

# Taking Stock of Exchanges: Bigger is Better

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## Introduction

The health insurance exchange is one of the most common, least controversial and indeed least conspicuous features of the health insurance legislation currently pending in Congress. Each of the versions of HR 3200, the House Tri-Committee bill, and both of the Senate Health, Education, Labor, and Pensions (HELP) and Finance Committee bills contains a version of the exchange. The exchange concept has been endorsed by policy advocates across a broad range of the political spectrum. An insurance exchange will almost certainly be part of the final 2009 legislation, if health reform is in fact adopted into law at all.

A health insurance exchange is basically an organized market for health insurance. Nevertheless the concept “health insurance exchange” is not clearly defined; indeed the vision of what an exchange is and how it would function varies significantly from bill to bill. An exchange could potentially play a major role in making health insurance more affordable or accessible. But, depending on how it is designed or implemented, the exchange could have little effect at all on the health care system, or even increase cost. Moreover, health insurance exchanges raise significant legal issues that are largely ignored by the current proposed legislation.

The exchange concept has by now a long history in health care reform efforts. The intellectual history of the exchange goes back to the concept of “managed competition” credited to Alain Enthoven’s work in the late 1970s.<sup>1</sup> The “health alliance,” an ambitious form of exchange, was at the heart of the Clinton Health Security Act.<sup>2</sup> During the 1990s, health insurance purchasing cooperatives were encouraged by legislation in a number of states and implemented by business and community groups in others, although most have since failed. The Federal Employees Health Benefits Program and the California Public Employees’ Retirement System (CALPERS) are often cited as long-standing and more or less successful examples of insurance exchanges.<sup>3</sup> The Medicare Advantage program and Medicare Part D include some elements of a health care exchange (choice among multiple plans) although not others (a common enrollment portal). The Massachusetts Connector is the most recent, and to date most successful, attempt to establish an exchange at the state level.

This paper first examines the different ways in which exchanges could be designed in a reformed health care system and the different roles that they could play. The paper next briefly explores experience with exchanges and what we can learn from it. It then describes the

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<sup>1</sup>Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 *Health Aff.* 24 (Supp. 1993).

<sup>2</sup>See Henry T. Greely, *Policy Issues in Health Alliances: Of Efficiency, Monopsony, and Equity*, 5 *Health Matrix* 37 (1995).

<sup>3</sup>See Mark Merlis, *A Health Insurance Exchange: Prototypes and Design Issues* (National Health Policy Forum, 2009).

different approaches taken by the three bills pending in Congress to exchange design and function. The following section examines the legal issues raised by exchanges as they are defined in the pending legislation. Finally, the paper concludes with policy recommendations as to how exchanges should be designed and function to play an effective role in a reformed health care system, noting in particular the strengths and weaknesses of the pending legislation.

## **Exchange Design and Function Issues**

All of the health care reform bills approved by jurisdictional committees in Congress include health insurance exchanges. Assuming that exchanges are part of final reform legislation, choices will need to be made with respect to a number of design issues.

The first of these is who will be covered by the exchange. Exchanges could serve to organize markets for insurance at a number of different levels. They could limit their enrollment to the nongroup market. They could additionally be opened to employees who would otherwise be covered by the small group market (groups of up to 10, 25, or 50, for example) with employees choosing among plans offered through the exchange and employers contributing to cover part or all of the premium. By further extension, exchanges could cover members of large groups under a certain size or all insureds.

The proportion of insureds covered by the exchange expands dramatically if large groups are covered, because, although most employers are small businesses, most employees work for larger employers.<sup>4</sup> The Clinton Health Security Act Health Alliances covered all insureds except those who worked for employers or were members of multi-employer union plans with 5000 or more employees (which could form corporate alliances), and thus covered a much larger proportion of the population than would be covered under current proposals, which are at least initially limited to the nongroup and small group markets.<sup>5</sup>

A related issue is the extent to which the exchange will be exclusive for those persons who are allowed to enroll in it. Here there are several possibilities. All insureds in a particular market could be required to purchase insurance through the exchange. Pre-existing insurance policies could be grandfathered in and their owners excused from exchange participation. Finally the exchange could be non-exclusive; new policies could be sold outside of the exchange.

Exchanges can also serve a range of functions.<sup>6</sup> An exchange could conceivably be nothing more than a website where individuals could compare and purchase health insurance policies. At the other end of the spectrum, it could be an active participant in the health

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<sup>4</sup> Of the over 5 million employers in the United States, only 103 thousand have more than 100 employees, yet these firms employ 73 million of the 115 million employees in the United States. See Table 2a. Employment Size of Employer and Nonemployer Firms, 2004, at <http://www.census.gov/epcd/www/smallbus.html>.

<sup>5</sup> See Greely, *supra* note 2, at 40-41

<sup>6</sup> See Linda J. Blumberg and Karen Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Urban Institute 2009).

insurance market, bargaining aggressively to reduce health care costs or imposing regulatory cost controls. Functions that could conceivably be performed by a health insurance exchange include:

- § Organizing the market by making it more transparent and standardized. Exchanges could be used to make insurance products descriptions more standardized and to facilitate price comparison by grouping policies in product tiers in terms of their actuarial value or cost-sharing limits (e.g. platinum, gold, silver, bronze).
- § Facilitating purchasing, and thereby simplifying choice. Individuals could actually purchase insurance through the exchange with their own funds or employer contributions. Allowing employers to pay premium payments through the exchange for their employees could expand employee choice, facilitate portability (since employees could keep their policy even as they changed employers), and permit multiple employers to make contributions for the benefit of part-time employees. An exchange could also reduce or eliminate the role and commissions of insurance brokers and agents, currently a major expense in the nongroup or small group market.
- § Increasing the size of the insurance purchasing pool, spreading risk more broadly and reducing risk selection.
- § Regulating health insurance coverage. Exchanges could be used to impose on insurers that participate in the exchange regulatory requirements not imposed on insurers generally, by, for example, defining essential benefits that must be covered or limiting cost-sharing. Exchanges could also monitor regulatory compliance.
- § Facilitating the imposition of individual mandates. One of the functions of the Massachusetts connector is to define “creditable coverage,” a minimum benefit standard that must be met to fulfill the requirements of the individual mandate.<sup>7</sup> The Connector also defines “affordability” for determining whether an individual is excused from meeting the mandate. If a national individual mandate is introduced with an affordability exception, it could be administered through the exchange.
- § Facilitating the use of health insurance premium subsidies. This again is a function of the Massachusetts Connector. Eligibility for subsidies can be determined through the exchange, which can then couple the subsidies with premium payments provided by individuals and employers to pay for insurance
- § Reallocating risk among insurers. The exchange can be used as a mechanism for prospectively adjusting premium payments to health insurers (or for moving money between insurers retroactively) to reward insurers who take on high-risk individuals at the expense of insurers who attract low-risk individuals.
- § Selecting high-value insurers. An exchange could (as Massachusetts does) only allow a limited number of insurers to offer policies in the exchange and could further only allow insurers to offer a limited range of policies. This would increase comparability and could allow the exchange to select insurers and policies that offer the best value for money. Insurers not selected to offer a policy could either be barred from the nongroup/small

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<sup>7</sup> Amy M. Kischko, Sara S. Bachman, Alyssa Vangeli, The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions (Commonwealth Fund, May 2009).

- group market, or could be allowed to offer policies outside of the exchange (but perhaps without access to public affordability subsidies).
- § Negotiating with insurers. An exchange could go further and negotiate directly with insurers, only allowing insurers to offer policies through the exchange that concluded satisfactory negotiations with the exchange.
  - § Regulating insurance premiums. Finally, an exchange could impose price controls or mandatory medical expense ratios on insurers, only allowing insurers to sell through the exchange (or in the small or nongroup market) that complied with regulatory requirements.

Other important variables that affect exchanges are the level at which they are created and the authority under which they operate. Exchanges could be established at the national, regional, state, or sub state level. They could be created by federal law, by state law, or privately. If they are authorized federal law, the federal law could establish national exchanges directly. Alternatively, the federal law could request the states to establish exchanges, funded in part or in whole by federal funds, with federal oversight and a federal fall-back program if the states failed to establish exchanges. Governmental coalitions could supplement existing insurance regulators or take over some or all of their functions. Private exchanges could be formed by employer coalitions, nonprofit organizations, or even for-profit firms.

### **Experience with Exchanges**

Experience to date with exchanges has been largely discouraging.<sup>8</sup> Past efforts by the states to establish exchanges have by and large failed. State-sponsored exchanges in California, Florida, and Texas enjoyed initial success but were not able to sustain it and eventually closed.<sup>9</sup> The most successful public exchanges have been the Federal Employee Health Benefits Program; state pension programs, like CALPERS; and the Massachusetts Connector (which is still perhaps too new to pronounce an unqualified success). These exchanges, however, have not been able to control cost growth significantly below that experienced in the private market generally. A few private purchasing cooperatives have also enjoyed some success in increasing employee choice for small group plans but have also not had a significant effect on cost.<sup>10</sup>

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

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<sup>8</sup> An excellent recent summary of the literature is found at Rand Compare, [www.randcompare.org/analysis/mechanism/purchasing\\_pools](http://www.randcompare.org/analysis/mechanism/purchasing_pools).

<sup>9</sup> Merlis, *supra* note 3, at 4; Cappy MaGarr, A Texas-Sized Health Care Failure, *New York Times* (Oct 6, 2009).

<sup>10</sup> Merlis, *supra* note 3, at 3; GAO, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices*, GAO/HEHS-00-49 (2000); Elliot Wicks, *Health Insurance Purchasing Cooperatives* (Commonwealth Fund 2002).

