



## Legal and Economic Analysis of Health Insurance Exchange Mechanisms<sup>1</sup>

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## 1. INTRODUCTION

Several states have recently proposed using health insurance exchange programs, also referred to as “connector” programs, as part of an attempt to move commercial health insurance markets away from employer-based organization and toward individual insurance policies decoupled from employers.<sup>3</sup> Such programs have some degree of intuitive appeal. Exchange programs may in some cases ease the burden on employers of directly funding health benefits and may also ease the burden on employees by decoupling the provision of health insurance and employment status.<sup>4</sup> However, exchange programs are likely to come with a host of tradeoffs and consequences, intended or otherwise, which could impede the programs’ ability to accomplish their main objective of reducing barriers to coverage.

## 2. DESCRIPTION

### 2.1 Mechanisms

In general, exchange mechanisms facilitate the availability, choice and adoption of private health insurance plans to eligible individuals. Exchanges also determine eligibility regarding the receipt of health plan benefits for residents, employers and their employees. Proposed and existing exchange programs require employers and employees to pay a payroll-based fee, most likely based on a percent of wages.<sup>5</sup> Standardized benefit packages would be identified, representing various levels of benefit generosity and/or cost sharing. For example, some exchange programs might offer multiple benefit packages through the exchange, one representing the minimum benefit package, and others with additional coverage; premiums would be set accordingly. Individuals and employees would purchase the benefit package directly from the exchange. Participating health insurers would supply insurance policies to the exchange. Employers could decide how much of the exchange premium they were willing or able to pay (i.e., a defined contribution), and employees would pay the difference. Payment by employers and employees would be made directly to the state-run exchange program. Employer and employee payments to the exchange would not be subject to revenue/income tax.

A critical element of exchange programs is tax deductibility of health insurance premiums. Employees of firms not offering health insurance benefits would be able to, under most variations of exchange, pay for health insurance using pre-tax earnings, thereby extending the same tax subsidy available to those receiving health insurance benefits through their

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<sup>3</sup> See generally Curtis and Neuschler 2006; Holahan and Blumberg 2006; Carlton 2007; Timiraos 2007; Schneider and Ohsfeldt 2007

<sup>4</sup> Holahan and Blumberg 2006

<sup>5</sup> To avoid penalizing high-wage firms, such a percentage would most likely have to be capped, perhaps in line with caps consistent with Social Security wages (i.e., wages  $\leq$  \$94,200).

employer. To do so, in most cases employers must maintain a premium-only Section 125 “cafeteria plan,” even if pre-tax dollars are channeled directly to the exchange program.

## 2.2 Variations

There are numerous variations of proposed exchange programs nationwide, and at least one, in Massachusetts, that will soon be fully implemented. Other states recently or currently considering versions of exchange mechanisms include California, Connecticut, Georgia, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, New Jersey, Oregon, Texas, Virginia, Washington, and Wisconsin.<sup>6</sup> These states, with relatively minor exceptions, appear to be primarily considering Massachusetts-style exchanges.<sup>7</sup>

Massachusetts’ recent passage of individual and employer mandates appears to have set the tone for health insurance reform debates in several other states.<sup>8</sup> The Massachusetts exchange is governed by a ten-member board charged with, among other tasks, determining whether “a health benefit plan meets certain standards regarding quality and value.”<sup>9</sup> All employers are required to establish Section 125 cafeteria plans to facilitate payment of pre-tax dollars to the exchange. Employees are eligible to purchase health insurance through the exchange if their employer does not offer health insurance.<sup>10</sup> However, non-offering employers (i.e., those paying a fee to the state instead of offering coverage) are free to contribute to employees’ purchase through the exchange. Workers with more than one job could pool contributions from multiple employers.

Exchange programs vary according to five criteria:<sup>11</sup> (1) eligibility; (2) scope of benefit packages; (3) degree of displacement of existing insurance markets (e.g., individual markets); (4) rating factors; and (5) the structure and organization of the exchange and its governing board. Given the breadth of these parameters, the feasible set of varieties of exchange mechanisms is potentially large. Many of these details have yet to be worked out in the states where exchanges, individual mandates, and risk pools have been proposed, and as we report in Section 3 there are concomitant legal issues that may also frustrate or in some cases block the implementation of such laws.

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<sup>6</sup> This list as of April 2007; legislatures in several states at this time were in the process of considering several bills relating to exchange-like mechanisms. See generally Burton, Friedenholz, and Martinez-Vidal 2007; SCI 2007; Silow-Carroll and Alteras 2004.

<sup>7</sup> See generally Karawaki 2006; Leitz and Osberg 2007; Maryland Chamber of Commerce 2007; Curtis, Foreland, and Neuschler 2003

<sup>8</sup> Holahan and Blumberg 2006; McDonough et al. 2006; Pauly 2007

<sup>9</sup> Bianchi 2007

<sup>10</sup> This is irrespective of the level of coverage offered through the employer. If an employer offers coverage below the “creditable coverage” floor used to enforce the mandate, the “employee in this case would need to obtain coverage under the individual mandate...but be unable to purchase coverage through the Connector” Bianchi 2007.

<sup>11</sup> Haislmaier and Owcharenko 2006; Waltman and Brackemyre 2007

### **2.2.1 Eligibility**

Exchanges vary in the definition of eligible populations. The Massachusetts plan replaces the existing individual market and will be available as an option for small-group employers. The exchange proposed in Missouri, for example, will determine eligibility regarding the receipt of health plan benefits for residents, employers and their employees, students attending upper level education in Missouri and other eligible individuals (Missouri residents; non-Missouri residents who work at least 20 hours in a Missouri business that does not offer its workers group health insurance; individuals enrolled in or eligible to enroll in a participating employer-subsidized plan; self-employed individuals; qualified dependents).<sup>12</sup> The bill provides for guaranteed issue of coverage at a standard rate to all persons who enroll in the exchange as part of a participating employer-group and to individuals with 18 months or more of previous, creditable coverage. In general, the exchanges proposed in most states cover the individual market only, the small group market only, individual and small group markets combined, or small groups up to 100 employees.

