchanges and what we can learn from it, describes the different approaches to exchange design and function taken by the House and Senate bills, and concludes with an examination of the policy issues raised by the pending legislation. The descriptions of the bills' provisions are summarized in the table at the end of this section.

The major policy issues that must be addressed in creating exchanges are:

*Should the exchange be established at the federal or at the state level?*

Insurance regulation has traditionally been a state function, and a number of states have had experience running exchanges. Establishing exchanges at the state level also would promote experimentation and responsiveness to localized concerns. On the other hand, health care reform is a national effort to create a nationwide reform. The Constitution does not permit Congress to “commandeer” the states to carry out the reform, and any attempt by the federal government to oversee state implementation of the reforms would be awkward at best, ineffectual at worst. The federal government has in fact had quite a lot of experience running exchanges like the Federal Employees Health Benefits Program. A national exchange could ensure uniform nationwide availability, with the capacity to assist those families that work or live in several states. There is also concern as to whether all states have the resources and willpower to be sufficiently aggressive in regulating insurers. A single national exchange with a local presence (perhaps through Social Security offices) is perhaps more likely to be implemented successfully.

*How can the plan be protected against adverse selection?*

The Achilles' heel of many earlier exchanges has been adverse selection—exchanges tend to attract (or to have dumped upon them) sicker and more costly enrollees. The obvious solution to this problem is to prohibit those individuals or groups who are eligible for insurance sold through the exchange from buying insurance anywhere else. Measures can be taken, however, to limit adverse selection even if insurance continues to be sold outside the exchange. First, exchanges should be opened up to all individuals and to groups large enough to give the exchange a viable risk pool. Second, plans inside and outside the exchange should have to play by the same rules and charge the same

premiums. Third, there should be implementation of risk-adjustment or reinsurance schemes covering insurers inside and outside the exchange to assure that plans attracting low risks compensate those that attract high risks. Finally, employers and insurers can be regulated to discourage them from steering bad risks into exchange plans.

*How can the exchange contribute to standardization and transparency?*

Exchanges can facilitate consumer choice by requiring all insurers that market policies within the exchange to cover the same essential benefit package and to provide insurance in standardized tiers of coverage for easy comparison. Exchanges also can require insurers to make available to consumers standardized information about a whole range of plan features and limitations (such as benefit coverage, cost-sharing obligations, exclusions, network providers, out-of-network costs, and information about consumer complaints, disenrollments, and satisfaction) to assist consumers in identifying and purchasing the coverage they need and can afford. This information should be made available in plain language and in a culturally and linguistically appropriate manner. Finally, exchanges should make available financial information concerning plans such as medical loss ratios or justifications offered for premium increases, in order to improve the public accountability of insurers.

*What can an exchange do to reduce administrative costs?*

One of the promises of exchanges is that they can reduce the costs of administering health insurance. That promise can be fulfilled if an exchange reduces the costs of marketing insurance and of enrolling members and eliminates the cost of risk underwriting. Another significant cost-cutting opportunity lies in the reduction or elimination of brokerage commissions, as the role of brokers in the individual market should be reduced or eliminated by the exchange. To succeed at reducing administrative costs by eliminating duplication of effort, however, the exchange needs to provide insurers with a large enough group of exchange-based enrollees so that the insurer can comfortably cease providing itself to those enrollees the services the exchange offers. Finally, a national exchange would save money by avoiding the duplication of functions that state exchanges will create.

*What avenues should the exchanges provide for appeals and judicial review?*

Exchanges will make a host of legal determinations, such as deciding which insurers, individuals, and employers can participate in the exchange. Exchanges may also play a role in deciding eligibility for subsidies or compliance with individual or employer mandates. Insurers that participate in the exchange will, of course, adjudicate claims and

respond to grievances. Procedures need to be in place for providing administrative and, when necessary, judicial review for these determinations.

*How can the exchanges control cost?*

It is hoped that exchanges will not only facilitate access to health care but also help control growth in health care costs. The primary route through which they may do so is “managed competition” among insurers as standardization and transparency of offerings drives insurers toward price competition. The presence of a public plan in the market could in particular encourage private insurers to offer more competitive prices. An exchange also could offer insurers a large number of purchasers and perhaps receive discounts in return. Finally, an exchange could negotiate with insurers to bring down premiums or refuse to permit those that unreasonably or excessively increase premiums to participate in the exchange. Cost control in the exchange is particularly important because many of its participants are going to be lower- or middle-income Americans who were previously unable to afford health insurance, and much of the cost of their insurance is going to be borne by the taxpayers through premium and cost-sharing subsidies. All available approaches to controlling costs should be pursued.

Over the next days and weeks, Congress will finalize legislation that will significantly change the way in which we finance health care in the United States. The health insurance exchange concept will almost certainly play a role in this reform. The exchange holds real promise as a tool of health policy, but as is almost always the case in public policy, the devil will be in the details of design and function. The two bills enacted by the House and Senate contain a host of good ideas that Congress can work with in putting together a final bill. There is, however, much that could be improved. It is to be hoped that this analysis will prove useful in the pursuit of that goal.

**Comparing the Health Insurance Exchange Provisions of the House and Senate Reform Bills**

	<b>Both House and Senate</b>	<b>House H.R. 3962</b>	<b>Senate H.R. 3590</b>
<b>Governance: state or federal?</b>		National exchange with state opt-out.	State exchanges. The Department of Health and Human Services will implement an exchange or will contract with a nonprofit to implement an exchange if the state declines or fails to do so. Regional or subsidiary exchanges possible.
<b>Exchange roles and duties</b>	Enrolling eligible individuals and employers in insurance plans, educating consumers, providing standardized information on health plans, accepting applications for premium subsidies.	Negotiating contracts with plans and administering risk pooling. The Commissioner of Health Choices can deny excessive premiums or premium increases.	Rating plans, certifying exemption from individual mandate, identifying employers for penalties based on employee receipt of premium subsidies. States can deny exchange participation to plans with unreasonable premium increases.
<b>Who can buy insurance through an exchange?</b>	Individuals without public or employment-based coverage; small employers can contribute to the cost of covering their employees through the exchange.	Small employers with up to 25 employees in 2013, 50 in 2014, 100 or larger thereafter.	Small employers with up to 100 employees; after 2017, larger than 100. Only nonincarcerated citizens and legal residents may participate.
<b>Can insurance be sold outside the exchange?</b>	Yes, for groups and for grandfathered policies.	Individual coverage can be sold only through the exchange.	Individual and group coverage can be sold outside the exchange. Insurers must use a single risk pool inside and outside the exchange for all individuals and a single risk pool for all small groups (unless they are combined), and the same price must be charged for qualified plans inside and outside the exchange.
<b>How are plans standardized and regulated in the exchange? Do the same requirements apply outside the exchange?</b>	Plans are classified in tiers based on actuarial value. Plans must cover essential benefits and limit cost-sharing.	All non-grandfathered plans, inside and outside the exchange, must be qualified health benefit plans and must comply with all of the insurance reforms in the bill. Exchange plans may be subject to additional requirements. Cooperative plans and the public plan may be offered only through the exchange.	Exchanges can also issue catastrophic coverage to enrollees who are under 30 or cannot find affordable coverage. Most of the insurance reforms in the legislation apply to all non-grandfathered plans, but some apply only to insured plans and others only to individual or small group plans. Exchange plans must be "qualified health plans" and must meet a number of additional requirements. Exchange plans

	Both House and Senate	House H.R. 3962	Senate H.R. 3590
			must implement quality-improvement strategies with market-based incentives. Multistate plans overseen by the Office of Personnel Management and cooperative plans may also be offered through the exchange.
<i>How do exchanges make health plans more transparent?</i>	Exchange-participating plans must disclose information about plan terms and conditions, payment policies, financial data, enrollment and disenrollment data, cost-sharing, out of network coverage, and in-network providers.	Health plans must ensure that their payment arrangements are transparent to providers.	Information must be disclosed in standardized form and must include "coverage fact labels" that illustrate common benefit scenarios. Health plans must report on programs to improve quality of care and patient safety and promote prevention and wellness. Exchanges must rate plans.
<i>How is risk adjustment addressed?</i>	Both bills include risk adjustment.	Risk is adjusted among plans in the exchange by adjusting premiums.	The bill provides for a permanent risk-adjustment program administered by the states and for two temporary programs, operational from 2014 to 2016, to provide reinsurance for the individual market and a risk-corridor payment program. None of these programs is administered through the exchanges.
<i>Are federal premium or cost-sharing subsidies available outside the exchange?</i>	No.		
<i>How is the exchange funded?</i>		Through a trust fund based on penalties collected for violations of the individual and employer mandate and additional appropriations.	Through federal start-up funds. Once operational, the exchanges will be funded through an assessment on insurers.

## **HEALTH INSURANCE EXCHANGES IN HEALTH CARE REFORM: LEGAL AND POLICY ISSUES**

### **INTRODUCTION**

The concept of the health insurance exchange is found in both HR 3962, adopted in November by the House, and in HR 3590, the bill adopted by the Senate in December, and has indeed been found in every earlier bill passed by a House or Senate committee in the 2009 health reform campaign. It has, however, provoked surprisingly little debate or even analysis. Indeed, it is one of the least controversial, even least conspicuous features of the health reform legislation. The exchange concept has been endorsed by policy advocates across a broad range of the political spectrum. An insurance exchange will almost certainly be part of the final 2009-2010 legislation, if health reform is finally adopted into law.

A health insurance exchange is basically an organized market for health insurance. Nevertheless, the term “health insurance exchange” is not clearly defined; indeed the vision of what an exchange is and how it would function varies significantly from proposal to proposal. An exchange could potentially play a major role in making health insurance more affordable and accessible, perhaps even in improving the quality of care. Competition among insurers structured through an exchange could move insurers away from competition that is based on attracting the best risk and toward competition based on price and quality. This could in turn limit premium growth (and thereby overall cost growth), cut administrative costs, reduce risk selection and smooth out risk distribution, and improve the quality of insurance coverage, perhaps even of health care itself. An exchange could ideally provide standardization of insurance products, thus improving coverage transparency and comparability of prices. But, depending on how it is designed and implemented, an exchange could have very little effect on the health care system, and could even increase cost.

The exchange concept has a long history in health care reform efforts. The intellectual history of the exchange goes back to the concept of “managed competition,” credited to Alain Enthoven’s work in the late 1970s.<sup>1</sup> The “health alliance,” an ambitious form of exchange, was at the heart of the Clinton Health Security Act.<sup>2</sup> During the 1990s, health insurance purchasing cooperatives were encouraged by legislation in a number of states and implemented by business and community groups in others, although many have since failed. The Federal Employees Health Benefits Program (FEHBP) and the California Public Employees’ Retirement System (CALPERS) are often cited as long-

standing and more or less successful examples of insurance exchanges, and exchange-like arrangements exist in the public employee benefit programs of many states.<sup>3</sup> The Medicare Advantage program and Medicare Part D include some elements of a health care exchange (choice among multiple plans), although not others (a common enrollment portal). The Massachusetts Connector is the most recent, and to date most successful, attempt to establish an exchange at the state level. Utah has also recently begun to implement an exchange.<sup>4</sup> Finally, The health care systems of other countries, notably the Netherlands, Switzerland, and Germany, have exchange-like features, including standardized benefit packages and risk adjustment among insurers..<sup>5</sup>

This paper first examines the different ways in which exchanges could be designed in a reformed health care system and the different roles that they could play. The paper next briefly explores experiences with exchanges and what we can learn from them. It then describes the different approaches taken by the House and Senate bills to exchange design and function. The paper then concludes with an examination of the policy issues raised by the pending legislation.

## **EXCHANGE DESIGN AND FUNCTION ISSUES**

Assuming that an exchange or multiple exchanges are part of final reform legislation, Congress, and ultimately the states or a federal agency, will need to make choices with respect to a number of design issues.