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

With rare exceptions, the cost-reductions promised by risk pooling have not yet been borne out in the experience of exchanges.<sup>11</sup> Most exchanges have covered only a small share of the potential market and themselves have become the victims of risk selection. Insurers that have the option of selling outside of the exchange have found exchanges unattractive because exchanges tend to include higher risk individuals and groups and because insurers prefer to control their own relationships with employers. Insurers have also found insuring employer groups through the exchange disadvantageous because employees are allowed to pick among insurers and plans rather than all being steered to one insurer and because employees can change insurers easily at open enrollment periods. When exchanges have tried to limit agent commissions, agents have simply steered applicants outside of the exchanges. Finally, exchanges have rarely reached the size where they can in fact reduce administrative costs. Indeed, they have sometimes duplicated functions also provided by insurers, employers, or agents, in fact increasing costs. Exchanges have also not become large enough to impose competitive pressure on the outside market. Because exchanges have failed to reduce costs, they have also failed to increase access to insurance.

This is not to say that experience with exchanges has been wholly negative. Where they have survived, they have increased choice of insurers for their participants, which has been valued by consumers. The FEHBP remains an example of the potential of exchanges—it has maintained good benefits and a wide choice of plans for participants and has been reasonably successful in controlling costs.<sup>12</sup> Nevertheless, experience to date with health insurance exchanges gives little reason to believe that the exchange in itself is a panacea to our cost, access, or quality deficits. The model as it has existed must be improved upon. This is the task of health reform.

### **Health Insurance Exchanges in Proposed Health Reform Legislation**

As noted at the outset, exchanges play a key role in each of the bills pending in Congress. How do the various bills pending in Congress envision the goal of exchanges? What functions do they assign to them? At what level would they require exchanges to operate? What would be

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<sup>11</sup> Richard E. Curtis, Edward Neuschler, and Rafe Forland, *Private Purchasing Pools to Harness Individual Tax Credits for Consumers*, 38 *Inquiry* 159-176 (2001); Stephen H. Long and M. Susan Marquis, *Have Small-Group Health Purchasing Alliances Increased Coverage?* 20 *Health Aff.* 154-163 (2001); GAO, *supra* note 10; Wicks, *supra* note 10; Elliot K. Wicks and Mark A. Hall, *Purchasing Cooperatives for Small Employers: Performance and Prospects*, 78 *Milbank Q.* 511-546 (2000).

<sup>12</sup> See Randall R. Bovbjerg, *Lessons for Health Reform from the Federal Employees Health Benefit Program* (Urban Institute 2009).

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

Three bills are currently pending in Congress, HR 3200 in the House and separate bills reported out of the Health, Education, Labor, and Pensions (HELP) Committee and the Finance Committees in the Senate. HR 3200 has in fact been marked up by three committees, the Energy and Commerce, Ways and Means, and Education and Labor Committees. I have located few amendments specific to the exchange provisions of HR 3200 (which does, unfortunately, not necessarily mean that more do not exist) and as of this writing a version incorporating and reconciling all amendments does not exist. The description that follows is based on HR 3200 as it was introduced to the Energy and Commerce Committee, the last of the committees to mark up the bill. The Finance language is from the final committee bill, and the HELP language from the amended Chairman's mark, without most amendments. Section numbers in the notes refer to either the section number of the bill in which the language is found or, where it is more specific, the section number in amendments or additions to a pre-existing law created by the bill.

The questions that follow are intended to illuminate the different approaches taken by the different bills.

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

HR 3200. The exchange operates at the national level, established within a new Health Choices Administration.<sup>13</sup> The Commissioner of the HCA can delegate authority to administer an exchange to a state or group of states if specific requirements are met, subject to revocation if the state ceases to meet the requirements of the bill.<sup>14</sup> The Commissioner retains enforcement authority regardless, and can specify further functions retained by the Commissioner and not delegated.<sup>15</sup>

HELP. The HELP bill calls exchanges gateways. They must be operated by governmental agencies or nonprofit entities, and are funded by surcharges on the insurance coverage bought through them.<sup>16</sup> They will normally function at the state level, but regional gateways can exist involving more than one state, and states may have more than one gateway serving distinct geographic areas.<sup>17</sup> Competing gateways within the same area are not permitted. "Establishing states," (states that enact the insurance reforms provided under subtitle A of the bill and provide insurance coverage to state and local employees) may establish their own gateways.<sup>18</sup> "Participating states" must adopt the insurance reforms and cover their state and local employees

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<sup>13</sup> § 201(b).

<sup>14</sup> §§ 208(a), (c)(2).

<sup>15</sup> § 208(d)(2).

<sup>16</sup> § 3101(b)(2), (5).

<sup>17</sup> § 3101(f)

<sup>18</sup> §§ 3104(a), (b).

but can request HHS to establish a gateway rather than establishing one themselves.<sup>19</sup> If, within four years of the enactment of the statute, a state fails to adopt the subtitle A reforms, those reforms will become immediately effective as a matter of federal law and HHS must establish a gateway in the state.<sup>20</sup> A state's residents will only become eligible for federal premium subsidies, however, if the state provides health insurance for its state and local government employees.

Finance bill. The states must establish exchanges by 2013 and interim exchanges by 2010.<sup>21</sup> Initial federal funding is provided for start-up costs.<sup>22</sup> If a state fails to do so, the federal government is required to contract with a non-governmental entity to create an exchange.<sup>23</sup> States do not need to establish an exchange if they can create an equally effective alternative.<sup>24</sup> States must create both an individual market insurance exchange and a small business health options (SHOP) program.<sup>25</sup> These can be the same exchange. The states may subcontract exchange functions.<sup>26</sup> Regional exchanges can also be established by interstate compacts.<sup>27</sup> The Secretary is supposed to establish and maintain a database of plan offerings for the exchanges.<sup>28</sup>

## *2) What is the role and what are the duties of the exchange?*

HR 3200. An exchange must: 1) establish standards for, accept bids from, negotiate and enter into contracts with qualified health benefit plans, 2) facilitate outreach and enrollment, 3) establish a risk pooling mechanism, 4) establish consumer protections,<sup>29</sup> and 5) administer subsidies.<sup>30</sup>

HELP. Gateways are responsible for certifying qualified health plans; providing consumers with information regarding health plans (network availability, premiums, out-of-pocket expense, use of preventive services); and collecting, analyzing, and responding to complaints and concerns regarding coverage.<sup>31</sup> The Gateways are supposed to identify individuals who lack qualifying coverage and to help them to enroll in a qualified health plan, Medicaid, CHIP or another federal

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<sup>19</sup> § 3104(c).

<sup>20</sup> § 3104(d)

<sup>21</sup> §§ 2225(b); 2235(a).

<sup>22</sup> § 2237(c).

<sup>23</sup> § 2225(b)(1)(B).

<sup>24</sup> § 2226.

<sup>25</sup> §§ 2225(b)(1); 2235(a).

<sup>26</sup> § 2235(b)(3)

<sup>27</sup> § 2235(b)(2).

<sup>28</sup> § 2235(e)(2)(C).

<sup>29</sup> § 201(b)

<sup>30</sup> § 241(b).

<sup>31</sup> § 3101(b)(4).

program.<sup>32</sup> Gateways are responsible for certifying health plans that meet the requirements of 3101(l) if “The Gateway determines that making available such health plan through such Gateway is in the interests of qualified individuals and qualified employers....”<sup>33</sup>

Finance. An exchange must: 1) provide a standard enrollment application for individuals and small businesses, 2) provide a standardized format for presenting insurance options, 3) create standardized marketing requirements for insurers, 4) develop and implement a rating system for insurance, 5) make available a call center for customer support, 6) provide for insurance enrollment at hospitals, schools, DMVs, social security offices, etc., and 7) conduct eligibility determinations for tax credits and subsidies.<sup>34</sup>

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

HR 3200. Individuals who don’t have employer or public coverage; employees of employers with up to 10 employees in 2013, 20 employees in 2014, and larger employers as permitted by the Commissioner 2015 and after.<sup>35</sup> If an employer offers insurance through an exchange, the employer contributes to the premiums through the exchange and the employees may enroll in any qualified insurer.<sup>36</sup>

HELP. “Qualified individuals” and “qualified employers” may purchase insurance through gateways.<sup>37</sup> A “qualified individual” includes an individual who resides in a state; is not incarcerated; is not eligible for public or employment-based coverage (unless the employment-based coverage does not meet minimum statutory requirements or is not affordable); and whose income exceeds 150% of the poverty level.<sup>38</sup> A “Qualified employer” means an employer who meets criteria established by a participating state or by HHS in other states.<sup>39</sup> In default of state or HHS-developed criteria, an employer may purchase insurance through an exchange for its employees if it has fewer than 50 employees. A qualified employer may specify the tier of coverage that it will cover for its employees (see below), but the employee may choose any insurer that offers coverage in that tier.<sup>40</sup>

Finance Committee. Any individual who is a legal resident and not incarcerated and who is seeking insurance in the nongroup market may purchase insurance through the exchange.<sup>41</sup>

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<sup>32</sup> § 3101(b)(7).

<sup>33</sup> § 3101(d).

<sup>34</sup> § 2236. These functions can also be performed by agreement by HHS or a state.

<sup>35</sup> § 202(c).

<sup>36</sup> § 202(e).

<sup>37</sup> § 3101(b).

<sup>38</sup> § 3116(a)(4).

<sup>39</sup> § 3116(a)(2).

<sup>40</sup> § 3101(h)(2).

<sup>41</sup> §§ 2231(a)(1); 2232(a), (c).

Beginning in 2015, states must allow small businesses with up to 100 employees to purchase insurance through an exchange.<sup>42</sup> Beginning in 2017, states may allow employers over 100. Employers can limit the qualified health plans or levels of coverage that their employees may purchase through the exchange.<sup>43</sup> Employees who are not offered affordable coverage (10% of income) can enroll in exchange.<sup>44</sup> Medicaid recipients between 100 and 133% of poverty can get insurance through exchange.<sup>45</sup> Members of Congress and their staff can only purchase insurance through the exchange.<sup>46</sup>

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

HR 3200. Only grandfathered policies can be sold to individuals outside of the exchange.<sup>47</sup> Employers can purchase qualified health plans outside of exchange for employees.<sup>48</sup>

HELP. Individuals and groups may retain grandfathered policies as long as their terms do not change significantly.<sup>49</sup> Plans that provide only “minimum qualifying coverage”<sup>50</sup> but that are not “qualified health plans” cannot be offered within the gateway or qualify for premium subsidies, but can be sold to individuals and employers outside of the exchange (and thus satisfy the individual and employer mandates).<sup>51</sup> The statute specifically provides that coverage need not be bought within the exchange, so plans with inferior coverage will continue to exist outside of the exchange.<sup>52</sup>

Finance. Individuals and employers can choose whether to purchase insurance through or outside of the exchange.<sup>53</sup> All qualified health benefit plans must be offered through the exchange.<sup>54</sup> The legislation provides for insurance to be offered under interstate compacts and

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<sup>42</sup> §§ 2230(a); 2231(a)(2); 2232(b); 2235(d).

