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No. 2011-15

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20 Kansas Journal of Law & Public Policy 237, 2011

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REGULATING TO PROMOTE COMPETITION IN DESIGNING HEALTH INSURANCE EXCHANGES

*Thomas L. Greaney**

I. INTRODUCTION

Many of the most contentious issues in the debate over health reform concern the performance and competitiveness of private health insurance. Abusive and unfair practices such as denying coverage to individuals with pre-existing conditions, improper rescissions of insurance policies, and experience rating provided a focal point for reform proponents and justified closer regulation of the industry. In addition, the dominance of large insurers serving individual and small group markets evidenced the need for inclusion of a government-sponsored "public option" among the plans to be offered to the newly insured. Finally, the purportedly excessive profits of the insurance industry and lavish salaries of their executives gave rise to measures designed to explicitly limit insurers' expenditures on costs other than health care services. These grievances coincide with the design of health reform legislation that relies on private insurance to serve a large portion of the nation's fifty million uninsured citizens.[1]

Drafters of the Patient Protection and Affordable Care Act ("ACA" or "Act") undertook a three-pronged approach to deal with the problems associated with health insurance. First, the ACA contains numerous provisions prohibiting health status underwriting and other objectionable practices. Second, the law mandates coverage of certain benefits and practices deemed universally desired by consumers. Third, the new law creates an entirely new market to serve the uninsured as well as others whose existing coverage is inadequate or unaffordable. As the centerpiece for implementing and overseeing these reforms, the ACA mandates creation of market-making entities—health insurance exchanges. Exchanges will certify insurers'

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1. Press Release, United States Bureau of the Census, Income, Poverty and Health Insurance Coverage in the United States (Sept. 16, 2010), *available at* http://www.census.gov/newsroom/releases/archives/income_wealth/cb10-144.html.

compliance with regulations, monitor their performance, and organize and police markets for individuals and small group purchases of health insurance. Exchanges will also take on administrative functions critical to many of the other key provisions of the reform, including establishing processes for beneficiaries to make choices and obtain tax credits (subsidies) and the ability to move seamlessly in and out of public programs, promulgating ratings of plans, and making comparative information widely available.

To be sure, this is a large undertaking, not only because the ACA mandates that exchanges undertake multiple and wide-ranging functions requiring diverse skills (organizing markets, certifying qualifications to enter, evaluating performance, structuring market competition, and regulating benefit options),[2] but also because exchanges must do so in a complex regulatory milieu. While the ACA gives state governments responsibility for establishing exchanges within a wide range of options, it confines those choices in several ways. First, federal regulations will interpret the law and place some specific requirements on the states. Second, existing federal law governing a variety of topics, including discrimination, will be applicable to employer-sponsored-plans, which may restrict the discretion of the state legislatures. Further, the law itself contains many specific prescriptions regarding insurance regulation that are delegated to other entities including the state departments of insurance and health and human services.

Despite the extensive regulatory regimen anticipated under the ACA, the Act still leaves much to the discretion of the states. This Article spotlights some of the key regulatory decisions states will confront in attempting to realize one of the central goals of the exchange concept: improving the efficiency of private health insurance markets. The complex array of interrelated choices inherent in designing exchanges poses a challenge for states seeking to maximize competition among insurers. Moreover, myriad policy concerns may also dictate choices in exchange design and regulation that affect competition in significant ways. Because making competition effective in insurance and provider markets is essential to the success of health reform, state legislatures establishing health exchanges should incorporate competition-promoting regulation in their designs. However, finding the best means of advancing competition is not a straightforward undertaking because variations in markets, cultures, and state regulations will necessitate individualized approaches. This Article examines some of the alternatives available to states and offers some generalized suggestions for dealing with core impediments to competition and using regulation where possible to deal with the serious problem of provider market concentration.

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(d)(4), 124 Stat. 119, 176–77 (2010) (to be codified at 42 U.S.C. § 18031).

II. THE AFFORDABLE CARE ACT, STATE LAW, AND THE EXCHANGES

States have operated exchanges in a variety of formats and under a multiplicity of market conditions. Although the concept offers the promise of significant cost-savings resulting from risk pooling, transaction costs savings, leverage with payers, and economies of scale, these advantages have not been realized.[3] A number of states initiated exchanges to serve their uninsured, but many of these exchanges floundered and were eventually abandoned.[4] The reasons for the lack of success included the fact that these exchanges were typically small, comprised of high-risk individuals, and often subject to adverse selection.[5] On the other hand, the federal government has successfully operated three large exchanges: the Federal Employee Health Benefits Program, the Medicare Advantage program, and the Medicare Part D drug program. The success of these programs is attributable in large part to certain built-in characteristics that insulate them to a large degree from the problems of size and selection that have plagued state programs undertaken thus far. The most salient models for the exchanges to be developed under the ACA are those of Massachusetts and Utah. While these exchanges might serve as polar prototypes for other states,[6] particularly in the contrasting role envisioned for the exchanges in promoting competition among insurers,[7] the new law imposes many requirements that will require close attention.