### **2.2.2 Benefit Packages**

Exchanges vary in the definition of the scope of benefits included in insurance products transacted through the exchange. For example, House Bill 6652 of Connecticut requires the exchange administrator to offer three health insurance plans to each applicant: an “affordable” health care plan; a “comprehensive” health care plan currently available from insurers; and a health savings account plus high deductible plan currently available from insurers. Through the exchange, an employer may purchase and offer these plans to their employees, but the employers are not required to offer a choice of the three plans. Similarly, the exchange proposed in Michigan would only offer eligible health coverage plans that have received the exchange’s seal of approval to individuals and groups and must offer at least one health coverage plan that provides for a high deductible with only catastrophic coverage.<sup>13</sup> The board must obtain coverage plans on behalf of the program that include, but are not limited to: wellness services; inpatient services; outpatient services / preventive care; prescription drugs; medically necessary inpatient and outpatient mental health services, as well as substance abuse services; and emergency care services.

### **2.2.3 Displacement**

An important feature of exchanges (and accompanying individual and/or employer mandates) is the extent to which the program displaces existing individual and small group markets. For example, the Massachusetts plan folds the individual market into the exchange, and will most likely include the small group market in the near future. The Missouri proposal is further reaching, calling for the dissolution of existing individual and

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<sup>12</sup> Text of Senate Bill 556 available at [www.senate.mo.gov/07info](http://www.senate.mo.gov/07info) (April 27, 2007)

<sup>13</sup> Senate Bill 278, available at [www.legislature.mi.gov](http://www.legislature.mi.gov) (April 27, 2007)

small group markets relatively soon after the program is implemented. In contrast, the exchange proposal in Washington D.C. would keep those markets largely intact.

#### **2.2.4 Rating Factors**

In some cases the exchange requires a change in existing rating factors, while in other cases rating factors remain the same. As an example of the latter, the Massachusetts exchange products will be sold on a guaranteed-issue basis with modified community rating, which is the same as the rating scheme prior to the implementation of the exchange. The Maryland exchange, in contrast, would allow adjustments for age and geography, and the Washington D.C. exchange would permit age adjustments within a wide rate-banding.<sup>14</sup>

#### **2.2.5 Exchange Structure**

There is considerable variation in how exchanges are structured and organized. For example, the Connecticut reforms require the Insurance Department to issue a request for proposals and ultimately award a five-year contract to administer the Connecticut exchange program. The contract must be awarded to a private non-profit organization.<sup>15</sup> In contrast, the seven-member governing board of the state of Washington's exchange program will be appointed by the governor.<sup>16</sup> The Massachusetts exchange is also governed by appointees, but selection of appointees is shared by the governor, the attorney general, and others.

### **3. LEGAL ISSUES**

It is likely that exchange programs will encounter legal challenges on several fronts, depending on the design and functioning of the program in question. The effectiveness of exchange programs in accomplishing their broad objectives (i.e., level playing fields; universal access) turns on their ability to adapt to the legal environment. We identify five issues of potential relevance: (1) preemption by the federal Employee Retirement Income Security Act of 1974 (ERISA); (2) implications of Section 125 of the federal Internal Revenue Code; (3) conflicts with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); (4) list billing; and (5) guaranteed issue.

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<sup>14</sup> Haislmaier and Owcharenko 2006

<sup>15</sup> OLR Bill Analysis, "An Act Establishing the Connecticut Healthy Steps Program," available at <http://www.cga.ct.gov/2007/BA/2007HB-06652-R000219-BA.htm> (April 27, 2007)

<sup>16</sup> State of Washington, Engrossed Second Substitute House Bill 1569, beginning at §3(1).

### 3.1 ERISA

Although ERISA was nominally intended to address employer pension plans, the interpretation of ERISA compliance has broadly included “employer-sponsored health benefit plans” (i.e., self-insured multi-state employer groups) from interstate variation in health insurance market laws by preempting conflicting and inconsistent state and local laws.<sup>17</sup> The key issues are whether, or the extent to which, a health reform initiative extends its reach to employers protected by ERISA. ERISA supersedes state laws that “relate to any employee benefit plan;” thus, states can regulate health maintenance organizations and other licensed insurance companies but cannot directly regulate employer-sponsored health plans. States can regulate health insurers that sell products to employer-sponsored plans but cannot regulate organizations that merely pay claims for employer-sponsored health plans (i.e., self-insured employers).

There are three important ERISA preemption amendments: (1) a 1983 amendment permitted the state of Hawaii to implement employer health insurance mandates adopted shortly before ERISA was enacted; (2) the Consolidated Budget Reconciliation Act of 1985 (COBRA) required ERISA plans to permit workers and dependants leaving work to continue their group coverage for specified periods; and (3) the Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposed a floor of certain benefits and insurance market standards on self-insured health plans while allowing states to impose additional standards for health insurance coverage.

ERISA has played a major role in determining the scope of feasible health insurance market reforms. Only the courts can interpret the meaning of ERISA preemption clauses, and thus far those interpretations have led to broad interpretations of preemption.<sup>18</sup> In general, ERISA preempts direct taxation of employer-sponsored plans as well as health care provider taxes or state laws that would impose costs or administrative burdens on these plans. Courts typically seek two types of information in cases of preemption challenge: (1) the extent to which the state law “relates to” ERISA plans; and (2) the extent to which the state law is “saved” from preemption because it is a law that primarily regulates insurance.

The extent to which current reform proposals in general and exchange programs in particular might result in ERISA preemption is unclear; as Mila Kofman, JD, noted during testimony before Congress, “it is difficult to predict (even for ERISA experts) how federal courts may interpret the scope of ERISA.” Indeed, several earlier versions of “pay or play” reforms were either struck down on ERISA grounds or withdrawn in light of the threat of an ERISA challenge.<sup>19</sup> In general, ERISA preemption has been upheld in instances where: (1) laws are directly aimed at private-sector employer-sponsored plans; (2) states require that employers offer employee health plans; (3) states impose taxes or other obligations on employer-sponsored health plans; (4) states require that employer-

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<sup>17</sup> EBRI 1995

<sup>18</sup> Butler 2000

<sup>19</sup> Butler 2000, 2002, 2003; Schiffbauer 2006

sponsored plans report information on the number of people covered, the design of benefits, or self-insurance features; or (5) states require employer-sponsored health plans to participate in health insurance purchasing pools or coordinate with public health coverage programs.

