



## **HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: EIGHT DIFFICULT ISSUES**

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September 2010

**ABSTRACT:** The state-level health insurance exchanges to be created under the Affordable Care Act (ACA) are expected to play a major role in the purchase and sale of health insurance when they become fully operational in 2014. This report focuses on eight of the most difficult issues that the states and the federal government face in implementing the exchanges: governance of the exchanges; avoidance of adverse selection; making self-funded plans compatible with exchanges; making exchanges attractive to employers; exchanges' use of their regulatory authority; determining the information that exchanges must make available to consumers and employers; the exchanges' role in making eligibility determinations for premium tax credits and cost-sharing reduction payments and their relationship with public insurance programs; and reducing administrative costs. The report also examines how the ACA handles those issues, and makes concrete recommendations as to how those issues should be addressed.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new Commonwealth Fund publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1444.



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## ACKNOWLEDGMENTS

I would like to thank Jon Kingsdale, Terry Gardiner, Karl Ideman, and Mark Hall for their careful review of earlier drafts, and Edwin Park, Sara Lueck, Dawn Horner, Shawn Nowicki, Joan Gardner, Philip Vogel, David Riemer, Alain Enthoven, Stephen Finan, Sabrina Corlette, and Bill Kramer for helpful suggestions.

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*Editorial support was provided by Joris Stuyck.*

## EXECUTIVE SUMMARY

This is the second report in a series examining the implementation of the health insurance exchange provisions of the Patient Protection and Affordable Care Act of 2010. The author analyzes eight of the most difficult issues that the states and federal government face in implementing the exchanges—which are expected to play a major role in the purchase and sale of health insurance once they become fully operational in 2014—and offers recommendations for addressing them.

*1. How should exchanges be governed? Should they be run by a state agency or by a nonprofit entity?*

In each state, the exchange should be placed within an independent agency, which should be explicitly exempted, as necessary, from specific state administrative law or government operations requirements. The governing board of the exchange could include representatives of state agencies with which the exchanges must work, interested parties, and persons with relevant expertise. Management, on the other hand, should be apolitical and professional. Exchanges should outsource those services for which competitive markets exist and for which performance can be readily monitored.

*2. The most significant problem that exchanges have grappled with historically has been adverse selection. What should be done to avoid adverse selection against and within exchanges?*

To the extent possible, state regulation of the individual and small-group market should be identical outside and inside the exchange. Some states may be able to eliminate the market outside the exchange. To discourage adverse selection both against and within the exchange, HHS should design a sophisticated but practical risk-adjustment system allowing states to adjust risk among participating and nonparticipating insurers.

*3. Opening the exchanges to large employer plans, and in particular to formerly self-insured employee benefit plans, poses a significant threat to the exchanges. What must be done to make self-insured plans compatible with exchanges?*

In defining “self-insured” status, the U.S. Department of Labor and Department of the Treasury should clarify that only employers who are capable of bearing—and do, in fact, bear—the substantial risk of the cost of health care for their group can be self-insured. States should consider extending the requirements of the Affordable Care Act to large plans and to grandfathered plans that qualify for exchange coverage.

*4. Exchanges must attract employers as well as individual enrollees if they are to succeed. What can be done to make exchanges attractive to employers?*

Exchanges should offer employers the possibility of an aggregated bill covering the premiums of all employees. The exchange should assume the task of allocating premiums among the various insurers and plans chosen by individual employees. Employers should be able either to pay a fixed percentage of the premium for a specified level of coverage, with the employee covering the remainder of the premium, or to charge employees a premium share based on category and richness of coverage and, if desired, on tobacco use and involvement in wellness incentive programs. Employers could also offer greater support to lower-income employees.

*5. The Affordable Care Act requires the exchanges to certify health plans that meet certain requirements for participation in the exchange. How should exchanges exercise this regulatory authority?*

Exchanges must use their certification power to ensure that health plans meet the statutory requirements for qualification and that plans do not impose unreasonable premium increases on their members. Legislation authorizing state exchanges should under no circumstances require exchanges to admit all insurers in the market, but should at least give exchanges the option of being an active purchaser. Exchanges should decide whether to take a more inclusive or exclusive approach to insurer participation based on the conditions in their own state and local markets. Exchanges should use their regulatory authority to lower prices and increase value to the extent that the competitive conditions in their markets allow. Exchanges should also standardize and limit the range of plan choices available within each tier to stimulate competition based on price and value.

*6. The Affordable Care Act requires the exchanges to make both descriptive and evaluative information available to consumers. How should the exchanges fulfill this responsibility?*

Exchanges should make information describing the benefits and limitations of available health insurance plans readily and easily accessible. To permit informed selection of an appropriate health plan through the exchange Internet portal, health plans should be contractually bound by information they disclose on their Web sites. Exchanges should develop rating systems that permit accurate comparison of the value of competing health plans, and satisfaction-survey programs that pay particular attention to the opinions of plan members who have serious health problems or financial problems related to their health needs. When conducting their evaluations, exchanges should be attentive to the opinions of both employers and individuals.

*7. Exchanges play a central role in making eligibility determinations for premium tax credits and cost-sharing reduction payments and for the Medicaid and Children's Health Insurance Programs. How should eligibility determinations work under the Affordable Care Act?*

Although the Affordable Care Act includes extensive provisions for determining eligibility for premium tax credits, cost-sharing reductions, Medicaid, and CHIP, the allocation of responsibility for making such determinations remains unclear and contradictory. The statute should be implemented in such a way as to permit an individual to apply initially either to the exchange or to the state Medicaid agency. Either entity must then ascertain that the individual is signed up for the appropriate program. The exchange and the Medicaid and CHIP programs should facilitate electronic applications that minimize the need for paper documentation. Interim assistance should be readily available in cases where eligibility cannot immediately be determined. The reconciliation requirements of the statute should be interpreted so as not to defeat the purpose of providing assistance to those who need it. Exchanges should see it as their responsibility to ensure the continued enrollment of eligible individuals and families for tax credits or public programs, rather than holding individuals responsible for continually having to work at maintaining their own eligibility.

*8. Exchanges must find ways to hold down administrative costs and must identify funding sources if they are to succeed. What can exchanges do to reduce administrative costs and attract funding?*

Exchanges should develop a variety of revenue sources to fund their work, including an assessment on all insurers in the market. Exchanges should seek opportunities to lower administrative costs both for insurers and for employers. State enabling legislation should neither require nor bar the use of agents and brokers for the purchase of insurance from the exchange. Agent and broker commissions should be rationalized, however, and should be consistent regardless of which health plan is being sold and whether it is inside or outside the exchange.



# HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: EIGHT DIFFICULT ISSUES

## INTRODUCTION

In an earlier Commonwealth Fund report, [\*Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues\*](#), the author discussed 13 key issues that must be addressed if health insurance exchanges—the centerpiece of the coverage reforms in the Patient Protection and Affordable Care Act of 2010 (ACA)—are to succeed in their purpose.<sup>1</sup> The report also examined how the new health reform law attempts to address those issues and identified policy options that the states and the federal government might pursue in responding to problems that may arise.

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

This report focuses on eight of the most difficult issues that the states and the federal government face in implementing ACA exchanges, examines in greater detail how the ACA handles those issues, and makes concrete recommendations as to how those issues should be addressed. The issues are:

1. How should exchanges be governed?
2. What should be done to avoid adverse selection against and within exchanges?
3. How can self-funded plans be made compatible with exchanges?
4. What can be done to make exchanges attractive to employers?
5. How should exchanges exercise their regulatory authority?
6. What information must exchanges make available to consumers and employers?
7. What role will exchanges play in making eligibility determinations for premium tax credits and cost-sharing reduction payments, and how will they relate to Medicaid and the Children's Health Insurance Program (CHIP)?

8. What can exchanges do to reduce their own administrative costs and the costs of their users, and how shall they be funded?

## **GOVERNANCE**

### **State Entity or Private Nonprofit?**

Decisions that states make with respect to the governance of exchanges will be central to the exchanges' success. However, the ACA says very little about exchange governance. Section 1311(d)(1) states, "An Exchange shall be a governmental agency or nonprofit entity that is established by a State." Section 1311(d)(5) provides that exchanges must be self-sustaining beginning in 2015 and must charge user fees or "otherwise generate funding" to support operations. This section also prohibits the use of funds for "staff retreats, promotional giveaways, excessive executive compensation," or lobbying. The ACA requires exchanges to consult with stakeholders including consumers, producers, small businesses and self-employed individuals, Medicaid offices, and advocates for hard-to-reach populations. Section 1313 contains a number of additional provisions to ensure the financial integrity and accountability of exchanges. Finally, the ACA permits states to authorize exchanges to outsource some of their responsibilities to state Medicaid offices and to qualified private entities that are not insurers and are not related to insurers.<sup>2</sup>

Current state exchanges either function within existing state departments or agencies or have been created as independent public entities. The Massachusetts Connector is an "independent public entity" not answerable to any other executive department or board, governed by a 10-member board composed of four designated public officers, three members appointed by the governor, and three appointed by the attorney general.<sup>3</sup> The Utah Health Exchange is operated by the state Office of Consumer Health Services, which is part of the Governor's Office of Economic Development.<sup>4</sup> The proposed California Health Benefits Exchange is also an independent agency governed by a five-member board, including one appointee of the California Secretary of Health and Human Services, two members appointed by the governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly.<sup>5</sup>

### **Legal Considerations**

The ACA offers states the option of locating the exchange in a "nonprofit entity that is established by the state."<sup>6</sup> Note that this provision does not allow a state simply to outsource exchange functions to an existing private nonprofit entity, but rather allows a state to establish a nonprofit entity to run the exchange. A state considering this option

must carefully examine whether the option is legal under its own law and, if so, whether it is advisable.

Some exchange functions could be handled readily by a private entity. These include operating a Web portal and processing enrollments or premium payments. As noted above, such functions can be outsourced to private entities under the ACA. Other functions, however, such as certifying that making a health plan available “is in the interests of qualified individuals and qualified employers,” or taking unreasonable premium increases “into account” in determining whether to offer a health plan, are arguably “inherently governmental.” Exchanges may also exercise governmental discretion in determining eligibility for premium subsidies or Medicaid.

The United States Constitution, in principle, limits the ability of Congress to delegate legislative decisions to other branches of government, and in particular to delegate governmental authority to private entities.<sup>7</sup> In fact, however, the federal courts almost never hold a delegation to be invalid, invariably finding that Congress has established “intelligible principles” to restrict decision-making. Constitutional law is stricter in some states, however. A number of state courts have in recent years struck down attempts by state legislatures to delegate to private entities the authority to make public decisions.<sup>8</sup> Delegations are particularly likely to be struck down in cases where the private decision-maker has a potential conflict of interest.<sup>9</sup> The facts in these cases vary considerably and are usually not analogous to the facts that would pertain to exchanges, but it is imperative that before considering the delegation of exchange responsibility to private entities states determine that doing so is constitutionally permissible

A publicly run exchange would be subject to a considerable number of state administrative and government operations laws. These would likely include laws on administrative procedure, administrative review, open meetings, freedom of information, privacy, civil service, and procurement. Such laws are usually statutory, but could have constitutional ramifications. The civil service provisions of the California State Constitution, for example, have been interpreted generally to require public employees to perform tasks that can be performed “adequately and competently” by civil servants.<sup>10</sup>

It is important that exchanges have the agility to react quickly to changes in insurance markets. Exchanges could be staffed with specialized committees composed of experienced experts who could resolve marketplace issues quickly and make recommendations to the exchange board. States may want to apply their administrative procedure acts somewhat flexibly to exchanges. States may also want to permit some

flexibility in the application of their civil service pay scales to be able to attract qualified top administrators. The Massachusetts Connector, for example, is exempted from certain provisions of the civil service acts.<sup>11</sup> The California exchange statute exempts certain employees from the civil service laws; authorizes the exchange to adopt emergency regulations until January 1, 2016; exempts the exchange from certain provisions of the public contracting law; and exempts certain records of the exchange from the public records act.<sup>12</sup>

But public law governing administrative agencies exists to ensure transparency, accountability, and public participation in the governance of public agencies and to avoid corruption and patronage. Those values are important to the operation of exchanges, as is evidenced by ACA provisions requiring exchanges to consult with stakeholders and by section 1313, which addresses the financial integrity of exchanges. In general, therefore, it is appropriate that some public-law provisions apply to exchanges.

### **Make or Buy?**

Retaining the exchange as a public function may be a more efficient use of public resources. The question of whether to establish an exchange as a government agency or as an independently contracted organization is analogous to the make-or-buy decisions common to private firms. One rule of thumb for privatizing government functions is the “yellow-pages rule”: If a product or service is relatively standardized and competitively available in the private sector (i.e., advertised in the yellow pages), it might make sense for government to purchase it privately rather than provide it itself. If, on the other hand,

- a) a product or service is not already provided in the private sector,
- b) gearing up to provide the product or service would require essentially the same (or greater) effort and impose the same (or higher) transaction costs in the private as in the public sector,
- c) private managers of the activity might pursue interests that would conflict with the public purpose of the activity,
- d) private performance would need to be monitored in any event by public officials (and might be costly to monitor if the product or service is unique),
- e) there are no economies of scale in providing the product or service in the private market, and
- f) hard-to-foresee changes in the program or in circumstances surrounding it might create risks that the government would ultimately have to bear even if the service

is independently contracted, then it probably makes more sense for the government to “make” the service rather than “buy” it in the public sector.<sup>13</sup>

An additional consideration in deciding whether the exchange should be operated by a public or private entity is that a private entity might face additional responsibilities under federal law. First, a privately run exchange might be subject to fiduciary responsibilities under the Employee Retirement Income Security Act (ERISA). ERISA defines a fiduciary as a person who has or exercises any discretionary authority with respect to the management or administration of the plan and defines a person as a private entity.<sup>14</sup> If, for example, an exchange exercises discretion over the plans that would be available to employee groups, it might be considered to be exercising discretionary authority. It would therefore be required under ERISA to exercise its authority for the exclusive benefit of plan participants and beneficiaries and “with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use.”<sup>15</sup> An exchange run by a private organization would also quite possibly be subject to regulation as a Multi-Employer Welfare Association, although as a fully insured MEWA it would be subject to state regulation, so the issue could be addressed in enabling legislation.<sup>16</sup> In light of these considerations, it would usually make sense to locate the policy-making plan certification, eligibility-determination, and plan-rating functions of the exchange in a public or quasi-public entity.

On the other hand, it will usually make sense for an exchange to outsource largely nondiscretionary, mechanical functions competitively available in the private sector. Those could include premium billing, collection, and reconciliation systems; enrollment and case installation services; data processing; and customer relations management. Such services are readily available and efficiently provided in the private sector. Substantial economies of scale would be lost if each state developed its own administrative systems in those areas. Moreover, the daunting list of tasks that exchanges must accomplish prior to 2014 will be greatly facilitated by the ability to outsource functions that can readily be handled by others, rather than having to build from scratch the capacity to carry out those functions themselves.<sup>17</sup> Exchanges should also not be limited to in-state vendors of services, as it is likely that a national market for exchange services will develop. State procurement laws that might limit access to national markets should explicitly exempt exchanges.

### **Agency or Board?**

In many states, it is unlikely that the exchange will fit within an existing government agency. Although the exchange must coordinate closely with the state insurance department or commissioner, it should not be housed in the insurance department. It is quite possible that not all insurance plans will be certified for participation in the exchange, and selecting among plans would be inconsistent with the impartiality that must be shown by an insurance commissioner.<sup>18</sup> Moreover, the fundamental role of an exchange is to market insurance products, while the basic role of an insurance commissioner is to regulate insurance and protect consumers.

It also will usually not make sense to house the exchange within the state Medicaid agency, since many participants will not be on Medicaid and will have different needs from those of Medicaid recipients (although it must coordinate its activities closely with the state Medicaid agency, as is discussed further below). It might make sense to house the exchange within a broader consumer protection agency, depending on the nature of that agency within the state. Other states may also want to follow Utah's example and house the exchange in the governor's office, where it might have more status and access to power and be less subject to the politics and bureaucracy of an existing agency. In most states, it will probably make sense to create a separate and independent agency, as Massachusetts has done.

If the exchange is placed in an independent agency, it will likely have a governing board. It is important that the exchange board be of manageable size (no more than 10 members; five to seven might be optimal). One model, which will probably be the most common, is a board that represents a variety of interests, fields of expertise, and political perspectives. In this model, the board could include representatives of other state agencies with which the exchange must interact, including the insurance division, the state Medicaid agency, and the health insurance consumer assistance or ombudsman program. Consumers, small businesses, and organized labor could also be represented on the board. It is inadvisable, however, to delegate a specific "consumer," "employer," or "employee" slot for the board, as the board might benefit from having multiple consumer, employer, or employee representatives who encompass a variety of competencies. Lower-income and minority communities (particularly those with limited English competency) and individuals with chronic diseases and disabilities have a special stake in the exchange, and should be represented.

Under an interest-representation model, health insurers and brokers or agents who either sell health insurance products through the exchange or compete with the exchange

should not be represented on the board, both because they have a conflict of interest and because they might gain an unfair advantage over competitors. Health care providers might also have a conflict of interest, as they are paid by health insurers and will face increasingly tough bargaining with insurers as insurers try to hold down costs in the new competitive environment. An advisory board could represent insurer, producer, and provider interests while avoiding a conflict of interest. Conflicts of interest should also be avoided by enacting legislation or incorporating by reference existing state legislative provisions that would prohibit exchange managers or board members from moving directly to or from the insurance industry.