The first of these is, who will be covered by the exchange? Several different markets currently exist for insurance, and exchanges could be limited to one or, alternatively, could serve several of these markets. Exchanges could limit their enrollment to the nongroup market. They could additionally be opened to employees who would otherwise be covered by the small-group market (groups of up to 25 or 50, for example) with employees choosing among plans offered through the exchange and employers contributing to cover part or all of the premium. By further extension, exchanges could cover members of large groups up to a given size, or indeed all insureds.

The proportion of insureds covered by the exchange expands dramatically if large groups are covered, because, although most employers are small businesses, most employees work for larger employers.<sup>6</sup> The Clinton Health Security Act Health Alliances covered all insureds except those who worked for employers with 5,000 or more employees or who were members of multiemployer union plans with 5,000 or more members, and thus covered a much larger proportion of the population than would be

covered under current proposals, which are, initially at least, limited to the nongroup and small-group markets.<sup>7</sup>

A related issue is the extent to which the exchange will be the exclusive gateway to purchasing insurance for those persons who qualify to enroll in it. Here there are several possibilities. All insureds in a particular market could be required to purchase insurance through the exchange. Pre-existing insurance policies could be grandfathered in and their owners excused from exchange participation. The exchange could be nonexclusive in the group market; that is, new group policies could be sold outside the exchange. The exchange could be nonexclusive even in the nongroup market, thus permitting insurance sold outside the exchange to compete with the exchange in all markets. Finally, insurance could be sold both inside and outside the exchange, but premium subsidies could be available only within the exchange, thus limiting the subsidized population to the exchange.

Exchanges can also serve a range of functions.<sup>8</sup> An exchange could conceivably be nothing more than a Web site where individuals compare and purchase health insurance policies. At the other end of the spectrum, it could be an active participant in the health insurance market, bargaining aggressively to reduce health care costs or imposing regulatory cost controls. Functions that could conceivably be performed by a health insurance exchange include:

- *Organizing the market by making it more transparent and improving comparability of plans.* Exchanges could be used to standardize insurance product descriptions and to facilitate price comparison by grouping policies in product tiers in terms of their actuarial value or cost-sharing limits (e.g., platinum, gold, silver, bronze).
- *Facilitating purchasing, and thereby simplifying choice.* Individuals could actually purchase insurance through the exchange with their own funds or employer contributions. Allowing employers to pay premium payments through the exchange for their employees could expand employee choice, facilitate portability (since employees could keep their policy even as they changed employers), and permit multiple employers to make contributions for the benefit of part-time employees. An exchange could reduce or eliminate the role and commissions of insurance brokers and agents, currently a major expense in the nongroup or small-group market. Exchanges could also serve as clearinghouses for public insurance coverage in general, directing eligible individuals who come to the exchange to other programs, such as the Medicaid, CHIP, or even Medicare programs.

- *Increasing the size of the insurance purchasing pool*, spreading risk more broadly and reducing risk selection.
- *Regulating health insurance coverage*. Exchanges could be used to impose on participating insurers regulatory requirements not imposed on insurers generally, by, for example, defining essential benefits that must be covered or limiting cost-sharing. Exchanges could also require reporting, collect data from insurers, and monitor regulatory compliance.
- *Facilitating the imposition of individual mandates*. One of the functions of the Massachusetts Connector is to define “creditable coverage,” a minimum benefit standard that must be met to fulfill the requirements of the individual mandate.<sup>9</sup> The Connector also defines “affordability” for determining whether an individual is excused from meeting the mandate. If a national individual mandate is adopted with an affordability exception, compliance could be monitored and exceptions could be granted through the exchange.
- *Facilitating the use of health insurance premium subsidies*. This again is a function of the Massachusetts Connector. Eligibility for subsidies can be determined through the exchange, which can then couple the subsidies with premium payments provided by individuals and employers to pay for insurance
- *Reallocating risk among insurers*. The exchange can be used as a mechanism for prospectively adjusting premium payments to health insurers (or for moving money among insurers retroactively) to reward insurers who take on high-risk individuals at the expense of insurers who attract low-risk individuals.
- *Selecting high-value insurers*. An exchange could (as Massachusetts does) allow only a limited number of insurers to offer policies in the exchange and, in addition, could permit insurers to offer only a limited range of policies. This would increase comparability and could allow the exchange to select insurers and policies that offer the best value. Insurers not selected to offer a policy could either be barred from the nongroup/small-group market or be allowed to offer policies outside the exchange (but without access to public affordability subsidies).
- *Negotiating with insurers*. An exchange could go further and negotiate directly with insurers, allowing only those with whom they had concluded satisfactory negotiations to offer policies through the exchange.
- *Regulating insurance premiums*. An exchange could impose price controls or mandatory medical expense ratios on insurers, allowing only insurers that comply

with regulatory requirements to sell through the exchange (or in the small- or nongroup market).

- *Facilitating research.* An exchange would be ideally situated to collect data from participating insurers; the data could then be used by researchers to improve our understanding of health insurance and health care financing and utilization

Another important decision that will need to be made regarding exchanges concerns the level of government at which they are created and the authority under which they operate. Exchanges could be established at the national, regional, state, or substate level. Exchanges could be created by federal law, by state law, or by private concerns. Congress could establish national exchanges directly through federal law. Alternatively, Congress could adopt a law requiring the states to establish exchanges under federal oversight, funded in whole or in part by federal funds, with a federal fall-back program for states that failed to establish viable exchanges. Either federal or state exchanges could contract with private entities to perform some of their functions. Exchanges could supplement existing federal or state insurance regulators or take over some or all of their functions. Finally, private exchanges could be formed by employer coalitions, nonprofit organizations, or even for-profit firms.

## **EXPERIENCE WITH EXCHANGES**

Previous experience with exchanges has on the whole been discouraging.<sup>10</sup> Efforts by the states to establish open exchanges have largely failed. State-sponsored exchanges in California, Florida, and Texas enjoyed initial success, but were not able to sustain it and eventually closed.<sup>11</sup> The most successful public exchanges have been the Federal Employee Health Benefits Program; state pension programs, like CALPERS, or state employee benefit programs; and the Massachusetts Connector (which is still perhaps too new to pronounce an unqualified success). These exchanges, however, have not been able to keep cost growth significantly below that experienced generally in the private market. A few private purchasing cooperatives have also enjoyed some success in increasing employee choice for small-group plans, but likewise have not had a significant effect on cost.<sup>12</sup>

One purported advantage of an exchange is that it can create a large risk pool, which should be more attractive to insurers than an atomistic market because it is less vulnerable to adverse selection. A second advantage is that an exchange can save on administrative costs both by reducing marketing costs and by creating economies of scale. A third is that an exchange should be able to increase consumer clout by offering a large group to insurers. All of these factors should reduce the cost of insurance, thus

expanding access if individuals and employers who have stayed out of the market find insurance purchased through the exchange to be affordable.

With rare exceptions, the cost reductions promised by risk pooling have not yet been borne out in the experience of exchanges.<sup>13</sup> Most exchanges have covered only a small share of the potential market and have themselves become victims of risk selection. Insurers that have the option of selling outside the exchange have found exchanges unattractive because they tend to include higher-risk individuals and groups and because insurers prefer to control their own relationships with employers. Insurers have also found insuring employer groups through exchanges to be disadvantageous because employees are allowed to pick among insurers and plans rather than all being steered to one insurer, and because employees can change insurers easily at open enrollment periods. Insurers have often continued to duplicate functions preformed by the exchange, such as marketing and enrollment, because the exchange does not provide a large enough share of their enrollees for them to cease performing the functions for their exchange members. When exchanges have tried to limit the commissions of agents, who largely duplicate the functions of the exchange, agents have simply steered applicants elsewhere. Exchanges have also rarely reached a size that would allow them to reduce administrative costs. Indeed, they have sometimes duplicated functions already provided by insurers, employers, or agents, thus increasing costs. Finally, exchanges have not become large enough to impose competitive pressure on the outside market. Because exchanges have failed to reduce costs, they have also failed to increase access to insurance.

This is not to say that experience with exchanges has been wholly negative. Where they have survived, exchanges have increased the choice of insurers available to their participants, and this has been valued by consumers. The FEHBP remains an example of the potential of exchanges—it has maintained good benefits and a wide choice of plans for participants and has been reasonably successful in controlling costs.<sup>14</sup> Nevertheless, experience to date with health insurance exchanges gives little reason to believe that the exchange in itself is a panacea for our cost, access, or quality deficits. The model as it has existed must be improved upon. This is the task of health reform.

## **HEALTH INSURANCE EXCHANGES IN THE PROPOSED HEALTH REFORM LEGISLATION**

As noted at the outset, exchanges play a key role in the bills passed by the House and Senate. How do these bills envision the goal of exchanges? What functions do they assign to them? At what level would they require exchanges to operate? What would be

the respective roles of the federal and state governments in their operation? How does the proposed legislation attempt to avoid the pitfalls of previous exchanges?

The text that follows describes the provisions of H.R. 3962, the health reform bill that has passed the House, and H.R. 3590, the bill that has passed the Senate, in each case incorporating all amendments. Section numbers in the notes refer either to the section number of the bill in which the language is found or, where it is more specific, to the section number in amendments or additions to a pre-existing law created by the bill. The questions are intended to illuminate the different approaches taken by the two bills.

*1. Does the exchange exist at the federal, the state, or some other level?*

HOUSE. The exchange operates at the national level, established within a new Health Choices Administration.<sup>15</sup> The Commissioner of the HCA can, however, permits individual states or groups of states to administer an exchange within their territory in place of the national exchange if specific requirements are met, subject to revocation if the state ceases to meet the requirements of the bill.<sup>16</sup> Even if the HCA delegates exchange authority to a state, the Commissioner retains enforcement authority and can further specify functions retained by the Commissioner and not delegated.<sup>17</sup>

SENATE. The Secretary of the Department of Health and Human Services (HHS) is responsible for issuing regulations to set standards for the operation of American Health Benefit Exchanges (“exchanges”) for individuals and for the Small Business Health Options Program exchanges (“SHOP exchanges”).<sup>18</sup> HHS will also promulgate regulations for implementing the insurance reforms found in the legislation, the offering of qualified health plans through the exchanges, the establishment of reinsurance and risk-adjustment mechanisms, and other regulatory requirements.<sup>19</sup> States may then elect to adopt, no later than January 1, 2014, the federal standards into their own laws or to adopt standards that HHS finds to be equivalent.<sup>20</sup> Exchanges must be administered by governmental agencies or nonprofit entities established by a state.<sup>21</sup> A state may elect to combine its exchange and SHOP exchange into a single exchange.<sup>22</sup> With the approval of HHS, states may participate in regional exchanges or establish subsidiary exchanges serving geographically distinct parts of the state.<sup>23</sup> States may also contract with “eligible entities,” (private entities with relevant experience that are not insurers or related to an insurer or a state Medicaid agency) to carry out some exchange responsibilities.<sup>24</sup>

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 itself will establish an exchange or contract with a nonprofit entity to do so.<sup>25</sup> HHS will also directly enforce the exchange law in states that fail to take these actions.<sup>26</sup>

The Senate bill provides two other options that states may choose. For plan years beginning in 2017, states may apply to HHS for a waiver, for up to five years, of the requirement that they establish an exchange (as well as other requirements of the legislation). A state may be granted such a waiver if HHS determines that the proposed state waiver program offers benefit coverage that is as comprehensive, cost-sharing that is as affordable, and coverage of as many people as what the reforms found in the bill would accomplish, and does so without increasing the federal deficit.<sup>27</sup> The state must also meet public notice, comment, and reporting requirements. Under the second option, states can, with HHS permission, create a “basic health plan” to provide one or more standard health plans to uninsured 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>28</sup>