Recently, a federal circuit court found that the Maryland Fair Share Act was preempted by ERISA. The Maryland legislature introduced the Fair Share Health Care Fund Act in April 2005. Maryland's governor vetoed the bill, but in January 2006 the Maryland legislature overturned the veto and passed the legislation.<sup>20</sup> The legislation required employers with more than 10,000 employees to spend at least 8 percent of their in-state payroll on health care benefits.<sup>21</sup> Employers also had the option of paying into the state's health program for the poor. Employers that did not comply with the requirements of the legislation would have been subject to a penalty equal to the shortfall. The legislation was coined the "Wal-Mart Bill" because Wal-Mart was the only employer in the state that would have been affected at the time of enactment. Two other companies in the state had enough employees to meet the legislation requirements, but were exempted because one was a non-profit organization and the other already spent enough money on health care benefits for its employees.

ERISA preemption was the result of a challenge brought by the Retail Industry Leaders Association (RILA)—a trade association representing large retailers like Wal-Mart. RILA sought a declaration that the Maryland Fair Share Health Care Fund Act ("Act") is preempted by ERISA. After a lengthy discussion regarding RILA's sufficient standing to bring the suit, the ripeness of the subject matter for judicial review and a question concerning the proper jurisdiction for the suit, the issue of ERISA preemption was discussed. Section 514(a) of ERISA provides that "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" is preempted by ERISA.<sup>22</sup> After noting that the Act creates health care spending requirements that were inapplicable in other jurisdictions and the requirements conflicted with the requirements of other states, the court stated that the Act was preempted by ERISA because the Act has a "connection with" an ERISA plan.

In reaching its decision, the Court also noted that the Act was targeted at the ERISA plan of a particular employer (i.e. Wal-Mart), and the effect of the Act would be to specifically require Wal-Mart to increase its health care benefits for Maryland employees and administer its plan in a way that would differentiate from its plan in other jurisdictions. The defendant argued that the Act was not a "mandate" since employers have a choice, but the defendant failed to specify a reason why an employer would pay the State as opposed to increasing its employees' benefits.

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<sup>20</sup> National Conference of State Legislatures, Maryland's Fair Share Health Care Fund Act Overturned in ERISA Challenge ([www.ncsl.org/programs/health](http://www.ncsl.org/programs/health), accessed January 29 2007).

<sup>21</sup> Burr, MT "Fair-Share Showdown" Inside Counsel, May 30, 2006.

<sup>22</sup> 29 U.S.C. § 1144(a)

Several other recent instances of reform (e.g., enacted in Massachusetts and proposed in California) requiring some variation on “pay or play” encounter a number of potential ERISA conflicts, including minimum employer contributions, standardized benefit packages, free-rider surcharges (also referred to as “in lieu” fees), and requiring a cafeteria plan. Each of these provisions has been identified as a potential conflict with ERISA and thus grounds for future legal challenges.<sup>23</sup> However, health insurance exchange programs *per se* are not likely in direct conflict with ERISA.<sup>24</sup> The key distinguishing characteristic is that exchange programs (at least as they are currently proposed or enacted) are voluntary<sup>25</sup> on the part of employers and do not “impose a requirement on the benefit plan of an employer and therefore would not preclude any uniform administrative practice.”<sup>26</sup> However, the specific attributes of the exchange program are important; slight changes in the design and functioning of the program could make such plans more susceptible to ERISA challenges.

Alternatively, the Massachusetts Act may be able to survive an ERISA challenge because of its “pay or play” provision.<sup>27</sup> The Massachusetts Act contains two “pay or play” provisions. First, employers have the option of “playing” by making a fair and reasonable contribution to employees’ health care or paying a fee to the state. The amount of the fee is approximately \$295 per employee,<sup>28</sup> which the author opines is a “mere indirect economic incentive” for a plan administrator and would likely survive an ERISA challenge. The “fair and reasonable” contribution has been interpreted to mean sponsoring a plan that covers 25 percent of its workers or a plan in which they pay one-third of the premium. As distinguished from the Maryland Act, either option under the Massachusetts Act seems rational. In fact, in some cases it would be cheaper for most employers to pay the \$295 fee per employee. Second, the Massachusetts Act contains a free rider surcharge that applies to employers with more than ten employees who do not contribute or provide employee health coverage if employees of the employer obtain free state health care above a certain threshold.

Employers can avoid any fee by offering employees the ability to pay for health insurance on a pre-tax basis through a cafeteria plan, which is allowed under section 125 of the Internal Revenue code. However, offering a cafeteria plan will be considered an exception to an ERISA plan if: (1) no contributions are made by an employer; (2)

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<sup>23</sup> Marathas 2006; Schiffbauer 2006

<sup>24</sup> Moffit 2006

<sup>25</sup> It is important to note that, in some cases, individual and small group health insurance reforms stipulate that existing market mechanisms are superseded by the new legislation. Thus, in these cases, it can be argued that “voluntary” programs are not entirely voluntary insofar as alternative options are fewer or non-existent following the enactment of reform legislation.

<sup>26</sup> Schiffbauer 2006, p.4

<sup>27</sup> Butler 2006; Monahan 2007; Marathas 2006

<sup>28</sup> States can levy additional fees for state-sponsored health services rendered to employees

participation is voluntary for the employees; (3) employer's function is simply to allow the insurer to publicize the program to employees, collect premiums through payroll and remit them to the insurer; and (4) the employer does not receive any consideration in connection with the program.

