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RISKY BUSINESS: HEALTH CARE REFORM’S IMPACT ON THE HEALTH-BENEFITS MARKET

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This rough draft discusses the insurance exchanges that each state must establish under the Patient Protection and Affordable Care Act (PPACA). The Draft begins by discussing the two largest barriers preventing a value-driven insurance market: market conditions that require insurance carriers to compete on risk and the average consumer’s difficulty in making informed, rational purchasing decisions. The Draft then provides a brief overview of the changes PPACA attempts to make and evaluates PPACA’s ability to disincentivize risk-based competition. After analyzing the possible roles for consumers in this new system, the Author concludes that while the insurance exchange provides a solid basis for reducing risk-driven competition, truly empowering consumers to drive the market will prove to be a difficult, if not impossible, task.

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I. INTRODUCTION

Few question the challenges facing health care in the United States.\(^1\) The increasing cost of medical services continues to place heavier burdens on both employers and individuals.\(^2\) These constantly-increasing costs combined with an employer-centered approach to providing health insurance have done little to expand accessibility to health care. Partially to blame for these issues is the current state of the health benefits market, in which insurance carriers must compete on risk to survive.

In 2010, however, Congress passed the Patient Protection and Affordable Care Act (PPACA).\(^3\) The goal of this legislation is to increase the value of and access to health care.\(^4\) To accomplish these goals, PPACA attempts to make sweeping changes to the health-benefits market.

This Paper begins by discussing the two largest barriers preventing a value-driven insurance market: market conditions that require insurance carriers to compete on risk and the average consumer’s difficulty in making informed, rational purchasing decisions. The Paper then provides a brief overview of the changes PPACA attempts to make and evaluates PPACA’s ability to disincentivize risk-based competition. After analyzing the possible roles for consumers in this new system, the Author concludes that while the insurance exchange provides a solid basis for reducing risk-driven competition, truly empowering consumers to drive the market will prove to be a difficult task.

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1 For a more detailed analysis of the current health insurance market, see generally D. ANDREW AUSTIN & THOMAS HUNGERFORD, CONG. RESEARCH SERV., R40834, THE MARKET STRUCTURE OF THE HEALTH INSURANCE INDUSTRY (2009).


4 BERNADETTE FERNANDEZ, HINDA CHAIKIND, CHRIS L. PETERSON, & BOB LYKE, CONG. RESEARCH SERV., R40517, HEALTH CARE REFORM: AN INTRODUCTION (2009).
II. BACKGROUND

In a properly functioning free market, a consumer will buy the product with the highest value.\(^5\) Consequently, each firm’s profitability is directly linked to value, and firms compete to create the highest-value product.\(^6\) Put simply, the consumers and firms’ interests are perfectly aligned: firms want the consumers’ money, and to get it, they must provide consumers with a high-value product. As a result, consumers define and drive value in a properly functioning free market.

In a properly functioning, consumer-driven health benefits market, consumers would choose a competitively priced insurance plan that provides the best outcomes for needed services, and carriers would increase the value of their plans to attract consumers.\(^7\) A completely free market approach to health insurance, however, has created an inefficient marketplace in which the consumer does not drive value.\(^8\)

Several major obstacles prevent the health insurance market from functioning properly. First, carriers must be very careful not to take on too much risk. As discussed below, even nonprofit insurance carriers must compete on risk to avoid insolvency. Consequently, minimizing risk is necessarily carriers’ primary concern, not consumer demand. Second, insurance plans are highly complex, and the average consumer has difficulty understanding them.\(^9\) As a result, consumers purchase plans that do not meet their actual needs. Ultimately, ineffective purchasing decisions coupled with risk-based competition prevent consumers from driving value.

\(^5\) Value is a function of both price and quality: the more quality per dollar, the better the value.
\(^6\) Firms can create a high-value product by providing moderate quality products at a lower price, higher quality products at a higher price, or anywhere in between.
\(^7\) Quality in health care often is defined as the best outcome for necessary services. See Michael E. Porter & Elizabeth Olmsted Teisburg, Redefining Health Care: Creating Value-driven Competition on Results (2006); see also Elizabeth A. McGlynn, Six Challenges in Measuring the Quality of Health Care, HEALTH AFFAIRS vol. 16, no. 3, p. 7 (1997).
\(^8\) See generally, Porter supra note 7 (discussing in greater detail the factors preventing value-driven competition in the health care market).
A. Consumer Decision Making

The purpose of health insurance is to protect the insured from the cost of future health problems. To make an informed purchasing decision, consumers must accurately assess their risk and then match that risk with the best form of health insurance, which includes the option not to insure. First, problems arise because many consumers perform inaccurate risk assessments on themselves, thinking that their risk of becoming sick is much lower than it actually is. For example, a healthy consumer might determine that she will need $1,200 in healthcare services next year. In reality, the possibility of her requiring health care is much greater. As a result, the consumer’s underestimation of risk will cause her to make a bad decision in regards to her health insurance.

In determining the best form of insurance, the consumer is motivated by value. In other words, the consumer will ask, “What plan covers my risk for the lowest price?” A consumer is unlikely to purchase insurance if a plan’s cost exceeds the consumer’s risk assessment. Based on the consumer’s risk assessment, the consumer could cover medical expenses for less than the cost of insurance. However, the consumer’s actual risk is much greater, which makes purchasing health insurance a better option. If the consumer cannot afford to cover the additional amount, the consumer may forgo healthcare. While this example illustrates the decision to purchase a benefits plan, the same issue presents itself if a consumer chooses a plan that causes the consumer to be underinsured.

Second, even if consumers could accurately assess their risk, they would not be able to match that risk with the best insurance plan because of the difficulty in understanding the plans. Under traditional economics, consumers will use the information available to them, make the


11 For example, if a consumer underestimates his or her risk, the consumer may opt for a plan that only covers emergency medical care, leaving the consumer to bear the cost of any non-emergency treatment.

12 See Oeschner & Schaler-Hayes, supra note 9 at 248-52.
most rational decision, and drive the market to match their demand.\textsuperscript{13} While the information available to consumers continues to increase, healthcare consumers are not using this information to make informed decisions.\textsuperscript{14} For example, when consumers are faced with considering tradeoffs, they tend to oversimplify things and make their decision based on one factor.\textsuperscript{15} Overall, consumers are ineffective at choosing health plans for themselves and therefore cannot currently drive the insurance market.\textsuperscript{16}

B. Cost, Risk Pools, and Employer-Provided Health Benefits

Historically, health insurance in the United States has taken an employer-centered approach in which individuals obtained health insurance through their employers.\textsuperscript{17} Small employers, however, are less likely to offer health insurance because each business represents a smaller pool that is more susceptible to fluctuations in risk.\textsuperscript{18} To account for these fluctuations in risk, insurance carriers require increased premiums and deductibles.\textsuperscript{19} Similarly, plans offered on the individual market have even higher premiums and deductibles because individually purchased health insurance is accompanied by even greater risk.\textsuperscript{20} For these reasons, small

\begin{itemize}
  \item \textsuperscript{15} See id. at 416.
  \item \textsuperscript{18} See id.
  \item \textsuperscript{19} See id.
  \item \textsuperscript{20} See infra Part II.C.
\end{itemize}
employers are less likely to provide insurance, and individuals are less likely to purchase insurance.

In contrast, large employers do not face the same problems. In addition to the having a larger pool, which reduces fluctuations in risk and therefore reduces premiums, large employers have increased bargaining power and can utilize administrative efficiencies. Large employers are capable of hiring internal consultants to make insurance purchases, while individuals and small employers must rely on brokers who will receive a commission, which is then added to the price of the premiums. In addition, the administrative costs of running an insurance program for one large employer are much cheaper than running several programs for several smaller employers. Ultimately, any administrative inefficiencies will increase the carrier’s cost, which the carrier will build into the price of the premium.

However, because of the constantly increasing cost of health care is affecting everyone, employer-sponsored health benefits may slowly become less of an option. Many employers are either choosing to drop their benefit plans or altering their plans by increasing the amount that individual employees must pay out of pocket. Consequently, more and more consumers may be pushed onto the individual market, where many will choose to forgo insurance.

To illustrate this point, the below chart shows changes in where individuals have obtained health insurance since 1994, with the percentages reflecting the percent change in the U.S. population.

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22 See id.


24 See Fronstin, supra note 17, at 5.
A quick glance at this chart shows that changes in employment coverage are inversely proportional to changes in the number of uninsured, and these changes do not appear to have a large impact on the number of individually purchased plans. In other words, when individuals do not receive insurance through their employers and do not qualify for public insurance, they appear to forgo coverage. A major reason these consumers may choose to forgo insurance is because the cost reductions associated with public and employer-supported plans are no longer available.

A major concern is that those most in need of health care services are least able to purchase an adequate plan on the individual market. Individuals with preexisting conditions are hardest hit by the higher premiums, and those who purchase an individual insurance plan typically have plans with higher deductibles and that cover fewer benefits. As a result, these individuals are paying more and more out of pocket for health care.