## *2. What are the role and duties of the exchange?*

HOUSE. The exchange must (1) establish standards for, accept bids from, and negotiate and enter into contracts with qualified health benefit plans, (2) facilitate outreach and enrollment, (3) establish a risk-pooling mechanism, (4) establish consumer protections,<sup>29</sup> and (5) administer the bill’s premium subsidies.<sup>30</sup> The Commissioner is responsible for soliciting bids and negotiating contracts with qualified insurance providers that offer plans through the exchange.<sup>31</sup> The Commissioner will deny requests from plans for premiums and premium increases deemed to be excessive.<sup>32</sup>

SENATE. An exchange must (1) make available qualified health plans to qualified individuals and employers (and cannot make available a plan that is not a qualified health plan),<sup>33</sup> (2) implement procedures for certification, recertification, and decertification of health plans as qualified health plans,<sup>34</sup> (3) provide a toll-free hot line for consumer assistance, (4) maintain a Web site with standardized comparative information on plans, (5) rate plans in accordance with criteria developed by HHS, (6) present information on health plans using a standardized format developed by HHS, (7) inform individuals about eligibility requirements for Medicaid, CHIP, or other state programs and help enroll eligible individuals in those plans as appropriate, (8) help establish eligibility for premium tax credits and cost-sharing reduction payments,<sup>35</sup> (9) certify that individuals are exempt from the individual responsibility mandate if no insurance is affordable to

them or if they meet other exemption requirements, (10) inform the IRS of the identities of individuals who are exempt from the individual mandate, employers whose employees are receiving premium tax credits because those employers did not make affordable or adequate coverage available, and individuals who change employers or cease to obtain coverage through the exchange who had not obtained affordable or adequate coverage through their employer, (11) provide employers with the names of employees who cease to obtain coverage under a qualified health plan during the plan year, and (12) establish a navigator program to help educate and inform the public about the availability of qualified health plans, premium assistance, and consumer assistance and assist with enrollment.<sup>36</sup> Finally, exchanges are responsible for consulting with consumers, individuals, and entities with experience in facilitating enrollment, small businesses and the self-employed, state Medicaid offices, and advocates for hard-to-reach populations as they carry out their duties.<sup>37</sup>

### *3. Who can buy insurance through an exchange?*

HOUSE. Individuals who don't have employer or public coverage and employees of employers with up to 25 employees in 2013 and 50 employees in 2014, and employers of 100 or larger if permitted by the Commissioner in 2015 and after.<sup>38</sup> If an employer offers insurance through an exchange, the employer pays its share of the premiums through the exchange and the employees may enroll in any qualified insurer.<sup>39</sup> Individuals who enroll in a qualified health benefits plan through an exchange may continue as long as they are enrolled in an exchange-participating plan, and employers who enroll their employees through an exchange may continue to do so regardless of later growth.<sup>40</sup> Noncitizens are not barred from the exchange.

SENATE. "Qualified individuals" and "qualified employers" may purchase insurance through an exchange.<sup>41</sup> A qualified individual may enroll in any qualified health plan, while an employee may enroll in any qualified health plan in the tier of coverage chosen by his or her employer.<sup>42</sup> A qualified individual is a nonincarcerated resident of a state who seeks to enroll in a qualified health plan in the individual market.<sup>43</sup> A qualified employer is a small employer that chooses to make all of its full-time employees eligible for one or more qualified health plans offered through the exchange.<sup>44</sup> "Small employer" is defined as an employer with an average of one to 100 employees on business days, although the state can, prior to 2016, define a small employer as having fewer than 51 employees.<sup>45</sup> Beginning in 2017, states may open their exchanges to larger groups, although health insurance issuers are not required to issue policies to larger groups.<sup>46</sup> Only United States citizens and legal residents can be treated as qualified individuals and

purchase qualified health plans through the exchange.<sup>47</sup> The federal government can only offer members of Congress and full- and part-time staff of their official offices health insurance through the exchange.<sup>48</sup>

#### *4. Can insurance policies be sold outside the exchange?*

HOUSE. Only grandfathered policies can be sold to individuals outside the exchange.<sup>49</sup> Individuals can add family members to grandfathered policies, but the terms of the grandfathered policies cannot change except as required by law, and insurers cannot raise premiums on grandfathered policies unless they do so for all enrollees in the same risk group at the same rate.<sup>50</sup> Employers can purchase qualified health plans outside the exchange for employees,<sup>51</sup> and may retain grandfathered coverage free from the requirements of the new bill through 2017.<sup>52</sup>

SENATE. Individuals and groups may retain existing group health plans and insurance coverage policies, and most of the requirements of the bill do not apply to grandfathered health plans.<sup>53</sup> Family members and new employees can be added to grandfathered health plans.<sup>54</sup> The bill does not specify to what extent changes can be made in a health plan before it ceases to be grandfathered.

Both an individual and a group health insurance market will continue to exist outside the exchange.<sup>55</sup> Qualified individuals cannot be restricted to insurance plans offered in the exchange.<sup>56</sup> The exchange and qualified health plans cannot penalize individuals for transferring to employment-based coverage or other forms of coverage outside the exchange.<sup>57</sup> Health insurance issuers must, however, treat all individual enrollees in their plans (inside and outside the exchange), other than enrollees in grandfathered plans, as a single pool and all enrollees in the small group market (other than grandfathered enrollees) as a single pool, or, if the state elects, treat members of both pools as a single pool.<sup>58</sup> State benefit requirements also continue to apply outside the exchange.<sup>59</sup> Issuers of qualified health plans must agree to charge the same premium rate for a plan both inside and outside the exchange.<sup>60</sup>

#### *5. How does the bill standardize and regulate health plans that are available through the exchange?*

HOUSE. Benefit plans must be structured to fit into one of four tiers: basic, enhanced, premium, and premium plus.<sup>61</sup> The tiers are defined in terms of actuarial value as compared to a reference plan with the essential benefit package and without cost-

sharing.<sup>62</sup> The basic plan must cover 70 percent of the actuarial value of the benefits offered under the reference benefits package, the enhanced plan 85 percent and the premium plan 95 percent.<sup>63</sup> Premium plus plans may offer extra benefits. All insurers must offer a basic plan. If insurers offer a basic plan, they may offer an enhanced plan. If they offer an enhanced plan, they may offer a premium plan. If they offer a premium plan, they may offer a premium plus plan.<sup>64</sup>

Qualified health benefit plans, both inside and outside the exchange, must meet a number of other requirements, some of which go into effect in 2010, others when the reforms are fully implemented in 2013. The immediate reforms include:

- medical loss ratios limited to 85 percent<sup>65</sup>
- a prohibition on rescission except on clear and convincing evidence, with opportunity for independent external review<sup>66</sup>
- review of premiums<sup>67</sup>
- an opportunity for extension of coverage to dependents under age 27 with no other health insurance coverage<sup>68</sup>
- limitations on pre-existing condition exclusions and a prohibition on treating acts of domestic violence as a pre-existing condition<sup>69</sup>
- required coverage of treatment for children with deformities<sup>70</sup>
- elimination of lifetime dollar limits on coverage<sup>71</sup>
- a prohibition on group plans reducing postretirement health benefits<sup>72</sup>

Most of these reforms become permanent after the exchanges are established in 2013. Additional permanent reforms include:

- a prohibition against pre-existing condition exclusions<sup>73</sup>
- a requirement of guaranteed issue and renewal<sup>74</sup>
- insurance rating rules that permit only variations based on age (2:1), geographic area, and family category<sup>75</sup>
- a prohibition against discrimination in benefits, including a mental health and substance abuse disorder parity requirement<sup>76</sup>
- a network adequacy requirement<sup>77</sup>
- a requirement of 90 days' notice of changes in coverage or cost-sharing<sup>78</sup>

- a requirement of timely payment of claims<sup>79</sup>
- application of standards for coordination and subrogation of benefits and administrative simplification<sup>80</sup>
- a requirement of dissemination of advance care planning information<sup>81</sup>

All qualified health benefit plans, inside or outside the exchange, must cover essential services, limit cost-sharing (with no cost-sharing for preventive services), exclude annual or lifetime limits, and assure network adequacy.<sup>82</sup> The essential benefit package must cover hospitalization; outpatient care (including emergency department services); professional services; services, equipment, and supplies incident to professional services; prescription drugs; rehabilitative and habilitative services; mental health and substance use disorder services; preventive services; maternity care; well-baby and well-child care and oral health, vision and hearing services, equipment, and supplies for children; and durable medical equipment, prosthetics, and orthotics and related supplies.<sup>83</sup> The essential benefit plan is to be established by HHS upon the recommendation of a public/private Health Benefits Advisory Committee.<sup>84</sup> If plans do not offer an adequate provider network, cost-sharing for out-of-network providers cannot exceed that for in-network providers.<sup>85</sup>

Plans marketed within the exchange (and plans marketed outside the exchange to the extent required by the Commissioner) must also comply with fair marketing, fair grievance and appeal, and transparency standards.<sup>86</sup> Exchanges can also market insurance plans that are made available through interstate compacts or from health insurance cooperatives.<sup>87</sup> Exchanges may make available insurance plans that cover abortions, but are not required to do so.

SENATE. The Senate bill distinguishes among four levels of coverage based on actuarial value, with an additional catastrophic policy.<sup>88</sup> The bronze-level plan has to provide benefits actuarially equivalent to 60 percent of the full actuarial value of benefits offered under the plan, the silver-level plan 70 percent, the gold-level 80 percent, and the platinum-level 90 percent.<sup>89</sup> Catastrophic policies are available only for persons under age 30 or for those who cannot otherwise find affordable coverage or who would suffer a hardship in buying other coverage.<sup>90</sup> Catastrophic plans must cover three primary care visits a year and preventive care, but otherwise the plan can impose a deductible at the maximum out-of-pocket level described below.<sup>91</sup>

Exchanges may offer only qualified health plans,<sup>92</sup> and premium assistance tax credits can be used only for qualified health plans.<sup>93</sup> Exchanges may certify as qualified only those health plans that meet the requirements of the statute, and only 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>94</sup> An exchange cannot exclude a plan because the plan is a fee-for-service plan or because the plan “provides treatments necessary to prevent patients’ deaths in circumstances the Exchange determines are inappropriate or too costly.”<sup>95</sup> Exchanges cannot impose premium cost controls, but they must require plans seeking certification to submit and post on their Web sites information justifying a premium increase prior to implementing the increase and must take excessive or unjustified premium increases into account in determining whether to make a health plan available through the exchange.<sup>96</sup> Exchanges may also offer interstate and multistate plans, as well as plans offered by cooperatives and “qualified direct primary care medical home plans.”<sup>97</sup>

Qualified health plans must comply with all of the requirements in the bill that apply to health plans generally, as described below. Qualified health plans must additionally offer the essential benefit package described below, be licensed in each state in which they offer coverage, agree to offer at least one plan at the silver and one at the gold level, charge the same premium for the plan both inside and outside the exchange, and comply with other HHS regulations.<sup>98</sup> States may prohibit exchange plans from covering abortions.<sup>99</sup>

In addition to these requirements, the Senate bill also instructs HHS to adopt regulations establishing certain criteria for the exchanges to use in certifying qualified health plans, namely that a plan will:

- meet marketing requirements prohibiting marketing practices and benefit designs that have the effect of discouraging high-risk enrollees
- ensure a sufficient number of in-network providers and provide information on the availability of providers 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 strategy

- use a uniform enrollment form
- use the standard benefit form (described below) for presenting health benefit options
- provide quality-measure performance data to enrollees and prospective enrollees<sup>100</sup>
- implement activities to reduce disparities in health and health care<sup>101</sup>