Much is still to be determined about the nature and functions of exchanges under the ACA. While the Act assigns a variety of specific tasks to the exchanges, it leaves numerous requirements to be explicated by federal regulation and grants enormous discretion to the states as to many of the key

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3. *See* TIMOTHY S. JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES IN HEALTH CARE REFORM: LEGAL AND POLICY ISSUES 5–6 (2009) [hereinafter JOST, LEGAL AND POLICY ISSUES]; *see generally* U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-00-49, PRIVATE HEALTH INSURANCE: COOPERATIVES OFFER SMALL EMPLOYERS PLAN CHOICE AND MARKET PRICES (2000); Stephen H. Long & M. Susan Marquis, *Have Small-Group Health Purchasing Alliances Increased Coverage?*, 20 HEALTH AFF. 154 (2001).

4. *See* LINDA J. BLUMBERG & KAREN POLLITZ, URBAN INST., HEALTH INSURANCE EXCHANGES: ORGANIZING HEALTH INSURANCE MARKETPLACES TO PROMOTE HEALTH REFORM GOALS 3 (2009) (health insurance purchasing cooperatives in Texas and Iowa which were required to use community rating fell victim to adverse selection as low risks remained in experience-rated traditional market); *see generally* MARK MERLIS, A HEALTH INSURANCE EXCHANGE: PROTOTYPES AND DESIGN ISSUES, Issue Brief No. 832 (National Health Policy Forum, 2009).

5. Another problem encountered by states has been the propensity of agents and brokers steering their customers away from the exchange when they can make higher commissions for sales outside of the exchange. *See* JOST, LEGAL AND POLICY ISSUES, *supra* note 3, at 6.

6. *See* Robert Pear, *Health Care Overhaul Depends on States' Insurance Exchanges*, N.Y. TIMES, Oct. 23, 2010, at A23 (comparing insurance exchanges in operation in Utah and Massachusetts).

7. *See infra* Part IV.A–B (discussing exchange models relying on selective contracting and open market approaches).

features of their exchanges.[8] The Act requires that each state desiring to establish an American Health Benefit ("AHB") Exchange for individuals and a Small Business Health Options Program ("SHOP") Exchange for small employers must do so by 2014.[9] States may fulfill these obligations in a variety of ways: (1) by combining the two pools and creating single exchange for small employers and individuals, (2) by creating multiple regional exchanges within their state, or (3) by combining with other states through setting up multi-state exchanges. However, states may elect not to establish an exchange at all. The ACA requires the Department of Health and Human Services ("HHS") to determine by January 2013, whether states have made satisfactory progress toward fulfilling these obligations.[10] If not, the federal government will establish and operate the exchange for the state.[11]

The ACA vests in the exchanges extensive responsibilities to certify plans as "qualified health plans" ("QHPs") for participation in the exchange and to monitor their performance.[12] A plan is eligible for participation only if it is determined "that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers."[13] That determination will also entail reviewing whether the plan satisfies the requirements under Section 1311 and the numerous criteria involving marketing, choice of providers, inclusion of essential community providers, accreditation, and quality improvement as set forth in forthcoming HHS regulations.[14] The ACA simultaneously restricts and countenances the authority of states to directly regulate the rates and terms offered by insurers participating in the exchanges. For example, exchanges may not refuse to certify a plan because it is a fee-for-service plan and may not impose price controls or exclude plans that provide excessive end-of-life care.[15] At the same time, plans seeking certification and seeking to increase their premiums must submit a justification to the exchange, which is posted on health plans' websites, and exchanges may refuse to renew plans proposing "excessive" rate increases.[16]

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8. The National Association of Insurance Commissioners have developed a model act designed to set forth the minimum requirements for enacting state exchange laws in compliance with the ACA. It is largely designed to serve as a template for legislatures and refrains from making specific recommendations on controversial issues. *See generally* AMERICAN HEALTH BENEFITS EXCHANGE MODEL ACT, (Proposed Official Draft 2010), *available at* http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

9. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311(b)(1), 124 Stat. 119, 173 (2010).