26 Almost three quarters of the people who attempt to purchase insurance on the individual market choose not to do so. See Doty et al., supra note 23, at 2.
27 See id. at 2-3.
28 See id. at 5-7; see also Heidi Whitmore, Jon Gabel, Jeremy Pickreign, & Roland McDevitt, The Individual Insurance Market Before Reform: Low Premiums and Low Benefits, Med. Care Res. & Rev. (Mar. 21, 2011).
29 See id.
C. Competing on Risk to Avoid Adverse Selection

Health insurance in the United States is not necessarily a consumer-driven market. However, many of the issues arise because the consumer that somewhat drives the market is the healthy consumer. Each carrier competes to attract healthy consumers, thereby reducing the carrier’s risk. As a result, carriers are incentivized to make choices to the detriment of unhealthy consumers because truly serving the needs of the unhealthy consumer runs counter to reductions in risk. Risk reductions lead to cost reductions, allowing the carrier to appeal to additional healthy consumers with decreased premiums. Consequently, the result of risk-driven competition is that as a consumer’s need for coverage increases, the consumer will receive less coverage or be required to pay more.30

Carriers use risk-rating systems to evaluate each consumer’s risk,31 which carriers can achieve through both direct and indirect rating systems.32 With a direct rating system, also referred to as underwriting, carriers evaluate the risk of an individual consumer to determine whether to increase charges, reduce coverage, or deny coverage for that consumer.33 With an indirect rating system, carriers apply policies to all of its consumers (for example, payment caps, waiting periods, targeted marketing, and copayments).34 Admittedly, some carriers have attempted to deviate from traditional underwriting and standardize premiums through managed care plans, but the insurance industry remains focused on risk-driven competition.35

A simplified look at consumer behavior will provide the rationale for this type of competition. Consumers will seek out a plan that best meets their individual needs. Consequently, an unhealthy consumer will seek out the plan that best covers the unhealthy consumer’s medical care. If a carrier fails to recognize the unhealthy consumer’s increased risk and charges both a healthy consumer the same amount as the unhealthy consumer, the price to the healthy consumer must increase to cover the increased cost of the unhealthy consumer. If the

32 See Light, supra note 30.
33 See id. at 2503.
34 See id.
carrier’s plan becomes significantly more expensive than comparable plans, the healthy consumer will join a different plan.

The unhealthy consumer, however, will be forced to stay in the plan. Other carriers would likely discover the consumer’s health status and either deny coverage completely, create exclusions and limitations to exclude the unhealthy consumer’s medical conditions from the policy, or increase the unhealthy consumer’s premium. In the end, the original carrier is stuck holding the more expensive, higher-risk unhealthy consumer, and the carrier’s competitor is cherry picking the more profitable, lower-risk healthy consumer. Consequently, the original carrier’s survival is dependent on developing and using the above-mentioned direct and indirect rating tools to distinguish between the two consumers and separate them into sub-categories.

Conversely, if the carrier is better than the competition at distinguishing between healthy and unhealthy consumers, then the carrier can charge healthy consumers less because the carrier is able to force the unhealthy consumer to bear more of the unhealthy consumer’s medical costs. If the competition allows the unhealthy consumer to slip into the healthy subgroup, the competition’s healthy consumers must pay more to cover the extra cost of the unhealthy consumers. As a result, the carrier will attract more healthy consumers, and the competition will attract more unhealthy consumers.

As this illustration demonstrates, insurance carriers are locked into this risk-driven competition because of two interconnected possibilities: Healthy consumers may leave the carrier’s pool if prices begin to rise, and unhealthy consumers may flood the pool if the carrier inadvertently provides the most valuable plan for the unhealthy consumer.36 If a carrier cannot accurately assess and avoid risk, unhealthy consumers who cannot purchase insurance elsewhere will begin to join the pool.37 Because the costs of these unhealthy consumers will pass to the healthy consumers, healthy consumers will begin to leave the pool because the healthy consumer can purchase health insurance for a lower price.38 If either situation begins to occur, a cycle

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36 See Tom Baker, Containing the Promise of Insurance: Adverse Selection and Risk Classification, in RISK AND MORALITY 258, 263-75 (Richard V. Ericson & Aaron Doyle eds., 2003); Swartz, supra note 31, at 284.
37 Baker, supra note 36, at 263-75.
38 The healthy consumer may either purchase the same benefits from a carrier with a healthier pool at a lower price or purchase fewer benefits for a lower price. See id. The healthy consumer does not need extra health coverage because the healthy consumer generally does not require the same kinds of medical care as unhealthy individuals. See Light, supra note 32.
known as “adverse selection” begins in which cost increases cause healthy individuals to leave the pool causing costs to increase even more.\textsuperscript{39} The pool then can fall into a “death spiral” in which the carrier repeatedly increases prices to compensate for the constantly increasing risk, causing more and more healthy consumers to drop out of the pool.\textsuperscript{40}

From a pure economic standpoint, competing on risk makes perfect sense. “Eliminating the most risky from an insurance pool reduces the average cost of insuring the members of the pool, allowing the insurer to offer a lower price and, possibly, obtain a greater profit.”\textsuperscript{41} In addition, even if a carrier has a nonprofit motive, not competing on risk could prove disastrous because the carrier would begin to draw the unhealthy consumers. Adverse selection would then begin, and if left unchecked, the carrier could ultimately become incapable of covering the huge financial obligations associated with having a high-risk pool.

It is important to note that a single carrier choosing to compete on risk will force other carriers to compete on risk as well. The first carrier pursues a risk-based strategy to gain a competitive advantage. By distinguishing between lower-risk and higher-risk consumers, this carrier can cherry pick the profitable, low-risk consumers and push the more costly, high-risk consumers to its competitors. The moment a carrier’s competitor begins to use a risk-classification system, the carrier must begin to use one as well. The competitor’s risk-rating systems allow the competitor to avoid covering the higher-risk consumers, who will still be looking for insurance. If the carrier does not identify those high-risk individuals, the carrier will possess a disproportionate percentage of high-risk consumers, causing adverse selection to begin.

While the above discussion focuses on adverse selection between plans, adverse selection can occur in a variety of different ways. For example, the next Part discusses adverse selection against an exchange, and later Parts discuss adverse selection between actuarial levels. Lastly, adverse selection can occur against the entire market when consumers decide whether to enroll in a health plan or to self insure.

\textsuperscript{39} See supra Part II.C.

\textsuperscript{40} In addition to the fear of adverse selection, many claim fairness supports the use of risk-driven competition (arguing that a low-risk consumer should not bear the burden of paying for a high-risk consumer). See Baker, supra note Error! Bookmark not defined., at 271-73; Light, supra note 32, at 2506-07.

\textsuperscript{41} See Baker, supra note 36, at 263.
D. Adverse Selection’s Impact on Insurance Exchanges

Adverse selection is the number one reason that many previous attempts to establish an insurance exchange have failed. As discussed in the previous section, adverse selection is the tendency of lower-risk individuals to withdraw from or not enter a particular insurance pool, leaving only higher-risk individuals. The Health Insurance Plan of California (HIPC) provides a prime example of how adverse selection affects an insurance exchange.

The HIPC began in 1993 as a purchasing alliance of small businesses, and the enacting legislation established market rules for insurance carriers participating in the exchange. Some of the goals of the HIPC were to make coverage more affordable and to increase the efficiency of the marketplace. In the early stages, a state body was responsible for contracting with insurers and collecting premium payments from the participating businesses, but in 1999, the HIPC became privatized as required by the original legislation and was renamed PacAdvantage.

Under the HIPC, neither insurance carriers nor small businesses were required to participate in the exchange, and insurance carriers were free to offer other plans outside of the exchange. Plans, however, could not deny coverage to any small business. For the most part, the premiums were based on grouping employees by age, family size, and geographic location, but a plan could adjust a particular employee’s premiums based on health history if the adjusted premium stayed within a certain percentage of the premium for that grouping.

The program failed to achieve its goals and ended its operations in 2006. This failure was primarily the result of lack of participation and adverse selection. A program officer from the California Healthcare Foundation stated the following:

Whenever you have participation in a pool that's basically voluntary on the part of both the small employers and the health plans, they will continue to do what's in their best interests. Health plans will not offer rates that are cheaper in the pool than they will outside because there is no business reason for them to do so. Similarly, businesses won't participate in the pool if they can find a cheaper option outside the pool.  

Because the HIPC allowed carriers to operate inside and outside the exchange, adverse selection gradually began to occur. Initially, plans outside the HIPC could adjust premiums for new enrollees based on individual health history, but those plans inside the HIPC could not. Small businesses with healthy employees could easily find affordable premiums on the outside market, but market conditions forced unhealthy entities into the HIPC. This created a death spiral in which premiums inside the HIPC were greater than premiums outside, and as a result, healthy people inside the HIPC went outside for cheaper premiums, causing premiums to rise even further.

Insurance carriers and brokers were a contributing factor to the adverse selection. The carriers and brokers felt threatened by open exchanges because they could have ended up with a disproportionate number of unhealthy individuals. Consequently, many carriers will choose not to participate in an exchange without a showing that healthy individuals will move into the exchange.

III. OVERVIEW

Differing opinions arise over the best way to approach an overhaul of such an expansive health care system. With such varied needs for health care services, trying to create a system that satisfies each individual’s interests is a difficult task. Further complicating the issue, individual needs for health care are not the only interest that must be considered. The cost to each individual, the cost to the government, economic ramifications, the impact on health care

51 Id.
52 See CAL. HEALTHCARE FOUND., supra note 46, at 4.
53 See Wojcik, supra note 50, at 4.
55 See CAL. HEALTHCARE FOUND., supra note 46, at 4.
providers and their supporting organizations, and the impact on the insurance industry are just a few of the factors that must be considered in creating a comprehensive overhaul of the health care system. Striking a balance between all these interests, which are often in direct competition with one another, makes this task even more difficult. The Patient Protection and Affordable Care Act\(^56\) (PPACA) attempts to tackle these issues and makes sweeping changes to the entire health-benefits market.

To expand coverage, PPACA creates individual and employer mandates for health benefits. PPACA requires individuals to have insurance through either a government-sponsored program, an employer-sponsored plan, a grandfathered plan,\(^57\) or a plan purchased on the individual market.\(^58\) In addition, employers with 50 or more full-time employees must provide health coverage to its employees.\(^59\)

To facilitate compliance with these requirements, PPACA requires each state to establish an American Health Benefit Exchange by 2014.\(^60\) Each state must have an individual exchange and a Small Business Health Options Program (SHOP Exchange), for small-group health plans.\(^61\) Only qualified health plans may participate in the Exchanges,\(^62\) and each Exchange is responsible for certifying health plans as qualified health plans.\(^63\)


\(^{57}\) A grandfathered plan is either an individual plan in which the individual was enrolled when PPACA was enacted or a group plan in existence at the time of PPACA’s enactment. See 75 Fed. Reg. 34566 (June 17, 2010) (to be codified at 45 C.F.R. pt. 147.140(a)); see also 42 U.S.C. § 18011.