The interest-group board model could, however, prove problematic. The exchange is, in essence, a business, and will succeed only to the extent to which it serves its customers. If a board that broadly represents political interests gets the politics right but provides a product that is not marketable, the exchange will not succeed. If the board degenerates into political turf wars, the result could be even more damaging. Some states may, therefore, want to appoint an apolitical, management-oriented board, which could be served by a secondary advisory board on which a range of interests could be represented. The exchange board could include individuals with select competencies—health economists, actuaries, or experts in health policy—rather than members representing interest groups. Whatever the makeup of the board (or boards), the management of an exchange must be impartial and committed to efficient and professional management.

Board members could be appointed by the governor or, if the state constitution's appointments clause permits, by legislative leadership or other elected state officers, as they are in Massachusetts and California. In most states it will probably make sense to have the board appointed by the governor subject to approval by the legislature, as the governor's office is more likely to have the capacity to vet candidates, and appointment by a single official is more likely to result in a board that balances the interest of stakeholders. If the governor must make appointments, legislative leadership could still recommend candidates.

### **Recommendations**

In each state, the exchange should be placed in an independent agency, which should be explicitly exempted, as necessary, from the requirements of specific state administrative law or government operations requirements. The governing board of the exchange could represent interested parties, state agencies with which the exchanges must work, and persons with relevant expertise. Management, on the other hand, should be apolitical and

professional. Exchanges should outsource services for which competitive markets exist and for which performance can be readily monitored.

## **ADVERSE SELECTION**

### **Adverse Selection Against the Exchange**

As noted in the first report, the greatest threat facing exchanges is adverse selection. As long as individual or small-group coverage is readily available outside the exchange, the potential exists for healthy individuals and groups to purchase insurance disproportionately outside the exchange.<sup>19</sup> If an exchange becomes essentially a high-risk pool, the exchange will become unattractive to insurers while coverage through the exchange will become unaffordable to individuals and to employers.

The ACA permits both an individual and a group health insurance market to continue to exist outside the exchange, leaving open the possibility of adverse selection against the exchange if lower-risk subscribers can find less-expensive coverage elsewhere. In addition, the ACA permits “grandfathering” of plans outside the exchange. Many of the requirements of the ACA do not apply to individual and group health plans that existed on the date the ACA was adopted.<sup>20</sup> As will be discussed below, the ability of individuals or employers to maintain grandfathered plans increases the risk of adverse selection because healthy individuals and groups can retain grandfathered health plans while higher-cost individuals and groups abandon grandfathered status for the exchange.

Fortunately, a number of ACA provisions will discourage adverse selection, as was discussed in my first report:

- Section 5000A(a) of the Internal Revenue Code, created by section 1501 of the ACA, requires individuals to have “minimum essential coverage.”<sup>21</sup> The requirement will discourage healthy individuals from staying out of the insurance market altogether.
- Most of the insurance reforms imposed by the legislation apply both within and outside the exchange. These include a number of provisions that might encourage adverse selection against the exchange if applied only within the exchange, such as the prohibition of health status underwriting.
- Individual and small-group plans, both within and outside the exchange, must cover the same defined “essential health benefits.”<sup>22</sup> Out-of-pocket limits are also the same inside and outside the exchange.<sup>23</sup>
- With the exception of enrollees in grandfathered plans, health insurance issuers must treat all individual enrollees in their plans (inside and outside the exchange)



as one single risk pool and all small-group enrollees as another single risk pool, or, if the state elects, treat members of both pools as a single risk pool.<sup>24</sup>

- Issuers of qualified health plans must charge the same premium rate for a plan inside and outside the exchange.<sup>25</sup>
- The ACA creates three risk-adjustment programs, two transitional and one permanent, which should reduce adverse selection against the exchange.<sup>26</sup> If plans outside the exchange attract a significantly healthier population than plans in the exchange, they will need to compensate the plans in the exchange.
- Finally, and most importantly, the ACA's premium assistance credits and cost-sharing reduction payments will be accessible only to individuals enrolled in qualified health plans through exchanges.<sup>27</sup> Tax credits will also be available to small employers only through the exchange.<sup>28</sup>

Because a market will continue to exist outside the exchange, however, the ACA does not eliminate the possibility of adverse selection. Only “qualified” health plans can be sold within the exchange. Qualified health plans must comply with all of the requirements in the ACA that apply to health plans generally, but must also comply with additional requirements that might make them more expensive than plans outside the exchange, in turn making the non-exchange plans more attractive to healthier individuals who might prefer less-expensive to more-protective plans.<sup>29</sup> The additional requirements may also make marketing plans through the exchange less attractive to insurers.

Health insurers within the exchange must offer gold- and silver-level coverage as a prerequisite to selling other levels of coverage.<sup>30</sup> Insurers, however, do not need to participate in the exchange if they choose not to, and can remain outside the exchange marketing “bronze”-level high cost-sharing plans, or catastrophic plans, which can be sold to people under 30 or to persons who cannot find affordable policies.<sup>31</sup> This leaves open the possibility for healthy individuals or small employers to purchase minimum coverage outside the exchange, threatening significant adverse selection against it. Self-insured plans are subject to even less-rigorous requirements under the ACA, and might offer coverage that is substantially less protective than exchange coverage, as is discussed in the next section.<sup>32</sup> Some adverse selection against the exchange will likely result.

Although the ACA does not allow the federal government to require individuals or employees to purchase insurance through the exchange, it does not prohibit the states from imposing additional requirements on the outside market to discourage adverse selection. The ACA only preempts state laws that would “prevent the application” of the

ACA, and state laws prohibiting or tightly regulating the sale of insurance outside the exchange would not violate that principle.<sup>33</sup> The only constraint on state regulation of the health insurance market is that states cannot, because of ERISA, directly regulate self-insured plans.

**States may consider requiring all insurance sales in the individual and small-group market to be made through the exchange?**

The states should take steps, therefore, to counteract adverse selection against the exchange. One approach the states could take to this problem would be to ban the sale of insurance in the individual and small-group market altogether outside the exchange. Doing so would not only solve the problem of adverse selection against the exchange, but would also greatly simplify the administration of the risk-adjustment program established by section 1343 (which applies inside and outside the exchange) and of other regulatory requirements imposed by the ACA.<sup>34</sup>

ACA section 1312(d) stipulates that “nothing in this Act shall be construed to prohibit” insurers from offering or individuals or employers from enrolling in plans outside the exchange. In other words, the ACA itself does not authorize the federal government to eliminate the outside market. States could, however, independently prohibit the sale of insurance to individuals and small groups outside the exchange. Section 1555 bars a requirement that insurers, individuals, or groups participate in a “federal health insurance program,” but the term is nowhere defined in the statute and would seem to apply to Medicare, Medicaid, or CHIP, or possibly to the multistate program under 1334, rather than to the exchanges. There is, therefore, nothing in the statute that would prohibit the states, as opposed to the federal government, from eliminating the outside market.

One issue that eliminating the outside market would raise would be coverage for undocumented aliens. The statute prohibits unlawful aliens from purchasing insurance through the exchange.<sup>35</sup> If the external market were eliminated, therefore, undocumented aliens would lack access to health insurance.

The significance of this problem is unclear.<sup>36</sup> In 2008, 7.7 million noncitizens obtained health insurance through their employment.<sup>37</sup> However, the documentation required to prove legal status when applying for employment is essentially the same as that required to enroll in the exchange under the ACA, so presumably those employees could participate in the exchange if their employers offered exchange coverage. About 1 million noncitizens purchased individual health insurance in 2008.<sup>38</sup> Presumably,

most of those individuals were in the United States legally, but there is probably no way of knowing.

Like anyone else, undocumented aliens must be screened and stabilized in emergencies by emergency departments under the Emergency Medical Treatment and Active Labor Act, so they at least have access to emergency care.<sup>39</sup> States can also cover emergency care for aliens under their Medicaid programs.<sup>40</sup> And they can subsidize uncompensated emergency care provided to undocumented aliens by hospitals, as the federal government did under a program from 2005 to 2009.<sup>41</sup> Community health centers, which will receive substantial additional funding under the ACA, serve the more routine health care needs of eligible individuals regardless of their immigration status. It may, therefore, be unnecessary for all states to preserve an outside insurance market solely to make insurance available to undocumented aliens, although the need for this market will differ from state to state.

Another consideration in determining whether or not to eliminate the outside market would be whether a state's constitution might bar it from doing so if the exchange engaged in selective contracting. As discussed at length in a previous paper, although insurance has traditionally been a heavily regulated industry—and federal and state courts have upheld a wide range of regulatory interventions in insurance markets, including restrictions on insurer participation in those markets—the total barring of insurers from a market based on selective contracting might raise constitutional issues, particularly under the constitutions of certain states.<sup>42</sup> States that allowed individual and small-group health insurance to be sold only through the exchange might therefore be restricted in their ability to engage in selective contracting within the exchange.

### **States could regulate the individual and small-group market identically inside and outside the exchange?**

Many states will probably find it impossible, either politically or practically, to eliminate the outside market. As an alternative, states could require plans outside the exchange to comply with the same regulations imposed on plans within the exchange.<sup>43</sup> As already noted, most of the requirements the ACA imposes on insurers apply to those both inside and outside the exchange. Section 1311, however, lists a number of additional requirements that must be met by all qualified health plans certified to participate within the exchange but not necessarily by nonparticipating plans. They include requirements that certified plans must:

- comply with requirements that prohibit marketing practices and benefit designs that discourage high-risk enrollees;

- include a sufficient number of in-network providers and supply information on the availability of providers in and out of network;
- include essential community providers that serve low-income, medically underserved individuals;
- be accredited on the basis of HEDIS data and CAHPS patient-experience surveys by an accreditation agency recognized by HHS;
- implement a quality-improvement strategy;<sup>44</sup>
- use a uniform enrollment form;
- use the standard benefit form for presenting health benefit options;
- provide information to enrollees and prospective enrollees on quality measures of performance;
- implement activities to reduce health and health care disparities; and
- report pediatric quality measures.

These requirements should also be applied generally to plans outside the exchange to ensure a level playing field and to discourage those plans from offering lower cost and lower quality. Most importantly, the same marketing and benefit design provisions should apply both within and outside the exchange to deter non-exchange plans from marketing their plans or structuring their benefits to attract better risk. Insurers outside the exchange should also be required to offer the same products that must be offered inside the exchange, including gold- and silver-level plans. Indeed, insurers both inside and outside the exchange could be required to offer all four precious-metal tiers, plus the catastrophic plan.<sup>45</sup> Outside insurers should be barred from offering only bronze and catastrophic plans, which could be used to attract disproportionate numbers of healthy applicants. If plans standardize benefit or cost-sharing packages inside the exchange (see below), the same standardization should apply outside the exchange. States should also ensure that plan pricing rules are the same inside and outside the exchange.<sup>46</sup> Insurers should further be barred from offering plans at different prices through affiliates inside and outside the exchange as a means of segregating good from bad risks. States that have entered into an interstate compact (permitted under ACA section 1333) should require plans to sell interstate policies only through the exchange, as plans sold by insurers licensed out of state present a special danger of risk selection.<sup>47</sup> To discourage brokers from steering business away from the exchange (an issue discussed further below), states should also attempt to maintain comparability between the commissions paid brokers inside and outside the exchange.<sup>48</sup>

Several of the additional requirements imposed on exchange-based plans, such as those relating to marketing and network adequacy requirements or requiring accreditation, are already addressed by state law in many states. Thirty-seven states, for example, already recognize health plan accreditation in some way while several require health plans to be accredited for licensure.<sup>49</sup> In states where accreditation is not already required, however, it might be wise to phase this requirement in over time as the accreditation process can take some time. Regulation of broker and agent commissions inside or outside the exchange is also likely to prove particularly contentious. States may face barriers, therefore, in eliminating all differences between markets inside and outside of the exchange, although this should be the goal.

Finally, insurance regulators must monitor grandfathered plans carefully to make sure that they are not “lemon dropping,” that is, encouraging high-cost enrollees to move to the exchange. Grandfathering existing plans was necessary to fulfill the president’s promise that “if you like your health care plan, you can keep your health care plan,” but poses a serious threat of risk selection against the exchanges. Nothing in the ACA prohibits the states from imposing on grandfathered plans requirements of the ACA that are only applied by the ACA to non-grandfathered plans. If states do not themselves impose these requirements on grandfathered plans, low-risk enrollees will face a great temptation to keep their grandfathered plans while high-risk enrollees will opt for the exchange. State insurance regulators should use their market-conduct regulatory authority to dissuade plans from encouraging this.

### **Adverse Selection and the Federal Exchange**

Coordination of the market inside and outside the exchange to avoid adverse selection will be particularly problematic in states in which the federal government operates the exchange because the state either has declined to do so or has failed to establish an exchange itself. Adverse selection will be an additional threat in those states because the federal government will have little regulatory authority over the outside market. It is possible that some state governments will even refuse to impose or fail to enforce the basic insurance regulatory requirements of the ACA, or will opt not to establish risk-adjustment and reinsurance programs. The ACA authorizes the federal government to directly enforce the ACA and to establish reinsurance and risk-adjustment programs under such circumstances.<sup>50</sup> Because it does not otherwise have supervisory authority over the outside market, however, the federal government will face challenges in implementing a risk-adjustment system outside the exchange.

Given that risk adjustment will be virtually the only leverage that HHS has over the outside market to combat adverse selection, it should begin as soon as possible designing an effective and powerful risk-adjustment system to protect the federal exchange against adverse selection. It should also move quickly so that states that are considering the possibility of having the federal government operate the exchange will understand how it proposes to address risk adjustment.

### **Adverse Selection Within the Exchange**

Another significant risk that must be considered in designing exchanges is that of adverse selection among insurers within the exchange. There is considerable evidence that higher-risk enrollees (older enrollees and enrollees with health problems) will not be evenly distributed among all types of health plans within the exchange. Higher-risk enrollees have traditionally tended to prefer PPOs with large networks as opposed to HMOs with tighter networks.<sup>51</sup> Enrollees with serious chronic illnesses want access to a wide range of specialists and treatments. Higher-risk enrollees also prefer plans with lower cost-sharing obligations.<sup>52</sup> Finally, higher-risk enrollees are less likely to elect to leave more-expensive for less-expensive plans during open-enrollment periods, particularly if they have an established relationship with a particular provider or professional who is only available through their current plan.<sup>53</sup>

Particular features of the ACA make the problem more acute. The ACA prohibits health plans from charging individual enrollees higher premiums on the basis of health status.<sup>54</sup> A health plan will nevertheless have to set its premiums to cover its costs, therefore health insurance issuers with unhealthier enrollees will have to raise their premiums for all members, driving away healthier enrollees. Moreover, in all plans, issuers must treat all individual and all small-group enrollees, respectively, as members of single risk pools (or as members of a combined risk pool if the state elects to combine individual and small-group pools), so adverse selection against a plan could raise the premiums for all plans offered by a particular insurer.<sup>55</sup>

The problems of risk selection both against and within the exchange are supposed to be addressed by the ACA reinsurance and risk-adjustment programs.<sup>56</sup> For the years 2014 through 2016, exactions will be collected from health insurance issuers and group health plans and paid to reinsured high-risk individuals.<sup>57</sup> This program will address risk selection only in the individual and not in the small-group market, and lasts only three years.<sup>58</sup>

In the long run, therefore, the key to protecting the exchange against adverse selection, and to retaining a range of products within the exchange that will appeal to different populations, will be the ACA's permanent risk-adjustment program.<sup>59</sup> The program is designed to move funds from health plans and insurers with lower-actuarial-risk enrollees to plans and insurers with higher-actuarial-risk enrollees. The risk-adjustment program applies inside and outside the exchange, to both the individual and the small-group market, although not to self-insured or grandfathered plans. Health insurance plans will still vary in cost according to the richness of their coverage, but the risk-adjustment program should diminish the degree to which the premium and tier placement of a plan is linked to the risk profile of its population.

Devising a sufficiently sophisticated and effective, yet practically operable, risk-adjustment system in order to implement the ACA poses a formidable challenge.<sup>60</sup> Risk adjustment cannot simply be based on demographic data, but must also take into account health status information. Demographic risk adjustment in Switzerland has done little to combat risk selection among plans.<sup>61</sup> Medicare has developed an increasingly sophisticated risk-adjustment methodology for adjusting payments to Medicare Advantage and Part D because of the limitations of earlier risk-adjustment systems, which were based on demographic data. But states may have a difficult time collecting the range of data that Medicare can collect to adjust for risk, particularly for plans outside the exchange. Insurers may in particular have a hard time assembling data to assess risk for short-term enrollees, who will likely be common in the individual exchange market as many individuals will be insured through the exchange only briefly between jobs or in transition between exchange coverage and Medicaid. HHS should develop as soon as possible a risk-adjustment system that is sufficiently sophisticated to address these issues.

HHS and the states should consider prospective as well as retrospective risk adjustment. Section 1343 applies risk adjustment to the experience of "a year" and does not clearly stipulate that risk adjustment must be retrospective. The Utah Health Exchange applies risk adjustment prospectively. Prospective risk adjustment could have the benefit of reducing the barrier to new insurers entering a market because they could be assured prospectively of higher payments if they attracted a higher-risk population.