10. *Id.* § 1321(c), 124 Stat. at 186–87.

11. *Id.*

12. *Id.* § 1301, 124 Stat. at 162–63.

13. *Id.* § 1311(e)(1)(B), 124 Stat. at 178.

14. *Id.* § 1311(c), 124 Stat. at 174.

15. *Id.* § 1311(e)(1)(B)(i)–(iii), 124 Stat. at 178.

16. *Id.* § 1311(e)(2), 124 Stat. at 178–79.

The ACA leaves some of the most important features of the exchanges affecting market competition to the discretion of the states. For example, states must make threshold decisions regarding the scope of their exchanges. A state can limit the maximum number of employees that an employer can qualify to participate in the small employer exchange. Although the law specifies that small businesses with up to 100 employees may provide plans for their employees through exchanges, states can lower that limit to fifty until 2016.[17] States are also free to make the exchange available to employers with more than 100 employees in 2017.[18]

A second group of decisions left to state discretion concerns the relationship between plans operating in the exchanges and those operating outside the exchanges. Most significantly, the ACA did not do away with markets for individual and small-group plans. Insurers therefore *may* have the option to offer plans inside the exchange, outside the exchange, or both. However, states may place important limits on the insurers' ability to do so. First, states might require otherwise—that is, a state may decide to make participation outside the exchange dependent on participation inside the exchange. At the same time, the Act provides strong incentives for insurers to offer plans inside the exchange. For example, federal subsidies that aid in the purchase of insurance (small employer tax credits and premium and cost-sharing subsidies for individuals) can only be used for plans purchased through the exchanges.[19] Further, in certifying QHPs, states must require that such plans sell at least silver and gold level plans (plans selling outside the exchange can sell at any level of bronze, silver, gold, or platinum).[20]

Moreover, the ACA takes important steps to level the regulatory playing field inside and outside the exchange. The Act requires that the market rules governing a wide variety of practices must apply both inside and outside the exchange. Other than "grandfathered plans," those plans offered inside and outside the exchange must provide essential benefit package.[21] Finally, insurers selling outside the exchange must create a single risk pool for all enrollees in its plans inside and outside the exchange.

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17. *Id.* § 1304(b), 124 Stat. at 172.

18. *Id.* § 1312(f)(2)(B)(i), 124 Stat. at 184.

19. *Id.* sec. 1401, § 36B, 124 Stat. at 213.

20. Exchanges must offer four levels of coverage (bronze, silver, gold, and platinum) that vary based on the percentage of benefits provided by the plan. Coverage levels range from sixty percent to ninety percent of the full actuarial value of plan benefits. In addition, a catastrophic plan can be offered to individuals up to age thirty or to individuals whose premiums exceed eight percent of their income. In order for an insurance plan to be certified as a qualified health plan in the Exchange, it must offer at least one plan at the Silver level and one plan at the Gold level. *See* FOCUS ON HEALTH: SUMMARY OF NEW HEALTH REFORM LAW, KAISER FAMILY FOUND., 5 (last modified Mar. 26, 2010), http://www.kff.org/healthreform/upload/8061.pdf.

21. *See infra* note 80 and accompanying text.

III. THE ECONOMICS OF HEALTH INSURANCE

If there is unanimity on any subject regarding health care, it is that health insurance markets are plagued by a number of market imperfections that cause them to function far less than optimally. Economists attribute these market imperfections to several factors: (1) moral hazard (the overuse of medical care resulting from the fact that insurance lowers the cost of each purchase for insureds);[22] (2) risk selection (insurers' strong incentives to seek a favorable or low-risk pool of insureds which can cause an unraveling of risk as the sick and the healthy become divided into different market segments);[23] (3) inadequate information and lack of transparency as to the terms of insurance coverage and the value of that coverage; [24] (4) agency issues arising from the fact that health purchasing decisions are mediated by employers and providers;[25] (5) monopolistic or oligopolistic insurance and provider markets; and (6) behavioral factors impairing effective decision-making including confusion resulting from excessive choice and factors limiting individuals' ability to make informed ex ante decisions.[26]

The inefficiencies associated with health insurance are particularly acute in the individual and small group markets. As a general matter, participants in these markets bear significantly higher premiums due to the lack of adequate pooling of risks, problems of selection, high administrative costs, and other inefficiencies. As noted, the ACA does away with some of the problems for these markets by eliminating health or status underwriting and increasing the size of the pools by subsidizing private insurance for individuals and employers unable to pay the existing levels of premiums. Equally important, however, are a number of regulatory steps needed to improve the functioning of insurance and provider markets to prevent the recurrence of some of the problems historically experienced in individual and small group markets. Foremost among those issues are market concentration and adverse selection.