\(^{58}\) I.R.C. § 5000A(a), (f)(1). For a more detailed discussion of this provision, see Part IV.B.1.

\(^{59}\) I.R.C. § 4980H. For a more detailed discussion of this provision, see Part IV.B.2.

\(^{60}\) See 42 U.S.C. § 18031(b)(1). To assist the states in establishing exchanges, the Secretary of Health and Human Services (Secretary) may award grants to a state if the Secretary determines that the state is making progress towards establishing an Exchange, implementing specified PPACA reforms, and meeting the Secretary’s benchmarks. See 42 U.S.C. § 18031(a). These grants, however, are no longer available after 2015, at which time each Exchange must be self-sustaining. See 42 U.S.C. § 18031(a), (d)(5).

While PPACA lays out a very detailed framework for the Exchange, many gaps were intentionally left open and much of the control is left with the Secretary of Health and Human Services (Secretary). To illustrate this point, the term the Secretary shall appears 862 times in the bill, and the term the Secretary may appears 295 times. Interestingly, State shall appears only 84 times, and State may appears only 59 times. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

\(^{61}\) See 42 U.S.C. § 18031(b)(1). A state is free to merge these two exchanges into one exchange. Id.

\(^{62}\) See 42 U.S.C. § 18031(d)(2)(B)(i). A health plan must meet several requirements to satisfy the definition of a qualified health plan. The Exchanges must find that a health plan is in the best interests of qualified employers and individuals to certify the plan as a qualified health plan. See 42 U.S.C. § 18031(e). At a minimum, the health plan
These exchanges will provide a number of tools to consumers. Under a navigator program, each Exchange will award grants to entities that have established or could establish relationships with individuals who are potentially qualified to enroll in a qualified health plan. These entities will educate consumers, facilitate enrollment in qualified health plans, and provide referrals for consumers with grievances. In addition to the navigators, each Exchange must provide a website that permits consumers to identify and compare health plans. This comparative information includes enrollee’s satisfaction with the plan and a rating of each plan based on that plan’s “relative quality and price.” Each exchange must also establish a telephone hotline to assist consumers. Overall, consumers will have a number of options to gain information and select a plan.

PPACA also implements several reforms to control costs and curb incentives for adverse selection. First, to control the overall costs of premiums, PPACA establishes a medical loss ratio for all carriers. Carriers must spend a minimum percentage of their premium revenue on

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must have a sufficient number of providers, not use marketing techniques to discourage individuals with health needs from enrolling, “be accredited with respect to local performance on clinical quality measures,” and utilize the uniform enrollment form and standard presentation format. 42 U.S.C. §§ 18021(a)(1)(A), 18031(c)(1). The health plan must also establish a quality improvement strategy that, using a payment structure, incentivizes the improvement of health outcomes and patient safety, a reduction in readmissions and health care disparities, and the implementation of health promotion activities. See 42 U.S.C. §§ 18021(a)(1)(A), 18031(c)(1)(E), (g)(1). In addition, a qualified health plan must cover essential health benefits, limit cost sharing, and cover at least 60% of the “full actuarial value of the benefits provided under the plan.” See 42 U.S.C. §§ 18021(a)(1)(B), 18022(a)(3), (d).

The issuer of a qualified health plan must be licensed, provide a minimum of one plan covering 70% and one plan covering 80% of the full actuarial value, and charge the same premium for each qualified health plan whether sold on the exchange or through an agent. See 42 U.S.C. § 18021(a)(1)(C).

63 See 42 U.S.C. § 18031(e)(1). However, an Exchange may not exclude a plan through the use of premium price controls or on the basis that the plan is fee for service or provides for treatments to prevent death “in circumstances the Exchange determines are inappropriate or too costly.” 42 U.S.C. § 18031(e)(1)(B).

64 See 42 U.S.C. § 18031(i)(1)-(2)(A). The funds for these grants must come from each Exchange’s operational funds and not the federal grants for establishing an Exchange. See 42 U.S.C. § 18031(i)(6). No health insurance issuer or any party receiving consideration from an insurance issuer may act as one of these entities. See 42 U.S.C. § 18031(i)(4).

65 See 42 U.S.C. § 18031(i)(3).


67 42 U.S.C. § 18031(c)(3).

reimbursement for clinical services or to improve the quality of care.\textsuperscript{69} Second, to control premium costs and curb adverse selection, PPACA creates a state-run risk adjustment program, which applies to all plans in the individual and small-group markets.\textsuperscript{70} Under this program, states will collect funds from plans whose members are below-average risk and distribute those funds to plans whose members are above-average risk.\textsuperscript{71} Third, to control initial costs in the individual market, each exchange must establish a temporary reinsurance program in which a reinsurance entity will receive payments from all carriers and distribute those payments to carriers that cover high-risk consumers in the individual market.\textsuperscript{72} Lastly, to protect against inaccurate rate setting, PPACA creates temporary risk corridors in which the Secretary must charge plans whose “allowable costs” are less than 97\% than the “target amount” and distribute those funds to plans whose allowable costs are more than 103\% of the target amount.\textsuperscript{73} This target amount is simply the aggregate premium payments for the plan minus administrative costs, and allowable costs are the total cost of providing the benefits minus administrative costs.\textsuperscript{74}

\section*{IV. Creating a New Marketplace}

In redesigning the health-benefits market, PPACA attempts to shift the market away from risk-driven competition. In doing so, the drafters had to determine the role of the existing employer-sponsored system, ensure carriers and consumers participate in the new market, and avoid potential pitfalls that could cause the exchange to collapse.

A. Will the Current Employer-Sponsored System Remain Intact?

In creating PPACA, the drafters had to determine what role the current employer-sponsored system would have in this new market. PPACA takes an interesting approach in that

\textsuperscript{69} 42 U.S.C. § 300gg-18. Plans in the small group and individual market must spend a minimum of 80\% their revenue from premiums, and plans in the large group market must spend 85\%. See id.

\textsuperscript{70} 42 U.S.C. § 18063. PPACA creates a similar program, known as risk corridors, run by the Secretary of Health and Human Services (Secretary). 42 U.S.C. § 18062. However, this program applies only to qualified health plans in the individual and small-group markets. Id.

\textsuperscript{71} 42 U.S.C. § 18063.

\textsuperscript{72} 42 U.S.C. § 18061. The reinsurance program will run for the first three years of the exchange. 42 U.S.C. § 18061(b)(1)(A).

\textsuperscript{73} See 42 U.S.C. § 18062(b).

\textsuperscript{74} See 42 U.S.C. § 18062(c).
it does not eliminate the existing employer-sponsored system. A main reason for this approach may be to provide a fallback plan, but a more likely reason is to pacify employees who were concerned that this new system threatened their benefits. Despite PPACA’s efforts to preserve this system, however, many employers may begin to drop insurance in this new market.

As an initial matter, PPACA uses several mechanisms to encourage the existing employer-sponsored system to continue. First, employer-sponsored benefits plans that were in existence at the time of PPACA’s enactment satisfy the individual and employer coverage mandates. Second, any employer with 50 or more full-time-equivalent employees faces a penalty for failing to offer health benefits to an employee. If an employer that provides benefits fails to cover an employee, the employer is subject to an annual $3,000 fine for each employee, excluding the first thirty employees. If an employer does not provide benefits to any of its employees, the employer is subject to an annual $2,000 fine for each employee, excluding the first thirty employees. Third, employers with more than 200 full-time employees must continue their health benefits plans.

Despite these mechanisms, however, many employers may still choose to drop coverage. As Paul Fronstin, a senior researcher and director at the Employee Benefit Research Institute, observes, “Employers are starting to ask, Is health coverage a benefit that I need to continue to offer? The underlying issue is what value employers get from supplying health coverage. If there is no value, they won’t continue to offer it.” The existence of an exchange in which individuals can receive affordable insurance decreases the need for an employer to provide health benefits to attract good employees. In other words, the exchanges reduce the value to the employee of receiving insurance through the employer and, as a result, reduce the employer’s benefit by eliminating insurance as a way of attracting and retaining employees.

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75 “Grandfathered plans” satisfy the minimum-essential-coverage requirement. I.R.C. 5000A. A grandfathered plan is either an individual plan in which the individual was enrolled when PPACA was enacted or a group plan in existence at the time of PPACA’s enactment. See 75 Fed. Reg. 34566 (June 17, 2010) (to be codified at 45 C.F.R. pt. 147.140(a)); see also 42 U.S.C. § 18011.
76 See I.R.C. § 4980H.
77 See I.R.C. § 4980H.
78 29 U.S.C. § 218A. These employers must continue their current employees’ enrollment and automatically enroll new employees in the employers’ health benefits plans. Id. Interestingly, as of March 2012, no regulations regarding penalties have been created for this provision.
While the penalties act as strong deterrents, they may not be enough to prevent employers from dropping coverage. The average premium paid by employers has risen from just under $1,900 in 1999 to over $4,500 in 2011.\textsuperscript{80} Paying a $2,000 penalty is far more appealing than paying $4,500 in premiums. Consequently, many employers may choose to drop insurance because the exchanges provide employers with an out and because the penalty is an insufficient incentive.\textsuperscript{81}

Arguably, many employers may choose not to eliminate its health plans because dropping health benefits may be negatively perceived by employees, and admittedly, employer provided insurance would still likely be cheaper than obtaining a plan through the individual exchange. Employee dissatisfaction, however, may not be enough keep some employers from dropping its health benefits.

If the ultimate result is that employers begin to drop insurance, much like the story of Cortez burning his ships so that his expedition would have no choice but to move forward, the United States will be faced with no option other than reforming the way in which health benefits are provided.