Finally, risk selection is a dynamic game. The capacity must exist for a rapid and flexible response. State enabling exchange legislation must task the exchange with continually and actively monitoring the insurance market to detect signs of adverse selection. It must also establish close coordination between the exchange and the entity

responsible for risk adjustment to ensure an effective response to risk selection when it occurs.

### **Recommendations**

To the extent possible, state regulation of the individual and small-group market outside the exchange should be identical to corresponding regulation inside the exchange. Some states may be able to eliminate the market outside the exchange. HHS should design a sophisticated but practical risk-adjustment system that states can use to discourage adverse selection against and within the exchange among participating and nonparticipating insurers.

## **EXCHANGES AND LARGE-GROUP AND SELF-INSURED PLANS**

### **The Need to Expand the Exchange**

The greatest potential threat that exchanges face from adverse selection is that posed by self-insured plans. ACA section 1321 requires that the states (or the federal government in non-electing states) establish Small Business Health Options Program (SHOP) exchanges through which “qualified employers” can offer health insurance to their employees. Under section 1304, qualified employers are small employers with up to 100 employees, although a state may limit exchange participation to employers with 50 or fewer employees prior to 2016. States currently define small employers as employers with 50 or fewer employees and many are likely to continue to do so.<sup>62</sup> Beginning in 2017, states may open the exchanges even more widely, expanding them to include employment-related groups of 100 or more.<sup>63</sup>[

It is generally believed that exchanges should enroll as many participants as possible. Indeed, small enrollments have proved a primary barrier to success for earlier exchange efforts. Too small a participant pool is problematic for several reasons:

1. If an exchange can offer insurers only a small number of enrollees, the exchange is unlikely to attract enough health insurance plans to provide its members with a range of choices and to generate robust competition. An exchange must offer insurers a market sufficiently large that it cannot be ignored.
2. Exchanges must have enough enrollees to create economies of scale and thereby reduce administrative costs. Exchanges will have fixed expenses such as personnel, IT, publication, legal, and audit costs, as well as rent and utilities. Spreading those expenses over a larger population will reduce the costs imposed on each participant.



3. Insurers are unlikely to market through an exchange unless they can be assured that they will have enough enrollees to create a credible insurance risk pool. Small insurance pools are volatile and susceptible to destabilization by large claims, and are thus problematic for insurers.
4. Exchanges must be able to offer a large enough group of enrollees to permit an insurer to obtain favorable discounts from providers. Virtually all health insurance plans today are network plans, and providers do not offer insurers generous discounts unless they believe that the insurer can deliver a significant share of an insurance market. Unless an exchange has a large pool of enrollees, it will not be able to offer enough customers to any one insurer for that insurer to negotiate favorable provider rates.

An obvious strategy for enlarging the pool of exchange participants is to accept the ACA default definition of small employer as 100 employees rather than to reduce it to 50, and to open the exchange as soon as possible to large employers. Unfortunately, this strategy makes the exchange even more vulnerable to adverse selection.

### **Categories of Employers**

To understand the reason for this vulnerability, it is important to realize that there are in fact four, not two, categories of employers under the ACA—small employers, large employers, grandfathered employers, and self-insured employers. There are also potentially five employer insurance markets—the exchange market, the small-group market outside the exchange, the large-group market outside the exchange, the grandfathered market, and the self-insured market.

As already noted, the small employer market is subject to many of the same regulatory requirements inside and outside the exchange. Indeed, many of the ACA insurance reforms (including some of the 2010 and 2014 reforms) apply to all non-grandfathered group health plans—large or small, in or out of the exchange, insured or self-insured. Some very important provisions do not, however, apply to large groups and self-insured plans. Most significantly, the essential benefit requirements apply only to individual and small-group plans (and to plans purchased by large employers in the exchange), not to large-group plans.<sup>64</sup> Large-group plans do not have to provide the listed essential benefits and are not limited by the precious-metal tier requirements. The requirement of a single risk pool, in and out of the exchange, also applies only to individual and small-group plans, not to large-group plans.<sup>65</sup> The risk-adjustment mechanism established by 1343 also does not apply to the large-group market. Finally, section 2701, which limits underwriting criteria to age, tobacco use, individual or family,

and geographic area, only applies in the individual and small-group market (although it applies to the large-group market generally if large-group plans are included in the exchange).

If a state opens up its exchange to large employers, large groups that participate in the exchange must purchase qualified health plans, i.e., the plans that they purchase for or make available to their employees must comply with all qualified health plan requirements, including the essential benefits requirements.<sup>66</sup> It is therefore very possible—indeed likely—that large groups participating in the exchange would offer their enrollees more generous benefits than some large groups that did not participate (although the essential benefit package is supposed to be actuarially equivalent to a typical employment-based plan).<sup>67</sup> Because insurers of large groups do not need to include their large-group members in a single risk pool with exchange participants and do not need to adjust risk between their large-group and exchange plans, it is very possible—indeed likely—that risk selection would occur against the exchange if large groups are allowed to participate. Healthy groups may remain outside the exchange, where leaner benefits are available; unhealthy groups will turn to the exchange for a more generous benefit package or for lower-than-experience-rated premiums.<sup>68</sup>

Grandfathered employment-related group health plans are subject to an even shorter list of ACA provisions. The only provisions that apply to them are the prohibitions on excessive waiting periods, rescissions, lifetime limits, and preexisting condition exclusions, as well as restrictions on annual limits and required coverage for adult children. The grandfathering provisions will undoubtedly result in some adverse selection against the exchange. Grandfathered groups under 100 are likely to remain outside the exchange as long as their experience is favorable and premiums are low, but will probably abandon their grandfathered status and turn to the exchange if their premiums rise above those offered in the exchange. The grandfather regulations will limit the ability of plans to remain outside the exchange, as significant increases in cost-sharing or in the employee's premium share will result in loss of grandfathered status, but it is likely that plans with healthy employees could remain grandfathered for longer periods.<sup>69</sup>

### **The Problem of Self-Insured Plans**

Most problematic for the exchanges will be self-insured plans. Like large-group plans, self-insured group plans are also not subject to the risk-adjustment requirements of section 1343, the risk-pooling requirements, or the essential benefit requirements.<sup>70</sup> They also are not subject to the minimum loss-ratio requirements, although the self-insured do

not technically have loss ratios since they are not insured by insurance companies. Although most self-insured plans are large-group plans, there is no legal reason why a small-group plan could not self-insure, so self-insured plans threaten both the large and small-group exchange market. Indeed, 4 percent of businesses with fewer than 50 employees, including 12 percent of employees of such businesses, are currently in self-insured plans.<sup>71</sup>

Self-insured plans are particularly problematic for exchanges because they are not subject to state regulation. Section 514(a) of ERISA supersedes state laws that “relate to” employee benefit plans. Section 514(b)(2)(A) saves from preemption state laws that regulate insurance, but section 514(b)(2)(B) provides that employee benefit plans shall not be deemed to be insurance companies.<sup>72</sup> The Supreme Court has interpreted this clause to exempt self-insured plans entirely from state regulation.<sup>73</sup>

Although the ACA uses the term “self-insured” in a number of provisions, nowhere does it define it. The term is also not defined in the Public Health Services Act or in ERISA. The term “self-insured medical reimbursement plan” is defined in the Internal Revenue Code (which prohibits self-insured plans from discriminating in favor of highly compensated employees) to mean “a plan of an employer to reimburse employees for [medical] expenses . . . for which reimbursement is not provided under a policy of accident and health insurance.”<sup>74</sup> Federal regulations implementing this provision clarify that a plan is not self-insured simply because it is experience-rated, but that an employer does not lose self-insured status simply because the plan is administered by an insurer, if risk is not transferred to the insurer.<sup>75</sup>

Federal court cases interpreting ERISA have held that self-insured plans do not lose their self-insured status simply because the plans have stop-loss coverage.<sup>76</sup> Moreover, some federal courts have held that states may not define self-insured status by setting a minimum attachment point for stop-loss coverage or otherwise regulate stop-loss coverage.<sup>77</sup> Both the Department of Labor and the courts, however, have recognized that stop-loss coverage with very low attachment points can make self-insured status a sham, although the limits are far from clear.<sup>78</sup> Insurers are selling “self-insured plans” to employee groups with as few as 10 members, and the prevalence of those plans may greatly increase as 2014, the effective date of the essential benefit coverage requirement, approaches and small-group plans seek to evade this requirement.

The threat to exchanges is obvious. If small businesses with healthy employees can remain “self-insured” until the health of their pool deteriorates and then join the

exchange, premiums within the exchange will increase and the exchange will become less viable. If a state opens its exchange to groups above 100, the threat is even greater, as legitimate self-insured plans will seek to insure their employees through the exchange when their experience deteriorates. Moreover, the self-insured plans that have proven most adept at providing high-quality benefits to their employees at low cost (which exist at many large firms) are likely to remain independent of the exchange, while less-successful self-insured plans turn to the exchange for coverage.

### **Solutions to the Self-Insured Plan Problem**

An obvious solution to the problem would be for the Department of Labor to issue a regulation defining how much risk an employee health benefit plan must carry to be a legitimate self-insured plan. The DOL could do so under its inherent authority to administer ERISA, and should do so now because the ACA makes it even more imperative that a valid distinction be drawn between legitimate and illegitimate self-insured plans. Department of Labor regulations define “employee welfare benefit plan,” and could also define “self-insured” plan.<sup>79</sup> The DOL concluded in advisory opinion 2003-03A that an insurance company that purported to offer 100 percent reinsurance coverage to “self-insured” ERISA plans was in fact an insurance company insuring an insured plan, and was subject to state regulation. The DOL should define self-insured plan so as to permit employers to self-insure only if they can legitimately bear a substantial share of the risk of an employee health benefit plan—that is, employers with a strong balance sheet and cash reserves. Employers with fewer than 100 members would probably not qualify.

Alternatively, a revised rule could raise stop-loss attachment limits to the level of the National Association of Insurance Commissioners (NAIC) model stop-loss coverage law, adjusted for inflation in health care costs since the NAIC model was last amended in 1999, to ensure that what is called stop-loss insurance is not, in fact, direct insurance.<sup>80</sup> In any event, the DOL should cooperate closely with the exchange and with state insurance commissioners to combat risk selection against the exchange.

Another approach would be for the Department of the Treasury to amend its regulations implementing the provision barring discrimination in favor of highly compensated employees to limit the definition of self-insured plans to plans that are truly self-insured. Section 2716 of the Public Health Service Act (PHSA), created by section 1001 of the ACA, extends the nondiscrimination provision to insured group plans as well, so the Treasury Department will have to draft new regulations in this area. It could use

the opportunity to revisit its earlier self-insured plan regulations. Congress could, of course, clarify the regulations as well through a technical corrections bill for the ACA.

What can the states or exchanges do to deal with the issues raised by grandfathered, large-group, and self-insured plans? One approach is to deal with the problem indirectly, by requiring state and local government plans to purchase insurance through the exchange. Prior to 2017, a state could establish a state and local government exchange parallel to the ACA exchange and require all plans that are offered in one exchange to be offered also in the other. Beginning in 2017, the exchanges could be combined. Doing so would create a large pool of exchange participants, partially offsetting the effects of adverse selection against the exchange by allowing other large groups to join.<sup>81</sup>

A state could address the problem of adverse selection by large groups and grandfathered groups by extending any regulations that apply to plans within the exchange to insurers that cover any other groups eligible for participating in the exchange, including grandfathered plans. Then, if the exchange were opened up to groups of up to 250 or 500, the state could extend the ACA's essential benefit, risk-pooling, risk-adjustment, qualified health plan, and other requirements imposed on plans within the exchange to all insurers covering groups of up to 250 or 500 as a matter of state law. These solutions, of course, would not address the problem of self-insured plans.

Indeed, it will be very difficult for a state to address the self-insured plan problem. States will not be able to experience-rate large employers once they are admitted into the exchange, as only the rating factors permitted by section 2704 may be used. It might be possible, however, for a state to limit in other ways the ability of self-insured plans to select adversely against the exchange. A state could certainly permit an employer to switch to exchange coverage only during an open-enrollment period, avoiding the most exploitative form of adverse selection.<sup>82</sup> It could also require plans that enter the exchange to remain for a fixed period of time, or face a waiting period if they tried to return after leaving prematurely.

Beyond this, it may be possible for an exchange to impose a surcharge on employers who do not enroll in the exchange at their first opportunity to do so—that is, if the employer does not enroll when the exchange is first available to employers of its size, or if the employer does not exist or does not offer health insurance at that point (effectively how Medicare Part D discourages adverse selection).<sup>83</sup> Such a surcharge may be barred as an impermissible rating factor under 2701, but arguably it is not a rating

factor but rather a late fee. If such a surcharge were to be imposed, it would have to be carefully calibrated to avoid effectively barring large plans from the exchange.

### **Recommendations**

The Departments of Labor and of the Treasury should define “self-insured” status to clarify that only employers who are capable of bearing, and do in fact bear, the substantial risk of the cost of health care for their group may qualify as self-insured. States should consider extending the requirements of the Affordable Care Act to large plans and to grandfathered plans that qualify for exchange coverage. Finally, states should consider imposing a surcharge on large employers or self-insured plans that elect to purchase health insurance through the exchange after bypassing an opportunity to do so when the exchange first became available.

## **MAKING EXCHANGES WORK FOR EMPLOYERS**

### **Exchanges Must Be Attractive to Employers**

The ACA makes the assumption that our employment-based health insurance system is working reasonably well, and should be preserved and expanded rather than replaced. While the discussion of exchanges (including this report) focuses largely on how the exchanges should serve individual consumers, the relationship between insurers and employers and employee groups is at least as important.

Exchanges are required under section 1311(d)(2)(A) to make qualified health plans available to qualified employers. Indeed, the ACA requires states to provide “for the establishment of a Small Business Health Options Program (in this title referred to as a ‘SHOP Exchange’) that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small-group market in the State.”<sup>84</sup>

For exchanges to succeed, they must be attractive to small employers. In most states, exchanges will need to enroll employees of small employers as well as individuals to reach a large enough pool of enrollees to overcome adverse selection issues, achieve administrative efficiencies, and create an attractive market for insurers. Exchanges must, therefore, actively market themselves to small employers and to brokers and agents who serve small employers. Exchanges should contract with navigators who are known and trusted by small businesses and their owners, and should do so well in advance of January 1, 2014, so that the exchanges will have small employers ready to join as soon as they open. Exchanges must be capable of relieving small employers of responsibility for basic benefit management services, like online enrollment, automated billing and collection,

electronic disbursements and reconciliation, the handling of employee additions and removals and plan selection, and other related functions.<sup>85</sup> They should also be able to assist employers in applying for the small business tax credit and to assist with the management of COBRA continuation coverage, 125 cafeteria plan, health savings or reimbursement accounts, flexible spending arrangements, and wellness programs.

### **What Insurance Options May Exchanges Offer Employers?**

One important factor that will determine whether exchanges are successful in serving employers is going to be how exchanges make qualified health plans available to employers. One model for providing health insurance to employees of qualified employers is described in section 1312(a)(2) of the ACA:

(A) A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

Elsewhere, however, the ACA seems to contemplate an alternative model. Section 1312(f)(2)(A) defines a qualified employer as

a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small-group market through an Exchange that offers qualified health plans.

Section 1312(f)(2)(B) permits exchanges beginning in 2017 to make coverage available to any

large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large-group market through the Exchange.

The ACA suggests the possibility, therefore, not just of an exchange marketing coverage selected by individual employees, but also of coverage under policies selected by small and perhaps eventually large employers.

The concept of the SHOP exchange was drawn from the SHOP bill introduced in 2009 and sponsored by Senators Durbin, Snowe, and Lincoln.<sup>86</sup> Their SHOP bill clearly included both options. Section 3105(b)(1) permitted employers to offer through the

SHOP program a group plan in which their employees would enroll, while section 3107(d)(7) permitted employee themselves to choose among participating plans in states with community rating. While the ACA does not incorporate the SHOP bill as such, it appears to include both models, albeit somewhat awkwardly.

How are group plans offered through the exchange supposed to be underwritten? Section 2701 governs premium rates under the ACA. Section 2701(a) provides, “With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small-group market,” premiums may vary only according to type of coverage (individual or family), geographic rating area, age, and tobacco use. Section 2701(a)(5) further provides that if the exchange is opened to large groups, the same underwriting rules must apply to all groups. The fact that section 2701 explicitly applies to small-group (and eventually large-group) as well as individual premiums suggests that groups, including groups participating in the exchange, can be underwritten on a group basis, considering the age, type of coverage, tobacco use, and geographic location of each group as a whole, allowing a participating employer to pay a single premium rate for an entire group. Again, this is consistent with the SHOP bill, which allowed an employer to pay a community rate based on the age, geographic location, industry, tobacco use, and type of coverage of the group members.<sup>87</sup>

Allowing employers to pay a single premium for group insurance purchased through the exchange is an obvious approach to providing exchange coverage. But employee choice within a tier also seems to be an option. Under this option, it will not be possible for employers to pay a single group rate to a single insurer, because employees might well choose different insurers.

### **Rate-Setting Issues Under Employee Choice**

Under the employee choice option several questions arise. First, will each employee be separately underwritten based on the section 2701 factors? Since each employee can choose a different plan issued by a different insurer, leaving one insurer with older smokers and another with younger nonsmokers, it is difficult to see how individual underwriting by health plans can be avoided (except, of course, in states that require strict community rating).