<sup>43</sup> § 2231(a)(2)(A).

<sup>44</sup> § 36B(c)(2)(C). An employer that fails to offer insurance and whose employees receive affordability credits through the exchange must pay a fee determined by multiplying the average credit nationwide times the number of employees receiving credits to a maximum of \$400 per employee

<sup>45</sup> § 1601.

<sup>46</sup> § 2231(a)(3).

<sup>47</sup> § 102(c)(1).

<sup>48</sup> § 312(a)(1).

<sup>49</sup> § 131.

<sup>50</sup> § 3013(b)(2)

<sup>51</sup> §§ 3101(c)(2); 3111(b)(1); 3116(a)(5).

<sup>52</sup> § 3101(c)(1).

<sup>53</sup> § 2231(a) Self-insured employers may not offer insurance through the exchange.

<sup>54</sup> § 2231(b). Qualified health benefits plans are plans that comply with the health insurance reforms and affordable health coverage requirements of the bill. § 2201(b).

national plans. National plans may also be offered through state exchanges.<sup>55</sup> The bill allows grandfathered policies outside of the exchange to be renewed and employers can add new employees to them, but no tax credits are available for grandfathered plans.<sup>56</sup> The states are permitted to offer a “basic” health plan outside of the exchange to individuals who do not have access to affordable coverage through their employment and who have household income of between 133% and 200% of poverty.<sup>57</sup> This coverage would be available outside of the exchange.

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<sup>55</sup> § 2227(b).

<sup>56</sup> § 2221.

<sup>57</sup> § 2228

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

HR 3200. Benefit plans are organized so as to fit into one of four tiers: basic, enhanced, premium, and premium plus.<sup>58</sup> The tiers are defined in terms of actuarial value compared to a reference essential benefit package without cost-sharing.<sup>59</sup> The basic plan must cover 70% of actuarial value, the enhanced plan 85% and the premium plan 95%.<sup>60</sup> Premium plus plans may offer extra benefits. All insurers must offer basic plan. If they offer a basic plan, they may offer an enhanced plan. If they offer an enhanced plan, they may offer a premium plan. If they offer a premium plan, they may offer a premium plus plan.<sup>61</sup> All qualified health benefits plans, in or out of the exchange, must cover essential services, limit cost-sharing (with no cost-sharing for preventive services), not include annual or lifetime limits, and assure network adequacy.<sup>62</sup> If plans do not offer an adequate provider network, cost-sharing for out-of-network providers cannot exceed that for in-network providers.<sup>63</sup> Plans marketed within the exchange (and plans marketed outside the exchange to the extent required by the Commissioner) must also comply with fair marketing, fair grievance and appeal, and transparency standards.<sup>64</sup>

HELP. The HELP bill also classifies benefit plans offered through the exchange in tiers, but its tiers are classified according to both actuarial value and maximum cost-sharing.<sup>65</sup> The basic plan must provide coverage with an actuarial value of at least 76% and cost-sharing not greater than that permitted under health savings account-eligible high-deductible health plans; a higher tier must provide coverage with 84% actuarial value and cost-sharing not exceeding 50% of maximum HSA/HDHP cost-sharing; and a third tier must cover 93% of actuarial value and cost-sharing not exceeding 20% of HSA/HDHP maximum cost-sharing. Gateways may only offer “qualified health plans,” while individual premium credits are only available for “qualified health plans.”<sup>66</sup> “Qualified health plans” have to be certified by a gateway, agree to offer plans in at least the two higher cost-sharing tier alternatives under the bill, and meet the requirements promulgated by the Secretary.<sup>67</sup> Gateways can only certify plans that meet the requirements of 3101 if the gateway “determines that making available such health plan through such Gateways is in the interests of qualified individuals and qualified employers in the State or States in which

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<sup>58</sup> § 203.

<sup>59</sup> § 122(c)(3)(B)

<sup>60</sup> §§ 122(c)(3)(A); 123(b)(5).

<sup>61</sup> § 203(b)

<sup>62</sup> §§ 121; 122

<sup>63</sup> § 204(c)(3).

<sup>64</sup> §§ 131; 132; 133

<sup>65</sup> § 3111

<sup>66</sup> § 3101(c)(3).

<sup>67</sup> § 3116(a)(3)..

such Gateway operates,”<sup>68</sup> which might give gateways some scope for negotiating with plans prior to including them. Additional certification requirements include:

- § Not employing marketing practices that discourage high-needs enrollees;
- § Using methods to ensure that insurance products are simple, comparable, and structured for ease of consumer choice;
- § Ensuring network adequacy and a wide choice of providers;
- § Provision of detailed information on benefits, cost-sharing, service area; premiums, methods of accessing providers, and a grievance and appeals process.
- § Coverage of essential benefits as provided in 3103(a);
- § NCQA accreditation or equivalent;
- § A quality improvement strategy (defined in 3013(m) to include a grab bag of current ideas for strategies to encourage quality and patient safety);
- § Adequate procedures for appeals of coverage determinations;
- § Not establishing a benefit design that is likely to substantially discourage enrollment by qualified individuals; and
- § Compliance with mental health parity requirements.<sup>69</sup>
- § Under committee amendments, providers cannot be excluded for refusing to assist in suicide or perform abortions for reasons of conscience.

The NAIC is supposed to develop model criteria, which HHS is supposed to consider. After January 1, 2012, plans may only contract with providers who meet specific patient safety and quality standards to be developed.

Finance. The Finance bill applies virtually uniformly to all insurance plans covering individuals and small groups inside and outside of the exchange. The Finance bill also has four tier levels, bronze, silver, gold, and platinum plus an extra catastrophic plan for adults under the age of 26<sup>70</sup> and child-only plans.<sup>71</sup> The tiers are defined in terms of actuarial value compared to a reference plan, with values set at 65%, 70%, 80%, and 90%, while the young adult catastrophic plan allows cost-sharing up to HSA/HDHP levels, except for preventive services. Plans must provide applicants, enrollees, and members with an outline of coverage following uniform standards promulgated by HHS.<sup>72</sup> All plans must cover essential benefits as listed in the statute and defined by HHS.<sup>73</sup> Emergency services must be available without prior authorization and without copayments or cost-sharing for emergency visits for out-of-network providers that exceed those for in network providers.<sup>74</sup> Plans cannot have annual or lifetime limits.<sup>75</sup> All plans must comply

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<sup>68</sup> § 3101(d)

<sup>69</sup> § 3101(l), (p).

<sup>70</sup> § 2243

<sup>71</sup> § 2243(d)

<sup>72</sup> § 2205

<sup>73</sup> §§ 2241; 2242. HHS may not require benefits more extensive than those covered by the typical employer plan. § 2242(e)(3)..

<sup>74</sup> § 2242(d)

<sup>75</sup> § 2242(a)(4).

with the rating reforms and benefit options applied to insurance plans generally by the law.<sup>76</sup> Cost-sharing is limited to the amounts permitted for HSA-linked high-deductible health plans.<sup>77</sup> Small employers must offer plan with a deductible that does not exceed \$2000 for individuals, \$4000 for families.<sup>78</sup> No cost-sharing for preventive services is permitted except where value-based insurance design.<sup>79</sup> All plans must provide parity in cost-sharing between various categories of benefits (inpatient, outpatient, physician, other items and services).<sup>80</sup> Parity in cost-sharing among different kinds of services requirements must be met for all plans.<sup>81</sup> Insurers must charge the same premiums for plans sold inside and outside of the exchange (and whether or not a policy is sold directly or through an agent).<sup>82</sup> All individuals, in and out of the exchange, must be included in a single risk pool, as must all enrollees who are members of small groups.<sup>83</sup> A state may elect to combine the individual and small group risk pools. Flexibility in plan design is permitted if it does not lead to adverse selection.<sup>84</sup> Each offeror of a qualified plan available through the exchange (presumably all individual and small group plans) must offer an internal and external appeals process, plus opportunity for judicial review.<sup>85</sup>

Only a few requirements seem to apply in particular to plans within the exchange. Exchange must offer at least one plan that covers abortion and one that does not.<sup>86</sup>

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

HR 3200. Nongroup insurance cannot be sold outside the exchange. The consumer protections provided by sections 131, 132, and 133 are applied to plans outside the exchange only to the extent determined by the Commissioner. Certain requirements such as covering essential community providers, providing culturally and linguistically appropriate services, not compelling providers to contract with exchange-participating plans, and others also only apply within the exchange and do not apply to non-exchange insurers.<sup>87</sup>

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<sup>76</sup> § 2201(b).

<sup>77</sup> § 2242(c)(2). Cost-sharing does not include out of network payment differentials or expenses for uncovered services.

<sup>78</sup> § 2242(c)(3).

<sup>79</sup> §§ 2242(c)(1), (c)(5).

<sup>80</sup> § 2242(c)(4).

<sup>81</sup> § 2242(c)(4).

<sup>82</sup> § 2241(3).

<sup>83</sup> § 2211(b).

<sup>84</sup> § 2241(e)(4).

<sup>85</sup> § 2225(e).

<sup>86</sup> § 2245(a)(3).

<sup>87</sup> § 204(b).