B. Consumer and Carrier Participation

To evaluate the need for participation, the true underlying goal of PPACA requires discussion. As previously mentioned, the stated goal of PPACA is to increase insurance coverage and access to health care while reducing costs.\textsuperscript{82} On its face, increasing consumer participation aims to increase coverage and reduce cost for everyone. In regards to increasing coverage, the answer seems easy: the more participation, the more coverage. In regards to cost, increasing the number of participants increases the size of the insurance pool, which helps

\begin{footnotesize}
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  \item \textsuperscript{80} \textit{Kaiser Family Foundation & Health Research and Educational Trust, Employer Health Benefits: 2011 Annual Survey} 68 (2011).
  \item \textsuperscript{81} A recent survey supports this conclusion. The survey concluded 30% of employers are likely to stop offering coverage and more than 50% of employers with high awareness of reform will do the same. Shubham Singhal, Jeris Stueland, \& Drew Ungerman, \textit{How US Health Care Reform Will Affect Employee Benefits}, M\textsc{c}Kinsey Qu\textsc{er}tery 2 (June 2011); see also Reinke, \textit{supra} note 164 (discussing studies that show most employers believe it is better to provide health benefits than to let employees purchase benefits on the exchanges but that also show a portion of employers have expressed an interest in dropping benefits).
\end{itemize}
\end{footnotesize}
carriers to minimize risk variation and therefore decrease costs. Ideally, these decreased costs will pass to consumers in the form of decreased premiums or increased coverage. The true goal of PPACA, however, is not this straightforward.

Increased coverage and decreased costs really means increased coverage and decreased costs for unhealthy consumers. The true purpose of increased coverage is to increase accessibility to health care, but healthy consumers do not have issues with access because they do not require health care services. In addition, because of its low risk, a pool of healthy consumers would already have low costs in today’s market. Instead, unhealthy consumers face the issues with access to needed care, and therefore the true goal of PPACA is to extend coverage to those individuals.

Healthy consumers’ participation is necessary, however, to expand coverage to unhealthy consumers, and without carrier participation, expanding coverage becomes impossible. To encourage carrier participation, carriers must feel confident that adverse selection will not occur.

1. Individual Consumer Participation

The need for health care heavily incentivizes unhealthy consumers to have coverage, but because of their high risk, coverage is either denied or unaffordable. On the other side, healthy consumers do not want to be included in a plan with unhealthy consumers because the premiums paid by the healthy consumers will be much higher to offset the risk of the unhealthy consumers. If healthy consumers are incentivized to join the pool, the cost to unhealthy consumers will decrease allowing the unhealthy consumers to join the pool. To address healthy consumers’ participation in Exchanges, Congress took several approaches: the insurance mandate, marketing and education, and the availability of subsidies.

Of these approaches, the individual insurance mandate is by far the most necessary but also is the most controversial and has the most uncertain future. Because unhealthy consumers

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83 See supra Part II.

84 As an aside, while the underlying goal of PPACA is to serve unhealthy consumers, Congress still considered other competing interests. Despite the focus on expanding coverage for unhealthy consumers, PPACA, by allowing carriers to consider certain risk factors in setting rates, acknowledges that increasing coverage of unhealthy consumers does not require complete risk spreading. See 42 U.S.C. § 300gg(a)(1).

85 The 6th circuit has held the insurance mandate to be constitutional while the 11th circuit has held it to be unconstitutional as exceeding Congress’s authority under the commerce clause. Compare Thomas More Law Center, No. 10-2388, slip op. (6th Cir. June 29, 2011); with Florida v. U.S. Dept. of Health and Human Services, Nos. 11-11021 & 11-11067, slip op. (11th Cir. Aug. 12, 2011).
are already incentivized to purchase insurance, the purpose of the mandate is to increase healthy consumer participation. Under the mandate, a non-exempt individual must be a member of a plan that provides minimum essential coverage. If a non-exempt individual is not a member of one of these plans after 2016, that individual faces a penalty of either up to $695, adjusted for cost of living, or 2.5% of income, whichever is greater. If, however, the cost of a plan that covers 60% of the actuarial value is less than this amount, the individual will be required to pay a penalty equal to the cost of that plan. This mandate, however, only requires that individuals have minimum essential coverage, and participation in the Exchange is voluntary on the part of the individual.

In addition to the mandate, the Exchange will use marketing and education to attract and retain healthy consumers. The internet portal and the Navigator program comprise the majority of these efforts. The Navigator program, which utilizes entities that have relationships with consumers, will refer enrollees with grievances to the appropriate state agency, provide public education to raise the awareness of qualified health plans, and provide information on enrollment.

The U.S. Supreme Court has granted cert. to review the mandate. See Florida v. Dept. of Health and Human Services, 648 F.3d 1235 (11th Cir. 2011), cert. granted No. 11-398 (Nov. 14, 2011).

86 See I.R.C. § 5000A(a) (1986). Plans meeting the minimum essential benefits requirement include employer-sponsored plans, grandfathered plans, government insurance programs, plans on the individual market, and any other plans that the Secretary of Health and Human Services deems appropriate. See I.R.C. § 5000A(f) (1986).

87 See I.R.C. § 5000A(c) (1986). The penalties begin in 2014 and gradually increase to the $695 and 2.5%. See id. In addition, the penalty is calculated based on the household and can therefore exceed the adjusted $695 if more than one individual in the household is not a member of a plan. See id.

88 Actuarial value measures “the relative percentage paid by a health benefits plan and its members. It is calculated using the medical claims from a standard population, along with a plan’s cost-sharing provisions, to simulate the payment of claims. The percentage of charges paid by the plan is the actuarial value.” Roland McDevitt, Watson Wyatt Worldwide, Actuarial Value: A Method for Comparing Health Plan Benefits 3 (2008) (prepared for the California HealthCare Foundation).

PPACA determines actuarial value by looking at the cost of providing essential health benefits to a standard population. 42 U.S.C. § 18022(d). To promote simplicity and easy comparison of plans, the Secretary has stated that actuarial value will likely be determined by a standardized set of data, issued by CMS, to determine a specific plan’s actuarial value (as opposed to using plan specific data). Actuarial Value and Cost Sharing Reductions Bulletin, Health and Human Services Bulletin (Feb. 24, 2012), available at http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

89 See id.

and certain tax credits. In addition, the internet portal will provide comparative information on plans.

The final incentive for participation in the exchange is the tax credits and other subsidies, which are only available through the exchange. First, applicable taxpayers are entitled to an income-tax credit for plans purchased through the individual exchange. Second, certain individuals are entitled to reductions in cost sharing for certain plans. Third, small businesses with fewer than 25 employees are entitled to a tax credit if the offer coverage to their employees through an exchange. Any individual or small business eligible for these government incentives must purchase insurance through the exchange to receive them. As an aside, this approach will help to attract carriers as well because carriers will be aware that these credits and other subsidies will attract consumers.

In theory, these efforts will cause healthy consumers to join the pool, lowering costs for unhealthy consumers. As a possible indication of this approach’s effectiveness, the Massachusetts reform, which forms the blueprint for PPACA, has seen a huge increase in the number of covered individuals.

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91 See 42 U.S.C. § 18031(i)(3).
93 See I.R.C. § 36B. To qualify for this credit, an individual’s income must be between 100% and 400% of the poverty level. I.R.C. § 36B(c)(1)(A).
94 See 42 U.S.C. § 18071. To qualify, a person must purchase silver-level coverage on the individual exchange and must have an income between 100% and 400% of the poverty line. See 42 U.S.C. § 18071(b). The Secretary must reimburse insurance issuers for the reductions in cost sharing. See 42 U.S.C. § 18071(c)(3)(A).
95 I.R.C. § 45R. To be eligible for this credit, the employee’s average salary cannot exceed a certain amount ($25,000 for the first three years). I.R.C. § 45R(d)(1)(B). The amount of the credit also decreases as the number of employees and wages increase. See I.R.C. § 45R(c).
97 Given the relative youth of the Massachusetts reform efforts and the polarized debates over health care reform, definitive conclusions cannot be drawn from the Massachusetts reform. However, it does provide an excellent guidepost for some of the issues that may arise in implementing PPACA.
98 See generally, Jonathan Gruber, Massachusetts Points the Way to Successful Health Care Reform, 30 J. POL’Y ANALYSIS & MGMT. 184 (2011); contra Douglas Holtz Ekin, Does Massachusetts’s Health Care Reform Point to Success with National Reform?, 30 J. POL’Y ANALYSIS & MGMT. 178 (2011) (two articles offering a point-counterpoint overview of the Massachusetts reform and citing to several studies on the subject).

In addition, coverage and access to health care are extremely high in Massachusetts, but many argue that this has lead to increased costs. See id. Regarding the long-term effects of PPACA on cost, no clear answer has presented itself. The many projections of PPACA’s impact on cost are varied, and these reports often premise their
2. Carrier Participation

While the mandate aims to increase overall coverage of insurance, adding healthy consumers to the pool is not enough to minimize the risk-driven competition that leads carriers to exclude unhealthy individuals. Carriers are still subject to adverse selection between plans. To encourage carriers to participate in a consumer-driven market, adverse selection must be minimized to prevent carriers from competing on risk.  

One of the biggest factors leading to the failure of the Health Insurance Plan of California, which had many of the same premium controls as PPACA, was the failure to set the same rules for plans inside and outside the exchange. Consequently, many carriers did not participate in the exchange out of fear that the exchange would be subject to adverse selection. PPACA, however, does not make this mistake. With only limited exceptions, the same burdens placed on carriers inside the exchange apply to carriers on the outside. For example, carriers offering plans in the individual or small group market, regardless of operating inside or outside the exchange, are limited on rate adjustments, cannot discriminate based on health status, and are subject to risk-adjustment payments.

In addition to removing this barrier, the Exchange encourages carrier participation by providing certain advantages. One advantage is the administrative efficiencies that accompany participation in the exchange. The portion of premiums attributable to administrative costs is estimated at between 25% and 40% for the individual market and between 15% and 25% for the

findings by discussing the inherent difficulty in accurately forecasting such a complex and novel system. See, e.g., Memorandum from Richard S. Foster, Chief Actuary for Centers for Medicare and Medicaid Services, Estimated Financial effects of the “Patient Protection and Affordable Care Act,” as Amended (Apr. 22, 2010); The Lewin Group, Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers (Staff Working Paper No. 11, 2010); see also David M. Cutler, Karen Davis & Kristof Stremikis, The Impact of Health Reform on Health System Spending (Commonwealth Fund Issue Brief, May 2010).