Second, can the employer simply make a single payment to the exchange and have the exchange allocate it among all the insurers insuring employees? Direct payment of premiums to the exchange was a troublesome issue under the health reform legislation because the Congressional Budget Office’s May 2009 analysis that established the budget



rules for evaluating health reform legislation concluded that payments channeled to insurers through a national exchange would become federal revenues when paid in, and federal outlays when paid out.<sup>88</sup> The House health reform bill, therefore, which established a national exchange, provided for premium payments to be made directly to insurers to avoid increasing the cost of the legislation. The CBO was not clear on whether premiums paid to state exchanges would become federal revenues, but section 1312 of the ACA provides that individuals may pay premiums directly to insurers rather than pay through the exchange.<sup>89</sup>

With the enactment of the legislation into law, the CBO's judgment as to how premiums should be handled is no longer important, and whether or not direct payment is possible is simply a question of the language of the statute and of good public policy. As a practical matter, small employers simply will not write a separate check to each insurer, at least as long as group contracts are available outside of the exchange. It is essential for the exchanges to come up with a composite or list-billing approach if the small-group exchange idea is to succeed. An important role of the exchange will be to aggregate bills submitted by separate insurers for individual employees and to present a single bill to the employer. The original SHOP legislation expressly permitted employers to forward employee premium payments and their own contributions to the SHOP exchange, which would forward premium payments to health insurance issuers.<sup>90</sup> Nothing in the ACA prohibits this aggregated billing approach.

If the exchange could present employers with an aggregate bill, an employer could apply against this bill its own premium contribution and collect from individual employees their individual contributions to the premium. If the employer were eligible for the small-employer tax credit, the employer could also collect this credit and apply it against the premium. Employees could contribute pretax dollars toward their premium share through section 125 plans (which employers may use for insurance purchased through the exchange, but only if the employer itself contributes).<sup>91</sup> Employers might even be able to make a partial contribution for part-time employees, which could be complemented by payments from other part-time employers (as is done in Utah).

But must the employer make any particular contribution or make it in any particular way? An employer with 50 or more workers is subject to a penalty under the ACA if it fails to offer health insurance coverage to its employees, if its employees must pay more than 9.5 percent of their income for health insurance coverage, or if an employment-based plan fails to cover 60 percent of the total allowed cost of benefits under the plan and any employees receive premium assistance tax credits.<sup>92</sup> That is to

say, an employment-based plan must have an actuarial value of at least 60 percent, although there is no requirement that the employer contribute any particular share of the premium as long as the employee is not required to pay more than 9.5 percent of income. In order to obtain a small-employer tax credit, however, an employer with fewer than 25 employees must pay at least 50 percent of the premiums of its employees. Finally, the Age Discrimination in Employment Act regulations prohibit employers from requiring older employees to pay a higher percentage of health insurance premiums than younger employees.<sup>93</sup>

One safe course for an employer, therefore, would be to offer to pay a specific percentage of its employees' premiums. As premiums may differ dramatically along with the richness of the benefits offered above the essential benefits, an employer could cap its contribution at a fixed percentage of, for example, the cost of the median or second-lowest cost plan in the tier selected by each employee. The employer would not run afoul of the ADEA in doing so, since no employee would be required to pay a higher proportion of premiums than another because of age, even though premiums would continue to vary based on age, and older employees would pay a higher dollar (though not percentage) amount. The employer could also offer to pay a higher percentage of the premium for lower-income employees, as some do now.

From the perspective of older employees, however, this approach may be problematic. Although it has not heretofore been illegal to require higher premium contributions from older employees as long as they are not required to pay a higher proportion of the premium, most employers have traditionally not varied premium contributions based on age. If older employees are required to contribute three times as much as younger employees, there will be significant rate shock. Younger employees, on the other hand, who tend to earn less, may be pleasantly surprised. If the exchange presents an aggregated bill to the employer, there is nothing in the law that would prohibit an employer from allocating responsibility to employees in accordance with its own human resources policies, and an employer could continue to base employee premium responsibility strictly on the richness of benefits chosen by the employee and on whether the employee has individual or family coverage (and possibly on whether the employee uses tobacco or engages in wellness-incentive programs). As firms tend to be led by older employees, this option might be the most attractive. It could create a disincentive for firms to hire older employees, but as the ACA 1-to-3 age-rating ratio is probably lower than the actual difference in cost between younger and older employees, there should be less of a disincentive than now exists for self-insured or experience-rated groups.

## **Recommendations**

Exchanges should offer employers the option of an aggregated bill covering the premiums of all employees. The exchange should assume the task of allocating premiums among the various insurers and plans chosen by individual employees. Employers should be able either to pay a fixed percentage of the premium for a specified level of coverage, with the employee covering the remainder of the premium, or to charge employees a premium share based on category and richness of coverage and, if desired, on tobacco use and involvement in wellness-incentive programs. Employers could also offer greater support to lower-income employees.

## **THE REGULATORY ROLE OF EXCHANGES**

### **Certifying Qualified Health Plans**

The scope of the regulatory authority of exchanges is a potential source of significant controversy. The ACA permits the exchange to offer only “qualified health plans.” As already noted, qualified health plans must meet all of the regulatory requirements imposed by the ACA on health insurance issuers in the individual and group market, but must also meet additional requirements imposed by ACA sections 1301 and 1311(c), including marketing, network adequacy, accreditation, and quality-improvement requirements.

In addition, the exchange may certify plans for participation only if it “determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates.”<sup>94</sup> The ACA further provides that the exchange may not refuse to certify a plan because it is a fee-for-service plan, may not impose price controls, and may not exclude plans that provide excessive end-of-life care. Section 1311 also provides that exchanges must

require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their Web sites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange.<sup>95</sup>

### **The Exchange as Web Site or as Active Purchaser**

To comply with these provisions, exchanges will certainly have to ensure that health plans meet certification requirements, and will have to review premium increases

proposed by qualified plans. Beyond this, the certification requirement could be implemented in a variety of ways. At one extreme, exchanges could simply certify all plans that meet the minimum requirements of the statute and that have not been guilty of egregious and unjustified premium increases. This model is preferred by most of the insurance industry and by free-market advocacy groups. Under this model, the entire market could be within the exchange, although an outside market could be retained for nonqualified health plans.<sup>96</sup>

At the other extreme, exchanges could set very high certification standards and use their market share to drive down prices and drive up value. They could also use their certification authority to pursue other policy goals, such as requiring that exchange plans also participate in Medicaid. They could even require insurers to submit bids to participate in the exchange, and limit participation to the plans that made the most attractive bids in terms of price, value, and other important variables. Massachusetts has limited participation in the Commonwealth Choice branch of its exchange, while the Utah Health Exchange, New York's HealthPass, and the Connecticut Small Business Exchange offer a limited selection of health plans.<sup>97</sup> The Federal Employees Health Benefits Program (FEHBP) model is something of a hybrid, negotiating with plans that request participation, but taking a generally permissive and inclusive approach.<sup>98</sup> FEHBP includes a small number of national plans and a large number of local and regional plans. As noted above, under an exclusive model, an outside market would in all likelihood need to continue, as insurers banned from the exchange would otherwise be excluded from the market, raising the question of whether property had been taken by regulation without just compensation.

Determining which model is most appropriate for a particular state will probably turn on several variables. One is the size of the exchange. If the exchange is limited to individuals who receive the premium tax credit, with few self-payers and small-employer participants, it will be unattractive to insurers and will lack bargaining power. It will in all likelihood, despite all of the exchange's efforts, have a less attractive risk profile than the outside market and may have difficulty imposing more than minimum standards. Similarly, an exchange in a market dominated by three or fewer insurers (a common situation across the country in local markets) will have difficulty bargaining with insurers for above-minimum standards. It could potentially attempt a bilateral monopoly approach, designating one carrier as the only carrier allowed to offer insurance through the exchange in return for price or value concessions, but this would run counter to the basic concept of the exchange. Moreover, this approach would create serious problems going forward: Rates would need to be renegotiated each year, with the insurer

bargaining from a position of great strength as there would be no other carrier in the market to serve as a viable alternative.

Most insurance markets in the United States are highly concentrated.<sup>99</sup> One of the biggest challenges that exchanges will face in these markets will be attracting new insurers into the market. Dominant insurers in the market will have exacted price concessions from providers, but providers may well be reluctant to offer those concessions to new entrants with a tiny market share. Moreover, small “bottom-feeder” insurers who currently thrive in the market by picking off low-risk individuals or groups (often by offering high cost-sharing, limited-benefit plans) will probably disappear once they are required to meet statutory minimum loss ratios. The ACA bar on lifetime and annual limits will also eliminate many low-cost, low-value plans.<sup>100</sup> To succeed, exchanges will have to gauge how to attract new major national insurers into their markets and encourage the creation of local and regional integrated delivery systems and HMOs (which could include cooperatives established under section 1322 of the ACA).

If, on the other hand, an exchange successfully captures most of the individual and small-group market, exchange participation may prove very attractive to insurers, and the exchange may be able to reap some benefit in the form of lower premiums or better value from participating insurers, particularly in competitive markets. In this situation, it may be able to impose more demanding regulatory conditions, or may even be able to negotiate with plans or require competitive bids.<sup>101</sup> In order to do so, however, the exchange itself will, paradoxically, have to outperform the non-exchange market competitively in its retail operations. The exchange will be able to shape the market only to the extent that its customer service and pricing allow it to dominate the market. Moreover, even a strong exchange may initially want to admit most of the insurers in the market and then cull poor performers, rather than start with a few plans and risk being locked into those plans in later years.

### **Standardization of Plans Within the Exchange**

A related issue is how many plan variations should be offered through the exchange. Although the ACA requires all health plans available in the individual and small-group market to offer all essential benefits, and limits plan offerings to the four precious-metal tiers (plus, under limited circumstances, a catastrophic plan), it also permits plans to offer additional benefits and does not prescribe how cost-sharing must be configured to reach the actuarial value corresponding to the level.<sup>102</sup> Two silver plans could therefore offer two dramatically different benefit packages (beyond the essential benefits) with significantly different cost-sharing configurations and still have a 70 percent actuarial

value (although premium tax subsidies and cost-sharing reduction payments would be pegged to the second-lowest-cost silver plan). Standardizing plans by actuarial value will not necessarily, therefore, create a manageable menu of plan options.

There is considerable evidence that consumers neither want nor need unlimited choice in health insurance offerings. Consumers can be overwhelmed by too much choice, particularly when making complex, high-stakes decisions like buying health insurance.<sup>103</sup> A consumer faced with a dozen different silver plans offered by a dozen different insurers might well find it very difficult to identify the most appropriate, highest-value plan. Research shows that increasing options beyond a manageable level may increase consumer inertia or reliance on friends or relatives for advice and impede a rational search strategy.<sup>104</sup> Price disparity in Medicare prescription drug plans, where consumers face an overwhelming variety of choices, also indicates that increasing choice among plans does not facilitate price competition.<sup>105</sup> There is, moreover, evidence that older or less healthy plan members are less likely to switch plans than younger or healthier members;<sup>106</sup> so increasing plan choice may encourage adverse selection.<sup>107</sup>

Medicare Supplement policies were standardized in 1992 to facilitate consumer education and choice, a goal that was largely achieved.<sup>108</sup> The Massachusetts Connector and Connecticut Business and Industry Association's Health Connections exchange also offer a limited menu of standardized health plans to facilitate choice.<sup>109</sup>

The ACA requirement that all plans offer essential benefits and the division of health plans under the ACA into tiers based on actuarial value were evidently intended to structure choice and focus it on price and value. However, because the ACA places no restrictions on the offer of benefits beyond the essential benefits (other than the requirement that qualified health plans not employ benefit designs that discourage enrollment by individuals with significant health needs),<sup>110</sup> it is likely that exchanges that do not structure health plan offerings in some way will offer an unmanageably large number of plans, and that some insurers will use benefit design to select risk. These consequences will be counterbalanced somewhat by the Internet tools offered by the exchanges for facilitating plan selection and by agents and brokers, who will continue to help consumers choose appropriate plans. The plan quality ratings and satisfaction survey results offered by exchanges should also help guide plan selection.

In the end, however, exchanges should encourage or require health insurers to offer a limited menu of plan supplemental benefit, cost-sharing, and network options to encourage competition based on price and value. These options should not be allowed to

ossify. An opportunity should be offered annually for insurers to propose new standardized options for promoting similar goals. Existing options should also be reviewed periodically to cull plan designs that have proved unattractive to consumers or that do not offer value.

### **Recommendations**

Exchanges must use their certification power to ensure that health plans meet the statutory requirements for qualification and that plans do not impose unreasonable premium increases on their members. Legislation authorizing state exchanges should under no circumstances require exchanges to admit all insurers in the market, but should at least give exchanges the option of being an active purchaser. Exchanges should decide whether to take a more inclusive or exclusive approach to insurer participation based on the conditions in their own state and local markets. Exchanges should use their regulatory authority to lower prices and increase value to the extent that the competitive conditions in their markets allow. Exchanges should also standardize and limit the range of plan choices available within each tier to stimulate competition based on price and value.

## **EXCHANGES AS SOURCES OF DESCRIPTIVE AND EVALUATIVE INFORMATION**

The ACA contains a host of transparency and disclosure requirements that will significantly expand the amount of information available to insurance consumers. This information can be classified in two categories—descriptive information and evaluative information.

### **Descriptive Information**

The ACA requires exchanges to provide descriptive information, presented as an accessible and readily understandable summary of plan benefits and limitations.<sup>111</sup> The act requires the Secretary of Health and Human Services, in consultation with the National Association of Insurance Commissioners (NAIC) and others, to develop standards for compiling and providing a summary of benefit and coverage information. Beginning in 2012, these standards apply to all group health plans (including self-insured plans and grandfathered plans) and health insurance issuers, whether plans are sold inside or outside the exchanges. The NAIC process for advising HHS on establishing these standards and definitions is already underway. The new requirements will preempt any existing state standards that require less-thorough disclosure.<sup>112</sup>

Group health plans and insurance issuers are further required to report to HHS, and to enrollees, information describing their programs for improving health outcomes,

reducing hospital readmissions, implementing patient safety and error reduction programs, and promoting prevention and wellness. HHS is to post these reports on a Web site, but the information should also be made available through the exchanges.<sup>113</sup>

Exchange-based plans have additional reporting requirements. Exchange plans must provide information on the availability of in- and out-of-network providers.<sup>114</sup> Exchange plans are also required to provide information on cost-sharing for out-of-network coverage and on enrollees' and participants' rights, as well as additional information on cost-sharing with respect to specific services from specific providers if an enrollee requests it.<sup>115</sup> Qualified health plans should also be required to disclose their actuarial value.

### **Descriptive Information Should Be Legally Binding**

One troubling aspect of the ACA consumer disclosure requirements, which apply to all plans (including self-insured and grandfathered plans) and apply specifically to all plans offered through the exchange is the requirement that the summary of benefits and coverage contain

(H) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions.

Section 2715 states at the outset that the summary must “accurately describe” the benefits and coverage under a plan “so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage).” If insurers or group health plans are permitted, however, to include language in the policy or certificate of coverage that varies from or limits the representations made by the summary, the summary will be of diminished value to consumers, who will still be subject to “gotcha” clauses when they actually submit claims against their insurance.

The basic concept of the exchange is that it permits a consumer to compare the terms of a number of health plans and choose the plan that is most appropriate for that consumer's needs. If the summaries that appear on the exchange's Web site do not accurately reflect the terms of the plans, the issue of consumer choice becomes problematic.

A key question that must be addressed by HHS (and DOL and IRS) regulations or by state law, therefore, is the relationship between the statutory summary plan description and the underlying contract. The language of ACA section 2715 describing the summary of benefits is quite similar to that used by ERISA to describe the summary plan



description (SPD) that must be provided to ERISA plan participants and beneficiaries. Section 102 of ERISA<sup>116</sup> requires that the SPD include specific information describing the plan and that it “shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”

The question of whether the language of the ERISA SPD or that of the underlying contract governs when a conflict arises has been often litigated.<sup>117</sup> In general, the courts recognize that the terms of the SPD prevail over the language of the underlying contract when there is a conflict. This ruling is consistent both with the common law of contracts, which views insurance contracts as adhesion contracts and conveys any ambiguities strictly against the insurer under the doctrine of *contra proferentem*,<sup>118</sup> and with the underlying intention of Congress in enacting ERISA to protect plan participants. Different circuits, however, impose different requirements for enforcement, some simply enforcing the terms of the SPD if there is a conflict between the SPD and the contract and some requiring that the plan participant or beneficiary show reliance or prejudice. All will enforce the terms of the SPD if detrimental reliance can be shown. If the SPD is inherently contradictory or is silent on an issue addressed by the contract, courts generally hold that the plan participant cannot rely on the SPD, and the contract governs. If the contract contains terms more generous than the SPD, the contract also governs.

Of course, the ERISA SPD and the ACA summary of plan benefits and coverage are not the same, and the law governing SPDs would not necessarily be followed by courts resolving conflicts between the ACA summary and the underlying contract. But the language of the ACA is quite similar to that of ERISA, the intent of Congress underlying both laws is to protect consumers, and the ERISA cases are consistent with the common law of most states insofar as they attempt to protect consumer expectations in the face of adhesion contracts.