In the Massachusetts case, the ERISA issues are mainly that a court could argue that the Commonwealth "is either indirectly or directly dictating to employers the benefits they should provide [and] will require employers to adjust their insurance programs" in such a way as to complicate the uniform administration of benefits nationally Marathas 2006, p.6. Defenders of the plan argue that the 1995 decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.* sets precedent for reforms that impact employers "indirectly" and/or "minimally." However, the aforementioned RILA case suggests that courts have considerable flexibility in the judgment of direct versus indirect effects.<sup>29</sup> In sum, many of the ERISA issues with respect to recent state-level health reforms remain unclear. Additional court challenges are likely in some of the states as reforms gain political traction, and the results of these cases will to some extent determine structure of future reform efforts.<sup>30</sup>

### 3.2 Section 125

Section 125 of the Internal Revenue Code allows employer groups to enable their employees to pay for their benefits on a pre-tax basis, primarily through premium-only plans, flexible spending accounts, and cafeteria plans. Such plans allow employees to select between taxable benefits (i.e. compensation) and non-taxable benefits (i.e. health insurance) without being taxed on the non-taxable benefits. One of the principal advantages of Section 125 plans, particularly with regard to recent reform initiatives, is that the employer needs only to adopt a plan that *allows* for this feature (i.e. allowing employees to make any coverage contributions on a pre-tax basis).

With regard to exchange programs, however, Section 125 may in some cases be problematic. In the case of Massachusetts, the connector program issued an emergency rule clarifying the Section 125 cafeteria plan requirements. According to the Massachusetts Health Care Reform Act, employers with more than ten employees must adopt and maintain a cafeteria plan and file a copy of the same with the Commonwealth Health Insurance Connector Authority.<sup>31</sup> Failing to comply with the cafeteria plan requirement may subject the employer to the Act's surcharge for state-funded health care

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<sup>29</sup> Marathas 2006

<sup>30</sup> Also note that the proposed federal Health Insurance Modernization and Affordability Act of 2006 ["HIMMA" S.1955, 109<sup>th</sup> Congress (2006)], were it or some version of it to pass, could potentially add additional criteria that might be used to preempt state health reforms along lines similar to ERISA preemptions. Some analysts view HIMMA-like legislation as going further than ERISA Stabile 2006.

<sup>31</sup> A quasi-governmental agency established under the Act to issue rules implementing the cafeteria plan requirement Mintz Levin 2007.

costs (i.e., the “free rider” surcharge). The cafeteria plan rules applies regardless whether coverage is offered on an insured or self-insured basis or purchased individually or on a group basis and through the exchange or another channel. The cafeteria plan must be in writing, filed with the exchange, and include the following provisions:

- a) A specific description of each of the benefits under the plan, including the time periods when benefits are unavailable;
- b) The plan’s eligibility rules regarding participation;
- c) The procedures governing participant elections under the plan, including the time period for making such elections, the extent to which the elections are irrevocable and when the elections would become effective;
- d) The manner in which employee contributions will be made to the plan;
- e) The maximum amount that an employer contributions is available to any participant of the plan as well as the maximum amount that an employee may contribute;
- f) The plan year on which the plan will operate.
- g) The plan must provide access to at least one or more “medical care coverage options” instead of cash compensation.

One potential problem is that Section 125 plans are intended only for the purchase of group health insurance. It is unclear whether it would be legal to purchase individual insurance policies within a Section 125 group, as would be the case under the Massachusetts plan, the proposed California plan(s), and other state initiatives.<sup>32</sup> A related complication arises with the practice of list billing, which creates substantial group/non-group ambiguity depending on the extent of involvement on the part of the employer. This legal issue is potentially more problematic in states where list billing is not permitted.

### **3.3 HIPAA and COBRA**

Another potential legal hurdle is navigating the complexities of HIPAA compliance.<sup>33</sup> Like ERISA-related legal issues, the extent to which exchange programs present legal issues with

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<sup>32</sup> Mintz Levin 2007

<sup>33</sup> HIPAA guarantees access to individual policies to eligible individuals. As described by the Department of Labor, eligible individuals are described as individuals that: have had insurance for at least 18 months without a break in coverage and where the most recent period of coverage was through a group health insurance plan; did not have their coverage terminated due to fraud or non-payment of insurance premiums; are ineligible for COBRA continuation or elected and exhausted their COBRA continuation; and are ineligible for Medicare or Medicaid. To protect HIPAA rights in the individual market, an individual must: elect and exhaust continuation coverage (if offered continuation coverage); begin looking for other coverage within 63 days of the termination of your old coverage (a break in coverage for 63 days or more will cause you to lose some rights under HIPAA). Note also that HIPAA plans and conversion plans are guaranteed available, but a person can be rejected for other types of coverage.

respect to HIPAA are at best unclear.<sup>34</sup> An analysis of an exchange program in California assumes that a large number of employers will elect to cease offering coverage, choosing instead to force their employees to obtain insurance through the statewide exchange program.<sup>35</sup> At the time of transition, and perhaps beyond, employee HIPAA status is unclear.<sup>36</sup> If employers are simultaneously establishing (or continuing) Section 125 status, it is unclear whether, for HIPAA purposes, employees technically retain group coverage status or are re-categorized as individual status.<sup>37</sup> If the latter, the exchange program (especially the products offered through the program) must be in compliance with HIPAA. In the vast majority of states' extant individual markets, the individual policies currently offered for sale would not meet HIPAA group coverage requirements. In states where the individual market permits medical underwriting, moving to guaranteed issue and community rating will apply strong upward pressure on costs in the individual market.<sup>38</sup>

It is also unclear the extent to which post-exchange HIPAA eligibility would vary according to the structure of the individual market (e.g., risk pools, guaranteed issue, etc.).<sup>39</sup> A related issue is extent to which persons purchasing insurance through the exchange would be COBRA eligible, and how more generally the state reform initiatives mesh with COBRA laws. At first glance, there appear to be some serious conflicts, particularly with regard to determining eligibility status. Again, as in the case of ERISA, slight changes in the design and functioning of the exchange program could make such plans more susceptible to HIPAA and COBRA challenges.