Qualified health plans are required to implement strategies for rewarding quality through market-based incentives. The plan should use a payment structure that provides incentives for:

- improving health outcomes through quality reporting, case management, care coordination, chronic disease management, medication and care compliance initiatives, and the use of medical homes
- implementation of activities to prevent hospital readmissions
- programs that improve patient safety and reduce medical errors, including the use of best clinical practices, evidence-based medicine, and health information technology
- implementation of wellness and health promotion activities<sup>102</sup>

Beginning in 2015, qualified health plans may contract with hospitals of more than 50 beds only if those hospitals have implemented a patient safety evaluation system and comprehensive patient discharge program.<sup>103</sup>

*6. If insurance policies can be sold outside the exchange, are they subject to the same regulations that govern policies sold within the exchange?*

HOUSE. Individual health insurance cannot be sold outside the exchange. Health insurance can, however, be sold to groups outside the exchange. The consumer protections provided by sections 231, 232, and 233 dealing with marketing, grievances and appeals, and disclosure and transparency are applied to plans outside the exchange only to the extent determined by the Commissioner.<sup>104</sup> Certain requirements, such as reporting required data, providing affordable premiums, implementing affordability credits, accepting all enrollments through the exchange (subject to capacity limits), participating in risk pooling, covering essential community providers, providing culturally and linguistically appropriate services, and allowing providers to contract with

exchange-participating plans, also apply only within the exchange and do not apply to non-exchange insurers.<sup>105</sup>

SENATE. Unlike the House bill, the Senate bill recognizes a number of categories of health insurance to which different requirements apply. Individuals are required under §5000A(a) of the Internal Revenue Code, added by section 1501 of the Senate bill, to have “minimum essential coverage.” Minimum essential coverage is defined, in turn, as including public insurance (such as Medicare and Medicaid), “an eligible employer-sponsored plan,” a “health plan offered in the individual market in the state,” or a grandfathered plan.<sup>106</sup> (“Eligible employer-sponsored” coverage is defined as including all employee benefit plans.)<sup>107</sup>

Subtitles A and C of Title I of the Senate bill add a number of requirements to Part A of Title XXVII of the Public Health Services Act that apply to all insured health plans, whether or not sold through the exchange, including provisions that:

- ban lifetime or annual dollar limits on coverage<sup>108</sup>
- prohibit rescissions except for fraud<sup>109</sup>
- require coverage of preventive health services without cost-sharing<sup>110</sup>
- extend coverage for single dependents to age 26<sup>111</sup>
- require the use of standardized explanations of coverage documents and definitions (see below)<sup>112</sup>
- require reporting on quality-of-care, patient safety, and wellness and prevention initiatives<sup>113</sup>
- report medical loss ratios and provide refunds to plan members if MLRs are less than 80 percent in the large-group market or 85 percent in the small-group market (unless higher MLRs are required by a state or lower MLRs are established by HHS)<sup>114</sup>
- provide internal and external review<sup>115</sup>
- require all health plans and insurers to cover emergency services without prior authorization or additional out-of-network cost-sharing, to permit pediatricians to be designated as primary care providers for children, and to permit women in plans that cover obstetrical and gynecological care to have direct access to obstetricians and gynecologists<sup>116</sup>

- require plans to allow their members to participate in approved clinical trials relating to the prevention, detection, or treatment of cancer or other life-threatening diseases and to cover the routine patient costs of trial participation<sup>117</sup>
- permit premium variation based only on age (3:1), geographic region, individual or family coverage, or tobacco use (1.5:1) (prohibiting rating based on health status and limiting rating based on other factors)<sup>118</sup>
- guarantee issue and renewability of coverage<sup>119</sup>
- prohibit pre-existing conditions exclusions or underwriting based on health status<sup>120</sup>
- prohibit discrimination against providers or individuals<sup>121</sup>
- prohibit waiting periods longer than 90 days<sup>122</sup>

Some of these requirements apply to group health plans (i.e., ERISA plans) and to health insurance issuers in the individual and group market, i.e., all health insurance plans except for grandfathered plans.<sup>123</sup> Others, however, apply only to insured individual or group plans or to plans in the individual or small-group market, and some explicitly do not apply to self-insured plans.

Most importantly, the provision requiring essential benefits applies only to issuers in the individual and small-group market (including, however, non-grandfathered plans inside and outside the exchange).<sup>124</sup> Essential health benefits include “at least” ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, prevention and wellness services, chronic disease management, and pediatric services including oral and vision care.<sup>125</sup> The scope of essential health benefits is supposed to be equal to the scope of those provided under the typical employer plan.<sup>126</sup>

The bill requires HHS to define the essential benefits package. The definition of essential benefits must ensure that benefits are balanced appropriately among the listed categories; that coverage decisions, reimbursement rates, incentive programs, and benefit design do not discriminate on the basis of age, disability, or expected length of life; that benefits take into account the health needs of diverse segments of the population; that benefits are not denied on the basis of disability, dependency, life expectancy, or quality of life; and that access to emergency care is not limited by a prior approval requirement, or to providers with in-network status, or by cost-sharing for out-of-network emergency care providers that exceeds that imposed for in-network care.<sup>127</sup> Out-of-pocket

expenditures cannot exceed the limit set for health savings account–linked high-deductible health plans for 2014. This limit increase annually thereafter in accordance with the rate of growth of health insurance premiums.<sup>128</sup> Deductibles in the small-group market cannot exceed \$2,000 for single individuals and \$4,000 for families.<sup>129</sup> States may require qualified health plans to provide additional benefits, but only if the state assumes the cost of those benefits for persons eligible for premium assistance credits or cost-sharing reduction payments.<sup>130</sup>

Self-insured ERISA plans and insured large-group plans are not required to cover essential benefits. They must, however, comply with the limits on cost-sharing.<sup>131</sup> Section 1562, “Conforming Amendments,” adds a new section 715 to ERISA, stating that all of the new health insurance regulatory provisions that the reform bill adds to Part A of title XXVII of the Public Health Services Act apply to ERISA plans, except for those that do not apply. The provisions that explicitly do not apply include the sections requiring equity in insurance coverage regardless of salary in insured group plans and the provision requiring minimum loss ratios, but other provisions that apply only to “health insurance issuers” would also seem not to apply to self-insured plans.

In any event, it is fair to say that qualified health plans must meet significantly more rigorous requirements than those applied to “minimum essential coverage.” Although qualified health plans may apparently be marketed outside the exchange, coverage sold outside the exchange does not have to comply with the qualified health plan requirements. This discrepancy enables healthy individuals or small employers to purchase minimum coverage outside the exchange, and may result in significant adverse selection against the exchange. Self-insured plans are subject to even less-rigorous requirements, leaving open the possibility of employer coverage that is substantially less protective than exchange coverage.

#### *7. How do the exchanges make health plan coverage more transparent?*

HOUSE. Under the House bill, the Commissioner is charged with developing standard definitions of insurance and medical terms and standards for disclosure of information by health plans.<sup>132</sup> Under section 233, the primary transparency provision of the bill, exchange-participating health benefit plans must disclose to the Commissioner and to the public, in an accurate and timely manner and in plain language, their plan documents; plan terms and conditions; claims payment policies and practices; financial data; enrollment, disenrollment, claim denial, and rating practices data; and information on cost-sharing and out-of-network coverage.<sup>133</sup> Employment-based health plans must

disclose to their participants the terms and conditions of the plan and financial information.<sup>134</sup> Plans are also required to disclose information on enrollee and participant rights, as well as, in a timely manner on request, information sufficient to allow individuals to determine the amount of cost-sharing they will be responsible for with respect to the furnishing of an item or service by a participating providers, through the Internet or otherwise.<sup>135</sup> Health plans are also required to ensure transparency of their payment arrangements to providers.<sup>136</sup> The House bill further requires pharmaceutical benefit managers to disclose to health plans and to the Commissioner information on the cost and volume of drugs, including generic usage, switching, etc., but this information is not available to the public except in aggregate form.<sup>137</sup> Section 234 provides that the transparency requirements imposed by section 233 apply outside the exchange only to the extent specified by the Commissioner.

Additional disclosure provisions are found elsewhere in the House bill. Section 215(b) requires health plans to list providers who participate in their networks on their own Web site and on the exchange's Web site. The Commissioner must establish an online system for consumers to identify the insurer networks in which providers participate. Section 217 requires health plans to give 90 days' notice of coverage decreases or cost-sharing increases. Section 309 provides that purchasers of insurance sold under interstate compacts must be told that the policy may not be subject to all insurance laws and regulations of the state in which they reside. The House bill requires that exchanges and exchange-qualified insurers communicate in a culturally and linguistically appropriate manner.<sup>138</sup>

SENATE. Section 1001 (creating §2715 of the Public Health Services Act) requires the Secretary of HHS, in consultation with NAIC and others, to develop standards for compiling and providing a summary of benefits and coverage explanation for group health plans (including self-insured plans and grandfathered plans created after the effective date of the legislation) and health insurance issuers (inside and outside the exchange). The standards must provide for a summary of benefits that:

- is in a standard format, with no more than four pages and no 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 pregnancy or serious chronic illness
- states whether the plan provides minimum essential coverage (meeting the individual mandate’s requirements) or ensures that 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)
- 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 ask additional questions and a Web address where the contract itself can be found

Plans must provide the summary of benefits and coverage explanation to applicants, enrollees, and policy holders. Enrollees are entitled to 60 days’ notice of modification of plan terms. Plans that fail to provide required information are subject to a fine of \$1,000 for each enrollee to whom the information was not provided. The requirements preempt any state standards that require less disclosure.

The Manager’s Amendment imposes on plans seeking exchange certification significant new disclosure requirements that are very similar to those found in the House bill, including disclosure of claims payment policies and practices, periodic financial disclosures, disclosure of data on enrollment and disenrollment, disclosure of data on claims denials and rating practices, disclosure of information on cost-sharing for out-of-network coverage and on enrollees’ and participants’ rights, and disclosure of “other information as determined appropriate” by HHS.<sup>139</sup> Exchange plans are also 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 Senate bill include the following:

- Health insurance issuers and HHS will post on their Web sites information about premium increases and justifications for those increases.<sup>140</sup>

- HHS will establish a Web site on which will be posted comparative information about insurers, including medical loss ratios, eligibility, availability, premium rates, and cost-sharing, consistent with the standards described above.<sup>141</sup>
- Group health plans and insurance issuers will report to HHS and to enrollees on programs designed to improve health outcomes, reduce hospital readmissions, implement patient safety and error reduction programs, and promote prevention and wellness (HHS is to post these reports on a Web site).<sup>142</sup>
- Insurance issuers will report the proportion of their total premium revenue spent on clinical services, activities to improve health care quality, and other non-claim costs (excluding taxes, and fees). HHS will post the reports on the Internet.<sup>143</sup>

Exchanges are required to rate plans based on quality and price and to make that information available to the public. Exchanges and qualified health plans are also charged with providing standardized information found in the uniform outline of coverage described above to allow consumers to compare plans.<sup>144</sup> Exchange-based plans must also provide information on the availability of in-network and out-of-network providers.<sup>145</sup>

The Senate bill repeatedly emphasizes that information must be made available in a culturally and linguistically appropriate manner so that all health plan enrollees or potential enrollees can benefit from the information.<sup>146</sup>

#### *8. Can agents and brokers collect commissions for exchange policies?*

HOUSE. The bill preserves a role for agents and brokers in enrolling individuals and employers through the exchange.<sup>147</sup>

SENATE. Agents and brokers may assist individuals and small groups in enrolling in qualified health plans and applying for premium tax credits and cost-sharing reductions.<sup>148</sup> The original bill permitted HHS to establish a brokerage commission schedule, but this provision was eliminated by the Manager's Amendment

#### *9. How is enrollment handled through the exchange?*

HOUSE. The exchange offers open enrollment once a year and special enrollment periods for special circumstances.<sup>149</sup> Individuals who receive subsidies and who do not otherwise enroll in plans are automatically enrolled in a plan.<sup>150</sup> The Commissioner is responsible for disseminating information to potential enrollees and assisting with

choice.<sup>151</sup> Premiums are paid directly to plans.<sup>152</sup> The bill also includes a program offering small businesses counseling and technical assistance in providing insurance to their employees through the exchange.<sup>153</sup>

SENATE. The basic function of exchanges is to assist individuals and employees of participating employers in enrolling in qualified health plans.<sup>154</sup> Exchanges offer annual open enrollment periods and special enrollment periods under particular circumstances.<sup>155</sup> Exchanges are also responsible for enrolling eligible individuals in Medicaid, CHIP, or any other available state or local public programs.<sup>156</sup> The bill provides start-up funding for state consumer assistance offices and insurance ombudsmen who will be assisting consumers in health plan enrollment.<sup>157</sup> It also requires exchanges to contract with “navigators,” organizations that can help inform the public about the availability of qualified health plans and financial assistance, and can help enroll individuals in qualified plans.<sup>158</sup>

*10. Does the exchange administer a risk-adjustment program? Does a risk-adjustment program reach outside the exchange?*

HOUSE. The bill provides for risk pooling through risk-adjusting premiums for plans within the exchange.<sup>159</sup> Risk adjustment only takes place within the exchange.