HELP. Health plans outside the exchange can offer “minimum qualifying coverage,” which is a lower standard than the qualified health benefit plans that must be offered through the exchange. “Minimum qualifying coverage” must meet standards promulgated by the HHS Secretary under 3103(a)(1)(B). These standards must exclude coverage that covers only a single disease or unreasonably limited set of diseases or conditions or that has out of pocket limits above those permitted under HSA compatible HDHPs.<sup>88</sup> Otherwise HHS must “establish such criteria . . . in a manner that results in the least practicable disruption of the health care marketplace, consistent with the goals and activities under this title.”<sup>89</sup> Separate criteria can be established for young adults. Minimum qualifying coverage need not include coverage of “essential services,” which must be covered by qualified health plans. Minimum qualifying plans also need not apparently meet the requirements that must be met for a qualified health plan to be certified by the gateway, described above.<sup>90</sup> Health insurance issuers must, however, consider all individual enrollees, inside and outside the exchange, to be in a single risk pool, and all small group enrollees, inside and outside the pool, to be in a single risk pool.<sup>91</sup>

Finance. The individual mandate requires coverage under a qualified health benefit plan, employer coverage, or coverage under a public program.<sup>92</sup> Small employers must provide qualified health coverage, large employers are held to lesser standards.<sup>93</sup> Qualified health plans must meet the same requirements inside and outside of the exchange.<sup>94</sup>

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

HR 3200. The Commissioner is supposed to develop standard definitions of terms used in health insurance coverage.<sup>95</sup> The Commissioner is also supposed to educate and inform the public, including vulnerable populations, about the exchange and exchange-participating plans.<sup>96</sup> The Commissioner is required to provide information on exchange-participating health plans--including information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction--in plain language and comparable form.<sup>97</sup> Qualified health plans are supposed to provide information in plain language regarding plan terms and conditions; plan payment policies and practices; financial disclosure; and data on enrollment, disenrollment,

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<sup>88</sup> § 3103(b)(2).

<sup>89</sup> § 3103(b)(2).

<sup>90</sup> § 3101(l).

<sup>91</sup> § 3101(j).

<sup>92</sup> § 5000A.

<sup>93</sup> § 2244. Large group plans cannot impose unreasonable annual or lifetime limits, must limit annual cost-sharing, and cannot require cost-sharing for preventive services.

<sup>94</sup> § 2241

<sup>95</sup> § 142.(e).

<sup>96</sup> § 205(a).

<sup>97</sup> § 205(c).

number of claim denials, rating practices, and payments with respect to out-of-network services.<sup>98</sup> Plans must give advance notice of plan changes.<sup>99</sup>

HELP. Gateways are required to develop and make available tools to provide consumers with accurate information on expected premiums and out-of-pocket expenses, the availability of in-network and out-of-network providers, the cost of the surcharge for using the exchange, data on the use of preventive services in the plan, and other matters on cost and expected experience under the plan.<sup>100</sup> Gateways are supposed to enter into contracts with “navigators” to conduct public education and distribute information about health plans and eligibility for affordability credits, including culturally and linguistically appropriate information.<sup>101</sup>

Finance. The bill contains extensive provisions on transparency and accountability that operate independent of the exchange. The NAIC is supposed to develop a standard format for describing health insurance coverage in an understandable and readable format of not more than four pages in length, describing dollar amounts of coverage for particular services; exceptions, reductions and limitations on coverage; cost-sharing provisions; renewability and continuation of coverage provisions; and a contact number and web address for requesting more information.<sup>102</sup> HHS is supposed to develop standard definitions of insurance and medical terms; standards for providing description of coverage, cost-sharing, and exclusions and limits for patient claims scenarios; and a format for providing insureds with an annual personalized statement summarizing their use of health care services and paid claims.<sup>103</sup>

*8) May agents and brokers collect commissions for exchange policies?*

HR 3200. Yes, under a Blue Dog amendment.

HELP. Not addressed.

Finance. States can establish a broker commission schedule.<sup>104</sup> Agents and brokers can enroll individuals and employers in any option available through exchanges.<sup>105</sup>

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<sup>98</sup> § 133(a)

<sup>99</sup> § 133(c).

<sup>100</sup> § 3101(b)(4).

<sup>101</sup> § 3105.

<sup>102</sup> § 1503

<sup>103</sup> § 1504.

<sup>104</sup> § 2235(c).

<sup>105</sup> § 2231(d)

9) *How is enrollment handled through the exchange?*

HR 3200. The exchange offers open enrollment once a year and special enrollment periods for special circumstances.<sup>106</sup> Individuals who receive subsidies and who do not otherwise enroll in plans are automatically enrolled.<sup>107</sup> The Commissioner is responsible for disseminating information and assisting with choice.<sup>108</sup> Premiums are paid directly to plans.<sup>109</sup>

HELP. The Gateways are supposed to identify individuals who lack qualifying coverage and to help them to enroll in a qualified health plan, Medicaid, CHIP, or another federal program.<sup>110</sup> A CHIP eligible person (or his or her parent) can enroll either in CHIP or in a qualified health plan. Qualified individuals may enroll in any available qualified plan.<sup>111</sup> Employers may limit their support for coverage to plans within a particular tier, and then employees may only choose plans within that tier.<sup>112</sup> Section 3105 provides for grants for “navigators,” community, consumer, labor, and trade organizations that are supposed to help with public education and plan enrollment. They are not supposed to be health insurance issuers or receive kickbacks from health insurers.

Finance. The Finance bill provides for standardized enrollment forms and annual open enrollment.<sup>113</sup> Consumers can enroll in health care plans through their local hospitals, schools, departments of motor vehicles, Social Security offices, and any other offices designated by the state. Individuals can also enroll in state programs such as Medicaid or CHIP through the exchange.<sup>114</sup>

10) *Does the exchange administer a risk adjustment program? Does it reach outside the exchange?*

HR 3200. Provides for risk pooling for plans within exchange through risk-adjusting of premiums.<sup>115</sup>

HELP. Gateways are supposed to assess charges on all health plans and health insurance issuers (but not self-insured ERISA plans) that insure individuals or employers eligible for exchange participation with lower than average risk and then to provide payments to plans and issuers

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<sup>106</sup> § 205(b).

<sup>107</sup> § 205(b)(3).

<sup>108</sup> § 205(c).

<sup>109</sup> § 205(b)(4).

<sup>110</sup> § 3101(c)(7).

<sup>111</sup> § 3101(h).

<sup>112</sup> § 3101(h)(2).

<sup>113</sup> § 2236(d).

<sup>114</sup> § 2239.

<sup>115</sup> § 206(b).

(other than self-insured ERISA plans) with higher than average risks.<sup>116</sup> HHS is supposed to establish criteria and methods for doing this.

Finance. The bill seems to include three risk adjustment programs. The first is a permanent program to be administered by the states and include all qualified health benefit plans and all grandfathered plans.<sup>117</sup> This program covers qualified health benefit plans and grandfathered plans, inside and outside of the exchange, and is administered by entities chosen by the states based on adjustment of premiums according to a risk adjustment plan developed by HHS or a state's own plan. It is unclear how the entity will adjust premiums outside of the exchange. Second, the bill includes a transitional reinsurance program to be implemented by the states. The bill has a risk adjustment program for the years 2013 to 2015 but it is not administered by the exchanges.<sup>118</sup> This program seems to apply only to the individual market. The federal government prequalifies entities to conduct risk adjustment and the state picks among these entities. Reinsurance premiums are collected from all insurers and are available for individuals enrolled in the individual exchange plans with high-risk conditions. During 2013 - 2015, a voluntary risk corridor program would be available as well for insurers in the individual and small group market.<sup>119</sup> The legislation does not specify whether either of these programs is limited to the exchange, although the purpose of the reinsurance program is to stabilize premiums in the individual market as the exchange is implemented.

*11) Are subsidies available outside of the exchange?*

HR 3200. Affordability credits are distributed through the exchange.<sup>120</sup>

HELP. No.

Finance. Premium and cost-sharing credits are available and administered through the exchange.<sup>121</sup>

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

HR 3200. No

HELP. It does not play a major role. Affordability is tied to the cost of the basic health plan. The mandate only applies in establishing or participating states.<sup>122</sup>

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<sup>116</sup> § 3101(c)(6).

<sup>117</sup> § 2212.

<sup>118</sup> § 2213

<sup>119</sup> § 2214

<sup>120</sup> § 241(b).

<sup>121</sup> §§2236(f); 2238; 2247(b).

<sup>122</sup> § 59B.

Finance. Yes, the exchange (or state) certifies that no policy is affordable to an individual seeking to be excused from the mandate.<sup>123</sup>

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

HR 3200. Exchanges are apparently not required to accept all qualified plans.<sup>124</sup> They can solicit bids and negotiate with entities offering plans. The federal acquisition regulations do not apply.

HELP. Gateways are responsible for certifying health plans that meet the requirements of 3101(l), and if “The Gateway determines that making available such health plan through such Gateway is in the interests of qualified individuals and qualified employers....”<sup>125</sup> This could give the gateway room to negotiate, although this is not clearly the intent of the provision.

Finance. The exchange must offer all licensed qualified health benefit plans.<sup>126</sup> Each state must assure that its exchange offers at least one health plan that is the equivalent of the standard Blue Cross/Blue Shield plan offered by the FEHBP.<sup>127</sup>

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

221(b). The Public plan is offered through the exchange only.<sup>128</sup>

HELP. The public plan is offered through the exchange only.<sup>129</sup>

Finance. There is no public plan. Cooperatives are available through the exchange.

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

HR 3200. The Commissioner provides a grievance and complaint mechanism.<sup>130</sup> The Commissioner can apply intermediate sanctions to insurers within the exchange or terminate participation of insurers.<sup>131</sup>

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<sup>123</sup> § 2236(f).

<sup>124</sup> § 204(a).

<sup>125</sup> § 3101(d).

<sup>126</sup> § 2231(c)

<sup>127</sup> § 2242(f).

<sup>128</sup> § 221(b).

<sup>129</sup> § 3106

<sup>130</sup> § 204(c)(4).

<sup>131</sup> § 204(c)(4).

HELP. The exchange does not have explicit enforcement responsibilities, although it is required to certify qualified plans.