### 3.4 List Billing

The practice of list billing raises additional portability and HIPAA issues with respect to exchanges. List billing allows one or more individuals who work for a common employer to have the premiums for individual health insurance policies payroll-deducted and remitted to the insurer by the employer. It is generally viewed as a billing convenience rather than a benefit plan as defined by state or federal law.<sup>40</sup> In order to not qualify as a group health insurance policy (which would have direct HIPAA implications), employers are not permitted to make any contributions toward the premium either directly or indirectly, including reimbursement or wage adjustment. In general, in list billing arrangements the employer makes no recommendation or suggestion to the employee as to which individual health insurance product to purchase. When combined with a Section 125 arrangement,

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<sup>34</sup> Kofman 2003

<sup>35</sup> Curtis and Neuschler 2006

<sup>36</sup> Chollet 2004

<sup>37</sup> Refer to Hall 2002. Also, it is generally unclear whether premium-only arrangements constitute HIPAA-compliant plans.

<sup>38</sup> This issue is further discussed in section 3.5.

<sup>39</sup> In addition, the status of HIPAA rights is unclear if connector/exchange enrollee leaves the connector/exchange by moving out of state.

<sup>40</sup> BCBSI 2006

employees can pay for list-billed individual policies with pre-tax dollars.<sup>41</sup> HIPAA requirements limit the extent to which states permit list billing, although variants of list billing are permitted in several states.<sup>42</sup>

It is unclear how list billing would work within the context of an exchange mechanism. Depending on the structure of the exchange program and the accompanying risk pooling arrangements and other laws governing the individual market (e.g., guaranteed issue), list billing *per se* may not be necessary. In the case of the Massachusetts Act, a Section 125 employer could opt to send employees to the exchange to purchase individual policies, and have the premiums paid pre-tax as in a list billing arrangement. However, the Massachusetts Act requires that employers make a contribution on behalf of employees in the form of establishing a Section 125 plan. Thus, that level of employer involvement would likely preclude list billing arrangements and the IRS would consider the policies a single group policy rather than a collection of individual policies. Group classification invokes HIPAA and all of its requirements.<sup>43</sup> Thus, in states with Massachusetts-like employer requirements, it is conceivable that no employer could operate a list billing type of arrangement and all policies purchased through the exchange would have to be HIPAA compliant. For example, the District of Columbia recently concluded that HIPAA group requirements would apply to non-group policies sold through an exchange if employers provide a financial contribution toward the premium.<sup>44</sup>

### 3.5 Guaranteed Issue

Guaranteed issue laws prohibit insurers from denying coverage to applicants based on health status. Several states require guaranteed issue for *all* individual market policies, with some variation in the guaranteed criteria.<sup>45</sup> Several other states require guaranteed issue for some

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<sup>41</sup> Wieske 2006

<sup>42</sup> *Ibid.* Examples of states where list billing is permitted include Arizona, Illinois, Pennsylvania, Texas, and West Virginia.

<sup>43</sup> According to Goodman (2006) “Under strict interpretation of HIPAA, employees (and their employers) should not be able to purchase individual insurance through Section 125 plans if there is medical underwriting.” The portability aspects of HIPAA refer to (1) guaranteed issue, (2) guaranteed “renewability” (with respect to all insurance products), and (3) rules governing limitations on pre-existing conditions, special enrollment rights, and health insurance non-discrimination (also refer to Bianchi 2007).

<sup>44</sup> NAIC 2006

<sup>45</sup> As of December 2006, states include Maine, Massachusetts, New Jersey, New York, Vermont, and Washington. See generally [www.statehealthfacts.org](http://www.statehealthfacts.org). Data compiled through review of state laws and regulations and interviews with state health insurance regulatory staff. For more detailed information on consumer protections in any state see Georgetown University's "Consumer Guides For Getting and Keeping Health Insurance" available at <http://www.healthinsuranceinfo.net/>.

products in the individual market, typically based on an individual's HIPAA eligibility.<sup>46</sup> Guaranteed issue also is enforced in the small group market<sup>47</sup> in all states, as a requirement of HIPAA. In the individual market, the passage of guaranteed issue legislation in the 1990s has led to an erosion of the individual insurance markets in those states, due mainly to the combination of adverse selection and community rating.<sup>48</sup>

With respect to exchange mechanisms, guaranteed issue poses a considerable challenge. By definition, most exchange programs (at least those currently proposed in some states) would be compelled to offer policies on a guaranteed issue basis. Moreover, the underwriting of such policies would be done, in most cases, on a community-rated or adjusted community-rated basis. Again, the combination of guaranteed issue and community rating would erode individual markets as health plans cease offering products in those markets due to escalating costs. However, those dynamics change somewhat with individual mandates (as opposed to voluntary purchasing pools), mainly by mitigating adverse selection by forcing high risk and low risk together in the exchange pool.<sup>49</sup>

Nevertheless, there are other ways in which adverse selection might occur. Whereas risk pooling within the exchange is spread across high and low risk due to the mandate, the risk profile of the exchange group versus the non-exchange group could be significantly different, with the exchange group disproportionately higher risk. Were this to occur over time, the costs of insuring the exchange group would become unreasonably high. Price escalation in the exchange group would be exacerbated by community rating. Over time, it is conceivable that the exchange group would be essentially priced out of the market, not unlike the experiences of most voluntary risk pools.<sup>50</sup>

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<sup>46</sup> See Kaiser Family Foundation "State Health Facts" at [www.statehealthfacts.org](http://www.statehealthfacts.org). According to the Kaiser Family Foundation State Health Facts, "HIPAA Eligible" individuals are guaranteed the right to purchase individual coverage with no pre-existing condition exclusion periods when they leave group coverage. To be HIPAA Eligible, a person must have had at least eighteen months of prior coverage, not interrupted by a gap of more than sixty-three days in a row, and the last day of prior coverage must have been in a group health plan. In addition, upon leaving group coverage one must elect and exhaust any available COBRA continuation coverage or similar state continuation coverage. A HIPAA eligible individual cannot be eligible for any other group coverage or Medicare, and must apply within sixty-three days for HIPAA coverage.

<sup>47</sup> The definition of small group varies somewhat by state, but is usually defined as either 1-50 or 2-50 employees. Some states make special considerations for self-employed groups of one ([www.statehealthfacts.org](http://www.statehealthfacts.org)).