SENATE. The bill includes three risk-adjustment programs. The first is a permanent program to be administered by the states.<sup>160</sup> This program covers health plans inside and outside the exchange, but not self-insured or grandfathered plans. The state will assess a charge on plans and insurers with low-risk enrollees and make payments to plans and insurers with high-risk enrollees. The second program included in the bill is a transitional reinsurance program to be implemented by the states for 36 months, from 2014 to 2016, under contracts with private reinsurers.<sup>161</sup> This program collects funds from health insurers and group health plans (through their administrators) and provides payments to insurers in the individual market for individuals with specific high-risk medical conditions. Third will be a risk corridor program, available during 2014–2016, for qualified health plans in the individual and small-group market.<sup>162</sup> This plan is a mystery in that it contemplates payment of premiums to the plans by HHS, which the legislation does not provide for (other than premium and cost-sharing subsidies). One wonders whether this provision got lost in the wrong bill.

*11. Are subsidies available outside the exchange?*

HOUSE. Affordability credits are distributed through the exchange.<sup>163</sup>

SENATE. Premium assistance credits and cost-sharing reduction payments are available only for individuals enrolled in qualified health plans through exchanges.<sup>164</sup>

*12) Does the exchange play a role in the individual or employer mandate?*

HOUSE. No.

SENATE. The exchange certifies that individuals are exempt from the mandate when no affordable qualified health plan is available to them through the exchange or when they meet other mandate exemptions.<sup>165</sup>

*13. Must the exchange accept all insurers that wish to sell policies through it? Can the exchange negotiate with insurers (and over what)?*

HOUSE. Exchanges are apparently not required to accept all qualified plans.<sup>166</sup> They can solicit bids and negotiate with entities offering plans. The federal acquisition regulations do not apply.

SENATE. Exchanges are responsible for certifying qualified health plans to enroll members through the exchange. To certify a plan, the exchange must determine that the plan meets all requirements of the exchange and “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>167</sup> As noted above, the exchange must take into account unjustified or excessive premium increases in making this determination, although it cannot regulate premiums directly.

*14. How is the exchange related to the public plan?*

HOUSE. The public plan is offered through the exchange only.<sup>168</sup>

SENATE. The Senate bill no longer includes a public plan. In the place of the public plan is a new program of “multistate plans” to be supervised by the Office of Personnel Management, which administers the Federal Employees Health Benefit Program.<sup>169</sup> At least two of the multistate plans are to be available in every state and at least one of these

must be nonprofit. The OPM is responsible for negotiating with these plans concerning medical loss ratios, profits, premiums, and other relevant terms and conditions.

The plans are supposed to be nationwide — initially covering at least 60 percent of the states, and, within four years, all of them. The plans must be licensed in every state in which they do business and must comply with state law, including state age premium-rating requirements more restrictive than the 3-to-1 ratio found in the Senate bill. They must also offer the essential benefit package and comply with all other requirements of the federal statute. States may require the plans to provide additional benefits, but then must pay for any additional premium subsidies. The program is to be kept completely separate from the FEHBP and will not adversely affect the operation of that program.

*15. What are the enforcement responsibilities of the exchange?*

HOUSE. The Commissioner provides a grievance and complaint mechanism.<sup>170</sup> The Commissioner can apply intermediate sanctions to insurers within the exchange or terminate the participation of insurers.<sup>171</sup>

SENATE. States are responsible for certifying, recertifying, and decertifying plans for participation in exchanges<sup>172</sup> They could presumably, therefore, decertify noncompliant plans.

*16. What remedies are available for persons or entities adversely affected by exchange decisions?*

HOUSE. There are no remedies explicitly available to individuals. A sanctioned insurer has the opportunity to submit a corrective action plan and receive notice and the opportunity for a hearing and an appeal of the initial decision before termination, except where there is an imminent and serious risk to health.<sup>173</sup>

SENATE. There are no provisions in the Senate bill for health insurers to appeal or challenge determinations that their plans are not qualified. The bill provides for the determination and redetermination of eligibility for individuals for premium and cost-sharing subsidies.<sup>174</sup> HHS is charged with providing for procedures for resolving eligibility appeals.<sup>175</sup> Exchanges are responsible for notifying individuals of the availability of these processes.<sup>176</sup> No provision is made for judicial review of eligibility determinations, although it would presumably be available under the Administrative Procedures Act or the Due Process Clause.

### *17. How is the exchange funded?*

HOUSE. The exchange is financed by a trust fund to which money is appropriated equivalent to the taxes collected under the bill from individuals who do not obtain or employers who do not provide coverage or pay for acceptable coverage, to be supplemented with other appropriations as necessary.<sup>177</sup> States that operate exchanges must provide matching funds.<sup>178</sup>

SENATE. The federal government will initially appropriate funds to assist the states in starting exchanges, but those funds will not be available after 2014.<sup>179</sup> After January 1, 2015, exchanges will be self-funding, most likely through user charges imposed on insurers.<sup>180</sup>

### **POLICY ISSUES RAISED BY THE LEGISLATION**

The two bills represent quite different understandings of what an exchange is, what it does, how it is organized, and how it functions. Those differences are likely to determine the extent to which the exchanges will accomplish their goals and whether they will avoid the problems that have afflicted earlier attempts at creating and operating exchanges. These issues will be discussed next.<sup>181</sup>

#### *Federal and State Relations*

The first, and perhaps ultimately most important, issue is whether the exchange is implemented at the federal or at the state level. Under the House bill, the federal government is responsible for forming the exchange, although the Commissioner of Health Choices can allow a state that meets specific criteria to form its own exchange. Under the Senate bill, the states are responsible for establishing exchanges, although the federal government can itself establish an exchange or contract with a nonprofit entity to do so in a state that fails or refuses to act.

The health reform legislation will be a federal law addressing problems that are national in scope. Americans throughout the country lack access to health care and are struggling with high and rapidly rising health care costs. Congress is attempting to address the problem by creating a national solution that will help all Americans. Consequently, there is a certain logic to having a national rather than a state-based exchange.

There are, moreover, good policy arguments for establishing an exchange at the national level. Most importantly, the exchange is being created under federal law, will be

carrying out functions specified by federal law, will be administering federal premium subsidies, and will initially receive federal start-up funds. As we have learned from our experience with Medicaid, HIPAA, and other programs, state implementation of a federal program is at best awkward, at worst ineffectual.<sup>182</sup> 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 use either the carrot of federal funds (as with Medicaid) or the stick of threatening to implement a federal fallback program in states that refuse to implement the mandated program themselves. In either event, the federal government ends up attempting to regulate a co-sovereign, an uncomfortable position to be in. It is particularly difficult when large sums of money are flowing from the federal government to the states, as could be the case with premium subsidies, creating a tempting pool for the states to use for their own purposes. This scenario has been a continuing source of friction in the Medicaid program.

On the other hand, there are also arguments for implementing the exchange at the state level. States have more experience with insurance regulation than does the federal government. Some states have even experience with forming and operating purchasing cooperatives (although, on the whole, that experience has not been positive, as noted above) and others operate their public employee health benefit programs through an exchange. Under each of the bills, the exchange has some regulatory functions and, in any event, will need to coordinate its activities with state regulators. Insurance is currently marketed primarily at the state or substate regional level, and many insurance products (including most HMOs) are likely to continue to be state-specific. The use of state-level exchanges would provide opportunities for experimentation with a variety of models and for learning from that experience. Some states would likely be more creative and protective of consumers in implementing the exchanges than the federal government is likely to be. State-level exchanges would be “closer to the ground,” making them perhaps more responsive to individuals who would be purchasing insurance and receiving credits through them.

But the states’ advantage in expertise over the federal government may be exaggerated. In fact, the three largest “exchanges” in the country—the Federal Employee Health Benefits Program, the Medicare Advantage program, and the Medicare Part D drug program—are run by the federal government. The federal government has also long been primarily responsible under ERISA for regulating employee benefit plans, the largest source of health insurance in the country. The federal government routinely takes the lead in other areas where it partners with state governments, as in fraud and abuse prevention, or in regulating the Medicare Advantage program, where insurers must be

licensed by the states. While the states at present are primarily in charge of insurance regulation, the quality of their enforcement efforts varies greatly, with some doing a clearly inadequate job.<sup>183</sup> The move toward nullification of health care reform in a number of states indicates that some states are not eager to be willing partners in that reform with the federal government.<sup>184</sup> Finally, the House bill allows truly innovative states to initiate their own exchanges with federal permission, providing the benefits of both a federal floor and state innovation.

There is also the problem of geographic coverage. Health insurance is sold in local markets. Many Americans live in local markets that span two or more states. Many Americans who work for firms that provide insurance through an exchange find that they live in one state and their employer's business is in another. Other Americans live part of the year in one state and part in another, or have children who are in college in another state. Through which exchange will these households purchase insurance and receive a subsidy? Will a state-based exchange be able to meet all their needs? Moreover, in a large state like California or Texas, exchanges will still be offering different products in different parts of the state, and a state exchange will hold little comparative advantage over a federal exchange.

One solution to consider is a nationally administered plan, offering insurance products that vary by locality, operating primarily through a Web-based portal or over the telephone, but with representation perhaps in local social security or state Medicaid offices for those who need personal consultation. It is also likely under a national plan that insurance agents and brokers would remain involved in purchasing decisions, thus providing another local portal, although hopefully their commissions would be reduced along with their role.

Alternatively, state implementation closely monitored by Congress could be a solution. Congress could require HHS to report annually on the progress of the individual states toward implementation and semiannually on its own response in states that declined to establish exchanges or did so inadequately. Congress would then have a much better sense of how implementation was proceeding and whether midcourse corrections were needed.

In any event, the question of federal versus state-based exchanges will certainly prove to be one of the most controversial issues to be resolved in the projected House/Senate conference committee.

### *Protection Against Adverse Selection*

The Achilles' heel of many earlier attempts at health insurance exchanges has been adverse selection against the exchange. As long as insurers can sell their products outside the exchange, they can siphon off good risks from the exchange, leaving the exchange with high-risk individuals and groups and high prices. Even if this scenario does not occur initially, insurers may be reluctant to sell their products through the exchange for fear that they will end up with bad risks. Another particular problem has been agents and brokers who steer their customers away from the exchange because they can make higher commissions for sales outside it.