One significant difference between the ACA and ERISA, however, is the language in the ACA specifically directing the consumer to consult the coverage document for the contractual language. No such language is found in section 102 of ERISA, although ERISA does give participants the right to examine and get copies of plan documents, and this right must be disclosed in the SPD.<sup>119</sup> It is hard to believe that Congress intended by this language to render the summary of plan benefits legally meaningless, particularly since the ACA requires the summary to “accurately describe” plan benefits. Moreover, the entire concept of the exchange as a market where consumers

can compare health plans and choose the one that is most appropriate for them collapses if the plan summaries that are available to consumers through the exchange have no binding effect.

HHS should promulgate regulations that clarify that the ACA summary of coverage and benefits must accurately describe the actual coverage of the plan, and that if the terms disclosed in the ACA summary of coverage and benefits contradict or are limited by the terms of the underlying policy or certificate of coverage to the detriment or potential detriment of the insured, the terms of the summary prevail. The regulations should also provide that if the coverage summary does not address an issue that it must address under the governing disclosure regulations, the insurer or group health plan may not enforce a limitation found in the contract that should have been disclosed. If HHS fails to do so, states should adopt legislation to bring about this result. Alternatively, states or exchanges should simply draft contract language and require that insurers use it for each of their standardized plans.

### **Evaluative Information**

The ACA requires exchanges to provide not just descriptive but also evaluative information to help consumers distinguish among plans. While the descriptive information will help consumers decide which plan offers the configuration of benefits and limitations most appropriate for them, evaluative information will allow them to understand better the real value of the available plans.

Some of the information that consumers can use to evaluate plans will be provided by the plans themselves. Separate provisions of the ACA require insurers to post justifications for “unreasonable” premium increases and information regarding their medical loss ratios.<sup>120</sup> The forms insurers will use to report their medical loss ratios should be available through the exchange, so that consumers can see how much their insurers are paying respectively for claims, various types of quality expenses, and various administrative expenses, including brokerage commissions.

Health insurance issuers seeking to sell their policies through the exchange must provide information on claims payment policies and practices and financial information, as well as data on enrollment and disenrollment and on claims denials and rating practices.<sup>121</sup> A plan that has generous benefits and limited cost-sharing might look good on paper, but if it has high rates of claims denials and disenrollment or a low medical loss ratio, consumers might want to avoid it.

While it is important that this information be available to consumers, consumer advocates, and the media, most individual consumers are unlikely to sift through and weigh numerous disjointed measures. Instead, research (including focus groups) should be used to find a few consolidated measures that are creditable and useful to consumers. Those measures should be used for the rating system that HHS is required to develop for the exchanges. The system is intended to rate available plans in each benefit tier based on relative price and quality.<sup>122</sup> The rating system should at least consider information on:

- plan premiums (including maximum and minimum as well as average for each geographic area);
- plan performance on payment policies and practices, enrollments and disenrollments, claims denials, financial soundness, and high medical loss ratios;
- effectiveness of quality-incentive programs, and
- member satisfaction surveys.

These consolidated ratings must be credible and timely if they are to be used by consumers. Enrollee experience in highly rated plans must comport with the plans' rankings at the time of enrollment.

The ACA requires HHS to develop a survey system to evaluate the level of enrollee satisfaction for each qualified plan offered through the exchange that had more than 500 enrollees in the previous year.<sup>123</sup> Exchanges are supposed to make comparative consumer satisfaction information available to individuals and employers through a Web portal in a manner that allows easy comparison of plans.<sup>124</sup> Satisfaction surveys should both address all aspects of plan performance that are important to consumers and allow consumers to provide an overall assessment of satisfaction in order to facilitate easy comparison. Consumers should be able to view the aggregated results of the survey information in much the same way that they can view user ratings of "apps" on the Apple Store or books on Amazon.com. Both a compilation and a breakdown of the consumer ratings should be presented.

Additionally, survey information from particular subsets of policyholders should be given special attention. The experiences of enrollees who have serious conditions or have incurred large medical expenses are much more relevant in assessing a plan than the experiences of enrollees who have been relatively healthy. If all enrollees' responses are aggregated without giving these populations sufficient attention, then a plan might appear to have high satisfaction rates simply because it has relatively healthy policyholders. To limit that risk, survey participants should be asked to report voluntarily whether they have

used a significant amount of medical care while covered by the plan they are rating. Participants should also be asked if they have incurred significant medical debt, which might indicate unreasonable cost-sharing. Consumers should then also be presented with a separate set of aggregated ratings from only those consumers who self-report such expenses.

Finally, exchanges should not limit themselves to traditional satisfaction surveys. They should also permit consumers to offer evaluative information on the exchange Web site in conjunction with their ratings. Indeed, many Web sites that offer other consumer products and services incorporate such written consumer feedback into the tools that are available to shoppers.

The provision of evaluative as well as descriptive information will better enable consumers to choose the qualified health plan that is best for them. It will also provide a powerful incentive for health plans to compete with respect to plan value and customer satisfaction as well as price. Finally, it will inform public policymakers—Congress, HHS, and the states—as to the performance of insurers as the exchanges become a reality.

### **Information for Employers**

While the provisions of the ACA seem to be oriented toward providing information for consumers, it is vital to remember that the SHOP, or combined, exchanges will also serve employers. Those employers will, at least initially, be small employers, many of which will lack a human resources manager or, indeed, a more sophisticated ability to make plan choices than the average consumer. Employees have traditionally depended on their employers to choose health insurance plans, and many will continue to look to them for guidance.

Exchanges must, therefore, provide information directed at employers as well as at employees. It could be information about the exchange itself as well as about health plans. Exchanges should, for example, conduct employer satisfaction surveys to ensure that they are providing employers with the services they need, as well as to determine why some employers are choosing to remain outside the exchange. Exchanges will also need to work closely with agents and brokers, who will likely continue to advise employers, to ensure that they have the information they need to assist employers (and employees) in their choices.

### **Presentation of Information**

Exchanges should provide both descriptive and evaluative information using a format that allows consumers to view information on each plan individually and also to compare two or more plans side by side. Information should be presented in a conversational style using shorter sentences, and should avoid uncommon words, compound or hyphenated words, and the use of multiple terms meaning the same thing. The information most important to consumers should be presented first. The exchange Web site should permit consumers to calculate their subsidy eligibility and out-of-pocket costs by plan and to search plans by the names of network physicians and formulary drugs.<sup>125</sup> Much of the work on these reporting systems will be done by HHS in building its Web portal, and the exchanges are expected (but not required) to adopt and build on HHS's efforts.

### **Recommendations**

Exchanges should make information describing the benefits and limitations of available health insurance plans readily and easily accessible. To permit accurate selection among health plans through the exchange Internet portal, health plans should be contractually bound by information they disclose on their Web sites. Exchanges should develop rating systems that permit accurate comparison of the value of competing health plans, and satisfaction survey programs that pay particular attention to the opinions of plan members who have serious health problems or financial problems related to their health needs. When conducting their evaluations, exchanges should be attentive to the opinions of employers as well as individuals.

### **EXCHANGES AND PUBLIC SUBSIDY ELIGIBILITY DETERMINATIONS**

Many individuals and families who approach the exchange will need financial assistance to purchase health insurance. Medicaid eligibility expands dramatically under the ACA, with Medicaid assistance available for individuals and families with incomes up to 133 percent of poverty.<sup>126</sup> Children up to the age of 19, and in many states up to age 21, will be eligible for Medicaid or CHIP. In all but two states, children are eligible for CHIP if their families have incomes of 200 percent of poverty or less, with 22 states providing coverage above that level.<sup>127</sup> Individuals and families with incomes above Medicaid and CHIP eligibility levels but at 400 percent of poverty or less will be eligible for premium tax credits and cost-sharing reductions.<sup>128</sup> In some families, children will receive Medicaid or CHIP while the parents receive premium tax credits. States may also supplement the federal premium tax credits available through the exchange.<sup>129</sup>

A number of provisions of the ACA, found both in Title I, dealing with private insurance, and in Title II, governing Medicaid, establish clear principles for governing the eligibility process:

- There is no wrong door. Regardless of where an individual or family in need shows up, its application for assistance must be routed to the right program.
- The only information requested of the applicant should be what is necessary to establish eligibility. If possible, no paper need change hands; all information should be submitted electronically.
- At the applicant's request, and if it is available, data can be collected from existing data banks rather than supplied by the applicant.
- Data will be transmitted seamlessly and securely between responsible agencies (the exchange, state, and federal agencies).
- If inconsistencies in information are identified, the exchange should first try to resolve them; if it cannot, the applicant may be enrolled temporarily in the premium tax credit program for 90 days and be given an opportunity to resolve the problem.
- If eligibility cannot be verified, the applicant will have an opportunity to appeal to HHS for premium subsidies, to the state for Medicaid, or possibly to both.
- If eligible for a subsidy program, the applicant will be enrolled in the appropriate program. All personal data will be handled confidentially, and accessed only to the minimal extent necessary.

While these principles are made clear in the ACA, how they will work out in practice is much less so, for the following reasons:

- As will be explained below, provisions governing the taking and processing of applications are unclear and to some extent contradictory, in particular with respect to the coordination of premium tax credit and Medicaid applications.
- Although the ACA attempts to align financial eligibility requirements between premium tax credits and Medicaid, it seems to require eligibility for Medicaid to be determined at point of application, while eligibility for tax credits can be based on reported income from earlier tax returns. This anomaly may necessitate different information being collected for the two different programs.
- While the statute attempts to create a simple electronic application process, the presentation of paper documents will still be necessary, perhaps often, to establish immigration status for persons who are not citizens or nationals, to prove income

where income at the point of application is determinative, and to establish the scope of employer coverage.

- The 90-day interim eligibility benefit established by the statute may be difficult to apply in practice because of the uncertainty that will exist for both applicant and health plan during this period.
- The requirement of reconciliation of tax credits paid and actual financial eligibility for tax credits at the time a tax return is filed may leave enrollees vulnerable to significant financial liability and will inject uncertainty and instability into the entire eligibility process.

Each of these issues will be discussed below.

It is vitally important that the ACA vision of a seamless, coordinated, efficient, electronic system be implemented for processing applications for tax credits, cost-reduction subsidies, Medicaid, and CHIP if the exchanges—and the ACA itself—are to succeed. That success will require creative interpretation and application of certain provisions of the ACA that create barriers to implementation of an efficient eligibility system. It is equally important, if not more so, that the subsidy determination process not stand in the way of unsubsidized individuals. For millions of individuals who are not entitled to subsidies, the market outside the exchange will continue to be readily available. Those individuals must be able to avoid completely the subsidy application process if they choose to do so, or face only a minimally burdensome screening if they choose to apply, so that they do not face any impediments to purchasing insurance through the exchange rather than through the outside market.

### **The Application Form**

The ACA requires HHS to develop a “single, streamlined” form to be used for applications for premium tax credits, cost-sharing reductions, Medicaid, CHIP, and the state’s basic health program (if it has one).<sup>130</sup> A state may create its own single, streamlined form as long as it is consistent with the standards established by HHS. States must use the same form for premium tax credit, Medicaid, and CHIP eligibility, which will all base income eligibility on modified adjusted gross income.<sup>131</sup> The state may use supplemental forms for individuals whose Medicaid eligibility is not determined on the basis of modified adjusted gross income (e.g., those who are eligible for Medicaid because they are elderly or because they receive Supplemental Security Income). The form must be structured so as to allow the applicant to fill it out without undue difficulty.

In theory, no additional paperwork should be required of applicants unless a data inconsistency is discovered and the law requires additional verification.<sup>132</sup> Indeed, the process, as presented in the ACA, is to be designed so that the application is completed online through a secure electronic data interface using a single application form, without the need to present a single physical piece of paper.<sup>133</sup> In some situations, however, additional physical documentation will be needed, as discussed below. Whether the need for documentation becomes the exception or the rule remains to be seen.

Applications for assistance may be submitted online, in person, by mail, or by telephone.<sup>134</sup> Online applications, which the ACA envisions as the primary avenue for enrollment, can be completed at home, at points of service (such as hospitals), at churches or other community-based organizations, by navigators, or by brokers or agents.<sup>135</sup> Federal grants are supposed to be available to help states establish the capability for receiving and processing applications electronically, although the ACA itself does not appropriate funds for those grants.<sup>136</sup> Applications may be filed with the exchange or state agency operating Medicaid, CHIP, or other basic health programs,<sup>137</sup> but in most instances the law contemplates that the application will be submitted to a Web site rather than a physical location. The exchange can outsource the eligibility process for tax credits and subsidies to a state Medicaid agency.

Exchanges will need to develop a process for screening applicants and directing them to the appropriate program. Exchanges must also identify individuals who are eligible for Medicaid or CHIP, and the states must enroll them.<sup>138</sup> If individuals are determined not to be eligible for Medicaid or CHIP, they must be screened for premium tax credit and cost-sharing reduction eligibility and enrolled if eligible.<sup>139</sup> States must also coordinate benefits for families who have some family members enrolled in Medicaid and CHIP and others receiving insurance within the exchange through premium assistance.<sup>140</sup> There will certainly be families in which the parents are receiving premium tax credits through the exchange, but children are on CHIP. There may even be some families in the exchange receiving assistance from Medicaid. Although Medicaid cannot pay for individual insurance purchased through the exchange, it could provide premium assistance for employer coverage purchased through the exchange.<sup>141</sup> Coordination will be very important in these circumstances. In particular, it will be important that exchanges offer health plans that both participate in Medicaid and CHIP and accept premium tax credits so that people who switch from one to the other, or families that are split between programs can remain with the same plan and use the same providers.



### **Collection of Eligibility Information**

The ACA sets out the specific information that an applicant for assistance must provide when applying for exchange coverage, a premium tax credit, or cost-sharing subsidies. It also requires that Medicaid and CHIP applications be accepted online using the same form that is used for premium tax credit applications, that states enroll applicants who apply for Medicaid through the exchange without a further eligibility determination, and that the IRS provide the same information for verifying Medicaid and CHIP applications that it provides for verifying premium tax credit applications.<sup>142</sup> Under ordinary circumstances, therefore, the information required for Medicaid and CHIP applications will be the same as is required for premium tax credit applications, although eligibility for Medicaid will ordinarily be determined at the point of application while premium tax subsidy eligibility will often be based on income from earlier reporting periods, unless a change of circumstances has occurred.<sup>143</sup>

To apply for a premium subsidy, an applicant must provide the name, address, and date of birth of each individual to be covered.<sup>144</sup> Applicants must also provide their taxpayer ID, their filing status, the number of individuals for whom a dependent deduction is allowed, the modified adjusted gross income for the taxpayer and for each dependent who is required to file a return, and other information required by HHS.<sup>145</sup> If the applicant is a citizen, he or she must provide an attestation of citizenship and a social security number.<sup>146</sup> If the applicant is a legal immigrant, he or she must provide a social security number and identifying information as deemed appropriate by HHS and Homeland Security.<sup>147</sup> Documentation will most likely be necessary to establish legal immigrant status.<sup>148</sup>

Most (if not all) tax credit applicants will request an advance determination so that the credit can be applied to premiums as they become due. In this situation, the determination can be based on the most recent taxable year for which information is available if income has remained largely unchanged.<sup>149</sup> But an advance determination can also be made on the basis of other information for applicants who have experienced a major change in their personal circumstances. The statute explicitly refers to a decrease of 20 percent or more in income, a change in family size or other household circumstances or filing status, and a filing for unemployment benefits as examples of changed circumstances that would allow eligibility to be determined using income from a later period or an estimate of income for the taxable year for which advance credits are being claimed. HHS can also consider “other significant changes affecting eligibility.”<sup>150</sup> The law leaves HHS to decide whether to develop the procedures related to a “change in circumstance,” including documentation required from the applicant, but the single

application will have to accommodate the information needed to establish eligibility based on a change in circumstances.<sup>151</sup>

The ACA states that Medicaid (and CHIP) eligibility will be determined based on modified gross household income, just as with premium tax credits, but considering income at the point of application rather than during an earlier tax year.<sup>152</sup> Unless states allow current income to be established by self-attestation, a literal reading of the income-at-point-of-application provision will defeat the statute's key goal of enabling recognition of eligibility without paper documentation for the Medicaid expansion population.<sup>153</sup> To make sense of this provision in the context of the rest of the statute, HHS should interpret it to mean that eligibility for Medicaid can be determined based on the most recent data available through data matching (see below) as of the date of the application.<sup>154</sup> Of course, for certain non-expansion Medicaid applicants (e.g., the elderly, SSI applicants, individuals eligible for Medicare premium and cost-sharing subsidies, long-term care applicants), establishing eligibility will continue to be more complicated and additional information may be needed, although opportunities may exist to simplify applications for these populations as well.<sup>155</sup>

### **Documentation/Verification**

Once an application is completed, the ACA requires the exchange to forward the information included in the application to HHS.<sup>156</sup> The ACA requires HHS to request that the Social Security Administration verify citizenship status for applicants who attest that they are citizens and that the Department of Homeland Security verify green-card or visa status for those who attest they are lawful aliens.<sup>157</sup> HHS will also request that the Department of the Treasury verify financial information provided on the application.<sup>158</sup> Any other information on the application can be verified by the exchange or by HHS. All verifications will be performed electronically, so they should be instantaneous. The ACA does not envision that applicants will need paper documentation to support the financial eligibility information provided on the application, although, as noted above, paper documentation may be required for proof of current income for Medicaid applicants or for advance-determination applicants claiming change of circumstances, and will also likely be required for determining immigration status of persons who are not citizens or nationals. Once eligibility for a premium tax credit or cost-reduction subsidy is verified, HHS will notify the exchange and Treasury<sup>159</sup> and, if advance payments are requested, Treasury can begin making payments directly to the insurer.<sup>160</sup>

The ACA also permits applicants for Medicaid, CHIP, a state's basic health care program, or premium tax subsidies to authorize eligibility determinations based on data

matching.<sup>161</sup> The ACA requires the states to develop a data-matching system to verify eligibility for these programs.<sup>162</sup> Data-matching information may be disclosed to HHS, the exchange, and exchange contractors, but may only be used for establishing eligibility and must otherwise be kept confidential.<sup>163</sup> Additionally, HHS can permit applicants to request that the exchange obtain tax information directly from the Department of the Treasury as necessary to complete an application.<sup>164</sup> State data-matching systems must be consistent with the exchange verification system, so in practical terms those systems will need to be combined or coordinated with the system operated through HHS. Indeed, it is possible that HHS will delegate to the state-run exchanges the responsibility for determining eligibility so that they can instantaneously access both the federal and state systems. State data-matching programs could be based on contracting with:

- the Income and Eligibility Verification System (IEVS), which contains data from the IRS, the Social Security Administration, state quarterly wage records and new-hire data, and immigration data from the Homeland Security Systematic Alien Verification for Entitlements (SAVE) program<sup>165</sup>;
- the National Directory of New Hires (NDNH), which contains quarterly wage records and new-hire data<sup>166</sup>; and
- information described in SSA 1942(a) eligibility files, which contains information on public benefit programs, state income tax records, state records about private insurance coverage maintained for purposes of Medicaid third-party liability enforcement, and state vital statistics (births) information.