99 Under PPACA, adverse selection could occur in four different ways: 1) adverse selection against the market as a whole; 2) adverse selection against the exchange; 3) adverse selection against an actuarial band; and 4) adverse selection between plans. Adverse selection against the exchange and adverse selection against actuarial bands is discussed in Part IV.A.4.

100 See supra Part II.C.


small group market.\textsuperscript{104} While carriers both inside and outside the exchange will see many of the same reductions in administrative costs, such as through the elimination of underwriting,\textsuperscript{105} carriers participating in the exchange likely will see additional reductions (for example, reductions in marketing costs). However, these reductions are largely dependent on the way in which the particular state designs its exchange.

Lastly, the exchanges will likely attract a large number of consumers. As a result, many carriers will simply want to be where the consumers are and participate in the exchanges.

While these measures may encourage carriers to participate in the exchanges, creating a competitive, consumer-driven market is impossible if carriers are in fear of adverse selection and consequently continue to compete on risk. As a result, PPACA attempts to minimize risk-based competition and prevent adverse selection issues.

C. Minimizing Risk-Based Competition and Addressing Adverse Selection

PPACA creates several mechanisms that minimize the appeal and possibility of risk-driven competition, which reduces the likelihood of adverse selection against certain plans. First, PPACA restricts the risk factors that a carrier may consider in setting rates to tobacco use, age, geographic location, and whether the consumer is seeking an individual or family plan.\textsuperscript{106} In addition, any rate adjustments based on these factors are subject to limitations.\textsuperscript{107} As a result, carriers have a limited amount of criteria to differentiate between healthy and unhealthy consumers and will have difficulty competing on risk.

Additional deterrents are the risk adjustment,\textsuperscript{108} reinsurance,\textsuperscript{109} and risk corridor\textsuperscript{110} programs. In the reinsurance program, each state must establish a reinsurance entity that will receive payments from all carriers and distribute those payments to carriers that cover high-risk


\textsuperscript{105} See id.

\textsuperscript{106} See 42 U.S.C. § 300gg(a)(1).

\textsuperscript{107} See id. For example, a rate increase based on age cannot exceed three times the rate of another adult, and a rate increase based on tobacco use cannot exceed 1.5 times the rate for a non-user. See id.

\textsuperscript{108} See 42 U.S.C. § 18063.

\textsuperscript{109} See 42 U.S.C. § 18061.

\textsuperscript{110} See 42 U.S.C. § 18062.
consumers in the individual market.\textsuperscript{111} In regards to the risk corridors, the Secretary must charge plans whose “allowable costs” are less than 97% than the “target amount” and distribute those funds to plans whose allowable costs are more than 103% of the target amount.\textsuperscript{112} This target amount is simply the aggregate premium payments for the plan minus administrative costs, and allowable costs are the total cost of providing the benefits minus administrative costs.\textsuperscript{113} Both the reinsurance program and the risk corridors are scheduled to expire in 2017.\textsuperscript{114} In regards to the state-run risk adjustment program, which has no sunset, the Secretary will establish criteria under which the states will charge plans with below-average actuarial risk and distribute those funds to plans with high actuarial risk.\textsuperscript{115}

These programs will essentially diminish the benefits of risk-driven competition, which should help in reducing carriers’ fears of adverse selection against the exchange and against certain plans.\textsuperscript{116} If a plan somehow cherry picks healthy consumers, the profit gained from having a healthy pool will be redistributed to plans who suffered the adverse consequences of the cherry picking. In addition, these programs reduce the incentive for carriers to operate in geographic areas that are lower risk or use marketing that targets low-risk consumers.\textsuperscript{117}

D. Potential Traps

While PPACA utilizes a number of mechanisms to minimize adverse selection, a number of potential traps remain. Regulators must be careful to avoid these traps if these reforms are to succeed. This Part discusses a few of these potential traps.

1. Adverse Selection against the Insurance Market

\begin{footnotesize}
\begin{enumerate}
\item[111] 42 U.S.C. § 18061.
\item[112] See 42 U.S.C. § 18062(b).
\item[113] See 42 U.S.C. § 18062(c).
\item[114] 42 U.S.C. §§ 18061-62.
\item[115] See 42 U.S.C. § 18063.
\item[116] “The purpose of these programs is to protect issuers from the effects of adverse selection and to protect consumers from increases in premiums due to the uncertainties that issuers face.” Ctr. for Medicare and Medicaid Services, PATIENT PROTECTION AND AFFORDABLE CARE ACT; ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS, EXCHANGE STANDARDS FOR EMPLOYERS (CMS-9989-FWP) AND STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT (CMS-9975-F): REGULATORY IMPACT ANALYSIS 38 (March 2012), available at http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf.
\item[117] In addition to these deterrents, PPACA specifically prohibits qualified health plans from targeting healthy consumers with their marketing.
\end{enumerate}
\end{footnotesize}
A major concern is that despite a number of penalties many individuals and small businesses will choose to self insure, causing adverse selection against the entire insurance market. In regards to individuals’ choice to self insure, PPACA’s individual insurance mandate and the Secretary’s proposed limited-enrollment periods go a long way in helping to ensure that healthy consumers participate in the market. However, if these measures are ineffective, adverse selection will surely result as unhealthy consumers flood the market and healthy consumers choose to self insure.

Healthy consumers would make this choice because they do not need healthcare services and would prefer to pay the penalty rather than pay a higher amount for insurance. The penalty can never exceed the cost of the average plan in the lowest actuarial level.\(^\text{118}\) As a result, many consumers may choose to risk it. Further adding to this problem, consumers tend to underestimate their own risk for needing healthcare.\(^\text{119}\) As a result, some consumers who would still benefit from insurance would instead choose to pay the penalty because they will incorrectly conclude the penalty is the most cost effective. The number of consumers who oppose PPACA may increase the likelihood of this issue arising, and states have raised concerns about consumers choosing to pay the fine.\(^\text{120}\)

The Secretary’s limited enrollment period could somewhat curtail this issue from arising if consumers realize that they cannot immediately purchase insurance when they need health care services.\(^\text{121}\) However, many consumers may not realize this fact or may not care.

\(^{118}\) I.R.C. § 5000A(c).

\(^{119}\) See Weinstein & Kline, supra note 10.

\(^{120}\) For example, California Health and Human Services Secretary, Kim Belshe, has stated that the question of whether “individuals and small business owners [will] buy coverage or opt, instead, to pay a fine” remains unanswered. Janette Lavelle, California Takes Lead in Health Insurance Exchange, UNION TRIBUNE (Oct. 20, 2010), available at http://www.sduniontribune.com/news/2010/oct/20/california-takes-lead-health-insurance-exchange/.

\(^{121}\) Massachusetts has had issues in regards to the “free rider” problem, in which individuals will jump into the pool when they need health services and then drop out again. For example, in 2009, Blue Cross and Blue Shield of Massachusetts’s short-term members had an average premium of $400 but their average claims exceeded $2,200. See Kay Lazar, Short-Term Customers Boosting Health Costs, THE BOSTON GLOBE (Apr. 4, 2010), http://www.boston.com/news/health/articles/2010/04/04/short_term_customers_boosting_health_costs/.

Massachusetts has a bill currently in committee seeking to address this issue by limiting enrollment in the open market to two 45-day long enrollment periods per year. S.B. 2447, 186th Sess. (Mass. 2010).
In addition to individuals’ option to self insure, many commentators have also expressed concern over whether small employers will choose to self insure, meaning the employer would pay for their employees’ healthcare directly. The belief is that employers with healthier employees will choose to self insure while employers with unhealthy employees will purchase plans on the market. Adverse selection would result because small businesses with a healthier pool could jump into the exchange if their health care costs rise above the costs in the exchange and jump out as their health care costs drop. This issue, however, may not be as significant of a problem as these commentators indicate.

Monetary penalties will likely deter small employers from self insuring. Individuals must have minimum essential coverage, and employers with 50 or more full-time employees must provide minimum essential coverage to its employees. If individuals or small employers fail to have minimum essential benefits, they are subject to monetary penalties. Arguably, self-insured plans that were not in effect when PPACA was enacted do not satisfy these mandates.

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122 See, e.g., Mark A. Hall, Regulating Stop-Loss Coverage May be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms, HEALTH AFFAIRS vol. 31, no. 2, p. 316 (2012). These commentators are especially concerned that small employers could use reinsurance (also referred to as stop-loss coverage) to cover any extreme losses. See id.


124 I.R.C. § 5000A.

125 I.R.C. § 4980H.

126 Id.

127 If a self-insured plan was not in effect prior to PPACA’s enactment (making the plan a grandfathered plan), individuals covered by the plan and employers offering the plan are likely subject to the penalties for not having minimum essential coverage. Both the individual and employer mandates require minimum essential coverage. I.R.C. §§ 4980H, 5000A. Minimum essential coverage is defined as a government-sponsored program, a plan in the individual market, an employer sponsored plan, a grandfathered plan, or a plan recognized by the Secretary. I.R.C. § 5000A(f)(1). Because the Secretary simply incorporates the statutory definitions and does not expressly recognize self-insured plans, a self-insured plan can only qualify as either a grandfathered plan or an employer-sponsored plan. See 77 Fed. Reg. 18445-46 (March 27, 2012) (to be codified at 45 C.F.R. pt. 155.20).

However, employer-sponsored plan is defined as a plan offered in the small or large group market. I.R.C. § 5000A(f). Small and large group markets are markets in which individuals obtain “health insurance coverage.” 42 U.S.C. § 18024(a). Note that while Section 18024 says that these definitions apply “in this chapter,” the statutory note shows that the language actually reads “in this title.” Id. Because both Sections 18024 and 5000A were enacted in the same title of PPACA, the definitions in 18024 apply to 5000A.