Finance. States are responsible for certifying, recertifying and decertifying plans for participation in the exchange.<sup>132</sup>

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

HR 3200. There are no remedies explicitly available to individuals. A sanctioned insurer has the opportunity to submit a corrective action plan and for notice and hearing and an appeal before termination, except where there is an imminent and serious risk to health.<sup>133</sup>

HELP. There are no provisions in the HELP bill for health insurers to appeal or challenge determinations that their plans are not qualified. The bill provides for the determination and redeterminations of eligibility for individuals for premium and cost-sharing subsidies.<sup>134</sup> HHS is supposed to provide for procedures for “resolving appeals of such determinations.” Eligibility can be terminated “after providing notice” for failure to provide information for eligibility determination or for ineligibility.<sup>135</sup> Ordinarily, HHS is supposed to delegate to the gateway or to the state in which it operates authority to make eligibility decisions.<sup>136</sup> This authority can be revoked if the gateway or state fails to conform to federal requirements after notice and hearing. No provision is made for judicial review of eligibility determinations.

Finance. Notice must be given to applicants for premium subsidies of inconsistencies or inability to verify information with an opportunity to resolve the problem.<sup>137</sup> The federal government must also provide an appeal process for adverse determinations on citizenship or financial eligibility issues.<sup>138</sup>

## **Legal Issues Involving Exchanges**

The House and the Senate bills take very different approaches to organizing health insurance exchanges. These differences represent different policy choices, choices that Congress is on the whole free to make. Before evaluating these choices, however, we must first ask are they legal? Does Congress face any legal constraints in the choices it makes, or can it do as it pleases?

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<sup>132</sup> § 2236(b)

<sup>133</sup> § 204(c)(4).

<sup>134</sup> § 3111(d).

<sup>135</sup> § 3111(d)(3)(F).

<sup>136</sup> § 3111(d)(3)(B).

<sup>137</sup> § 2238(e)(3).

<sup>138</sup> § 2238(f).

The only absolute constraints on Congress are those imposed by the Constitution. Even if the legislation is constitutional, however, Congress should attend to how the legislation interacts with existing federal law and state law. Each of these issues will now be discussed.

### *Constitutional Constraints*

The authority of Congress to establish insurance exchanges under the Supreme Court's current understanding of the Constitution is unquestionable. For over sixty years the Supreme Court has recognized the power of Congress under the Commerce Clause to regulate the sale of insurance.<sup>139</sup> Health insurance is in fact sold in interstate commerce and used to purchase products that are sold in interstate commerce. The HR 3200 approach of establishing federal insurance exchanges to regulate the sale of insurance is thus clearly within the power of Congress.

The approach taken by the Senate bills is somewhat more problematic. Both bills would depend on the states in the first instance to implement exchanges. Under the HELP bill the states would be encouraged to establish exchanges complying with federal standards. Subsidies would be offered to states that established exchanges. In states that either requested the federal government to establish an exchange on their territory or that failed to establish an exchange themselves, the federal government would have fallback authority to establish an exchange itself. The Finance Committee bill, explicitly states that the states "shall" establish individual and SHOP exchanges.<sup>140</sup> But like the HELP bill it provides a fallback—if a state fails to do so after two years, the federal government may contract with a non-governmental entity to establish an exchange.

Congress does not have the power to "commandeer" state officials to carry out federal regulatory programs under its enumerated powers and is precluded from doing so by the Tenth Amendment.<sup>141</sup> Congress probably cannot, therefore, "require" the states to establish exchanges. Under the Spending Clause, Congress can require the states to implement a program in accordance with federal law if compliance is a condition of funding.<sup>142</sup> States that decline the funding do not need to comply. Although the Senate bills only offer start-up funding, states that accepted it would probably thereafter have to comply with federal requirements. More importantly, federal premium subsidies will be paid through the state exchanges, thus states that choose not to establish an exchange will risk control over a considerable flow of money into their state. Congress can alternatively invite the states to implement federal programs, retaining fallback authority in the federal government if a state fails to accept the federal invitation. This is the approach taken by the HELP bill and the Finance bill. It is constitutional, although it will inevitably be awkward for the federal government to actually determine that a state exchange is out of compliance with federal law and then to move in to take over the program.

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<sup>139</sup> *South-Eastern Underwriters Ass'n v. United States*, 322 U.S. 533 (1944).

<sup>140</sup> § 2235

<sup>141</sup> *Printz v. U.S.*, 521 U.S. 898 (1997); *New York v. U.S.*, 505 U.S. 144 (1992).

<sup>142</sup> *South Dakota v. Dole*, 483 U.S. 203 (1987).

Assuming that Congress can work out a relationship with the states in administering the exchanges, what further constitutional constraints does it face? The Fifth Amendment of the Constitution provides that no one shall be “deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.” The right to contract for the sale of insurance is a liberty or property interest protected by the Due Process Clause and arguably a private property interest protected by the Takings Clause.<sup>143</sup>

Insurance regulations have often faced constitutional challenges. They have generally been challenged as denying substantive due process or as violating the takings clause.<sup>144</sup> Government regulation of economic conduct, including insurance regulation, is acceptable under the Due Process and Equal Protection clauses as long as it bears a rational relationship to a legitimate government interest.<sup>145</sup> A challenge to a regulatory law brought under the Takings clause--which bars the government from taking private property for public use without just compensation--can only succeed if the law goes “too far” in the severity of its impact.<sup>146</sup> The Court has applied a three-part test on an ad hoc basis to determine whether a regulatory taking has occurred. It considers the diminution in value of the property imposed by the regulation, the

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<sup>143</sup> See *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 223-24 (1986) (contact rights can be property for purposes of the takings clause, but when contracts deal with a issue that is subject to regulation by Congress, parties may not remove transactions from the regulatory power of Congress by making contracts.). See also, *Peick v. Pension Benefit Guaranty Corporation*, 724 F.2d 1247 (7<sup>th</sup> Cir. 1983) (regulation of contact rights should be evaluated under due process, not the takings clause).

Insofar as the exchanges are understood as administering a benefits program (i.e. the affordability subsidies) rather than as regulators regulating insurance companies, it is arguable that no particular insurer has a property or liberty right in participating in the program. See *Geriatrics, Inc. v. Harris*, 640 F.2d 262 (10<sup>th</sup> Cir. 1981) (no property right in nursing facility to renewal of certification to participate in Medicaid). An insurer would probably have a right, however, to due process before being terminated for cause. *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975); *Patchogue Nursing Center v. Bowen*, 797 F.2d 1137 (2<sup>nd</sup> Cir. 1986).

<sup>144</sup> Rufus E. Brown, *Constitutional Limits on State Insurance Regulation*, 29 *Tort & Ins. L. J.* 651 (1994).

<sup>145</sup> See, e.g. *Exxon Corp. v. Eagerton*, 462 U.S. 176 (1983); *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955); and *New Jersey Ass’n of Health Plans v. Farmer*, 777 A.2d 385, 402 (N.J. 2000). Some states, however, have interpreted their state constitutions more restrictively to strike down economic regulation. See, e.g. *In re Certificate of Need for Aston Park Hosp. Inc.*, 193 S.E.2d 729 (N.C.1973); *Chicago Title Ins. Co. v. Butler* (770 So.2d 1210 (Fla.2000); *Department of Insurance v. Dade County Consumer Advocate's Office*, 492 So.2d 1032 (Fla.1986).

<sup>146</sup> *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393 (1922). Different rules apply when physical property is taken, but are not relevant here.

extent to which the regulation interferes with the owner's investment-backed expectations, and the character of the government action.<sup>147</sup>

The government's power to regulate insurance is far reaching. Insurance has long been a heavily regulated industry, and constitutional challenges to requirements imposed by health reform legislation or by an exchange through regulation or negotiation are unlikely to succeed unless the requirements are wholly irrational or confiscatory.<sup>148</sup> In its many decisions reviewing insurance regulation, the Supreme Court has consistently permitted government broad regulatory powers. Half a century ago the Supreme Court stated "What was [said in an earlier case] about the police power-that it 'extends to all the great public needs' and may be utilized in aid of what the legislative judgment deems necessary to the public welfare, is peculiarly apt when the business of insurance is involved-a business to which the government has long had a 'special relation.'"<sup>149</sup> That case upheld a California statute that allocated high-risk insureds among auto insurers through an assigned risk scheme. The Court summarily disposed of the appeal, citing twenty-one cases in which the Court had earlier rejected due process challenges against various state insurance regulations, including rate-setting schemes. The Court has not since deviated from this course.

Provisions in the legislation requiring insurers to cover particular benefits or to standardize benefits are very unlikely to be invalidated. Courts have repeatedly rejected constitutional challenges to state insurance mandates including statutes requiring insurers to provide maternity coverage<sup>150</sup> and coverage for mental disorders.<sup>151</sup> In the one actual reported case involving an insurance purchasing exchange, a federal court in Kentucky rejected a Due Process and Commerce Clause challenge brought by an insurer against a statutory requirement that insurers offer only standard plans approved by a health policy board.<sup>152</sup>

Courts are also unlikely to invalidate risk-pooling or reallocation requirements such as those found in each of the current bills. Indeed, the regulation upheld in the Supreme Court case cited above imposed a risk reallocation scheme. In a case involving New York's attempt to create a risk-pooling mechanism the court observed that an insurer has no "constitutionally protected

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<sup>147</sup> Penn Central Trans. Co. v. City of New York, 438 U.S. 104 (1978); Connelly v. Pension Benefit Guar. Corp. 475 U.S. 211 (1986); Vesta Fire Ins. Corp. v. State of Fla., 141 F.3d 1427 (11<sup>th</sup> Cir. 1998).

<sup>148</sup> See O'Gorman & Young, Inc. v. Hartford Fire Ins. Co., 282 U.S. 251 (1931); Gerling Global Reinsurance Corp. of America v. Low, 296 F.3d 832 (9<sup>th</sup> Cir. 2002); Stephens v. State Farm Mut. Auto. Ins. Co. 894 S.W.2d 624 (Ky 1995) (discussing the application of the takings clause to insurance regulation cases).

<sup>149</sup> California State Auto. Ass'n Inter-Ins. Bureau v. Maloney, 341 U.S. 105, 109 (1951).