While data matching may become a useful tool for establishing eligibility, data banks often lag three to six months behind current facts, and will need to be considerably improved before they will routinely provide reliable point-of-application information.

### **Resolving Inconsistencies/Interim Enrollment**

If the verification process reveals an inconsistency involving citizenship or lawful status, HHS will notify the exchange, which must handle it in the same way as citizenship inconsistencies are handled under Medicaid.<sup>167</sup> That approach allows the exchange to enroll an applicant for up to 90 days while additional documentation is requested, but must disenroll the applicant within 30 days thereafter if an inconsistency cannot be resolved.<sup>168</sup>

If inconsistency is found in financial information, the exchange must make a reasonable effort to resolve it.<sup>169</sup> If it cannot, it must notify the applicant and give the applicant 90 days to resolve the problem. (The 90-day period can be extended by HHS

during 2014). During the 90-day period, the exchange must determine eligibility on the basis of the information provided by the applicant, but if the inconsistency is not resolved by the end of the 90-day period, the exchange must notify the applicant and eligibility must thereafter be determined based on the record.<sup>170</sup> The 90-day interim enrollment period provides important protection for applicants. Again, information in the data banks will often be outdated and, particularly where a change in circumstances is involved, additional documentation will be needed to establish eligibility. In situations involving changed circumstances, however, applicants will be in particular need of health insurance, and it is vital that they be able to enroll before eligibility is fully established.

Interim enrollment, however, will carry some risk. If an applicant is approved on an interim basis but is later found ineligible or eligible for a smaller subsidy, the applicant may need to repay some or all of the tax credit when reconciliation is applied (see below). If an employee applicant is approved because employee coverage is unavailable or inadequate (see below), but coverage is subsequently found to be available or adequate, the employee may need to repay all or part of the credit and may also be unable to opt back into employee coverage until the next open-enrollment period. An individual may enroll in a plan based on the results of an interim eligibility determination and then find that a less (or more) expensive plan may be appropriate once final eligibility is determined. Finally, it is possible that insurers may be reluctant to take enrollees with only interim approval. Short-term coverage, however, is likely to be common in the exchange, as the ACA allows enrollees to transfer from individual exchange coverage to employee coverage without penalty.<sup>171</sup> It is likely that many enrollees will be insured through the exchange only during short periods of unemployment. Insurers, therefore, are unlikely to refuse potentially short-term enrollments. Applicants should be advised of the risks of interim enrollment, but many will undoubtedly decide that the benefits outweigh the risks.

If, in the end, an application for a premium tax credit is denied, HHS must, in consultation with Homeland Security, the Social Security Administration, and Treasury, offer an appeal process.<sup>172</sup> The exchange must notify those who are denied subsidies of the availability of this process.<sup>173</sup>

### **Reconciliations**

The most problematic ACA provision for the operation of the premium tax credits is the requirement that advance payments of the tax credit be reconciled with the amount of the tax credit for which an individual is ultimately eligible at the time he or she files a tax return.<sup>174</sup> Eligibility for premium tax credits is formally calculated under the statute on a

month-by-month basis; that is, the annual credit is the sum of the amounts for which a taxpayer is eligible for each (or any) of the 12 months of a tax year.<sup>175</sup> To be eligible for a premium tax credit in any given month, a taxpayer or a member of his or her family must be financially eligible and must not be eligible for affordable and adequate employer-sponsored coverage (including coverage under a free-choice voucher or grandfathered plan) or for a public program such as Medicare, Medicaid, CHIP, TRICARE, or the Veterans Health Administration program. Premium tax credits cover the taxpayer and all persons whom the taxpayer claims as dependents for tax-filing purposes. Financial eligibility is based on the income of the taxpayer and of all persons in the taxpayer's household who are required to file a tax return.<sup>176</sup>

At the time the taxpayer files a return, the advance payments and the tax credit for which the taxpayer is eligible must be reconciled; that is, the amount of the tax credit must be reduced by the amount of advanced payments. If the taxpayer is entitled to more than was paid in the advance payment, the taxpayer will receive either a tax refund or a reduction in tax liability otherwise owed. Of course, the opposite is also possible; the advance payment may be an overpayment, as can happen in a number of scenarios. The taxpayer's income may fluctuate over the course of a year, making an initial determination of eligibility inaccurate. The ACA requires HHS to establish procedures by which it "redetermines eligibility on a periodic basis in appropriate circumstances," but continual redetermination by HHS is neither likely nor desirable, and it is inevitable that there will be some routine inconsistency between initial eligibility determinations and end-of-the year reconciliations.<sup>177</sup>

More problematic are instances where eligibility determinations were accurate for the months for which eligibility was determined, but total household income for the year is greater than the income on which an eligibility determination was based. If the taxpayer had a high income during the first part of the year and then experienced a dramatic reduction in income through job loss, for example, he or she may be eligible for a premium tax credit for the remaining months of the year because of a "change of circumstances" but still have a total income for the year above the eligibility level. Conversely, the taxpayer may be eligible for a premium tax credit in the early months of the year but then be hired for a high-paying job and earn enough that eligibility is reduced or eliminated for the entire year. Finally, if a family member ceases to be a dependent during the course of the year, eligibility may change as well because the family becomes smaller.

Section 36B(f)(2) provides that if total advance payments exceed the amount of the tax credit for which the taxpayer is ultimately determined to be eligible, the amount of the excess will be added to the tax otherwise due. For families with incomes below 400 percent of poverty, the recovery cannot exceed \$400 (\$250 for unmarried individuals), indexed for inflation, but for taxpayers whose income exceeds 400 percent of poverty, the statute evidently contemplates full recovery of the advance tax payments.

The fear of end-of-year liability could be a very substantial deterrent to participation in the advance premium tax credit program. Only 3 percent of those eligible for the earned income tax credit elect to receive advance payments, in large part because of concern about liability at end-of-year reconciliation.<sup>178</sup> The limit on recoveries is, of course, helpful, but many families who are fully eligible for the tax credit at some point during the year may end up with end-of-year modified adjusted gross income above 400 percent of poverty, and thus owe a full repayment of credits they received. Moreover, even \$400 is a substantial amount for a family with limited means, particularly if the family was in fact eligible for each month it received a subsidy.

Fortunately, section 36B(g) specifically authorizes the IRS to “prescribe such regulations as may be necessary” to implement the reconciliation provision. The IRS should use this authority to mitigate the most harmful effects of the reconciliation requirement. One step that the IRS should consider for taxpayers who did not knowingly misrepresent their income, and whose income at reconciliation exceeds 400 percent of poverty, is limiting repayment to only \$400 plus the amount (above \$400) attributable to subsidies received during months in which the applicant was actually not eligible for the subsidy. This step would mitigate the “cliff” approach of a strict application of the reconciliation provisions, under which an individual whose income equals 399 percent of poverty is at risk of at most a \$400 repayment, but an individual whose income equals 401 percent of poverty is liable for full repayment. A second possibility would be to excuse repayment from individuals who became eligible for a premium tax credit because of a change in circumstances midyear, but at the end of the year were ineligible or had reduced eligibility because of income earned before the change of circumstances. In the absence of such a provision, change-in-circumstances advance payments would simply be loans rather than actual tax credits for many recipients. The fact that section 36B(f)(3)(E) requires exchanges to provide the IRS with “any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit” suggests that a change in circumstances should be relevant to the determination of the final credit. A third possibility would be to limit all repayment liability to credits received for months in which the taxpayer was not in fact

eligible (or was entitled to lower advance credits than those actually received). This would be consistent with section 36B, which provides for credits on a per-month basis. None of these solutions squares strictly with the wording of section 36B(f), of course, but a strict and literal reading of section 36B(f) would effectively destroy much of the usefulness of the advance premium tax credit provisions.

Fortunately, no end-of-year reconciliation is necessary for cost-sharing reduction subsidies.

### **The Exchange and Individual and Employer Responsibility Requirements**

Individuals can also apply to the exchange for premium tax credits and cost-reduction subsidies based on the assertion that their employer does not provide minimum essential coverage or that coverage provided by the employer is unaffordable or inadequate. The latter circumstance exists when the employee must pay 9.5 percent of income for the premium or when the plan has an actuarial value below 60 percent.<sup>179</sup> When an applicant for a premium tax credit claims that this provision applies, the applicant must state or describe in the application:

- the name, address, and, if known, employer ID of the employer;
- whether or not the employee is full-time;
- the lowest-cost coverage option available to the employee through the employer and the amount of a required contribution for that option; and
- if a claim is made that the employee coverage is unaffordable, information as to family size and household income.<sup>180</sup>

A person receiving a premium subsidy on the basis of the employer's coverage being inadequate or unaffordable must notify the exchange if he or she subsequently changes employment or obtains additional employment. The recipient must also report any dependents who obtain new or additional employment with reportable income.<sup>181</sup> Reporting inadequate or unaffordable coverage is another instance in which paper documents may need to be submitted to substantiate eligibility.

If HHS determines that an employer does not provide insurance or that employer-provided insurance is unaffordable, it will notify the employer and notify the exchange, which must also notify the employer.<sup>182</sup> HHS must also establish an appeal process for employers who are found liable for a penalty because they do not provide health insurance or affordable health insurance.

Finally, an individual who applies for an exemption from the individual coverage mandate must provide the exchange with information on his or her status as a member of an exempt religious sect, a health care sharing ministry, or the Indian Health Service, or any information that is relevant to a claim for a hardship exemption. If the individual is claiming that coverage is unaffordable, he or she must provide information on household income and status.<sup>183</sup> If an inconsistency involving an application for a waiver of individual mandate liability cannot be resolved, the exchange must notify the applicant.<sup>184</sup>

### **Confidentiality and Penalties for False Information**

The ACA requires that eligibility information be kept confidential and used only for eligibility purposes.<sup>185</sup> Even when an employee claims that his or her employer is providing unaffordable insurance, the employer is entitled to know only the name of the employee and that the employee's income falls below the threshold.<sup>186</sup> The ACA establishes penalties for those who provide false information in the application process, either negligently or willfully, but contains a reasonable-cause exception and prohibits the use of levies or liens to collect the penalties.<sup>187</sup>

### **Recommendations**

Although the Affordable Care Act includes extensive provisions describing how eligibility for premium tax credits, cost-sharing reductions, Medicaid, and CHIP are to be determined, the allocation of responsibility for making such determinations remains unclear and contradictory. The statute should be implemented in such a way as to permit an individual to apply initially either to the exchange or to the state Medicaid agency. Either entity must then make certain that the individual is signed up for the appropriate program. The exchange and the Medicaid and CHIP programs should facilitate electronic applications without the need for paper documentation. Interim assistance should be readily available and effective in cases where eligibility cannot immediately be determined. The reconciliation requirements of the statute should be interpreted so as not to defeat the purpose of providing assistance to those who need it. Exchanges should see it as their responsibility to ensure the continued enrollment of eligible individuals and families for tax credits or public programs, rather than holding individuals responsible for continually having to work at maintaining their own eligibility.

## **ADMINISTRATIVE COSTS AND FUNDING OF THE EXCHANGE**

### **Funding the Exchange**

To be successful, exchanges must be able to offer insurance plans that provide at least as much value for money as insurance plans available in the non-exchange market. Because all plans offered by exchanges must be certified as qualified health plans, they are likely



to be of high quality. In the end, however, the premium charged by a plan will be a key factor in determining whether or not individuals and employers purchase insurance inside or outside the exchange, particularly for families and employers who are not eligible for the tax credit. Unless a state requires the market outside the exchange to abide by the same rules as qualified health plans inside the exchange, or unless the exchanges are extraordinarily sensitive about imposing extra costs on qualified health plans, plans inside the exchange may have to charge higher premiums than those outside.

Moreover, exchanges themselves will not be without cost. They are responsible for establishing eligibility for Medicaid and for premium tax credits, as described above. They are supposed 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>188</sup> Exchanges will have a substantial role in creating, collecting, managing, and distributing information and in rating participating plans.<sup>189</sup> The exchanges will also have regulatory responsibilities that will require resources.

The states will receive planning grants from the federal government to get underway, but must fully support the exchanges after 2014. Exchanges may also be able to apply for federal grants to develop new enrollment systems, either directly or through the states in which they operate.<sup>190</sup> The ACA further recognizes that exchanges may receive funding from external sources on an ongoing basis.<sup>191</sup> To the extent that the exchanges assist in processing applications for Medicaid and other state health programs, they should be reimbursed by the state, which in turn should be reimbursed by the federal government for the federal share of those administrative costs.<sup>192</sup> Beyond this reimbursement, however, it is unlikely that states will choose to subsidize exchanges. Although the ACA does not explicitly provide for federal funding of exchange activities related to establishing eligibility for federal premium tax credits, such funding could be treated as a cost of the federal premium tax credit program.

The ACA assumes, however, that most of the operational funding for exchanges will come from assessments on insurers, as it does for existing exchanges.<sup>193</sup> Currently, Massachusetts insurers pay the exchange an assessment of about 3 percent. The cost of the assessments insurers pay to exchanges will undoubtedly be passed on to consumers and employers. Alternatively, an exchange could assess a charge directly against the individuals and employers who use it, adding the charge to the cost of insurance premiums.

Alternative approaches to funding should also be considered. One would be a tax on all insurers in the health insurance market, including administrators of self-funded plans, to fund the exchanges. The tax would be justified by the fact that the current shifting of the cost of covering the uninsured from providers to insurers would be reduced by the presence of the exchange, as the exchange will cover many of the uninsured. The exchange will also expand insurance markets, benefiting all insurers. Another approach would be to assess a tax against providers to finance the exchange, again recognizing that they will have much smaller uncompensated care costs once the exchanges are in place.

### **Reducing Administrative Costs**

However exchanges are funded, they must be able to reduce the costs to insurers or to enrollees by at least enough to offset their own cost. For subsidized enrollees, exchange coverage will be attractive because they will not be faced with the full cost of the insurance. Most employers and many middle- and upper-income families will not receive subsidies, however, so exchanges will have to find alternative approaches to lowering costs to purchasers.

One approach would be simply to motivate insurers to offer premiums within the exchange that are lower than those available outside it by providing them with an exchange market large enough for competitive forces to drive down premiums. Alternatively, or additionally, insurers could reduce premiums if the exchange were able to lower their administrative costs, making it less expensive for insurers to offer coverage within the exchange than outside it (although it is likely that an insurer will simply spread any administrative savings—or additional administrative costs—experienced in the exchange over its entire book of business). Finally, if exchanges can lower the administrative costs incurred by purchasers, and in particular by employers, purchasing through the exchange might be attractive even if nominal premiums charged are the same or slightly higher than non-exchange premiums.

Most exchanges to date have not been able to reduce administrative costs significantly.<sup>194</sup> Indeed, some have increased rather than reduced costs, as they have simply added their own administrative costs without reducing the costs of either employers or insurers.<sup>195</sup> Moreover, it has often proved difficult to realize savings that should be available. If the exchange provides only a small share of an insurer's business, the insurer will maintain, and often duplicate, administrative functions rather than ceding them to the exchange.<sup>196</sup> If exchanges cannot save administrative costs, they may have a difficult time competing with outside insurance.

Provisions of the ACA should generally reduce insurers' administrative costs. The medical loss ratio provisions of the ACA require insurers to spend at least 80 percent of their premium revenues (after various deductions) on the costs of clinical care and quality-improvement activities in the individual and small-group market, and 85 percent in the large-group market. By eliminating health status underwriting, the ACA should reduce the underwriting costs of insurers, as well as saving the time now spent by agents and brokers helping applicants with preexisting conditions to find coverage. The health information technology provisions of the ACA require health plans to have in place by the beginning of 2012 operating rules for health plan eligibility and claim status, and by the beginning of 2014 operating rules for electronic fund transfers and health care payment and remittance advices.<sup>197</sup> By the beginning of 2016, plans must have in place data and information systems that comply with standards and operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization.<sup>198</sup> Electronic processing of this information should lower administrative costs. These are general requirements, however, not exclusive to the exchange.