One obvious solution to the adverse selection problem is to allow insurers to sell their products only through the exchange, as the House bill does with individual policies, although it allows employment-related groups eligible for the exchange to purchase outside the exchange as well. The Senate bill allows insurers to sell their products both inside and outside the exchange in both the individual and small-group market. Both bills allow grandfathered policies to continue to be sold outside the exchange. Respecting grandfathered coverage is apparently based on the legislation's promise that, if you like the insurance you have, you can keep it.

Measures can be taken, however, to address the adverse selection problem and still preserve a market outside the exchange. First, the larger the pool covered by the exchange, the more likely it is to combine good and bad risks. Both the House and Senate bills limit the use of premium and affordability subsidies to the exchange. This restriction in itself should create a sizable market for insurance within the exchange. Moreover, although each of the bills starts with covering individuals and small groups, each also contemplates eventually expanding the exchange's coverage to include larger employers. But even large exchanges can be victims of adverse selection if they end up attracting higher-risk individuals and groups, especially if they enroll them in large numbers.

If exchanges are created on a state-by-state basis, there is a risk that some smaller states may not have large enough risk pools. A recent paper from the Committee for Economic Development, authored by Alain Enthoven and others, asserts that the minimum size for a stable risk pool is 100,000, and that some state exchanges will probably not achieve that size.<sup>185</sup> The authors of the study also contend that what is important is not only the size of the exchange, but also the percentage of the private market that the exchange includes. They assert that "each exchange should have a minimum participant pool of at least 20 to 25 percent of non-Medicaid/non-Medicare population in its coverage area."<sup>186</sup> The minimum percentage of population is important

not only to address adverse selection, but also to make certain that private insurers see the risk pool as large enough to justify their participation in it. By this reasoning, not only should all enrollees in the nongroup market be required to participate in it, as in the House bill, but all small groups should be required to participate as well, and the exchange should be opened to larger groups.

Adverse selection can also be limited if plans both inside and outside the exchange that cover the same markets have to play by the same rules. With few exceptions, the House bill applies the same coverage and cost-sharing rules to individual and small-employer plans inside and outside the exchange, thus making it more difficult for insurers to sell cheaper low-coverage policies outside the exchange. The Senate bill, on the other hand, permits “minimum essential coverage” plans to exist outside the exchange in the individual and small-group markets, increasing the risk of adverse selection. The Senate bill does, however, require individual and small-group non-exchange plans to cover the same essential benefits as plans sold through the exchange, all individuals within and outside the exchange to be treated as if they were in a single risk pool, all small groups inside and outside the exchange also to be treated as a single risk pool (with a state option to combine the risk pools), and all insurers within and outside the exchange to charge the same premium for a qualified health plan. These provisions should help considerably in combating adverse selection, although they may be difficult to enforce outside the exchange.

Another tool for combating adverse selection is risk adjustment. If insurers that attract good risks have to compensate insurers who end up with bad risks, the incentive to select risk is reduced. Risk reallocation schemes are common in insurance regulation and have generally been upheld against constitutional challenges as long as the scheme is established prospectively.

The House bill provides only for risk adjustment within the exchange, and so will do little to protect exchanges from adverse selection. The Senate bill provides for risk reallocation both within and outside the exchange and thus could make a substantial contribution to addressing the risk selection problem. Indeed, the Senate bill provides for three risk reallocation schemes, one permanent and two temporary.

It is, however, difficult to see how the Senate schemes are going to work. Risk reallocation is not easy, and requires the collection and analysis of a great deal of data if it is to be successful. Collecting that data outside the exchange is going to be difficult. Moreover, the mechanism through which risk reallocation is accomplished outside the

exchange is not clear. The Senate risk corridor provision, for example, calls for risk adjustment of premiums. Within the exchange, payments from affordability subsidies can be adjusted to compensate for risk. Outside the exchange, however, the government has nothing to do with the payment of premiums, so it is not clear how premiums will be adjusted. Of course, funds can be transferred from insurers with low-risk insureds to those with high-risk insureds retroactively, which is apparently what the permanent risk-adjustment scheme in the Senate bill contemplates. This will require, however, a fairly intrusive level of insurance regulation.

Finally, regulation can be used to discourage employers or insurers from steering bad risks into the exchange. The House bill requires the Commissioner to develop standards to determine whether employers or insurers are taking actions to affect the risk pool by inducing individuals to decline coverage under a plan offered by the employer and instead enter the exchange.<sup>187</sup> It is not clear what sanctions will be imposed if steering is uncovered.

The easiest solution to the adverse selection problem is to make the purchase of insurance through the exchange mandatory for all individuals and small groups that are eligible for it, as the House bill does with the individual market. Failing that, what may work is some combination of uniform benefits, single risk pools, uniform prices, risk reallocation inside and outside the exchange, and regulation. The Senate bill includes a number of provisions to establish uniformity inside and outside the exchange. Its risk-adjustment mechanism, however, may prove difficult to implement.

#### *Standardization and Transparency*

An important potential benefit of exchanges is that they make insurance plans more standardized and transparent, thus enabling consumers to make more informed choices and promoting head-to-head competition among plans. The House and Senate bills both do a reasonably good job of standardizing plans. Both require plans sold within the exchange to cover essential benefits, limit cost-sharing (albeit at very high levels), exclude (or restrict) annual or lifetime limits, and provide an opportunity to appeal coverage decisions. Each bill also standardizes and specifies tiers of coverage defined by actuarial value (in effect, levels of cost-sharing) into which plans must fit, thus facilitating comparison of plans by purchasers. The House bill also largely standardizes plans both inside and outside the exchange. The Senate bill does so less clearly, but does require individual and small group plans both within and outside the exchange to provide the same essential benefits and observe the same limits on cost-sharing.

Both bills also include provisions that should make plan coverage more transparent. Both, for example, require the disclosure of information about premiums, cost-sharing, network providers, benefits, and other issues of concern to consumers. The Senate bill, described above, offers a particularly detailed and creative approach to transparency. It requires the exchanges to rate plans for cost, quality, and price and to describe each insurance plan using standard defined terms in a four-page summary description, and requires plans to provide model scenarios describing coverage and cost-sharing for particular medical conditions. Both bills require culturally and linguistic appropriate communications, an issue that becomes ever more important as our country becomes more ethnically diverse. Either bill would be a great advance in transparency and disclosure beyond what is currently available in most states.

While transparency of information about plan performance is important, so also is the privacy of information that exchanges possess concerning their participants. There is nothing readily visible in the House or Senate bill that protects the confidentiality of personally identifiable information held by exchanges, and it is not clear that existing privacy law would protect that information.<sup>188</sup> This issue should be addressed, probably through an amendment to the HIPAA privacy statute or regulations to make exchanges “covered entities.”

#### *Reducing Administrative Costs*

Part of the promise of exchanges is that they can reduce administrative costs, making health insurance more affordable and accessible. In principle, that goal is attainable. Large-group employer plans have much lower administrative costs than small-group plans, which in turn have lower administrative costs than are found in the nongroup market. Exchanges create large purchasing pools within the nongroup and small-group market, which should offer some efficiencies. Administrative costs are a significant factor in health insurance markets, and controlling them could be a major contribution of reforms.

Exchanges themselves cost money, however. The Senate bill provides for surcharges on insurers to fund exchanges. The House bill would fund the exchanges from the excise taxes received from individuals or employers who fail to comply with coverage mandates, and from additional appropriations. The exchanges reduce overall costs, therefore, only if these added expenses are offset by savings elsewhere.

The risk-underwriting and rating reforms in the bill generally should reduce administrative costs, both inside and outside the exchange. Enrollment in health plans

through the exchange could reduce the cost to health plans of enrolling members, while information transmitted through the exchange could reduce marketing costs. However, as long as an exchange has only a small market share it is unlikely to achieve significant administrative cost savings because insurers are likely to continue their current functions, largely duplicating exchange functions. If an exchange could achieve sufficient market share, on the other hand, it might reduce the administrative costs of insurers, thus reducing the overall costs of health insurance coverage.

A significant opportunity to reduce health insurance administrative costs might be found in reducing brokerage commissions. Brokerage commissions consume from 2 to 8 percent of the premiums of group plans and a much higher percentage of premiums in the nongroup market.<sup>189</sup> Although brokers may still have a useful role in serving employers as benefit consultants, they would seem to be redundant in the nongroup market with the presence of the exchange, and unnecessary for individual employees who enroll in insurance through the exchange. Eliminating their commissions could result in substantial cost reductions for the health care system overall.

Both the House and the Senate bill retain brokerage commissions. The Senate bill would have permitted HHS to establish a schedule for brokerage commissions, but that provision was eliminated by the Manager's Amendment. Insurance brokers are an extraordinarily powerful group politically, and they can be counted on to protect their privileges. Moreover, as long as insurance exists outside of the exchange, brokers can steer business away from it. Massachusetts was unable to eliminate brokers from the Connector.

Finally, one of the surest paths to reducing the administrative costs of operating the exchange itself would seem to be a single national exchange like that provided for in the House bill. Operating 50 or more state exchanges would likely result in duplication of effort and wasted resources. Moreover, a single national exchange could provide for greater uniformity of regulation, which should in turn lead to more streamlined and efficient enforcement.

#### *Appeals and Judicial Review*

As described in the House and Senate bills, exchanges could make a host of determinations affecting individuals and other entities, including:

- whether, and to what extent, individuals qualify for an affordability subsidy
- whether individuals cease to qualify for a subsidy when their incomes increase

- whether individuals are liable for refunding an excessive or improperly paid subsidy
- whether individuals or employers are qualified to participate in an exchange
- whether insurers are qualified to participate in the exchange or have complied with other statutory requirements

Health plans that market their services through an exchange will additionally need to determine:

- whether individuals are covered for services by a private plan participating in an exchange (gateway) or by the public plan
- whether individuals have met the cost-sharing requirements of a private plan participating in an exchange (gateway) or of the public plan

Finally, under the Senate legislation, the federal government will need to determine whether states are properly enforcing federal law or operating an exchange.

The exchanges can help facilitate appeals, perhaps even decide them in some instances. They can also make a valuable contribution by simply correcting errors and clearing up misunderstandings. Depending on how the exchange is set up, it could play an ombudsman role (although both the House and the Senate bill provide independently for an insurance ombudsman).<sup>190</sup>

The bills do a pretty good job of addressing remedies for individuals affected by health plan decisions. Both the House and the Senate bill require internal and external review procedures, and the House bill preserves state judicial review of claims appeals and grievances. The bills are less generous, however, with provision for the appeal of the decisions of exchanges themselves. The House bill provides appeal rights for plans terminated from exchanges, while the Senate bill provides for appeals by persons denied affordability subsidies. Neither of the bills mentions judicial review for these decisions. Each of these determinations probably involves a property or liberty interest protected by the Due Process clause, but an explicit provision for review would be helpful.

The Senate legislation largely delegates to the states the tasks of running the exchanges and enforcing the insurance reforms. Presumably the decisions of the states are subject to review under state administrative law and state judicial review procedures, and state hearing officers and courts would apply the federal law in reviewing decisions. But each state will have different procedures and afford different levels of protection to

appellants. And if each state comes up with a different interpretation of the law, it will be difficult to reconcile the varying approaches.

It would be helpful if Congress would specify appeal and review procedures now rather than being required to do so later by the courts. This step is particularly important, because if Congress wrote these appeal and judicial review provisions into the bill it could specifically mark certain legislative determinations as not subject to judicial review—such as the level of subsidies or the definition of affordability—as it now routinely does when establishing Medicare prospective payment systems.<sup>191</sup>

### *Cost Control*

One of the primary justifications for creating exchanges is that they will help moderate health insurance premium increases. They could do so through increased competition among health plans brought about by greater comparability and transparency. Exchanges might also bring down administrative costs. A final function of an exchange could be to try to reduce the cost of insurance through regulation or through negotiations.