<sup>150</sup> Health Ins. Ass'n of America v. Harnett, 44 N.Y.2d 302, 376 N.E.2d 1280, 1284-1285, 405 N.Y.S.2d 634, 639 (1978).

<sup>151</sup> New Hampshire-Vermont Health Service v. Whaland, 410 A.2d 642 (1979)

<sup>152</sup> Golden Rule Ins. Co. v. Stephens, 912 F.Supp. 261 (E.D.Ky. 1995).

interest in maintaining a healthier than average risk pool.”<sup>153</sup> Federal and state courts have repeatedly upheld various schemes for reallocating and assigning risk among insurers.<sup>154</sup>

It is also unlikely that the courts would strike down legislation that would limit the number of insurers allowed to participate in health insurance exchanges.<sup>155</sup> In analogous areas, courts have upheld the constitutionality of certificate of need programs, which prohibit private health care providers from entering markets or expanding their market participation without permission from the state.<sup>156</sup> The courts would probably also uphold legislation prohibiting insurers that sold within the exchange from selling policies outside of it. Analogous Medicare amendments that prohibited physicians from selling their services to Medicare beneficiaries outside of the Medicare program unless the physician left the Medicare program for two years have been upheld.<sup>157</sup>

The authority of the government to regulate insurance, however, is not unbounded. A number of cases have successfully challenged particularly severe forms of insurance regulation under the Takings Clause. To this point, takings challenges have been brought against state rather than federal insurance regulation, although the Takings Clause applies equally to both the federal and state governments. Successful challenges have been brought, for example, against laws rolling back or freezing rates, requiring insurers to fund residual markets using profits from other states or lines of business, applying assessments retroactively on insurers that have left a market, and prohibiting insurers from exiting markets.<sup>158</sup> The success of these challenges is to some extent specific to particular jurisdictions; laws similar to those successfully challenged in one jurisdiction have sometimes survived similar constitutional challenges in other jurisdictions.

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<sup>153</sup> Colonial Life Ins. Co. v. Curiale, 617 N.Y.S.2d 377 (1994).

<sup>154</sup> See Ala. Municipal Ins. Corp. v. Ala. Ins. Underwriting Ass’n, 2008 WL 4493433 (M.D.Ala. 2008) (upholding against takings challenge an assessment for an underwriting association formed to assure coverage of coastal properties); U.S. Fidelity & Guaranty Co. v. McKeithen, 39 F.Supp.2d 747 (Md. La. 1999) (upholding assessments for workers’ compensation fund); New Jersey Association of Health Plans v. Farmer, 777 A.2d 385 (N.J. 2000) (upholding assessments against HMOs to satisfy claims against insolvent HMOs). .

<sup>155</sup> See, e.g. Massachusetts Indem. and Life Ins. Co. v. Texas State Bd. of Ins., 685 S.W.2d 104 (Tex.App.1985) (limiting the number of temporary life insurance agents available to an insurer); Matter of Plan for Orderly Withdrawal From New Jersey of Twin City Fire Ins. Co, 591 A.2d 1005 (N.J. Super.A.D.,1991) (prohibiting an insurer from continuing to do business in some insurance lines if it dropped others).

<sup>156</sup> Goodin v. State of Oklahoma ex rel. Oklahoma Welfare Commission, Dept. of Institutions, Social and Rehabilitative Services, 436 F.Supp. 583 (D.C.Okl.. 1977); Attoma v. State Department of Social Welfare, 270 N.Y.S.2d 167 (1966); Merry Heart Nursing and Con. Home v. Dougherty, 330 A.2d 370 (1974).

<sup>157</sup> United Seniors Ass’n, Inc. v. Shalala, 2 F.Supp.2d 39 (D.D.C.,1998).

<sup>158</sup> Brown, supra note 144; United States Fidelity & Guaranty Co. v. McKeithen, 226 F.3d 412 (2000) (retroactive assessment on insurer who had left market).

In general, however, the courts have come to recognize that insurers have been treated by government like public utilities, and like public utilities insurers are ultimately entitled to rates that are not confiscatory and provide a “fair and reasonable return”<sup>159</sup> It is not enough that a rate barely protects the insurer from insolvency; it must in fact permit a reasonable return on investments.<sup>160</sup> But diminution in value of an insurer is not confiscation, indeed some courts have articulated the constitutional standard as protecting against “deep financial hardship.”<sup>161</sup> The Constitution does not require any particular form of rate regulation, only a rate that is not confiscatory.<sup>162</sup> Moreover, a reasonable rate of return is not guaranteed for each individual policy, but rather to the range of policies issued by the insurer.<sup>163</sup> Indeed, insurance rates are not necessarily constitutionally inadequate simply because aggregate rates are not sufficient to guarantee a profit to all companies engaged in a particular business.<sup>164</sup> Finally, the Constitution does not necessarily guarantee a return to businesses that are not “well and economically operated,” indeed it does not protect industries that are not conducted efficiently.<sup>165</sup> Health insurers who do not bargain vigorously with providers to bring down health care costs or control their own administrative costs cannot depend on the Constitution to assure them a continued profit.

The exchanges should not encounter serious constitutional barriers against imposing coverage mandates on insurers or implementing programs to reallocate risks among insurers. They are likely to be permitted to negotiate rates with insurers as long as insurers are not forced to accept rates that do not permit a reasonable return on their investment. Total exclusion from the market of insurers who are not able to negotiate rates that do permit a reasonable return on their investment or of insurers because there are enough insurers in the market may, however, prove problematic.

### *Other legal Issues*

Two other legal issues merit brief discussion. First, Congress should take care in aligning the proposed legislation with existing laws to avoid confusion and conflict. The primary laws that may cause problems are the McCarran-Ferguson Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Health Insurance Portability and Accountability Act of 1996

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<sup>159</sup> Guaranty National Ins. Co. v. Gates, 916 F.2d 508 (9<sup>th</sup> Cir. 1990); Calfarm Ins. Co. v. Deukmejian, 771 P.2d 1247 (Cal. 1989). See also F.P.C. v. Hope Natural Gas, 320 U.S. 591 (1944). (analyzing the implications of the takings clause for utility rate-setting).

<sup>160</sup> Geeslin v. State Farm Lloyds, 255 S.W.2d 786, 785 (Tex. Ct. App. 2008)

<sup>161</sup> 20<sup>th</sup> Century Insurance Co. v. Garamendi, 878 P.2d 566, 616-17 (Cal. 1994).

<sup>162</sup> See Duquesne Light Co. v. Barasch, 488 U.S. 299, 307-08 (1989)..

<sup>163</sup> Reinkemeyer v. Safeco Ins. Co. 16 P.3d 1069, 1074 (Nev. 2001).

<sup>164</sup> Aenta. Ins. Co. v. Hyde, 275 US 440, 447 (1928).

<sup>165</sup> Aetna Ins. Co. v. Hyde, 275 U.S. 440, 448 (1928); Automobile Insurers Bureau of Mass. v. Comm’r of Ins., 650 N.E. 2d 1234, 1242 (Mass. 1995).

(HIPAA). McCarran-Ferguson provides that federal statutes will not be presumed to preempt state insurance regulation “unless the law specifically relates to the business of insurance.”<sup>166</sup> Each of these bills clearly and explicitly does, so this should not be a problem.

Second, ERISA preempts state laws that “relate to” employee benefit plans, but specifically allows states to regulate insurers, but not self-insured plans.<sup>167</sup> The Finance Committee bill states that ERISA continues to apply to group health plans,<sup>168</sup> while HR 3200 states that ERISA continues to apply outside of the exchanges.<sup>169</sup> The HELP bill excludes self-insured ERISA plans from its risk adjustment provisions and from several of the insurance reforms but does not otherwise address the continued application of ERISA.<sup>170</sup>

The Senate versions of the reform legislation would seem to enhance the authority of the states over group health plans. Self-insured plans by definition do not participate in the exchanges, but other insurance reforms (no lifetime or annual limits or cost-sharing, for example) do apply to group plans generally and will be enforced through the states. To the extent that Congress delegates regulation of group health plans to the states through the exchanges, it must be clear as to how the new law relates to ERISA preemption.

HIPAA, provisions of which appear in the Public Health Act, ERISA, and the Internal Revenue Code, has been until now the primary federal law regulating insurance underwriting. The Senate HELP bill carefully integrates the new law into the existing requirements of HIPAA. HR 3200 and the Finance bill largely overwrite HIPAA without attempting to amend it section by section, although it presumably still applies to grandfathered plans. Better drafting here could save problems of interpretation down the line.

The second issue is how the reform legislation relates to state law. The states have traditionally been primarily responsible for regulating health insurance and the new legislation represents a massive shift in authority from the states to the federal government (although the Senate legislation largely redelegates authority to the states). The new federal legislation would preempt state law to the extent that it does so explicitly or that its terms conflict with state law. Each of the bills states that it is not intended to supersede state law except to the extent that state law is inconsistent with its terms.<sup>171</sup> While it might be difficult for Congress to be more specific as to when the federal law preempts state law and when it does not, the history of ERISA

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<sup>166</sup> 15 U.S.C. § 1012.

<sup>167</sup> 29 U.S.C. § 1144.

<sup>168</sup> Finance § 2225(c)(3). The bill also excludes self-insured plans from provisions of the legislation that apply to health benefit plans. § 2201(c).

<sup>169</sup> HR 3200, § 151(a)(2).

<sup>170</sup> HELP, §§ 9815(b), 3101(a)(6).

<sup>171</sup> HR 3200 § 151, HELP § 3101(n), Finance § 2225 (state laws that offer greater protection to insureds not preempted).

preemption, where more than twenty Supreme Court decisions have not yet sorted out the scope of preemption, suggests that this issue will lead to future difficulties.

### **Policy Issues Raised by the Legislation**

The different bills represent quite different understandings of what an exchange is, what it does, how it is organized, and how it functions. These differences are likely to significantly affect the extent to which the exchanges accomplish their goals and avoid the problems that have afflicted earlier attempts at creating and operating exchanges. These issues will be discussed next.