<sup>48</sup> Wieske 2006

<sup>49</sup> Curtis and Neuschler 2006

<sup>50</sup> These arguments have been made by several observers. See generally Curtis and Neuschler 2005; Curtis, Forland, and Neuschler 2003; Curtis, Neuschler, and Forland 2001; Yegian et al. 2000. Also note that this issue is further explored in Section 4.3.

## 4. OTHER ISSUES

### 4.1 Access

It is unclear whether exchange programs *per se* will increase or improve access to medical care. Consider first the issue of purchasing pools—a critical component of the functioning of exchange mechanisms. Most evidence to date suggests that voluntary purchasing pools have failed to improve access.<sup>51</sup> Voluntary risk pools lack “group stability;” according to Curtis and Neuschler 2005 “To maintain stability and cohesion in this voluntary environment, and in the absence of other incentives, a pool needs to be able to offer its members a lower price than the outside market” (p.2). However, voluntary risk pools are susceptible to adverse selection because they “attract people who know that they need health care or who face higher prices elsewhere.”<sup>52</sup> Adverse selection ultimately drives up premiums, which causes marginal members of the pool (i.e., those who were very close to the cost-benefit threshold) to drop out of the pool thereby exacerbating the selection problem (because the “marginal” members of the pool are presumably healthier than those for which the pool continues to be cost beneficial even as rates rise). Adding to these problems, most voluntary pools have not incorporated insurance agents into the overall structure and goals of the pool, and the diminished role for agents has been shown to have reduced enrollment in voluntary pools.<sup>53</sup>

It is unlikely that mandatory pools will be more successful, but for somewhat different reasons. Many of those who report that they are uninsured in cross-sectional surveys are in a transitional spell without insurance. Most of these transitional spells result from loss of health insurance benefits after a change in jobs or loss of Medicaid eligibility due to changes in household income; the median duration of these transitional spells is less than 12 months.<sup>54</sup> Data concerning the duration of spells without insurance yields “half-empty v. half-full” interpretations. On the one hand, the cross-sectional measure significantly overstates the number of individuals who are chronically uninsured. On the other hand, the usual cross-sectional measure understates the number of individuals with “unstable” health insurance coverage over time.<sup>55</sup> Moreover, some of the insured have health insurance with very limited coverage.<sup>56</sup>

Individuals who lose health insurance due to job change have the option to purchase an extension to bridge the spell under COBRA and HIPAA. But the purchase of optional

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<sup>51</sup> Long and Marquis 2001; Curtis, Neuschler, and Forland 2001; Curtis and Neuschler 2005

<sup>52</sup> Curtis and Neuschler 2005, p.3

<sup>53</sup> Curtis, Neuschler, and Forland 2001

<sup>54</sup> Copeland 1998; Congressional Budget Office 2003

<sup>55</sup> Ohsfeldt and Schneider 2006

<sup>56</sup> Schoen et al. 2005

extensions is rare,<sup>57</sup> in part because individuals have to pay the full premium for an extension for the insurance plan they had while employed – including the portion of the premium previously paid by their employer. They cannot switch to a cheaper policy in response to the higher out-of-pocket premium. Many states have attempted to reduce spells without insurance for means-tested public insurance programs (e.g., Medicaid) by defining minimum eligibility duration to be 12 months or more, but the cost impact for state governments often is substantial.<sup>58</sup>

The uninsured are disproportionately young adults between the ages of 18 and 34. Most of these individuals are self-employed, employed in companies with only a few employees, or employed only part-time. Some of these individuals have existing health conditions that would preclude them from obtaining health insurance in the individual insurance market, but most in this age group are in good health and should be able to secure private health insurance at some premium. Although any objective definition of the “ability to pay” for health insurance is problematic, about half of all adults without insurance are in households with an income level that exceeds the federal poverty level by 200 percent or more, and about 20 percent are in households with an income level that exceeds the federal poverty level by 400 percent or more.<sup>59</sup>

The reason most often given by individuals for not purchasing health insurance in surveys is that it is “too expensive.”<sup>60</sup> But the meaning of this response is unclear; individuals who are young or perceive themselves to be at low risk may view health insurance at prevailing premiums as a poor value, even if they have the financial means to pay.<sup>61</sup> In this sense, some of the uninsured “choose” to be uninsured.<sup>62</sup> State insurance regulations that mandate health insurers to cover numerous types of services may exacerbate the problem, insofar as regulations prohibit the offering of low-cost bare-bones or catastrophic health insurance policies.<sup>63</sup> But even when regulations permitted bare-bones policies, traditionally they did not fare well in individual or small-group markets. This is beginning to change as insurers are more actively marketing new low cost policies with benefit designs intended to address the perceptions of “low value” among the healthy uninsured.<sup>64</sup>

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<sup>57</sup> Berger et al. 1999

<sup>58</sup> Short 2000

<sup>59</sup> ERIU 2005

<sup>60</sup> Kaiser Family Foundation 2004

<sup>61</sup> Ohsfeldt and Schneider 2006

<sup>62</sup> Pauly and Nichols 2004; Schur, Feldman, and Zhao 2004

<sup>63</sup> See Jensen and Morrissey 1999. Moreover, the demand for low-cost “bare-bones” policies is generally very low. Thus, even in cases where states have passed legislation allowing such policies, they have proven to have little impact on improving take-up rates and access.

<sup>64</sup> Fuhrmans 2005

## 4.2 Fairness

A very important determinant of the success of a health reform proposal of any kind is the extent to which it effects (or treats) all target groups equally. The demise of the Reagan Administration's efforts at offering additional catastrophic coverage to Medicare enrollees is apposite—as the program took shape, it became clear to Medicare beneficiaries and their advocates that the cost of the program would fall disproportionately on them, with little financial risk sharing from healthier groups. Exchange programs the individual and employer mandates associated therewith are particularly susceptible to issues related to fairness.<sup>65</sup>

The main problem is that approximately 75 percent of “low income” households (i.e., incomes between 100 and 300 percent of the federal poverty level) have private insurance.<sup>66</sup> Under the Massachusetts plan and the California proposals, for example, the low-income insured employed are disproportionately penalized.<sup>67</sup> Compared to higher wage earners, a greater proportion of their gross wages are spent on health insurance (i.e., the “forgone” wages traded off for health benefits).<sup>68</sup> The financial burden that they face in the form of lower wages is not taken into account in the distribution of subsidies. If these workers chose not to purchase employer-based insurance, they would be entitled to the subsidy, but if they continue to choose to purchase health insurance, the same low income individuals do not receive the subsidy. Insofar as the presence of an exchange program encourages employers to drop coverage, these workers become eligible for subsidies while their counterparts working for employers continuing to offer coverage would be ineligible for the subsidy.