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22. *See generally* Mark V. Pauly, *Overinsurance and Public Provision of Insurance: The Roles of Moral Hazard and Adverse Selection*, 88 Q. J. ECON. 44 (1974); Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 531–37 (1968). Analysts question the extent and welfare effects of moral hazard in health care. *See, e.g.*, John A. Nyman, *The Economics of Moral Hazard Revisited*, 18 J. HEALTH ECON. 811 (1999).

23. *See generally* David M. Cutler & Sarah Reber, *Paying for Health Insurance: The Tradeoff Between Competition and Adverse Selection* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 5796, 1996).

24. Mark A. Hall & Carl E. Schneider, *Patients As Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 645–47 (2008).

25. Lawrence Casalino, *Managing Uncertainty: Intermediate Organizations as Triple Agents*, 26 J. HEALTH POL. POL'Y & L. 1055, 1061–63 (2001).

26. *See* Richard G. Frank, *Behavioral Economics and Health Economics*, *in* BEHAVIORAL ECONOMICS AND ITS APPLICATIONS 195–222 (Peter Diamond & Hannu Vartiainen eds., 2007).

A. Provider Market Competition and Entry Barriers Facing Insurers

Despite the rhetorical and political focus on the insurance industry, the structure of hospital and specialty physician markets poses the greatest impediment to effective competition in healthcare. As suggested elsewhere, provider markets evidence the worst of both worlds—hospital and physician markets that are *both* concentrated *and* fragmented.[27] Owing in part to several misguided court decisions and the enforcers' seven-year hiatus on challenging hospital mergers,[28] hospital markets have become highly concentrated around the country. By one estimate, ninety three percent of the nation's population now lives in concentrated hospital markets.[29] Further, abundant evidence shows that consumers have borne the brunt of hospitals' exercise of market power. A summary of empirical studies of the effects of hospital consolidation in the 1990s indicates that anticompetitive horizontal mergers raised overall inpatient prices by at least five percent and by forty percent or more when merging hospitals were closely located.[30]

The causal connection between provider concentration and increasing health care costs finds further support in an important study by the Attorney General of Massachusetts. The report, which closely examines private insurance prices, offers a number of significant conclusions.[31] First, it found that prices paid to hospitals and physicians vary significantly, and that higher prices are not associated with quality, complexity, proportion of government patients, or academic status.[32] Second, provider prices in Massachusetts are correlated to market leverage.[33] Hospitals and physician groups with bargaining power extracted higher prices that are not explained by the factors, such as quality, mentioned above. Third, high cost providers appear to gain market share at the expense of less costly providers.[34] Finally, the report concluded that a variety of contractual devices such as payment parity agreements and product participation provisions have reinforced and perpetuated pricing disparities.[35] The contention that provider market power is

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27. Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, NEW ENG. J. MED. (2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1013404; *see generally* Thomas Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT. L. REV. 217 (2009).

28. *See* Thomas L. Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857, app. 917–20 (2004).

29. CLAUDIA H. WILLIAMS ET AL., ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE?, POLICY BRIEF NO. 9 (Feb. 2006), *available at* http://www.rwjf.org/files/research/no9policybrief.pdf.

30. *Id.*

31. OFFICE OF MASS. ATTORNEY GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Mar. 16, 2010).

32. *Id.* at 3.

33. *Id.* at 4.

34. *Id.* at 38–40.

35. *Id.* at 40–43.

primarily responsible for driving insurance premium increases in recent years finds support in other studies as well. A study drawing on site visits to six California markets in 2008 found that bargaining power of hospitals and large single-specialty physician groups had increased significantly over the past decade as a result of extensive merger activity; the resulting provider leverage has had a "major impact on California premium trends."[36] Notably, the study found some situations in which the market power of large groups outweighed the advantages for health plans of entering into capitation for insurers.[37]