#### *Federal and State Relations*

The first, and perhaps ultimately most important issue, is whether the exchange is formed at the federal or state level. Under the HR 3200, the federal government is responsible for forming the exchange, although the Commissioner of Health Choices can allow a state that meets specific criteria to form its own exchange. Under the Finance Committee bill, the states are responsible for establishing exchanges, although the federal government can contract with a nonprofit entity to form an exchange if a state fails to do so. Under the HELP legislation, the states would have the option of creating exchanges, but may alternatively request the federal government to do so. If a state fails to create an exchange, the federal government has fallback authority to start one.

The health reform legislation is a federal law addressing problems that are national in scope. Americans throughout the country lack access to health care and are struggling with high and rapidly rising health care costs. Congress is attempting to create a national solution to this problem that will help all Americans. The exchanges should, by this logic, operate at the federal level as well.

There are, moreover, good policy reasons for locating the exchange at the national level. Most importantly, the exchanges are being created under federal law, will be carrying out functions specified by federal law, will be administering federal premium subsidies, and will initially receive federal start-up funds. As we have learned from our experience with Medicaid, HIPAA, and other programs, state implementation of a federal program is at best awkward.<sup>172</sup> As

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<sup>172</sup> Experience with HIPAA is particularly instructive, since it took the same approach of asking the states to implement legislation and providing a federal fallback option if they failed to do so. See Karen Pollitz, et al., Early Experience with “New Federalism” in Health Insurance Regulation, Health Aff., 19(4), July./Aug. 2000, at 7. Most states had already implemented the HIPAA group market reforms and those that had not already done so adopted them quickly. The states had been much less active in regulating the individual market and a number of states failed to implement the HIPAA reforms. Most states that did implement them chose one of the options permitted by the law other than the federal fallback position. In most states the option chosen was

noted above, the federal government cannot under our constitutional system “commandeer” state government for its purposes, and to secure state cooperation in implementing a federal program must either use the carrot of federal funds (as with Medicaid) or the stick of a threat of implementation of a federal fallback program in states that refuse to implement the mandated program themselves. In either event, the federal government ends up attempting to regulate a co-sovereign, an awkward position to be in. It is particularly difficult when large sums of money are flowing through the states, as would be true with the premium subsidies, creating a tempting pool for the states to use for their own purposes. This has been a constant problem in the Medicaid program.

There are reasons, of course, for locating the exchange at the state level. States have more experience with regulating insurance than the federal government. Some states even have had experience with forming and operating purchasing cooperatives (although, on the whole, that experience has not been positive, as noted above). Under each of the bills, the exchange has some regulatory functions and, in any event will need to coordinate its activities with state regulators. Insurance is marketed currently primarily at the state or sub-state regional level, and many insurance products (including most HMOs) are likely to continue to be state-specific. The use of

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to offer individuals coverage in the state high risk pool. Some states, however, simply did not comply. Some of these states notified HHS that they did not intend to comply and helped HHS to itself enforce the law. Others notified HHS that they would not comply at the very last minute before HHS enforcement was to begin and offered HHS no assistance with implementation. Finally, some states simply did not implement parts of the law but failed to communicate this to HHS, leaving HHS uncertain as to how to proceed.

Implementation of the law by HHS was slow and uneven. Repeated GAO reports criticized HHS for its failure to enforce the law and implement the federal fallback requirements. See GAO, Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve (GAO-01-652R, May 7, 2001); GAO, Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States (GAO/HEH-00-85, March 31, 2000); GAO, HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-21R, July 22, 1998). The HHS enforcement effort was understaffed and under-resourced, and regulatory guidance was slow in coming. HHS apparently made minimal efforts to monitor HIPAA compliance by government plans, which was an additional part of its responsibility. Eventually, after more than a decade, compliance was nominally achieved in all states. Testimony presented to the House Oversight Committee last year, however, revealed that compliance oversight at HHS has largely ceased. See House Committee on Oversight and Government Reform, Hearing on Business Practices in the Individual Insurance Market: Termination of Coverage, July 17, 2008, <http://oversight.house.gov/documents/20080818093759.pdf>. The four person office at HHS responsible for compliance relies solely on complaints, and has received only five complaints in the last five years. Blatant violations of the individual plan guaranteed renewal provisions widely reported in the press had been completely ignored by HHS.

state level exchanges would provide opportunities for experimentation with a variety of models and for learning from that experience. A few states would likely be more creative and protective of consumers in implementing the exchanges than the federal government is likely to be. State level exchanges would be “closer to the ground,” which might make them more responsive to individuals who would be purchasing insurance and receiving credits through them.

But the advantage of the states over the federal government in expertise can be exaggerated. In fact, the three biggest “exchanges” in the country are run by the federal government—the Federal Employee Health Benefits Program, the Medicare Advantage program, and the Medicare Part D drug program. The federal government has also long been primarily responsible under ERISA for regulating employee benefit plans, the largest source of health insurance in the country. The Finance bill establishes national plans, which logically should be regulated by a national exchange. The federal government routinely partners with state governments in other areas where the federal government takes the lead, as in fraud and abuse enforcement, or in regulating the Medicare Advantage program, where insurers must be licensed by the states. While the states currently are primarily in charge of insurance regulation, they vary greatly in the quality of their enforcement efforts, with some doing a clearly inadequate job. The move toward nullification of health care reform in a number of states indicates that some states are not eager to be willing partners with the federal government in health care reform.<sup>173</sup> Finally, HR 3200 allows truly innovative states to initiate their own exchanges with federal permission, allowing both the benefits of a federal floor and of state innovation.

There is the problem of geography as well. Health insurance is sold in local markets. Many Americans live in local markets that span two or more states. Many Americans who work for firms that provide insurance through an exchange will find that they live in one state and their employer’s business is in another. Through which exchange will they purchase insurance and receive a subsidy? Moreover, in a large state like California or Texas, exchanges will still be offering different products in different parts of the state, and will hold little comparative advantage over a federal exchange.

The best solution is a nationally administered plan, offering insurance products that vary by locality, operating primarily through a web-based portal or over the telephone, but with representation perhaps in local social security offices for those who need to talk to a person. It is also likely that insurance agents and brokers would remain involved in purchasing decisions, thus providing another local portal, although hopefully their commissions would be reduced to recognize their diminished role.

### *Protection against Adverse Selection*

The Achilles heel of many earlier attempts at health insurance exchanges has been adverse selection against the exchange. As long as insurers can sell their products outside the exchange,

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<sup>173</sup> See <http://oneillhealthreform.wordpress.com/2009/09/29/firing-again-on-fort-sumpter/>

they can siphon off good risks from the exchange, leaving the exchange with high risk individuals and groups and high prices. Even if this dynamic does not in fact occur initially, insurers are reluctant to sell their products through the exchange for fear that they will end up with bad risks. A particular problem has also been agents and brokers steering their customers away from the exchange when they can make higher commissions for sales outside of the exchange.

One obvious solution to the adverse selection problem is to allow insurers to sell their products only through the exchange. HR 3200 does this with individual policies but allows employment-related groups eligible for the exchange to either purchase through the exchange or outside of it. The Senate bills allow insurers to sell their products both in and out of the exchange in both the individual and small group market. All bills allow grandfathered policies to continue to be sold outside the exchange. Limiting coverage to the exchange is apparently viewed as too inconsistent with the promise that if you like the insurance you have you can keep it.

Measures can be taken, however, to address the adverse selection problem and still preserve a market outside the exchange. First, the larger the pool covered by the exchange, the more likely it is to combine good and bad risks. All of the bills limit the use of premium and affordability subsidies to the exchange. This should in itself create a huge market for insurance within the exchange. Moreover, though each of the bills starts with covering individuals and small groups, each contemplates expanding the coverage of the exchange to eventually include larger employers. This too will help. But even large exchanges can be the victims of adverse selection if they end up attracting higher risk individuals and groups, even if they enroll a great many of them.

Second, adverse selection can be limited if plans in and out of the exchange that cover the same markets have to play by the same rules. HR 3200 and the Senate Finance bill apply basically the same coverage and cost-sharing rules to individual and small employer plans in and out of the exchange, thus making it more difficult for insurers to sell cheaper low-coverage policies outside the exchange. The HELP bill, on the other hand, does permit “minimum qualifying coverage” plans to exist outside the exchange in the individual and small group markets, increasing the risk of adverse selection. Both the Senate bills require all individuals in and out of the exchange to be treated as being in a single risk pool and all small groups in and out of the exchange to also be treated as a single risk pool. This provision should help, although it will be difficult to enforce, particularly under the Finance bill which permits very broad scope for non-health status underwriting. Finally, the Finance bill requires insurers to charge the same price for plans sold both in and out of the exchange, which should also help reduce adverse selection against the exchange if it is enforced.

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

HR 3200 only provides for risk adjustment within the exchange, and so will do little to protect exchanges from adverse selection. The Senate bills provide for risk reallocation both in and out of the exchange and thus could make a substantial contribution to addressing this problem. Indeed, the Finance bill provides for three risk reallocation schemes, one apparently permanent and two temporary.

It is, however, difficult to see how these schemes are going to work. Risk reallocation is not easy and requires a great deal of data if it is going to be done successfully. Collecting this data outside of the exchange is going to be difficult. Moreover, the mechanism through which risk reallocation is accomplished outside of the exchange is not clear. The Finance bill, for example, calls for risk adjustment of premiums. Within the exchange, payments from affordability subsidies can be adjusted to compensate for risk. Outside of the exchange, however, premiums are paid directly to the insurer without any state intervention. How these will be adjusted is not clear. Of course, funds can be transferred from insurers with low risk insureds to those with high risk insureds retroactively, which is apparently what the HELP bill contemplates. This may help.

The easiest solution to this problem is to require all individuals and small groups that are eligible for insurance through the exchange to purchase through the exchange, as HR 3200 does with the individual market. Failing that, some combination of uniform benefits, single risk pools, uniform prices, and risk reallocation in and out of the exchange may work. The Senate Finance bill probably does the best job of bringing uniformity in and out of the exchange, but its risk adjustment mechanism is hard to follow. The risk reallocation approach of the HELP bill is much more straightforward.