## 4.3 Risk Pools and Adverse Selection

It is not clear whether the combination individual and employer mandates and exchange mechanisms will lessen the problems associated with adverse selection. Previous attempts at voluntary risk pools in California (e.g., Pac Advantage for small firms) resulted in severe adverse selection, which in turn raised premiums beyond the level which could be obtained by small employers purchasing health insurance outside of the risk pool.<sup>69</sup> The success of an exchange program in controlling the negative effects of adverse selection depends largely on the specific design mechanisms and the dedication on the part of administrators in maintaining the integrity of the pool. Employers who drop coverage and force employees into the state risk pool may have employees with higher health costs on average.<sup>70</sup> In

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<sup>65</sup> Sinaiko 2004; Miller 2006; Curtis and Neuschler 2006; Pauly 2007; Moffit and Owcharenko 2007

<sup>66</sup> Ohsfeldt and Schneider 2006

<sup>67</sup> Pauly 2007

<sup>68</sup> See generally Pauly 1997

<sup>69</sup> Curtis and Neuschler 2005; Curtis, Forland, and Neuschler 2003; Curtis, Neuschler, and Forland 2001; Yegian et al. 2000

<sup>70</sup> Sinaiko 2004

general, the individual market is significantly more susceptible to adverse selection.<sup>71</sup> Even in the case of mandatory risk pools, these problems may be exacerbated by non-compliance insofar as the non-compliant are disproportionately lower risk.

The “in lieu” tax of four percent of payroll, as proposed in the California governor’s plan, will be a bargain for sicker employer groups and at worst neutral for healthier groups. Adverse selection of this sort is likely to cause the exchange risk pool to become disproportionately expensive. The rising costs of the state risk pool will be exacerbated by the financing restrictions imposed by the four percent “in lieu” payroll tax, as medical care costs continue to rise at rates outpacing wages.

A related problem with exchange programs is the potential for adverse selection among participating carriers. An exchange program would have to assure a “level playing field” among participating carriers to protect individual carriers that may, for a variety of reasons, enroll a disproportionate share of sicker subscribers.<sup>72</sup>

#### **4.4 Employer as Advocate**

The insurance exchange approach operates on the assumption that employers’ role in the provision of health insurance is at best value-neutral. In the current employer-based system, there are many employers that are willingly and in some cases enthusiastically involved in securing high-quality low-cost care for their employees. In addition to establishing quality floors for health care obtained through employer-sponsored health insurance, employers are positioned to reduce the transaction costs of health benefit enrollment, advocate on behalf of employees with unique health care needs or those engaged in disputes with their health insurer, and bargain for lower premiums. In addition, in some cases employers have assumed active roles in helping their employees save medical care costs.<sup>73</sup>

#### **4.5 Medical Costs**

The main drivers of medical care costs are advances in medical technology, the overall lack of price-sensitivity in medical care transactions (i.e., moral hazard), the aging population, and the lack of efficiency-enhancing competition in many markets.<sup>74</sup> Exchange programs do not per se address any of these problems, and arguably exacerbate moral hazard. In conjunction with adverse selection, rising medical costs will apply substantial pressure over time on the premiums charged through the exchange. As health insurance costs become a larger proportion of total household income, individuals will consider dropping coverage (even with the threat of tax-based penalties) or substantially curtailing non-health related

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<sup>71</sup> Chollet 2004

<sup>72</sup> Curtis and Neuschler 2006

<sup>73</sup> For example refer to Rubenstein 2006

<sup>74</sup> FTC 2004; Ohsfeldt and Schneider 2006

expenses.<sup>75</sup> Underlying medical costs, and to a lesser extent adverse selection, are the main reasons why carriers in Massachusetts put forth prices for state risk pool benefit packages that were approximately 100 percent higher than those estimated by the carriers during the debate and planning phases of the reform initiatives. As a consequence of these errors in cost predictions, for example, there has been debate in Massachusetts as to whether premium bids are too high and whether coverage of prescription drugs should be included in the mandatory minimum benefit package.<sup>76</sup>

A related cost issue is that of “crowding out.” Crowd out is to be distinguished from adverse selection in that crowd out is not necessarily related to the risk profiles of enrollees. Rather, in the case of the Massachusetts plan or the proposed California plans, crowd out occurs as more and more employers drop coverage and place employees into the state risk pool. A rapidly growing state risk pool would be highly susceptible to financing issues; the pool would have to be enlarged in lock step with growth in the underlying health care costs.<sup>77</sup> Moreover, as the risk pool covers a broader spectrum of enrollees, the proportion of higher-income enrollees will increase. The presence of higher-income enrollees in the risk pool will exert upward pressure on the generosity and scope of benefits, thereby adding even greater upward pressure on costs. Thus, it is likely that the “in lieu” tax rate would have to be increased over time and that individual cost sharing would also have to be increased.

#### **4.6 Economic Impact**

The full implementation of an exchange program will affect the structure and performance of existing health insurance markets. Based on a hypothetical exchange model for California, Curtis and Neuschler estimate the “direct” net costs of the program to be \$1.7 billion, due mainly to coverage expansions and loss of state tax revenue.<sup>78</sup> But the net costs of implementing an exchange program must take into account the costs of several other factors, including: (1) the macro-economic effects of the elimination of all or most of the business activities associated with the functioning of the employer-based model of delivery (e.g., licensed health insurance producers); (2) the macro-economic effects of premium increases (due to, for example, net increases in the risk pool severity and elimination of the employer-level bargaining ability); and (3) the macro-economic effects of increasing employer contributions (in the case of employers who previously had not offered health insurance).