Neither of the bills gives the exchanges the authority to set insurance prices. Both bills impose mandatory minimum medical loss ratio requirements, although they are not enforced through the exchanges.<sup>192</sup> But the House bill also requires the exchange to negotiate contracts with qualified plans, and price could certainly be an issue subject to negotiation. The Senate bill does not explicitly provide for negotiations, but does require the exchange to certify that making available a plan offered by an insurer is in the interest of individuals and employers before offering it through the exchange. The bill also, as modified by the Manager's Amendment, requires the exchanges to "take into account" excessive or unjustified premium increases in deciding whether to certify a health plan for exchange participation.<sup>193</sup>

An exchange containing all purchasers in the nongroup market and eventually many employees of firms that now purchase insurance in the group market (or that do not currently insure their employees) could be attractive to insurers willing to trade price for volume. If the exchange offered plans from only a handful of insurers, it might be able to insist on substantial discounts.<sup>194</sup>

The key to cost control here is competition from a strong public plan. In many markets, one or a handful of insurers control an overwhelming share of the market, and an exchange offers little potential for creating competition without new entrants.<sup>195</sup> If one of the competitors offered by the exchange is a public plan paying lower prices to

providers than private plans and minimizing administrative costs, private plans in the exchange would face a strong incentive to bring down their own provider payments and administrative costs. If not, the experience of previous exchanges—minimal cost control—may again be replicated. At this point, however, a strong public plan seems very unlikely to be part of the final legislation. The Senate multistate plan provision is unlikely to create additional competition, since most of the plans that participate will already be offering insurance through the exchanges.<sup>196</sup>

There should be no constitutional impediment to negotiations between an exchange and insurers as long as efficient insurers are allowed to make a fair and reasonable return. If an exchange attempted to force an insurer to forego a fair and reasonable return in order to be included in an exchange, the insurer could raise a due process or takings challenge. Such a challenge would be less likely to succeed if the insurer could continue to sell policies in the state outside the exchange. Even if all insurers were required to sell through the exchange, as is true in the individual market in the House bill, the exchange could negotiate for cost control if the insurer were still permitted to make a fair and reasonable return on its investment. Indeed, following the precedent set by state certificate-of-need programs, the exchange could conceivably restrict the market to a limited number of low-cost or high-value insurers.

## **CONCLUSION**

Over the next days and weeks, Congress will in all likelihood finalize legislation that will significantly change the way in which we finance health care in the United States. The health insurance exchange concept will almost certainly play a role in this reform. A robust health insurance exchange holds real promise as a tool for advancing the goals of affordability and comprehensive coverage, but to realize that promise Congress must heed the lessons learned from the failed designs of previous exchanges. Specifically, Congress must ensure that the risk pool in the exchange is large and diverse and must take strong measures to suppress adverse selection and the steering of bad risk into the exchange. The easiest solution to the adverse selection problem is to require all individuals and small groups that are eligible for insurance through the exchange to purchase only through the exchange, as the House bill does with the individual market.

For the exchange to enable consumers to make informed choices, Congress must also ensure that consumers have accessible, reliable, linguistically accessible, and transparent information about the insurance plans in the exchange. Both the Senate and the House bill provisions would make important advances in transparency and disclosure of needed information concerning health plans, although the Senate bill, as amended,

offers a better approach. In addition, the final bill should address the need for the exchange to protect the confidentiality of personal identifiable information held by the exchange, perhaps by amending the Health Insurance Portability and Accountability Act to include exchanges as covered entities.

Both the House and the Senate bill provide for consumers to appeal adverse health plan decisions; however, only the Senate bill provides for appeals by persons denied affordability subsidies. The final bill would be improved if Congress specified clear appeal and review procedures.

Both the House and the Senate allow for a combination of state and federal roles in regulation of insurance and administration of the health insurance exchange. The House bill establishes a national responsibility on the part of the federal government but offers states with initiative and capacity the opportunity to take on the responsibility of forming and operating an exchange. In the Senate bill, states have the primary responsibility and the federal government has responsibility only when a state defaults on its presumptive obligation. While there are arguments for state-based exchanges, there are, on balance, better policy arguments for placing the primary responsibility for operating the exchange at the national level, as the House bill does. The House bill allows truly innovative states to initiate their own exchanges, allowing for the benefits of both national standards and state laboratories for creativity. A national exchange also is one of the surest paths to reducing the administrative costs of operating the exchange itself. The House provision, which requires the national exchange to negotiate contracts with qualified plans, has the potential to help moderate health insurance premiums and costs for both consumers and taxpayer-funded subsidies. The authority of the exchange to negotiate contracts with health insurance plans is particularly important and necessary should Congress opt not to include stronger cost controls such as a public plan option.

As is almost always the case in public policy, the devil of implementing health insurance exchanges will be in the details of its design and function. The two bills enacted by the House and Senate contain a host of good ideas that Congress can work with in putting together a final bill. There is, however, much that could be improved. It is to be hoped that this analysis will prove useful in the pursuit of that goal.

## NOTES

<sup>1</sup> A. C. Enthoven, “The History and Principles of Managed Competition,” *Health Affairs*, Jan. 1993 12(Suppl.):24–48.

<sup>2</sup> See H. T. Greely, “Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity,” *Health Matrix*, Winter 1995 5(1):37–82.

<sup>3</sup> See M. Merlis, *A Health Insurance Exchange: Prototypes and Design Issues*, Issue brief no. 832 (Washington, D.C.: National Health Policy Forum, June 2009).

<sup>4</sup> L. Rosetta, “Utah Health Exchange Goes Live August 19,” *Salt Lake Tribune*, Aug. 10, 2009, [http://www.sltrib.com/news/ci\\_13026812](http://www.sltrib.com/news/ci_13026812). The Utah exchange seems to be getting off to a rocky start. See L. Rosetta, “A Fix for the Utah Health Exchange?” *Salt Lake Tribune*, Dec. 21, 2009, [http://www.sltrib.com/ci\\_14046151?source=email](http://www.sltrib.com/ci_14046151?source=email).

<sup>5</sup> See C. Schoen, D. Helms, and A. Folsom, [\*Harnessing Health Care Markets for the Public Interest: Insights for U.S. Health Reform from the German and Dutch Multipayer Systems\*](#) (New York: The Commonwealth Fund, Dec. 2009); R. E. Leu, F. F. H. Rutten, W. Brouwer et al., [\*The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets\*](#) (New York: The Commonwealth Fund, Jan. 2009).

<sup>6</sup> Of the more than 5 million employers in the United States, only 103,000 have more than 100 employees, yet those firms employ 73 million of the 115 million employees in the United States. See Table 2a. Employment Size of Employer and Nonemployer Firms, 2004, at <http://www.census.gov/epcd/www/smallbus.html>.

<sup>7</sup> See Greely, *supra* note 2, at pp. 40–41.

<sup>8</sup> See L. J. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, D.C.: Urban Institute, 2009); and J. Kingsdale and J. M. Bertko, *Health Insurance Exchanges: A Typology and Guide to Key Design Issues* (Waltham, Mass.: Health Industry Forum, July 2009), available at <http://healthforum.brandeis.edu/meetings/materials/2009-20-july/KingsdaleBertkoFinal7.10.09.pdf>.

<sup>9</sup> A. M. Lischko, S. S. Bachman, and A. Vangeli, [\*The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions\*](#) (New York: The Commonwealth Fund, May 2009).

<sup>10</sup> An excellent recent summary of the literature is found at Rand Compare, [http://www.randcompare.org/analysis/mechanism/purchasing\\_pools](http://www.randcompare.org/analysis/mechanism/purchasing_pools).

<sup>11</sup> Merlis, *supra* note 3, at 4; C. MaGarr, “A Texas-Sized Health Care Failure,” *New York Times*, Oct 6, 2009.

<sup>12</sup> Merlis, *supra* note 3, at 3; GAO, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices*, GAO/HEHS-00-49 (2000); and E. Wicks, [\*Health Insurance Purchasing Cooperatives\*](#) (New York: The Commonwealth Fund, 2002).

<sup>13</sup> R. E. Curtis, E. Neuschler, and R. Forland, “Private Purchasing Pools to Harness Individual Tax Credits for Consumers,” *Inquiry*, Summer 2001 38(2):159–76; S. H. Long and M. S. Marquis, “Have Small-Group Health Purchasing Alliances Increased Coverage?” *Health Affairs*, Jan./Feb. 2001 20(1):154–63; GAO, *supra* note 12; Wicks, *supra* note 12; E. K. Wicks and M. A. Hall, “Purchasing Cooperatives for Small Employers: Performance and Prospects,” *Milbank Quarterly*, 2000 78(4):511–46.

<sup>14</sup> See R. R. Bovbjerg, *Lessons for Health Reform from the Federal Employees Health Benefit Program* (Washington, D.C.: Urban Institute, 2009).

<sup>15</sup> § 301(a).

<sup>16</sup> § 308(a), (c)(2).

<sup>17</sup> § 308(d)(2).

<sup>18</sup> § 1321(a)(1)(A). See § 1311(b) for a definition of exchanges and SHOP exchanges.

<sup>19</sup> § 1321(a)(1).

<sup>20</sup> §§ 1311(b), 1321(b).

<sup>21</sup> § 1311(d)(1).

<sup>22</sup> § 1311(b)(2).

<sup>23</sup> § 1311(f)(1) & (2).

<sup>24</sup> § 1311(f)(3).

<sup>25</sup> § 1321(c)(1). There is a presumption that existing state-operated exchanges can continue to operate unless HHS concludes otherwise. § 1321(e).

<sup>26</sup> § 1321(c)(2), cross-referencing current 42 U.S.C. § 300gg-22(b), which will be renumbered under the bill.

<sup>27</sup> § 1332.

<sup>28</sup> § 1331.

<sup>29</sup> § 301(b)

<sup>30</sup> §§ 306(a), 341.

<sup>31</sup> § 304(a)(2).

<sup>32</sup> § 304(a)(2)(C).

<sup>33</sup> § 1311(d) Exchanges may also allow insurers to offer stand-alone pediatric dental coverage plans rather than offer pediatric dental coverage through a qualified plan. *Id.*

<sup>34</sup> Functions 2 through 12 are found in § 1311(d)(4). Certification requirements are described below.

<sup>35</sup> See also § 1413.

<sup>36</sup> § 1311(i).

<sup>37</sup> § 1311(d)(6).

<sup>38</sup> § 302(c),(d), (e).

<sup>39</sup> § 302(e)(6).

<sup>40</sup> § 302(d)(3), (e)(5).

<sup>41</sup> § 1311(d)(2).

<sup>42</sup> § 1312(a). See the explanation of tiers of coverage below.

<sup>43</sup> § 1312(f)(1).

<sup>44</sup> § 1304(b)(2).

<sup>45</sup> § 1304(b)(3). The statute provides special rules for aggregation of related employers, dealing with new employers, and allowing small employers that grow to continue to be treated as small employers once they are in the exchange.

<sup>46</sup> § 1312(f)(2).

<sup>47</sup> § 1312(f)(3).

<sup>48</sup> § 1312(d)(3)(D).

<sup>49</sup> § 202(c)(1).

<sup>50</sup> § 202(a).

<sup>51</sup> § 412(a)(1).

<sup>52</sup> § 202(b).

<sup>53</sup> § 1251(a) Under the Manager's Amendment, the provisions of the bill relating to disclosure of standardized information and medical loss ratio increases apply to grandfathered plans that begin after the date of enactment. § 1251(a)(3). The Act also does not apply to insurance implemented under collective bargaining agreements as long as the agreement stays in force, although changes made to conform to the Act do not terminate an agreement.

<sup>54</sup> § 1251(b) & (c).

<sup>55</sup> § 1312(d).