### *Standardization and Transparency*

Two related potential benefits of exchanges are that they make insurance plans more standard and more transparent, thus enabling consumers to make more informed choices and promoting head to head competition among plans. All of the bills do a reasonably good job with standardizing plans. All require plans sold within the exchange to cover essential benefits, limit cost-sharing (albeit at very high levels), exclude (or limit) annual or lifetime limits, and provide an opportunity for appealing coverage decisions. Each bill also standardizes and specifies tiers of coverage defined by actuarial value (in effect, levels of cost-sharing) into which plans must fit. This should also facilitate comparison of plans by purchasers. HR 3200 and the Finance bill standardize plans both inside and outside of the exchange, permitting consumers to also consider the benefits of purchasing within the exchange or going outside of it.

All bills also include provisions that should make plan coverage more transparent. All, for example, require the disclosure of information about premiums, cost-sharing, network providers, benefits, and other issues of concern to consumers. The Finance Committee provisions, described above, offer by far the most detailed and creative approach to transparency. In particular, rating plans for cost and quality and price, describing each insurance plan using standard defined terms

in a four-page summary description, and providing model scenarios describing coverage and cost-sharing for particular medical conditions should go a long way toward making the purchase of health insurance much more understandable. In sum, all of the bills do a reasonably good job at standardization, the Finance bill is best on transparency.

### *Reducing Administrative Costs*

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

Exchanges themselves cost money, however. The Senate bills provide for surcharges on insurance premiums to fund exchanges, which the HELP bill limits to 4 percent.<sup>174</sup> HR 3200 would fund the exchanges from the excise taxes received from individuals or employers who fail to comply with coverage mandates.<sup>175</sup> The exchanges only reduce overall costs, therefore, if these added expenses are offset by savings elsewhere.

The rating reforms in the bill generally should reduce underwriting costs, both in and out of the exchange. Enrollment in health plans through the exchange could reduce the cost to health plans of enrolling members, while information transmitted through the exchange could reduce marketing costs. As long as the exchange has only a small market share it is unlikely to achieve significant administrative cost savings because insurers are likely to continue to carry on their current functions, largely duplicating exchange functions. If an exchange can achieve sufficient market power, however, it might in fact reduce the administrative costs of insurers, thus reducing the overall costs of health insurance coverage.

The main opportunity for reducing health insurance administrative costs, however, is in reducing brokerage commissions. Brokerage commissions are a major cost in health care. They consume from 2 to 8 percent of the premiums of group plans and a much higher percentage of premiums in the nongroup market.<sup>176</sup> Although brokers may still serve a useful role in serving employers as benefits consultants, they would seem to be completely redundant with the exchange in the nongroup market and for individual employees who enroll in insurance through

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<sup>174</sup> HELP 3101(b)(5). See also Finance § 2237; HR 3200

<sup>175</sup> § 207.

<sup>176</sup> See, Leslie Jackson Conwell, *The Role of Health Insurance Brokers* (Center for Studying Health Systems Change, 2002) <http://www.hschange.org/CONTENT/480/480.pdf>

the exchange. Eliminating their commissions could result in substantial cost reductions for the health care system overall.

Both the Blue Dog amendments to HR 3200 and the Senate Finance bill retain brokerage commissions, although the Finance bill would regulate them. Insurance brokers are an extraordinarily powerful group politically, however, and they will not disappear overnight. Moreover, as long as insurance exists outside of the exchange they have the potential of steering business away from the exchange. Massachusetts was unable to eliminate brokers from the Connector. Brokers' fees, however, should be regulated, recognizing that they in fact no longer play a useful role once the exchange is established. The Finance Committee bill contains this possibility.

Finally, one of the surest paths to reducing the administrative costs of operating the exchange itself is to have a single national exchange like that provided for in HR 3200. Operating fifty or more state exchanges represents a tremendous duplication of effort and waste of resources. Moreover, a single national exchange would provide for greater uniformity of regulation, which should in turn lead to more streamlined and efficient enforcement.

### *Appeals and Judicial Review*

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

- § individuals qualify for an affordability subsidy and to what extent;
- § individuals cease to qualify for a subsidy when their income increases;
- § individuals are liable to refund an excessive or improperly paid subsidy;
- § individuals or employers are qualified to participate in an exchange (gateways); or
- § insurers are qualified to participate in the exchange (gateways) or have complied with other statutory requirements.

Health plans that market their services through an exchange will additionally need to make determinations whether

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

Finally, the federal government will need to determine whether states are properly enforcing federal law or operating a gateway or exchange (under the Senate legislation); and others.

The bills do a pretty good job of dealing with remedies for individuals affected by health plan decisions. HR 3200 requires internal and external review procedures and preserves state judicial review of claims appeals and grievances.<sup>177</sup> A long and complex amendment was added to HR 3200 in the Energy and Commerce Committee greatly elaborating these procedures. The

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<sup>177</sup> § 132.

Senate Finance bill contains a less elaborate but probably adequate provision for internal and external appeals and judicial review.<sup>178</sup> The HELP bill is least helpful, providing only that an appeals process should be provided for plan determinations.<sup>179</sup> HR 3200 and the Senate bill also establish an ombudsman office to help with appeals.<sup>180</sup>

The bills are less generous, however, with provision for appeals of exchange decisions. HR 3200 provides appeal rights for plans terminated from exchanges, while the HELP and Finance bills provide for appeals for persons denied affordability subsidies. None of the bills mention judicial review for these decisions. Each of these determinations probably involves a property or liberty interest protected by the Due Process clause, as noted above.

The Senate legislation largely delegates to the states the tasks of running the exchanges, enforcing the insurance reforms, and awarding subsidies. Presumably the decisions of the states are subject to review under state administrative law and state judicial review procedures, and state hearing officers and courts would apply the federal law in reviewing decisions. But each state will have different procedures and afford different levels of protection to appellants. And if each state comes up with a different interpretation of the law, the Supreme Court will have a real mess to straighten out. If a state puts in place laws, regulations, or policies contrary to the federal law, or simply does not comply with it, claims might be brought by injured individuals in federal court under the Supremacy Clause or perhaps under 42 U.S.C. § 1983 to challenge the state law, as now often happens under the Medicaid program.

Congress would be well advised to specify appeal and review procedures now rather than be required to do so later by the courts. This is particularly important because if Congress wrote these provisions into the bill it could specifically mark certain legislative determinations as not subject to judicial review—such as the level of subsidies or the definition of affordability—as it now routinely does when establishing Medicare prospective payment systems.<sup>181</sup>

### *Cost Control*

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

None of the bills gives the exchanges the authority to set insurance prices. The House bill imposes mandatory minimum medical loss ratio requirements, but these are not enforced through

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<sup>178</sup> § 2225(e).

<sup>179</sup> § 3101(l)

<sup>180</sup> HR 3200 § 144; Finance § 2229(a).

<sup>181</sup> See, e.g. 42 U.S.C. § 1395ww(d)(7).

the exchanges.<sup>182</sup> But HR 3200 also requires the exchange to negotiate contracts with qualified plans, and price could certainly be an issue subject to negotiation. The HELP bill does not explicitly provide for negotiations, but does require the gateway to certify that making available a plan offered by an insurer is in the interest of individuals and employers before offering it through the exchange.<sup>183</sup>

An exchange containing all purchasers in the nongroup market and eventually many employees of firms that now purchase insurance in the group market (or that do not currently insure their employees) could offer an attractive market to insurers willing to trade price for volume. If the exchange only offered plans from a handful of insurers, it might be able to insist on substantial discounts.<sup>184</sup>

The key to cost control here is offering a strong public plan. In many markets, one or a handful of insurers control an overwhelming share of the market, and an exchange offers little potential for creating competition without new entrants.<sup>185</sup> If one of the competitors offered by the exchange is a public plan paying providers a price close to Medicare rates and minimizing administrative costs, private plans in the exchange would face a strong incentive to bring down their own provider payments and administrative costs. If not, the experience of other exchanges—minimal cost control—may again be replicated.

There should be no impediment to negotiations between an exchange and insurers as long as efficient insurers are allowed to make a fair and reasonable return. If an exchange attempted to force an insurer to forego a fair and reasonable return to be included in an exchange, the insurer could raise a due process or takings challenge. Such a challenge would be less likely to succeed if the insurer could continue to sell policies in the state outside of the exchange. Even if all insurers were required to sell through the exchange, as is true in the nongroup market in HR 3200, the exchange could negotiate for cost control if the insurer were still permitted to make a fair and reasonable return on its investment. Indeed, following the certificate of need precedent, the exchange could conceivably limit the market to a limited number of low-cost or high-value insurers.

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<sup>182</sup> HR 3200 § 2714.

<sup>183</sup> HELP § 3101(d). The Finance bill requires the exchange to offer all plans, leaving no room for negotiations.

<sup>184</sup> The Massachusetts Connector includes five insurers in the subsidized Commonwealth Care program and six in the nonsubsidized Commonwealth Choice program.

<sup>185</sup> See Reed Abelson, Health Insurance Exchanges: Will They Work? *New York Times*, Oct. 6, 2009. See on insurance industry concentration, James Robinson, Consolidation and the Transformation of Competition in Health Insurance, 23 *Health Aff.* 11-24 (2004).

## **Conclusion**

Over the next days and weeks, Congress will in all likelihood finalize legislation that will significantly change the way in which we finance health care in the United States. The health insurance exchange concept will almost certainly play a role in this reform. It is to be hoped that Congress does not simply take for granted that the exchange is in itself necessarily a useful policy tool. There is in fact little in the history of our experience with exchanges to lead us to think this to be true. As is almost always the case in public policy, the devil is in the details—everything will depend on how the exchange is designed and how it functions. On the other hand, there are few serious legal impediments to Congress designing an exchange that could potentially improve consumer, access, choice, and satisfaction and control costs. The three bills pending in Congress in fact contain a host of good ideas that Congress can work with in putting together a final bill. All, however, could be improved. It is to be hoped that this guide will prove useful in the pursuit of this goal.