Exchanges could perform a number of administrative functions that could further lower insurer costs, including processing applications for coverage and for subsidies, billing enrollees and employees for premiums, providing financial reconciliation, paying commissions, providing Web site development and maintenance, marketing and outreach, and broker and human resources training.<sup>199</sup> By affording continuity of coverage when employees change jobs, exchanges can reduce insurer marketing costs.<sup>200</sup> By creating greater transparency, exchanges can make insurers' administrative costs more visible, thus creating additional pressure on insurers to lower them.

An exchange can also reduce employers' costs by taking over some of the functions of administering and maintaining insurance policies, which employers would otherwise have to either handle themselves or contract out. If an employer can simply pick a tier of coverage and allow its employees to choose their own coverage individually, without that employer having to negotiate an explicit package of benefits and cost-sharing, and, most importantly, if the employer can simply receive an aggregated bill and let the exchange manage enrollments, disenrollments, changes, and premium payments, there will be considerable savings in time, aggravation, and probably money over the cost of offering plan choice to employees. Of course, most small employers do not offer plan choice, and the savings that the exchange can offer an employer that would otherwise offer a single plan will be much smaller.

## **The Role of Agents and Brokers**

The most contentious cost-saving measure that exchanges may attempt is limiting or eliminating insurance agents' and brokers' commissions. Agent and broker commissions can account for 10 to 15 percent of the health insurance premium in the individual market, perhaps even more in the first year of a policy. Commissions tend to be somewhat lower in the small-group than in the individual market, and much lower in the large-group market.

The Utah Health Exchange pays commissions based on a flat per-member, per-month amount of \$37.<sup>201</sup> Other exchanges pay on a percentage basis, usually reflecting the local market. Medicare Advantage plans pay a flat dollar amount.<sup>202</sup>

As insurance plan enrollment moves increasingly online, one possible future scenario is that brokers and agents largely disappear from health insurance markets, just as online travel-booking services have largely replaced travel agents over the past two decades. There are reasons, however, to believe otherwise. First, agents and brokers provide useful services beyond simply selling a policy. Even though health insurance products will become much more standardized under health reform, and comparing them will become much easier, health insurance will remain a complex product, and brokers will continue to play a role in assisting enrollees with complex needs. They will continue to be particularly helpful to small employers, for whom they often take on the functions of a human resources manager. Agents and brokers will also have a continuing role in servicing policies they have sold, serving as advocates for their clients in claims disputes, for example. Second, insurance agents are a political force that will have to be dealt with. They are the pillars of many small communities, and exert disproportionate influence over local chambers of commerce and small-business associations. They also have powerful lobbies at the state and federal level, and were quite effective in lobbying Congress for an explicit continuing role in the exchanges and in blocking federal regulation of brokers' commissions.<sup>203</sup> Third, as long as they have a role in the market outside the exchange, they must also have a role on the inside. If they can earn commissions outside but not inside the exchange, they will shift business away from it. They may even engage in "street underwriting," moving high-cost business to the exchange and low-cost business outside. Agents have played a major role in undermining exchanges in the past, as attempts to eliminate brokerage commissions have simply led brokers to steer clients away from the exchange.<sup>204</sup>

There are several steps that exchanges can take, however, to address agent and broker commissions. First, exchanges should limit brokerage commissions to a flat per-

member, per-month dollar amount, as the Utah Health Exchange has done. Percentage commissions create a perverse incentive for agents and brokers to try to sell more-expensive policies and should be avoided. Second, agents and brokers should receive similar commissions regardless of the insurer whose policy they sell. They should face no incentive to steer enrollees to any particular insurer. Third, commissions should be the same for renewals as for new enrollments. Paying enhanced commissions for new enrollments gives agents an incentive to “churn” enrollees from plan to plan rather than making sure that they enroll initially with the most appropriate plan and then providing service that keeps them satisfied with their plan. Medicare Advantage has switched from paying enhanced commissions in the first year to paying level commissions, except in cases where the enrollee is enrolling in the Medicare Advantage program for the first time. Enhanced first-year commissions will also be less justifiable after 2014 because the exchanges will simplify consumer search and enrollment and because the absence of health status underwriting will simplify the task of agents and brokers seeking to place higher-risk enrollees. Finally, and probably most controversially, agents and brokers should receive the same commission for sales both inside and outside the exchange. Ideally, this step would be accomplished through state legislation prohibiting higher commissions outside the exchange. Failing this, however, the exchange could conduct market testing and simply attempt to keep its commissions competitive. Because all insurers, including grandfathered plans, must comply with the medical loss ratio requirements of section 2178, commissions are likely to be constrained throughout the small-group and individual market, and the exchanges could simply try to remain competitive.

A different approach would be that the exchange contract with brokers and agents as navigators. The roles of agent and broker could thereby be reinvented under the exchange. Section 1311 expressly lists brokers and agents as potential navigators, but also states that navigators cannot receive compensation directly or indirectly from insurers. Exchanges could contract with brokers or agents at a fixed contract rate, or perhaps even a per-enrollee rate, to assist enrollees in selecting plans and in dealing with service issues. The broker and agent would face no conflict of interest, but would owe allegiance solely to the enrollee. The exchange would need to build the cost of the contract into its administrative costs, but as the agent’s or broker’s commission would be eliminated, the result would still be a net lower cost for the consumer.

### **Recommendations**

Exchanges should develop a variety of revenue sources to fund their work, including an assessment on all insurers in the market. Exchanges should seek opportunities to lower

administrative costs both for insurers and for employers. State enabling legislation should neither require nor bar the use of agents and brokers for the purchase of insurance from the exchange. Agent and broker commissions should be rationalized, however, and should be similar regardless of which health plan is being sold and whether it is inside or outside the exchange.

## NOTES

<sup>1</sup> T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

<sup>2</sup> § 1311(f)(3).

<sup>3</sup> Mass. Gen Laws Ann. 176Q sec. 2.

<sup>4</sup> Utah Code 63M-1-2504(1).

<sup>5</sup> SB 900, sec. 100500(a).

<sup>6</sup> § 1311(d).

<sup>7</sup> *Carter v. Carter Coal Co.*, 298 U.S. 238 (1936).

<sup>8</sup> *County of Riverside v. Superior Court*, 132 Cal. Rptr.2d 723 (2003) (private arbitration); *Emmett McLoughlin Realty Inc. v. Pima County*, 58 P.3d 39 (Ariz. 2002) (zoning); *City of Santa Fe v. Bourdeaux*, 256 S.W.3d 819 (Tex. 2008) (private arbitration board); *Sedlak v. Dick*, 887 P.2d 1119 (Kansas 1995) (selection of workers' compensation board); *Cary v. City of Rapid City*, 559 N.W.2d 891 (S.D. 1997) (zoning to neighbors); *Rogers v. Medical Assn of Ga.* 259 S.E.2d 85 (1979) (medical association appoints members of med board).

<sup>9</sup> See, e.g., *City of Santa Fe v. Bourdeaux*, 256 S.W.3d 819 (Tex. 2008).

<sup>10</sup> *Professional Engineers v. Department of Transportation*, 15 Cal.4th 543 (Cal. 1997).

<sup>11</sup> M.G.L.A. ch. 176Q, sec. 2(d) and (e).

<sup>12</sup> AB 1602, §§ 100503(m); 100504(a)(6); 100505; 100508.

<sup>13</sup> D. Super, "Privatization, Policy Paralysis, and the Poor," *California Law Review* 2003 96:393–469.

<sup>14</sup> 29 U.S.C. § 1002(21). Person is defined as including only private entity, 29 U.S.C. § 1002(9), so a state-operated exchange would not be an ERISA fiduciary.

<sup>15</sup> 29 U.S.C. § 1104(a)(1).

<sup>16</sup> T. Jost, *Health Insurance Exchanges: Legal Issues* (Washington, D.C.: O'Neill Institute for National and Global Health Law, 2009), 18–19. A private exchange may also be classified as a multiple employer group health plan under the Medicare as Secondary Payer rules, which would make the insurance it offered primary to Medicare for plans with 20 or more employees and for plans with fewer than 20 if the exchange included any employers with more than 20 employers and did not expressly elect not to be covered for the rest. 42 U.S.C. § 1395y(b)(1)(A)(iii). At least one private current small group exchange is so classified, although if the exchange were established under state law rather than by a private association, it might escape this classification.

<sup>17</sup> Alternatively, HHS or a consortium of states could develop systems that could be used by most or all of the states, like the HHS Web portal.

<sup>18</sup> R. Curtis presentation, *NAIC Exchange Hearings*, July 22, 2010, available at [http://www.naic.org/documents/committees\\_b\\_exchanges\\_10072223\\_curtis\\_presentation.ppt.pdf](http://www.naic.org/documents/committees_b_exchanges_10072223_curtis_presentation.ppt.pdf).

<sup>19</sup> L. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, D.C.: Urban Institute, 2009), 3.

<sup>20</sup> § 1251(a).

<sup>21</sup> § 5000A(a) and (f) added by the ACA § 1501(b).

<sup>22</sup> § 1302(b)(1) and PHSA § 2707, added by the ACA § 1201.

<sup>23</sup> § 1302(c) and PHSA § 2707, added by the ACA § 1201.

<sup>24</sup> § 1312(c).

<sup>25</sup> § 1301(a)(1)(C)(iii).

<sup>26</sup> M. Hall, “The Three Types of Reinsurance Created by Federal Health Reform,” *Health Affairs* 2010 29(6):1168–72.

<sup>27</sup> See § 36B(b)(2) of the Internal Revenue Code added by § 1401 of THE ACA and §1402(b)(1).

<sup>28</sup> § 1421.

<sup>29</sup> See C. Peterson and B. Fernandez, *The ACA Requirements for Offering Insurance Inside Versus Outside an Exchange* (Washington, D.C.: Congressional Research Service, 2010).

<sup>30</sup> § 1301(a)(1)(C)(ii) and (iii).

<sup>31</sup> § 1302(e).

<sup>32</sup> T. Jost, *How Does the Health Reform Legislation Affect Self-Insured Plans?* Available at <http://oneillhealthreform.wordpress.com/2010/03/31/how-does-the-health-reform-legislation-affect-self-insured-plans/>.

<sup>33</sup> § 1321(d).

<sup>34</sup> It is likely that collecting the information necessary to operate the ACA § 1343 risk-adjustment program will be easier inside the exchange, where the exchange will have information on premiums and enrollment and can threaten plans that do not comply with decertification, than outside, where access to information will likely be more limited and options for dealing with noncompliant plans will be fewer and more drastic.

<sup>35</sup> § 1312(f)(3).

<sup>36</sup> See Kaiser Family Foundation, *Immigrants’ Health Coverage and Health Reform: Key Questions and Answers* (Menlo Park, Calif.: Kaiser Family Foundation, 2009), available at <http://www.kff.org/healthreform/upload/7982.pdf>.

<sup>37</sup> U.S. Census, *Current Population Survey, Health Insurance Status and Type of Coverage by Selected Characteristics, 2008* (Washington, D.C.: U.S. Census, 2009), available at [http://www.census.gov/hhes/www/cpstables/032009/health/h01\\_001.htm](http://www.census.gov/hhes/www/cpstables/032009/health/h01_001.htm).

<sup>38</sup> *Ibid.*

<sup>39</sup> 42 U.S.C. § 1395dd.1396dd.

<sup>40</sup> 42 U.S.C. § 1396b(v).

<sup>41</sup> See CMS, *Section 1011: Federal Reimbursement of Health Services Provided to Undocumented Aliens*, [https://www.cms.gov/MLNProducts/downloads/Section\\_1011\\_Fact\\_Sheet.pdf](https://www.cms.gov/MLNProducts/downloads/Section_1011_Fact_Sheet.pdf).

<sup>42</sup> T. Jost, *Health Insurance Exchanges: Legal Issues*, *supra*, at 7–9.

<sup>43</sup> S. Lueck, *States Should Structure Insurance Exchanges to Minimize Adverse Selection* (Washington, D.C.: Center on Budget and Policy Priorities, 2010).

<sup>44</sup> Beginning in 2015, qualified health plans may also only contract with hospitals with more than 50 beds if the hospital has implemented a patient safety evaluation system and comprehensive patient discharge program. § 1311(h).



<sup>45</sup> The California legislation requires insurers to offer all five tiers in the exchange, and insurers outside of the exchange to offer the same tiers that they offer in the exchange. AB 1602, § 100503(d), (e) and (f).

<sup>46</sup> The ACA requires this for qualified health plans, § 1302(a)(1)(C)(iii), but the rule should apply for all health plans.

<sup>47</sup> See L. Blumberg and K. Pollitz, *Cross-State Risk Pooling Under Health Care Reform: An Analytic Review of the Provisions in the House and Senate Bill* (Washington, Urban Institute, 2010), available at <http://www.urban.org/UploadedPDF/412124-cross-state-risk.pdf>.

<sup>48</sup> M. Russo, L. Etherton, and L. McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform* (Boston, Mass.: U.S. PIRG Education Fund, 2010), 19.

<sup>49</sup> See *State Recognition of NCQA*, available at <http://www.ncqa.org/tabid/135/Default.aspx>.

<sup>50</sup> § 1321(c).

<sup>51</sup> T. C. Buchmueller, “Consumer-Oriented Health Care Reform Strategies: A Review of the Evidence on Managed Competition and Consumer-Directed Health Insurance,” *Milbank Quarterly*, 2009 87(4):820–24, 826–28.

<sup>52</sup> *Ibid.*, 830–31.

<sup>53</sup> B. A. Strombom, T. C. Buchmueller, and P. J. Feldstein, “Switching Costs, Price Sensitivity and Health Plan Choice Switching Costs, Price Sensitivity and Health Plan Choice,” *Journal of Health Economics* 2002 21:89–116; J. M. Naessens, M. Kahn, N. D. Shah et al., “Premiums, Copayments, and Health Status on Choice of Plans,” *Medical Care* 2008 46(10):1033–40.

<sup>54</sup> §§ 2701, 2704.

<sup>55</sup> § 1312(c).

<sup>56</sup> M. Hall, “The Three Types of Reinsurance Created by Federal Health Reform,” *Health Affairs* 2010 29(6):1168–72.

<sup>57</sup> § 1341.

<sup>58</sup> § 1341.

<sup>59</sup> § 1343.

<sup>60</sup> See American Academy of Actuaries, *Issue Brief, Risk Assessment and Risk Adjustment* (Washington, D.C.: American Academy of Actuaries, 2010), available at [http://www.actuary.org/pdf/health/Risk\\_Adjustment\\_Issue\\_Brief\\_Final\\_5-26-10.pdf](http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf).

<sup>61</sup> W. P. M. M. van de Ven, K. Beck, C. Van de Voorde et al., “Risk Adjustment and Risk Selection in Europe: Six Years Later,” *Health Policy* 2007 83(2):162–79; W. P. M. M. van de Ven, K. Beck, F. Buchner et al., “Risk Adjustment and Risk Selection on the Sickness Fund Insurance of Five European Countries,” *Health Policy* 2003 65(1):75–98.

<sup>62</sup> This is because HIPAA defined small employer to mean employers with 50 or fewer employees. 42 U.S.C. § 300gg-91(e)(4).

<sup>63</sup> § 1312(f)(2)(B).

<sup>64</sup> § 2707.

<sup>65</sup> § 1312(c).

<sup>66</sup> § 1312(f)(2)(B)(ii).

<sup>67</sup> § 1302(b)(2)(A).

<sup>68</sup> As long as an employer provides a plan that does not cost employees more than 9.5 percent of their household income and covers at least 60 percent of plan costs, the employee will be unable to obtain premium tax credits through the exchange and the employer will not be subject to a penalty. IRC § 36B(c)(2)(C)(i), added by ACA § 1401.

<sup>69</sup> See Fact Sheet: Keeping the Plan You Have: The Affordable Care Act and “Grandfathered” Health Plans, [http://www.healthreform.gov/newsroom/keeping\\_the\\_health\\_plan\\_you\\_have.html](http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html).

<sup>70</sup> §§ 2707, 1301.

<sup>71</sup> These data were supplied by the Center on Budget and Policy Priorities based on analysis of MEPS data.

<sup>72</sup> 29 U.S.C. § 1144.

<sup>73</sup> FMC Corporation v. Holliday, 498 U.S. 52 (1990).

<sup>74</sup> 26 USC § 105(h)(6).

<sup>75</sup> 26 C.F.R. § 1.105-11(b).

<sup>76</sup> Bill Gray Enterprises v. Gourley, 248 F.3d 206 (3rd Cir. 2001); United Food and Commercial Workers v. Pacyga, 801 F.2d 1157 (9th Cir. 1986); Thompson v. Talquin Building Products, 928 F.2d 649 (4th Cir. 1991).

<sup>77</sup> American Medical Security Inc., v. Bartlett, 111 F.3d 358 (4th Cir. 1997).

<sup>78</sup> See McDaniel v. North American Indemnity, 2008 WL 1336832 (S.D. Ind. 2008).

<sup>79</sup> 29 CFR 2510.3-1.