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<sup>75</sup> This consequence comes with its own set of problems; for a recent review, refer to Schneider et al. 2006

<sup>76</sup> Dembner 2007

<sup>77</sup> Growth in health care costs has outpaced growth in employee wages over the past two decades, a trend that is likely to continue. The implication for publicly financed health care programs is that growth in budgets attributable to growth in wages (i.e., through income taxes) are insufficient to cover cost increases over time. Thus, the difference between wage growth and medical cost inflation must be financed through additional taxes and assessments (see generally Ohsfeldt and Schneider 2006).

<sup>78</sup> Curtis and Neuschler 2006

## 4.7 Service Quality

Exchange programs require choices on the part of employees and, to a lesser degree, employers. Currently, licensed health insurance producers serve that role. It is unclear who or what would serve advocacy and support roles under an exchange program. It is likely that the primary interface with a health insurance plan will be through the government-run exchange program or with the plan directly. Both of these options have limitations. Customer service has always been somewhat of a challenge for government agencies, which have been slow to view users as customers or clients.<sup>79</sup> Direct interface with health plans is not likely to offer a superior alternative; customer satisfaction with dealings directly with their health insurers has been consistently low.<sup>80</sup> In addition, as discussed earlier, producers and agents have served a vital role in boosting enrollment in voluntary risk pools.

## 4.8 Adaptation

Exchange programs replace several existing market functions with government functions. An important question “what does public administration have to offer?” No form of organization is per se superior; each has its merits, and each is designed to facilitate specific kinds of transactions.<sup>81</sup> A critical component of the assessment of a centralized government health care system is to identify the comparative strengths and weaknesses of public versus private governance. Public governance seems to work well for defense, parks, police and safety, and alike. But apart from those familiar examples of public goods and services, there are many goods and services for which the public versus private question is largely unresolved. Examples of the latter include utilities, education, prisons, health care, transportation, and other traditionally government services.<sup>82</sup>

For a given organizational problem or issue (e.g., extending health coverage to all), the pivotal question should be “what does public administration have to offer?” The key differentiator, as Williamson has maintained, lies in the ability of these types of organizations to adapt to change.<sup>83</sup> An important omission from the Lewin report<sup>84</sup> on the California single-payer initiative of 2006 was a simulation of how private plans and government plans are likely to differ in their ability to adapt to changes in the health care market place. Bureaucracies are relatively good at adaptation which requires a coordinated

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<sup>79</sup> This topic is covered in more detail in the section on adaptation (section 4.8).

<sup>80</sup> WSJ MarketWatch 2007

<sup>81</sup> Coase 1988; Hart 1995; Furubotn and Richter 1997; Williamson 1991, 1999

<sup>82</sup> For example refer to Schwartz and Watson 2003

<sup>83</sup> Williamson 1991

<sup>84</sup> See Sheils and Haught 2005.

response,<sup>85</sup> but the set of feasible responses within a bureaucracy are typically smaller in number, constrained by existing routines and weak internal property rights.<sup>86</sup> Conversely, autonomous organizations are better at the kind of adaptation that requires timely responses to changes in demand, prices, and operating costs.

For example, coordinated government bureaucracies such as the U.S. Postal Service are relatively good at (i.e., efficient) performing certain tasks, but they have clearly been followers as the delivery industry has evolved. Innovative and adaptive firms like Federal Express and United Parcel Service captured large market shares by out-innovating their government counterpart.<sup>87</sup> All else equal, gains from bureaucratic coordination, which the U.S. Postal Service does well, are often offset by incentive attenuation. Incentive attenuation includes reduced incentives to attract new customers, reduced incentives to invest in up-to-date capital and equipment, reduced incentives to innovate (processes and products),<sup>88</sup> and reduced productivity (i.e., from reduced ability of decision-makers and risk takers to share in entrepreneurial returns).

#### **4.9 Administrative Costs**

Some argue that exchange programs offer substantial reductions in administrative costs incurred by employers and insurers.<sup>89</sup> It is likely that such savings are exaggerated. Lower administrative costs are observed in large employer groups (and in large groups such as CalPERS), but the reasons that these large groups have lower administrative costs are not likely to be applicable to exchange programs. According to Pauly 2007, p.5 “large groups reduce neither the health-care costs of those insured nor the costs of processing claims.” Instead, Pauly argues, large groups reduce the administrative transaction costs associated with extending benefits to a large number of employees. Conversely, exchange program must deal with very large numbers of diverse subscribers individually.

### **5. CONCLUSION**

Health insurance exchange mechanisms are not without tradeoffs and by themselves are far from a perfect means to improve overall health insurance access. We identify five important legal obstacles to the optimal functioning of exchange programs, and we

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<sup>85</sup> According to Williamson, coordinated adaptation refers to “the conscious, deliberate, and purposeful efforts to craft adaptive internal coordinating mechanisms” (p.103).

<sup>86</sup> See generally Nelson and Winter 1982; Milgrom and Roberts 1990, 1992; Williamson 1991

<sup>87</sup> Birla 2005

<sup>88</sup> Including pressure from constituencies who do not desire any form of adaptation or change.

<sup>89</sup> Holahan and Blumberg 2006; McDonough et al. 2006.

identify an additional nine economic issues that could potentially limit the value and effectiveness of health insurance exchange mechanisms. In terms of legal issues-- even assuming states' reforms involving risk pools, employer mandates, individual mandates, and exchanges will clear ERISA challenges-- there are a number of other complicated legal issues that should be taken into consideration. These include portability and group versus non-group distinctions (i.e., Section 125, HIPAA, COBRA, and list billing) as well as the adverse selection and cost challenges posed by guaranteed issue and community rating.

In addition to these complexities, there are a host of economic issues inherent to mandates and government-administered exchanges, chief among them are concerns over whether exchange mechanisms could improve access appreciably, the fairness of the programs, the costs of the programs, service quality, adaptation, and overall economic impact. Thus, given the dearth of studies of the legal and economic aspects of combinations of mandates and exchanges, it seems clear that more study should be done prior to the consideration of these policies.

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