Similarly, the definitions of 42 U.S.C. § 18021 apply, which incorporates 42 U.S.C. § 300gg-91 and defines health insurance coverage as “medical care … under any hospital or medical service policy or certificate,
If this conclusion is true, both the employer choosing self insurance and its employees are likely subject to the penalties. As a result, an employer would not start to self insure because their employees would be subject to the penalty, and if the employer employs 50 or more full-time-equivalent employees, the employer would be subject to penalties as well. Consequently, adverse selection would not result from employers with a healthier pool choosing to self insure.\textsuperscript{128}

However, if this conclusion is inaccurate and new self-insured plans qualify as minimum essential coverage, states must take measures to prevent small employers from jumping in and out of the exchange by using self insurance. Because small employers represent a smaller pool (and therefore have more fluctuations in risk), these employers who choose to self insure will necessarily require reinsurance to prevent large losses. Consequently, states could deter self insurance, thereby preventing adverse selection, by either banning reinsurance entirely or otherwise limiting the availability of reinsurance.

2. Adverse Selection against Actuarial Levels

An additional issue that poses a threat to the Exchange is the ability of individual consumers to move from one actuarial level to another. PPACA provides that every carrier, regardless of participating in the Exchange, must accept every individual or employer that applies for coverage.\textsuperscript{129} While this provision is essential to the underlying goals of PPACA, it

\textsuperscript{128} Grandfathered, self-insured small employers likely are not a major problem. In 2010, only 16\% of employers with between 3 and 199 employees chose to self insure. KAISER FAMILY FOUNDATION & HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 151 (2011). Under PPACA, however, small employers will never have more than 100 employees, and prior to 2016, states may choose to limit small employers to only 50 employees. 42 U.S.C. § 18024(b). Because fewer and fewer employers choose to self insure as the number of employees decrease, the percentage of small employers who self insure is likely significantly less than 16\%. Consequently, very few employers eligible to participate in the SHOP exchanges will have a grandfathered, self-insured plan.

\textsuperscript{129} See 42 U.S.C. § 300gg-1(a).
does create the potential for adverse selection against the higher actuarial levels and against plans sold on the exchange.

On the one hand, consumer mobility between plans should not be discouraged because mobility encourages the competition between carriers that theoretically results in quality and price improvements. However, the risk of adverse selection arises because with unlimited enrollment consumers could switch between plans in different actuarial levels. As a result, a consumer could choose to pay a lower premium for a bronze level plan, which would satisfy the individual mandate, and then switch to a plan in the platinum level if the consumer requires health care.

The Secretary, however, does somewhat restrict consumer mobility by setting limited enrollment periods for the individual exchanges. Each exchange will have one open enrollment period of 53 days, which appears to only apply to qualified health plans. If the enrollment period only applies to qualified health plans, plans offered outside the exchange are not expressly subject to the enrollment periods.

Despite this enrollment period, adverse selection against the higher actuarial plans is still a potential problem. First, consumers could still delay needed medical services until the open enrollment period and jump into a higher actuarial level. Potentially exacerbating this problem, the Secretary’s proposed regulations regarding enrollment periods only apply to

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130 PPACA creates actuarial bands based on the plan covering 60%, 70%, 80%, or 90% of the actuarial value (respectively labeled bronze level, silver level, gold level, and platinum level). See 42 U.S.C. § 18022(d).

131 77 Fed. Reg. 18462 (proposed March 27, 2012) (to be codified at 45 C.F.R. 155.410). In addition, the proposed regulations permit special enrollment for individuals who lose their coverage because they are no longer eligible for their previous coverage due to change in employment or marital status, gain a dependant, become a legal alien, experience errors in enrollment, are enrolled in a plan that materially violates a contract provision, have a change in eligibility for cost sharing reductions, permanently move locations, or experience exceptional circumstances as determined by the Secretary. 77 Fed. Reg. 18463 (proposed March 27, 2012) (to be codified at 45 C.F.R. 155.420).

While small employers are permitted to purchase a group plan through the exchange at any time, these small employers may only alter their group plan once a year during annual election periods. 77 Fed. Reg. 18466 (proposed March 27, 2012) (to be codified at 45 C.F.R. 155.725).

132 Consumers would still need to wait for the open enrollment period to jump into a higher actuarial level because, even if the Secretary’s open enrollment period does not apply to plans outside the exchange, carriers would not offer higher actuarial plans outside the exchange. Carriers would still fear adverse selection resulting from consumers jumping into the higher actuarial plans. On the positive side, this encourages carriers to offer their higher actuarial plans inside the exchange.
qualified health plans, meaning all plans offered on the exchange. As a result, a carrier could have unrestricted availability for its non-qualified health plans in the bronze level. Consumers could jump into the higher actuarial level during the open enrollment period, acquire the needed medical services, and then drop back into a bronze plan at any time. This situation would open the door for adverse selection.

Requiring all carriers, regardless of operating inside or outside the exchange, to have plans in each actuarial level would somewhat reduce the effects of this problem because each carrier would theoretically bear its share of the adverse selection. An additional solution could be to create a waiting period. Under this approach, consumers who switch to higher actuarial levels would still only be covered at the lower actuarial amount for a specified period of time.

3. Adverse Selection against Certain Plans and the Exchange

In addition, carriers could create adverse selection issues by continuing to compete on risk. First, carriers may continue to compete on risk by devaluing a particular plan. For example, carriers might significantly reduce the number of medical service providers, create

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134 A simple approach would be for the exchange to require the insurance coverage to last until the next open enrollment period. However, the Secretary’s proposed regulations expressly allow a consumer to terminate coverage if the consumer becomes covered under another plan with minimum essential coverage. 77 Fed. Reg. 18463 (March 27, 2012) (to be codified at 45 C.F.R. 155.430(b)(2)(ii), (d)(2)). Because the new bronze-level plan would satisfy minimum essential coverage, the exchange must allow the consumer to terminate the higher actuarial plan.
135 PPACA requires that carriers in the Exchange offer plans in at least both the silver and gold levels. See 42 U.S.C. § 18021(a)(1)(C)(ii).
136 Other measures, however, may be necessary if carriers use the actuarial levels as a way of competing on risk. For example, depending on how the rating systems operate, a carrier could put little focus on its high actuarial level plans but put heavy emphasis on receiving a high rating on the low actuarial plans. As a result, this carrier would receive less than its share of the burden when a consumer switches to a higher actuarial level because the consumer would likely choose a different carrier with a better plan. In other words, carriers would be competing on risk in the high actuarial levels.
administrative barriers to payment,\textsuperscript{137} or implement utilization controls.\textsuperscript{138} Other carriers who do not use these tactics could soon become subject to adverse selection against their plans. The adverse selection would result because these tactics would drive away unhealthy consumers who need the medical services and who are dissatisfied with the carrier. Only healthy consumers would remain with that carrier and prices would drop, but other carriers would pick up the unhealthy consumers. As a result, carriers could engage in a race to adopt these tactics.

Disclosure requirements,\textsuperscript{139} rating plans based on quality and consumer satisfaction,\textsuperscript{140} and the risk adjustment and reinsurance programs\textsuperscript{141} are aimed at deterring unwanted risk-driven competition. As discussed in Part V, however, consumers may not effectively use the disclosures and ratings to make purchasing decisions, reducing the negative impact to carriers who use these tactics. Even worse, healthy consumers who are simply shopping for the lowest price may actually be drawn to plans that use these tactics. While the risk adjustment and reinsurance programs will prevent plans from entering a death spiral, these programs simply place a cap on the profitability of these tactics and may not be an effective deterrent. PPACA also expressly prohibits carriers from discouraging unhealthy individuals from enrolling,\textsuperscript{142} but enforcing this provision may prove to be difficult. Overall, carriers’ fear of adverse selection will always be present, and no mechanism can completely prevent carriers from competing on risk.

4. Producers: Friend or Foe?

Insurance producers (also known as brokers or agents) create an interesting dilemma for the exchanges. Producers represent a knowledgeable resource with extensive experience with insurance plans, and this knowledge and experience could prove to be either an asset or a liability for the exchanges. If nothing is done and producers only operate outside the exchange,\textsuperscript{137}

\textsuperscript{137} For example, a carrier might require patients to get preapproval for certain procedures or medical-service providers to submit lengthy documentation. \\
\textsuperscript{138} Utilization controls refer to the practice of the carrier employing medical professionals to determine the necessity and propriety of medical services requests. WILLIAM O. CLEVERLY, ET AL., ESSENTIALS OF HEALTHCARE FINANCE 7TH ED. 159 (2011). \\
\textsuperscript{139} Plans in the exchange must disclose payment and policy practices along with out-of-network cost sharing. 42 U.S.C. § 18031(e)(3). \\
\textsuperscript{140} 42 U.S.C. § 18031(c). \\
\textsuperscript{141} See supra Part IV.A.1.b. \\
\textsuperscript{142} 42 U.S.C. 13031(c)(1)(A).
producers will attempt to steer consumers away from the exchanges. Producers will have no other choice if they want to continue their profession. Even worse, a carrier could encourage producers to cherry pick healthy consumers on the carrier’s behalf and steer unhealthy consumers toward the exchange, causing adverse selection against the exchange.

In contrast, eliminating producers altogether would destroy an existing source of knowledge and experience. Consequently, states must somehow incorporate producers into this new market. One possible approach is to incorporate producers as navigators.\textsuperscript{143}\textsuperscript{143} PPACA prevents navigators from receiving payments from carriers.\textsuperscript{144}\textsuperscript{144} However, exchanges may pay navigators out of the exchanges’ operational expenses.\textsuperscript{145}\textsuperscript{145} Consequently, producers would no longer work directly for carriers, removing the issues arising from collusion between carriers and producers. Alternatively, the Secretary’s proposed regulations permit states to allow producers to enroll individuals and small employers in the exchanges.\textsuperscript{146}\textsuperscript{146} Ultimately, each state can control the role of producers and the relationship between carriers and producers.