<sup>56</sup> § 1312(d)(1) & (3).

<sup>57</sup> § 1312(d)(4).

<sup>58</sup> § 1312(c).

<sup>59</sup> § 1312(d)(2).

<sup>60</sup> § 1301(a)(1)(C)(iii).

<sup>61</sup> § 303.

<sup>62</sup> § 222(c)(3)(B)

<sup>63</sup> §§ 222(c)(3)(A); 223(b)(6).

<sup>64</sup> § 303(b).

<sup>65</sup> § 102.

<sup>66</sup> § 103.

<sup>67</sup> § 104.

<sup>68</sup> § 105.

<sup>69</sup> §§ 106, 107.

<sup>70</sup> § 108.

<sup>71</sup> § 109.

<sup>72</sup> § 110.

<sup>73</sup> § 211.

<sup>74</sup> § 212.

<sup>75</sup> § 213.

<sup>76</sup> § 214.

<sup>77</sup> § 215.

<sup>78</sup> § 217.

<sup>79</sup> § 235.

<sup>80</sup> §§ 236, 237.

<sup>81</sup> § 240.

<sup>82</sup> §§ 221; 222(a).

<sup>83</sup> §222(b).

<sup>84</sup> § 223. The procedures to be followed in defining the package are described in § 224.

<sup>85</sup> § 304(c)(3).

<sup>86</sup> §§ 231; 232; 233.

<sup>87</sup> §§ 309, 310.

<sup>88</sup> § 1302(d)(1).

<sup>89</sup> § 1302(d). Employer contributions to a health savings account may be taken into consideration in determining the level of coverage for an employment-based plan.

<sup>90</sup> § 1302(e).

<sup>91</sup> § 1302(e)(1).

<sup>92</sup> § 1311(d)(2).

<sup>93</sup> § 1402.

<sup>94</sup> § 1311(e)(1).

<sup>95</sup> §1311(e)(1).

<sup>96</sup> § 1311(e)(2).

<sup>97</sup> §§ 1301(a), 1322, 1333, 1334.

<sup>98</sup> § 1301(a)(1). Qualified health plans must also be offered at each level covering only children under the age of 21. § 1302(f).

<sup>99</sup> § 1303(a).

<sup>100</sup> § 1311(c).

<sup>101</sup> § 1311(g)(1).

<sup>102</sup> § 1311(g).

<sup>103</sup> § 1311(h).

<sup>104</sup> § 234.

<sup>105</sup> § 304(b).

<sup>106</sup> § 5000A(f).

<sup>107</sup> § 5000A(f)(2).

<sup>108</sup> § 2711. Prior to 2014, “restricted annual limits” are allowed. Limits will also continue to be permitted on specific covered benefits that are not “essential benefits.”

<sup>109</sup> § 2712.

<sup>110</sup> § 2713.

<sup>111</sup> § 2714.

<sup>112</sup> § 2715.

<sup>113</sup> § 2717.

<sup>114</sup> § 2718. This provision applies also to grandfathered plans established after the effective date.

<sup>115</sup> § 2719.

<sup>116</sup> § 2719A.

<sup>117</sup> § 2709.

<sup>118</sup> § 2701.

<sup>119</sup> §§ 2702, 2703.

<sup>120</sup> §§ 2704, 2705. Under the Manager's Amendment, the prohibition on pre-existing conditions becomes effective for enrollees under 19 six months after enactment.

<sup>121</sup> § 2706.

<sup>122</sup> § 2708.

<sup>123</sup> See "The Amended Title XXVII of the Public Health Services Act," posted on December 14, 2009, at <http://www.oneillhealthreformblog.org> for a listing of the provisions and of the health plans or insurers to which they apply.

<sup>124</sup> § 2707.

<sup>125</sup> § 1302(b)(1).

<sup>126</sup> § 1302(b)(2).

<sup>127</sup> § 1302(b)(4).

<sup>128</sup> § 1302(c).

<sup>129</sup> § 1302(c)(2).

<sup>130</sup> §1311(d)(3).

<sup>131</sup> §§ 2707(b), 1302(c)(1).

<sup>132</sup> §§ 233(a), 242(e).

<sup>133</sup> § 233(a)(1).

<sup>134</sup> § 233(a)(2).

<sup>135</sup> § 233(a).

<sup>136</sup> § 233(b).

<sup>137</sup> § 233(c).

<sup>138</sup> §§ 304(b)(8), 305(f).

<sup>139</sup> §1311(e)(3).

<sup>140</sup> §1003, adding to the Public Health Services Act §2794.

<sup>141</sup> §1103.

<sup>142</sup> § 2717.  
<sup>143</sup> § 2718.  
<sup>144</sup> § 1311(c)(1)(G).  
<sup>145</sup> § 1311(c)(1)(B).  
<sup>146</sup> See §§ 2715(b)(2), 2719(a)(1)(B), & 1311(g)(a) & (i)(3)(E).  
<sup>147</sup> § 305(g).  
<sup>148</sup> § 1312(e).  
<sup>149</sup> § 305(b).  
<sup>150</sup> § 305(b)(3).  
<sup>151</sup> § 305(c).  
<sup>152</sup> § 305(b)(4).  
<sup>153</sup> § 305(h) & (i).  
<sup>154</sup> § 1311(b).  
<sup>155</sup> § 1311(c)(5).  
<sup>156</sup> §§ 1311(d)(4)(F). 1413.  
<sup>157</sup> § 2793(c)(4).  
<sup>158</sup> § 1311(i).  
<sup>159</sup> § 306(b).  
<sup>160</sup> § 1343.  
<sup>161</sup> § 1341.  
<sup>162</sup> § 1342.  
<sup>163</sup> § 341(b).  
<sup>164</sup> § 36B(b)(2) of the Internal Revenue Code added by § 1401; §1402(b)(1).  
<sup>165</sup> § 1311(d)(4)(H).  
<sup>166</sup> § 304(a).  
<sup>167</sup> § 1311(e)(1).  
<sup>168</sup> § 321(b)(1).  
<sup>169</sup> § 1334.  
<sup>170</sup> § 304(c)(4).  
<sup>171</sup> § 304(c)(4).  
<sup>172</sup> §1311(d)(4).  
<sup>173</sup> § 304(c)(4).  
<sup>174</sup> § 1411.  
<sup>175</sup> § 1411(f).  
<sup>176</sup> § 1411(e)(4)(C).

<sup>177</sup> § 307.

<sup>178</sup> § 308(f).

<sup>179</sup> § 1311(a).

<sup>180</sup> § 1311(d)(5).

<sup>181</sup> This paper omits a discussion of the significant constitutional and legal issues raised by exchanges. For a discussion of those issues, see Timothy Jost, “More Legal Issues Raised by Health Insurance Exchange Legislation,” <http://oneillhealthreform.wordpress.com/2009/10/24/more-legal-issues-raised-by-health-insurance-exchange-legislation/>; Timothy Jost, “Constitutional Limits on Insurance Regulation,” <http://oneillhealthreform.wordpress.com/2009/10/23/constitutional-limits-on-insurance-regulation/>; and Timothy Jost, *Health Insurance Exchanges: Legal Issues* (2009), [http://www.law.georgetown.edu/oneillinstitute/projects/reform/Papers/Insurance\\_Exchanges.pdf](http://www.law.georgetown.edu/oneillinstitute/projects/reform/Papers/Insurance_Exchanges.pdf), all found on Georgetown Law Center O’Neill Institute’s Legal Solutions in Health Reform Web site.

<sup>182</sup> Experience with HIPAA is particularly instructive, since it took the same approach, i.e., asking the states to implement legislation and providing a federal fallback option if they failed to do so. See K. Pollitz et al., “Early Experience with ‘New Federalism’ in Health Insurance Regulation,” *Health Affairs*, 19(4), July./Aug. 2000, at 7. Most states had already implemented the HIPAA group market reforms, and those that had not already done so adopted them quickly. The states had been much less active in regulating the individual market, and a number of states failed to implement the HIPAA reforms. Most states that did implement them chose one of the options permitted by the law other than the federal fallback position. In most states the option chosen was to offer individuals coverage in the state high-risk pool. Some states, however, simply did not comply. Some of those states notified HHS that they did not intend to comply and helped HHS itself to enforce the law. Others notified HHS, at the very last minute before HHS enforcement was to begin, that they would not comply and offered HHS no assistance with implementation. Finally, some states simply did not implement parts of the law but failed to communicate that information to HHS, leaving HHS uncertain as to how to proceed.

Implementation of the law by HHS was slow and uneven. Repeated GAO reports criticized HHS for its failure to enforce the law and implement the federal fallback requirements. See GAO, “Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve” (GAO-01-652R, May 7, 2001); GAO, “Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States” (GAO/HEH-00-85, March 31, 2000); GAO, “HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws” (GAO/HEHS-98-21R, July 22, 1998). The HHS enforcement effort was understaffed and underresourced, and regulatory guidance was slow in coming. HHS apparently made minimal effort to monitor HIPAA compliance by government plans, an additional part of its responsibility. Eventually, after more than a decade, compliance was nominally achieved in all states. Testimony presented to the House Oversight Committee last year, however, revealed that compliance oversight at HHS had largely ceased. See House Committee on Oversight and Government Reform, “Hearing on Business Practices in the Individual Insurance Market: Termination of Coverage,” July 17, 2008, <http://purl.access.gpo.gov/GPO/LPS110059>. The four-person office at HHS responsible for compliance relies solely on complaints, and has received only five complaints in the last five years. Blatant violations of the individual plan guaranteed-renewal provisions, widely reported in the press, had been completely ignored by HHS. See also, P. Harbarger, H. Haycock, and M. K. Ledford, *Post-Claims Underwriting and Rescission Practices* (Princeton, N.J.: Robert Wood Johnson Foundation, 2009), available at <http://www.rwjf.org/files/research/52428.pdf>.

<sup>183</sup> See Families USA, “Failing Grades,” <http://www.familiesusa.org/resources/publications/reports/failing-grades.html>, and “Insurance Company Rules, Where Is the Referee?” [http://www.insurancecompanyrules.org/learn\\_more/where\\_is\\_referee](http://www.insurancecompanyrules.org/learn_more/where_is_referee).

<sup>184</sup> See <http://oneillhealthreform.wordpress.com/2009/09/29/firing-again-on-fort-sumpter/>.

<sup>185</sup> A. Enthoven, W. Kramer, D. Riemer et al., “Making Exchanges Work in Health-Care 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>186</sup> Ibid.

<sup>187</sup> § 414.

<sup>188</sup> Timothy Stoltzfus Jost, “Health Insurance Exchanges: Legal Issues”, supra note 181 at 20.

<sup>189</sup> See L. J. Conwell, *The Role of Health Insurance Brokers* (Washington, D.C.: Center for Studying Health Systems Change, 2002), available at <http://www.hschange.org/CONTENT/480/480.pdf>.

<sup>190</sup> House § 244; Senate § 2793.

<sup>191</sup> See, e.g., 42 U.S.C. § 1395ww(d)(7).

<sup>192</sup> House bill § 102; Senate bill § 2718.

<sup>193</sup> § 1311(e)(2).

<sup>194</sup> The Massachusetts Connector includes five insurers in the subsidized Commonwealth Care program and six in the nonsubsidized Commonwealth Choice program.

<sup>195</sup> See R. Abelson, “Health Insurance Exchanges: Will They Work?”, *New York Times*, Oct. 6, 2009. See discussing insurance industry concentration, J. Robinson, “Consolidation and the Transformation of Competition in Health Insurance,” *Health Affairs*, Nov./Dec. 2004 23(6):11–24.

<sup>196</sup> This, at any rate, is the projection of the Congressional Budget Office. See letter from Douglas Elmendorf to Senator Reid, December 19, 2009, at 9, 19.