<sup>80</sup> Section 3 of the NAIC Stop Loss Insurance Model Act, provides:

A.(1) An insurer shall not issue a stop loss insurance policy that:

(a) Has an annual attachment point for claims incurred per individual which is lower than \$20,000;

(b) Has an annual aggregate attachment point, for groups of fifty (50) or fewer, that is lower than the greater of:

(i) \$4,000 times the number of group members;

(ii) 120 percent of expected claims; or

(iii) \$20,000;

(c) Has an annual aggregate attachment point for groups of fifty-one (51) or more that is lower than 110 percent of expected claims; or

(d) Provides direct coverage of health care expenses of an individual.

<sup>81</sup> David Riemer has proposed this idea.

<sup>82</sup> § 1311(c)(6).

<sup>83</sup> 42 U.S.C. § 1395w-113.

<sup>84</sup> 1311(b)(1)(B).

<sup>85</sup> T. McCorvie, *Operating and Administering Health Insurance Exchanges: After 16 Years a Few Truths and Perspectives* (Orlando, Fla.: Workable Solutions, Inc., 2010), 3.

<sup>86</sup> S. 979.

<sup>87</sup> § 3107(d)(5).

<sup>88</sup> Congressional Budget Office, *The Budgetary Treatment of Proposals to Change the Nation's Health Care System* (Washington, D.C.: CBO, 2009), available at <http://www.cbo.gov/ftpdocs/102xx/doc10243/05-27-HealthInsuranceProposals.pdf>.

<sup>89</sup> The direct payment option was also necessitated by the Senate approach to the abortion issue, which requires a separate premium payment for individuals who desire abortion coverage. § 1303.

<sup>90</sup> § 3104(f).

<sup>91</sup> § 1515.

<sup>92</sup> IRC § 36B(c)(2)(C)(ii) and (iii) added by ACA § 1401.

<sup>93</sup> 29 CFR 1625.10(d)(4)(2).

<sup>94</sup> § 1311(e)(1).

<sup>95</sup> § 1311(e)(2).

<sup>96</sup> § 1312(d)(1).

<sup>97</sup> Massachusetts has nine, Utah has five.

<sup>98</sup> W. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, D.C.: AEI Press, 2009), 56–60.

<sup>99</sup> J. C. Robinson, “Consolidation and the Transformation of Competition in Health Insurance,” *Health Affairs* 2004 23(6):11–24; American Medical Association, *AMA Study Shows Competition Disappearing in the Health Insurance Industry* (Chicago: AMA, 2010), available at <http://www.ama-assn.org/ama/pub/news/news/health-insurance-competition.shtml>.

<sup>100</sup> § 2711(a)(1), added by ACA § 1001.

<sup>101</sup> If an exchange does use competitive bidding, it may need to either comply with state procurement law or be statutorily exempted from it.

<sup>102</sup> Section 1302(a) requires all plans to offer essential benefits in the required tiers. Section 1302(d) prescribes the actuarial value of the precious metal tiers, which is to be determined based on the “full actuarial value of the benefits provided under the plan” and that the level of coverage shall be determined on the basis that the essential benefits will be provided to a standard population rather than the plan’s actual population. Section 1302(d)(3) also requires HHS to establish rules as to the allowable variance in actuarial value for health plans. Section 1302(e) provides for catastrophic plans for persons aged under 30 and for those who cannot otherwise find an affordable health plan. Section 1302(b)(5) permits plans to offer benefits additional to the essential benefits package.

<sup>103</sup> B. Schwartz, *The Paradox of Choice: Why More Is Less* (New York: Harper Collins, 2004); R. G. Frank and R. J. Zeckhauser, “Health Insurance Exchanges—Making Markets Work,” *New England Journal of Medicine* 2009 361(12):1135–37; H. Kunruehter, R. Meyer, R. Zeckhauser et al., “High Stakes Decision Making: Normative, Descriptive and Prescriptive Considerations,” *Marketing Letter* 2002 13:259–68.

<sup>104</sup> Research in Switzerland, for example, where consumers can choose from among 30 to 75 health plans depending on their canton (state) and where information on plan characteristics is widely available shows that consumers were less likely to switch plans and less likely to respond to price when more choices were available. R. G. Frank and K. Lamiraud, *Choice, Price Competition, and Complexity in Markets for Health Insurance*, NBER Working Paper 13817 (Cambridge, Mass.: National Bureau of Economic Research, Feb. 2008).

<sup>105</sup> Frank and Zeckhauser, *supra*, at 1136; J. T. Abaluck and J. Gruber, *Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program*, NBER Working Paper 14759 (Cambridge, Mass.: National Bureau of Economic Research, 2009).

<sup>106</sup> A. Atherly, C. Florence, and K. E. Thorpe, “Health Plan Switching Among Members of the Federal Employee Health Benefits Program,” *Inquiry* 2005 42:255–65; B. A. Stombom, T. C. Buchmueller, and P. J. Feldstein, “Switching Costs, Price Sensitivity and Health Plan Choice,” *Journal of Health Economics* 2003 21:89–116.; T. C. Buchmueller, “Consumer-Oriented Health Care Reform Strategies: A Review of the Evidence on Managed Competition and Consumer-Directed Insurance,” *Milbank Quarterly* 2009 87(4):820–41.

<sup>107</sup> Swiss health insurers have, again, proved remarkably adept at using benefit design to select risk despite the standardization of core benefits. W. P. M. M. van de Ven, K. Beck, C. Van de Voorde et al., “Risk Adjustment and Risk Selection in Europe: Six Years Later,” *Health Policy* 2007 83(2):162–79; W. M. P. P. van de Ven, K. Beck, F. Buchner et al., “Risk Adjustment and Risk Selection on the Sickness Fund Insurance of Five European Countries,” *Health Policy* 2003 65(1):75–98.

<sup>108</sup> P. D. Fox, R. E. Snyder, and T. Fox, “Medigap Reform Legislation of 1990: A 10-Year Review,” *Health Care Financing Review* 2003 24(3):121–37, 132–34.

<sup>109</sup> J. Kingsdale and J. Bertko, “Insurance Exchanges Under Health Reform: Six Design Issues for the States,” *Health Affairs* 2010 29(6):1158–62; C. Barber and M. Miller, *A Consumer Guide to Creating a Health Insurance Connector* (Boston: Community Catalyst, 2007), 5, available at [http://kshealthconsumer.com/wp-content/uploads/2010/04/july\\_consumer\\_guide\\_to\\_hi\\_connectors.pdf](http://kshealthconsumer.com/wp-content/uploads/2010/04/july_consumer_guide_to_hi_connectors.pdf).

<sup>110</sup> § 1311(c)(1)(A).

<sup>111</sup> PHSa § 2715, added by ACA § 1001 The exchanges are required to use this format for providing information regarding plans. § 1311(c)(1)(G).

<sup>112</sup> PHSa § 2715(e), added by § 1001 of the ACA.

<sup>113</sup> PHSa § 2717, added by § 1001 of the ACA.

<sup>114</sup> § 1311(c)(1)(B).

<sup>115</sup> §1311(e)(3)(C).

<sup>116</sup> 29 U.S.C. § 1022.

<sup>117</sup> *Washington v. Murphy Oil USA, Inc.*, 497 F.3d 453, 458 n. 1 (5th Cir. 2007); M. R. Bosau, “Defining the Parameters: When an ERISA Summary Plan Description Trumps the Corresponding Plan Document,” 7 *DePaul Bus. and Com. L.J.* 2009 7:521–53. The Supreme Court will decide a case this term addressing the question of the binding nature of an SPD in the pension context. *CIBNA Corp. v. Amara*, No. 09-804.

<sup>118</sup> See *Lubeznik v. HealthChicago, Inc.* 644 N.E.2d 777 (Ill.App. 1994).

<sup>119</sup> 29 C.F.R. § 2520.102–3.

<sup>120</sup> PHSa §§ 2718, 2794, added by ACA § 1001, 1003.

<sup>121</sup> § 1311(e)(3)(A).

<sup>122</sup> § 1311(c)(3).

<sup>123</sup> § 1311(c)(4).

<sup>124</sup> § 1311(c)(4).

<sup>125</sup> Connecture, “Health Insurance Exchanges: Are You Ready?” webinar, Sept. 1, 2010.

<sup>126</sup> In fact, 5 percentage points of income is disregarded for determining Medicaid eligibility, therefore the actual eligibility limit is 138 percent of poverty. 42 U.S.C. § 1396a(e)(14)(I) added by section 2002 of the ACA. Because current Medicaid income disregards are eliminated, however, some families will not be eligible for Medicaid who would have been eligible under current eligibility rules if income eligibility were otherwise increased to 133 percent of poverty.

<sup>127</sup> The current median eligibility level for CHIP is 235 percent of poverty. Pregnant women may also receive Medicaid at higher income levels. For current Medicaid eligibility, see [http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/eligibility by state.pdf](http://ccf.georgetown.edu/index/cms-filesystem-action?file=statistics/eligibility%20by%20state.pdf).

<sup>128</sup> Actual cost-sharing is reduced up to 250 percent of poverty while between 250 percent and 400 percent of poverty the out-of-pocket limit is reduced. § 1402(c).

<sup>129</sup> § 1412(e).

<sup>130</sup> §§ 1413(b)(1)(A), 1413(e). The basic health program, established by ACA § 1331, permits states to establish a program outside of the exchange to provide standard health benefit plans to persons above the Medicaid eligibility level but below 200 percent of poverty.

<sup>131</sup> SSA § 1943(b)(1)(c), added by ACA § 2201.

<sup>132</sup> § 1413(b)(2).

<sup>133</sup> § 1413(c)(1), 1411(c)(4).

<sup>134</sup> § 1413(b)(1)(A)(2).

<sup>135</sup> § 3021(b)(4) of the PHSA, added by ACA. § 1561. Although the ACA provides for point-of-service applications, indeed section 2202 of the ACA permits hospitals to make presumptive Medicaid eligibility determinations, enrollment in the premium tax credit program will only be possible during annual enrollment periods unless HHS provides otherwise. § 1412(b)(1)(A).

<sup>136</sup> SSA § 3021(d), added by ACA § 1561.

<sup>137</sup> § 1413(b)(1)(A)(3).

<sup>138</sup> § 1943(b)(1)(B).

<sup>139</sup> § 1943(b)(1)(C).

<sup>140</sup> § 1943(b)(1)(E).

<sup>141</sup> § 2003.

<sup>142</sup> § 1414, SSA § 1902(e)(14), added by ACA § 2002; ACA § 2101(d); SSA § 1943(b), added by ACA § 2201.

<sup>143</sup> See SSA § 1902(e)(14)(H) added by ACA § 2002, provides that the rules on using modified adjusted gross income and household income for determining Medicaid eligibility shall not be construed as affecting or limiting federal or state Medicaid rules “regarding sources of countable income.” While the meaning of this provision is not clear, it cannot possibly mean that the states are free to redefine “sources of countable income” to defeat the use of MAGI and household income in determining Medicaid eligibility, since this would undermine the coordination between Medicaid and premium subsidies that is a key principle of the Affordable Care Act. It could perhaps be interpreted to mean that, at least for a transitional period, income should not be attributed to Medicaid recipients that would not have been attributed to them under traditional source of income rules but that might be included within the ACA definition of household income, like the income of step-parents.

<sup>144</sup> § 1411(b)(1).

<sup>145</sup> IRC § 6103(l)(21), added by ACA § 1414.

<sup>146</sup> § 1411(b)(2)(A).

<sup>147</sup> § 1411(b)(2)(B).

<sup>148</sup> Although its provisions are not explicitly incorporated into the ACA, the current system for establishing eligibility for public benefits requires that persons who are not U.S. citizens or nationals present documentary evidence of eligibility. 42 U.S.C. § 1320b-7(d)(2).

<sup>149</sup> § 1412(b). Section 1411 also allows an applicant to apply for a tax credit at the time of tax filing, in which case financial eligibility will be based on MAGI for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins (i.e. a person applying in 2013 for an advance premium credit for the 2014 taxable year would submit information from their 2012 tax return). If the advance determination program works properly (and is not undermined by the reconciliation requirement), it would seem that the retroactive tax credit option would rarely be used.

<sup>150</sup> § 1412(b)(2).

<sup>151</sup> § 1412(b)(2).

<sup>152</sup> § 1902(e)(14)(A), (H).

<sup>153</sup> § 1413.

<sup>154</sup> See S. Dorn, *State Implementation of National Health Care Reform: Harnessing Federal Resources to Meet State Policy Goals* (Washington, D.C.: State Coverage Initiatives, 2010), 13–14, available at <http://www.rwjf.org/files/research/66488.pdf>.

<sup>155</sup> Ibid.

<sup>156</sup> § 1412(a)(1), (a)(2).

<sup>157</sup> § 1411(c)(2). Proof of identity has been required to obtain a Social Security card only since 1971 and proof of citizenship since 1978. Persons whose registration with Social Security antedates these dates may need to provide documentary proof of citizenship. G. Donnelly, “Counterfeiting and Misuse of the Social Security Card and State and Local Documents,” Testimony Before the House Committee on the Judiciary, (1999), available at [http://www.ssa.gov/legislation/testimony\\_072299.html](http://www.ssa.gov/legislation/testimony_072299.html).

<sup>158</sup> § 1411(a)(2).

<sup>159</sup> § 1412(a)(2), 1411(d).

<sup>160</sup> § 1412(a)(3).

<sup>161</sup> § 1413(c)(2)(B).

<sup>162</sup> § 1413(c).

<sup>163</sup> § 1413(c)(2)(C), SSA § 1942.

<sup>164</sup> § 1411(c)(4)(B).

<sup>165</sup> SSA § 1137.

<sup>166</sup> SSA § 453(i).

<sup>167</sup> § 1411(e)(3).

<sup>168</sup> SSA § 1902(ee). Special rules apply if some members of the taxpayer’s household are not legally present in the United States. IRC § 36B(e), added by ACA § 1401.

<sup>169</sup> § 1411(e)(4).

<sup>170</sup> § 1411(e)(4)(B)(i) and (ii).

<sup>171</sup> § 1312(d)(4).

<sup>172</sup> § 1411(f).

<sup>173</sup> § 1411(e)(4)(C).

<sup>174</sup> IRC § 36B(f), added by ACA § 1401.

<sup>175</sup> IRC § 36B(a), added by ACA § 1401.

<sup>176</sup> IRC § 36B(d), added by ACA § 1401.

<sup>177</sup> § 1411(f)(1)(B).

<sup>178</sup> Government Accountability Office, *Advance Earned Income Tax Credit: Low Use and Small Dollar's Paid Impeded IRS's Efforts to Reduce High Noncompliance* (Washington, D.C.: GAO, 2007), available at <http://www.gao.gov/new.items/d071110.pdf>.

<sup>179</sup> IRC § 36B(c)(2)(C)(i) and (ii) added by ACA § 1401.

<sup>180</sup> § 1411(b)(4).

<sup>181</sup> § 1411(b)(4).

<sup>182</sup> § 1411(e)(4)(B)(iii).

<sup>183</sup> § 1411(b)(5).

<sup>184</sup> § 1411(e)(4)(B)(iv).

<sup>185</sup> § 1411(g).

<sup>186</sup> § 1411(f).

<sup>187</sup> § 1411(h).

<sup>188</sup> § 1311(i).

<sup>189</sup> § 1311(c)(3), (e)(3).

<sup>190</sup> PHSA § 3021(d), added by ACA § 1561.

<sup>191</sup> § 1311(d)(5)(A).

<sup>192</sup> 42 C.F.R. § 436.1001.

<sup>193</sup> § 1311(d)(5)(A).

<sup>194</sup> RAND COMPARE, *Effects of Purchasing Pool Options* (Santa Monica, Calif.: RAND Corporation, 2009), available at <http://www.randcompare.org/policy-options/purchasing-pools>.

<sup>195</sup> E. Wicks and M. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects," *Milbank Quarterly* 2000 78(4):511-46.

<sup>196</sup> R. Curtis and E. Neuschler, *What Health Insurance Exchanges or Choice Pools Can and Can't do About Risks and Costs* (Washington, D.C.: Institute for Health Policy Solutions, 2009), 7.

<sup>197</sup> § 1104(g)(4)(B)(i) and (ii).

<sup>198</sup> § 1104(g)(4)(B)(iii).

<sup>199</sup> A. Lishko, *State Coverage Initiatives: Health Insurance Connectors and Exchanges: A Primer for State Officials* (Washington, D.C.: AcademyHealth, 2007), 5. State high risk pools already perform many of these functions, and the exchanges could learn from their experience.

<sup>200</sup> L. Blumberg and K. Pollitz, *Health Insurance Exchange*, supra, at 4; K. Swartz, *Reinsuring Health: Why More Middle-Class People are Uninsured and What Government Can Do About It* (New York: Russell Sage, 2006).

<sup>201</sup> S. Davis, “Brokers Wonder Whether Health Insurance Exchanges Will Help or Hinder Their Client Base, Commission Rates,” *AIS Health Business Daily*, May 14, 2010, available at <http://www.aishealth.com/Bnow/hbd051410.html>.

<sup>202</sup> *CMS Re-issues Draft 2010 Medicare Advantage, Prescription Drug Plan and Health Plans Call Letter*, available at <http://www.crowell.com/NewsEvents/Newsletter.aspx?id=1168>

<sup>203</sup> § 1312(e).

<sup>204</sup> Wicks and Hall, supra, at 538.