5. Minimum Essential Benefits and the Race to the Bottom

The next issue relates to the benefits covered by each plan. As discussed above, PPACA requires plans offered in the individual or small group market to cover essential health benefits,\textsuperscript{147}\textsuperscript{147} but plans are free to offer additional benefits.\textsuperscript{148}\textsuperscript{148} If a plan chooses to cover a benefit in addition to the essential health benefits, individuals in need of that benefit will be drawn to that plan, and adverse selection will result.\textsuperscript{149}\textsuperscript{149} To avoid this scenario, carriers will engage in a race to the bottom and only offer the minimum essential health benefits.\textsuperscript{150}\textsuperscript{150}

\textsuperscript{143} PPACA expressly includes producers as an entity eligible to receive a navigator grant. 42 U.S.C. § 18031(i)(2)(B).
\textsuperscript{144} 42 U.S.C. § 18031(i)(4).
\textsuperscript{145} 42 U.S.C. § 18031(i)(6).
\textsuperscript{147} See §§ 300gg-6, 18021(a)(1)(B).
\textsuperscript{148} See 42 U.S.C. § 18022(b)(5).
\textsuperscript{149} This issue arose in the Federal Employee Health Benefits Program, which acts as a marketplace for federal employees to purchase health insurance. Originally, the market provided both “high option” and “low option” plans, and the high option plans included reduced cost sharing and other enhanced benefits. Because unhealthy consumers switched into the high option plans, those plans experienced adverse selection and were forced to reduce their benefits. Even though the reduction in benefits caused the benefits to be only marginally better than the low option plans, the cost of the high option plans were significantly higher because of the risk pool. See Karl Polzer, The Federal Employees Health Benefits Program: What Lessons Can It Offer Policymakers?, NATIONAL HEALTH
This race to the bottom, however, is only a problem if the essential health benefits are badly defined and unresponsive to changing requirements.\textsuperscript{151} Consequently, the States must adequately define minimum essential benefits to ensure that consumers’ needs are being met.\textsuperscript{152}

Overall, despite these potential pitfalls, PPACA will almost certainly reduce risk-driven competition. But the question remains, does PPACA enable consumers to create a value-driven market?

V. CAN CONSUMERS PROVIDE THE BASIS FOR VALUE-DRIVEN COMPETITION?

As discussed above, PPACA uses a variety of mechanisms to reform the health-benefits market. These mechanisms are intended to create individual and small group health-benefits markets that function more like other markets. Many see this as an opportunity to empower

\textsuperscript{150} A significant percentage of consumers, likely the healthiest consumer, will still base their decision on price, as opposed to other measures. To attract these healthy consumers, carriers will engage in a race to the bottom with benefits to reduce premiums. See Thomas C. Buchmueller and Paul J. Feldstein, \textit{The Effect of Price on Switching Among Health Plans}, 16 \textit{Journal of Health Economics} 231 (1997); Keith M. Marzilli Ericson & Amanda Starc, \textit{Age-Based Heterogeneity and Pricing Regulation on the Massachusetts Health Insurance Exchange} 23-24 (Working Paper Jan. 5, 2012), available at http://hcmg.wharton.upenn.edu/documents/research/Pd_elast_v17-KMME.pdf.

\textsuperscript{151} To help ensure that essential health benefits are reasonably defined, PPACA limits the health plans that members of Congress and their staff may purchase to qualified health plans. See 42 U.S.C. § 18032(d)(3)(D). Per the legislation, the Secretary is responsible for defining essential health benefits, but states are free to require carriers to cover additional benefits. See 42 U.S.C. § 18022(b). However, if a state chooses to do this, the state must pay for the cost of the additional benefit. See 42 U.S.C. § 18031(d)(3)(B).

Surprisingly, the Secretary has indicated that the states will define essential health benefits. See CTR. FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 8-9 (Dec. 16, 2011), available at http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. Under the Secretary’s proposed approach, each state will select a benchmark plan from the state’s existing small group or individual markets, the Federal Employee Health Benefits Plans, or the state’s largest HMO. \textit{Id.} at 9. If a state chooses to add additional benefits not included in the benchmark plan, the state would be responsible for the costs of those benefits. \textit{Id.}

\textsuperscript{152} The Secretary and states retain some discretion to allow for innovations in benefits (e.g., permitting different services to satisfy a particular essential-benefit requirement). See Oeschner & Schaler-Hayes, \textit{supra} note 9 at 290-92 (discussing the different approaches).
consumers. While PPACA does attempt to push the market in this direction, truly empowering consumers to drive the market may prove to be a difficult task.

A. PPACA’s Mechanisms for Empowering Consumers

PPACA creates a number of mechanisms designed to facilitate consumer decision making. The two primary mechanisms designed to enable consumers to drive the market are navigators and the internet portal. With the navigator program, entities that have or could have relationships with consumers would receive grants to, among other things, conduct public education and facilitate enrollment in qualified health plans. PPACA, however, includes very limited information on navigators. The key to this program’s success is ensuring that navigators’ interests are truly aligned with that of the consumers they serve. Yet to be determined, however, is who exactly will serve as navigators and how a navigator system will be structured.

153 PPACA also creates the Consumer Operated and Oriented Plan (CO-OP), but these plans likely will do little to empower consumers. Under the CO-OP program, the Secretary will issue loans for the establishment of member-controlled nonprofit insurance carriers. 42 U.S.C. 18042. Members of the CO-OP’s plans are responsible for selecting the board. See id. This consumer control and nonprofit status would appear to create organizations that enable consumers. However, these organizations must continue to compete with other carriers and are still subject to adverse selection. In addition, a member-appointed board is unlikely to translate into a mechanism for consumers to improve quality. Control over the board may not be enough to allow consumers to influence the product offerings. Consumers may still have difficulty understanding the plans, and CO-OP members are more likely to switch to another carrier rather than use their board selection power as a means of improving their current plan. While these CO-OPs may be useful for other goals of PPACA, they will have little impact on empowering consumers.

154 42 U.S.C. § 18031(i)(2), (3). In addition, the Secretary’s proposed regulations permit producers (brokers and agents) to enroll consumers in the exchange. See 77 Fed. Reg. 18449 (March 27, 2012) (to be codified at 45 C.F.R. 155.220).


156 However, PPACA expressly names several entities that could serve as navigators: “trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers.” 42 U.S.C. § 18031(i)(2)(B).
In addition to the navigators, internet portals will provide comparative information regarding each of the plans,\textsuperscript{157} which includes a rating of each plan based on that plan’s “relative quality and price” and consumer satisfaction.\textsuperscript{158} Under the Secretary’s regulations, the web portal will be required to display the following for each plan: premium and cost sharing information, summary of benefits, level of coverage, consumer satisfaction ratings, quality reviews, the medical loss ratio, the transparency of coverage measures, and the provider directory.\textsuperscript{159}

If not designed properly, however, the information provided on these internet portals will do little to empower consumers. Taking a consumer-driven approach to resolving cost issues is nothing new. For example, the good faith estimates (GFEs) required for residential loans attempt to make apples-to-apples comparisons of different loans (without standardizing the loans) and are intended to provide consumers with the information to compare loan-closing costs.\textsuperscript{160} The purpose of this information is to encourage competition and reduce overall closing costs.\textsuperscript{161} While the research evaluating the effectiveness of GFEs is limited, most studies conclude that these disclosures have been ineffective.\textsuperscript{162} These studies lead one commentator to conclude, “Congress rejected other approaches in favor of disclosure based on the gamble that disclosure would succeed. It is time to rigorously test this assumption and to explore other options.”\textsuperscript{163}

The information provided on the internet portal could have the same impact. As discussed above, the internet portal will provide a large amount of information to consumers. On the positive side, this information provides the criteria that most consumers find relevant.\textsuperscript{164}

\textsuperscript{157} See 42 § 18031(c)(5), (d)(4)(C).
\textsuperscript{158} 42 § 18031(c)(3).
\textsuperscript{161} See id.
\textsuperscript{162} See id.
\textsuperscript{163} Id. at 27.
\textsuperscript{164} Studies have shown that consumers consider the following factors in making health benefits decisions:
Consumers, however, may have difficulty accessing and understanding the information. This result seems even more likely given that the vast majority of consumers initially using the exchange will have no higher than a high school education. In addition, this information may be an oversimplification of complex plans that will affect different consumers differently. Consequently, oversimplified data might be great for the majority of consumers but utterly fail to meet the needs of others. Lastly, these consumers may overemphasize the importance of certain criteria while downplaying other criteria. For example, consumers could focus on the consumer ratings while downplaying the importance of the quality reviews. As a result, carriers could offset practices that negatively affect value by engaging in activities that improve consumer satisfaction (for example, sending a birthday card to enrollees).

(1) access (to chosen doctor, to specialists, length of time to get an appointment, ability to get care when needed, telephone access); (2) amount of paperwork; (3) benefits; (4) choice of provider (of doctors, of hospitals, ability to keep one’s own doctor); (5) communication/interpersonal skills/caring of provider; (6) convenience (of choosing doctor, getting care, location); (7) coordination of care; (8) costs; (9) courtesy and manner of physicians and staff; (10) hospital ratings; (11) good value for the money; (12) plan administrative hassles; and (13) quality (of care overall, of particular types of care, of providers).


166 One study concluded, “The difficulties found in weighting various quality measures consistently imply that the common practice of providing several different quality measures in a single report to serve the interests of multiple subgroups in the population may be counterproductive.” Judith H. Hibbard et. al, Strategies for Reporting Health Plan Performance Information to Consumers: Evidence from Controlled Studies, 37 HEALTH SERVICES RESEARCH 291, 311 (2002). The researcher concluded, “there is a need to guide consumers with special health problems or situations to the key performance indicators that are most important for their needs.” Id.


In the survey, 51% of consumers said that a government agency rating system would have little or no influence on the consumers’ choice of health plan, and 44% said the same for consumer groups rating systems. See id. at 23-24. In contrast, 77% said that a rating system based on patient surveys would have a lot or some influence on their decisions. See id. As a result, consumers may have tendency to put too much emphasis on consumer ratings while downplaying other ratings. See also Judith H. Hibbard et. al, Strategies for Reporting Health Plan Performance Information to Consumers: Evidence from Controlled Studies, 37 HEALTH SERVICES RESEARCH 291 (April 2002) (concluding that the way in which this information is presented may also have an impact).
To address these issues, states must constantly reevaluate their portals to ensure each consumer chooses a plan that best meets that consumer’s needs.\textsuperscript{168} For example, States may wish to guide a particular consumer to either a specific plan design or the information most relevant to that consumer.\textsuperscript{169} Alternatively, states may wish to emphasize navigators who could guide consumers through the portal. Unfortunately, a system that successfully accomplishes these goals has yet to present itself, and empowering consumers may prove to be a difficult task.

B. Quandary for the States

Several barriers prevent consumers from driving the market. The first problem arises from the consumers themselves. Consumers have difficulty in understanding and comparing plans and do not select plans that best meet their individual needs. Consequently, carriers are not incentivized to design plans that accurately reflect consumers’ needs because consumers do not make informed purchasing decisions. The second problem arises from an attempt to address the first. Many exchanges may choose to minimize the number of plans,\textsuperscript{170} which would enable consumers to more easily understand and compare plans. This approach often limits innovation, and consumers must depend on regulators to ensure the available products accurately reflect consumer demand. Consequently, regulators, not consumers, are in the driver’s seat.

Ultimately, the states are left with the difficult decision of choosing whether to allow any qualified health plan to participate in the exchange or limit the number of plans.\textsuperscript{171} As discussed

\textsuperscript{168} See Hibbard, supra note 166. Studies on these websites should focus on the effect of “design and implementation on the [website]’s impact” and its ability to influence the quality of health care. Constance H. Fung, et. al, Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care, 148 ANNALS OF INTERNAL MED. 111, 121 (2008).

\textsuperscript{169} See Judith H. Hibbard, Engaging Health Care Consumers to Improve the Quality of Care, 41 supp. MEDICAL CARE I-61, I-63 (2003).

\textsuperscript{170} While a state could limit the number of plans either through selective contracting or by serving as an “active purchaser,” simply noting that these states seeks to limit the number of plans is sufficient for purposes of this discussion. With selective contracting, the state would impose additional requirements not included in PPACA and consequently limit the number of plans that can participate in the exchange. In contrast, an active purchaser actively bargains with carriers to negotiate the best deals and allows only those plans on the exchange (acting much like an employer in the current employer-sponsored system).

\textsuperscript{171} 76 Fed. Reg. 41891 (proposed July 15, 2011).

\textit{1. The Utah Approach & Consumers' Difficulty in Understanding and Comparing Plans}

Utah was one of the first states to implement an insurance exchange. Utah takes a market-organizer approach in which the exchange provides a trading ground where carriers and consumers can meet.\footnote{See Deloitte Ctr. For Health Solutions, \textit{Health Insurance Exchanges:A Strategic Perspective} 4 (2011), available at http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Reform%20Issues%20Briefs/US_CHS_HealthInsuranceExchanges_AStrategicPerspective_072711.pdf; Reichart, supra note \textbf{Error! Bookmark not defined.}.} A market organizer serves as a source of information, compares health plans, and is associated with decreased standardization and increased innovation.\footnote{See State Health Access Data Assistance Ctr., \textit{Health Insurance Exchanges:Implementation and Data Consideration for States and Existing Models for Comparison} 2 (2010), available at http://www.shadac.org/files/shadac/publications/IssueBrief23.pdf} One of the most noticeable characteristics of this approach is the large number of plans offered on the exchange.\footnote{In a survey based on the exchange’s limited launch, 55% of the consumers said that “choosing a health plan was not an easy process.” \textit{The Utah Health Exchange: Results of the Limited Launch}, available at http://le.utah.gov/interim/2009/pdf/00001674.pdf.} For example, Utah recently offered 146 different plans on its exchange.

Consequently, consumers have a wide range of products to choose from, and carriers have the flexibility to innovate. The large number of plans, however, makes choosing a plan difficult for consumers.\footnote{John Buntin, \textit{A Closer Look: Utah’s Health Insurance Exchange}, \textit{GOVERNING} (Apr. 26, 2011) (interviewing the director of Utah’s health exchange), available at http://www.governing.com/topics/health-human-services/closer-look-utah-health-insurance-exchange.html#continued.} Put simply, the large number of plans encourages innovation, but...
because consumers do not make informed purchasing decisions, consumers are not driving the market.

Ultimately, the underlying goal for states taking this approach is to empower consumers, and the design of the internet portal and navigator program is even more important. The internet portals and navigators are the sole mechanisms ensuring that consumers are making informed purchasing decisions. Informed purchasing decisions will lead to market innovations that will improve the value of plans. As discussed previously, however, designing the internet portal and navigator programs to empower consumers will be difficult, if not impossible.

2. The Massachusetts Approach and Carriers’ Inability to Innovate

In contrast to Utah’s approach, Massachusetts uses its exchange to standardize products, negotiate lower premiums, and reduce the number of plans.177 Exchanges taking this approach determine which health plans and carriers qualify for the exchange, use strict reporting requirements, negotiate with plans, and are associated with increased standardization and decreased innovation.178

The hallmark of this approach is the limited number of plans on the exchange. In its unsubsidized program, Massachusetts has three actuarial bands: gold, silver, and bronze. Within each actuarial band, Massachusetts permits only specific product designs.179 The exchange has

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178 See Deloitte Ctr. For Health Solutions, supra note Error! Bookmark not defined.. Massachusetts has two different programs: one that offers subsidized plans to qualified individuals and another program that is unsubsidized. The exchange has said that its purpose in reducing the number of product offerings in its unsubsidized program is to “enhance[e] transparency and better enable[e] consumers to more simply compare and enroll in health plans.” MASSACHUSETTS HEALTH CONNECTOR, 2010 REPORT TO THE MASSACHUSETTS LEGISLATURE: IMPLEMENTATION OF HEALTH CARE REFORM 12 (Nov. 2010), available at https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServle t/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%252 02010.pdf.

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one product design in gold, three in silver, and three in bronze.\textsuperscript{180} Overall, Massachusetts offers only 35 plans on its exchange.\textsuperscript{181}

Consumer research has concluded that consumers view the Massachusetts exchange as simplifying the purchase of insurance and providing an unbiased source of information to compare plans.\textsuperscript{182} While this streamlining of products makes consumer choice easier, carriers are not able to innovate in ways that could be beneficial to consumers. The founding director of the Massachusetts’ exchange observed that “customers want[] more standardization between plans so they c[an] compare apples to apples …, but that can quash innovation.”\textsuperscript{183} Interestingly, using standardization as a way to create a properly functioning market has prevented consumers from driving the innovations that could potentially increase the value of plans.\textsuperscript{184}

Ultimately, carriers in this type of market are reacting to regulators’ requirements, not consumer demand. Consumers must go through regulators to ensure that plans match their needs. Consequently, states taking this approach must ensure that regulators constantly monitor

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\textsuperscript{180} CommChoice Seal of Approval RFR (Jan. 13, 2011), available at https://www.mahealthconnector.org/portal/site/connector/template.sitemap/. Interestingly, these product designs apply only to plans offered within the exchange.
\textsuperscript{181} Alan G. Raymond, Blue Cross Blue Shield of Massachusetts Foundation, Massachusetts Health Reform: A Five-Year Progress Report 18 (Nov. 2011).

Amy Lischko, an assistant professor at the Tufts University School of Medicine, noted that the Massachusetts exchange “is moving to standardize the plans, making them all look the same, and some plans with innovations that existed earlier haven’t been allowed in.” Thomas Reinke, Will the Employer-Based System Collapse?, MANAGED CARE MAGAZINE (July 2010), http://www.managedcaremag.com/archives/1007/1007.backlash.html.
\textsuperscript{184} This dilemma also raises another interesting question: Should states limit the participants in an exchange to encourage an outside market in which innovation is necessary to compete with plans inside the exchange? A member of Minnesota’s Health Insurance Exchange Working Group argued, “By its nature, the Exchange will likely limit consumer options as it has done in Massachusetts. . . . [W]e feel it is important to maintain a robust and flexible market outside the Exchange so that consumers will continue to have a full range of options available and a marketplace that provides plan innovation.” Health Insurance Exchange Working Group, Legislative Commission on Health Care Access, Responses to Homework Questions 3(Sept. 23, 2010), available at http://www.commissions.leg.state.mn.us/lchca/exchange/homework_numbered9-23-10.pdf.
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consumers’ needs and alter the product offerings accordingly. Without this monitoring, consumers will have little to do with driving the health-benefits market.

VI. CONCLUSION

Effectively changing the existing health care system necessarily involves taking a wide range of interests into account, and accurately forecasting the results of such a sweeping change is inherently difficult if not impossible. However, given the challenges facing the current health care system, few could argue that changes are not necessary, and given the interrelated parties and procedures involved, only a comprehensive overhaul is likely to have any impact.

PPACA lessens the potential for adverse selection and reduces carriers’ incentive and ability to compete on risk. However, adverse selection is still a possibility, and opportunities for risk-based competition remain. The fear of adverse selection and an increasingly competitive marketplace may result in carriers attempting to take advantage of the remaining opportunities to compete on risk. States must be mindful of these pitfalls and should adopt measures in addition to those contained in PPACA.

In addition, many see PPACA as providing an opportunity to create a consumer-driven health benefits market, and PPACA incorporates several mechanisms aimed at empowering consumers. PPACA’s mechanisms alone, however, are not enough. Consequently, states face a difficult decision in deciding whether to take a more active role in the types of plans offered in the exchange or attempt to design a system in which consumers are truly empowered to drive the market. A state that chooses the latter may find that truly empowering consumers is a difficult, if not impossible, task.

Overall, supporters argue that PPACA provides a basis for solving many of the challenges facing the health benefits market in the United States and will forever change how this market operates. In contrast, critics argue that PPACA is doomed to fail and cannot overcome the barriers that have caused previous exchanges to collapse. To quote Thomas Jefferson, “The experiment is going on, however, … and at the end of the chapter, we shall see which opinion experience approves.”