Provider market concentration has important implications for the competitive outcome of insurance markets. As discussed *infra*, addressing the problem of interaction between dominant insurers and dominant providers is critical to assuring the competitive benefits of enhanced competition through the exchanges.[38] In addition, concentration in hospital and specialty physician markets has proved to be the major impediment to new entry into local insurance markets. Entry is complicated by the need to obtain discounted provider contracts.[39] This is because the prevailing practice in almost all markets is for large insurance carriers and provider systems to individually negotiate prices that ultimately reflect significant discounts off list prices that physicians and hospitals charge patients without insurance.[40] Because the size of these discounts depend in part on volume or plan enrollment, prices vary widely and the lowest rates are not available to health plans lacking the leverage to insist on such discounts. A recent study by the Department of Justice of cases and investigations involving the possibility of de novo entry or expansion into concentrated insurance markets concluded that provider contracting is a major impediment to entry where large insurers can bargain effectively for discounts that are unavailable to smaller rivals. The Department

36. Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. no. 4, 699, 700–04 (2010); *see also* Robert Town et al., *The Welfare Consequences of Hospital Mergers* (Nat'l Bureau of Econ. Research, Working Paper No. 12244, 2006) (hospital mergers raised HMO premiums 3.2% and caused .3% decline in private insurance in 2001).

37. Berenson et al., *supra* note 36, at 704.

38. *See infra* notes 55–60 and accompanying text.

39. *Consumer Operated and Oriented Plans Sold Through Health Insurance Exchanges Before the Consumer Operated and Oriented Plan (CO-OP) Advisory Board*, (Kan. 2011) (statement of Sandy Praeger, Kansas Comm'r of Insurance and Chair, NAIR Health Insurance and Managed Care Committee) ("CO-OP plans will face the same formidable challenges that all new insurers face. The most daunting of these will be the difficulty of assembling a provider network and negotiating provider payment rates that allow them to be viable, all before they have amassed significant market share that will give them leverage in negotiations and make themselves attractive to providers. Furthermore, CO-OP plans will have to engage in substantial marketing activities to garner the name recognition necessary to attract the market share they will need to be successful over the long-term.").

40. *Id.*; Christine A. Varney, Assistant Attorney Gen., Antitrust Div., U.S. Dep't of Justice, Remarks as prepared for the American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference 4–5 (May 24, 2010) (transcript available at http://www.justice.gov/atr/public/speeches/258898.pdf).

of Justice determined:

> [The] biggest obstacle to an insurer's entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.41

B. Should We Be Concerned About Insurer Market Power?

The Obama Administration has placed much of the responsibility for health cost inflation on the insurance industry. As a candidate, President Obama pointed to the dearth of antitrust enforcement efforts directed at mergers of health insurers as emblematic of the lack of attention paid to that sector.[42] Proponents of health reform placed the lion's share of the blame for increasing health care costs on the health insurers,[43] a move that united populist sentiments and pro-market moderates. Studies of market concentration undertaken by the American Medical Association claimed that in twenty-four of the forty-three states studied, the two largest insurers had a combined market share of seventy percent or more; in fifty four percent of metropolitan markets, at least one insurer had a market share of fifty percent or greater, and in ninety two percent of the metropolitan markets, at least one insurer had a market share of thirty percent or greater.[44]

However, the magnitude of the economic impact of consolidation of the insurance industry is subject to controversy. Some question whether increased firm size in local health insurance markets enables plans to raise premiums

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41. Varney, *supra* note 40, at 9.

42. Statement of Senator Barack Obama for the American Antitrust Institute (Sep. 27, 2007), *available at* http://www.antitrustinstitute.org/files/aai-%20Presidential%20campaign%20-%20Obama%209-07_092720071759.pdf ("The consequences of lax [antitrust] enforcement for consumers are clear. Take health care, for example. There have been over 400 health care mergers in the last 10 years. The American Medical Association reports that 95% of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under [twenty percent] since 2000. These changes were supposed to make the industry more efficient, but instead premiums have skyrocketed, increasing over [eighty seven] percent over the past six years.").

43. *See, e.g.*, *PBS News Hour: Obama Targets Insurers in Health Reform Push* (PBS television broadcast Mar. 8, 2010), http://www.pbs.org/newshour/bb/health/jan-june10/healthcare_03-08.html; *see also* Theodore R. Marmor & Jonathan Oberlander, *Health Reform: The Fateful Moment*, THE NEW YORK REVIEW OF BOOKS, (Aug. 13, 2007) (reviewing TOM DASCHLE ET AL., CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS (2008)), *available at* http://www.nybooks.com/articles/archives/2009/aug/13/health-reform-the-fateful-moment/.

44. Robert J. Mills, *AMA Study Shows Competition Disappearing in the Health Insurance Industry*, AM. MED. ASS'N, Feb. 23, 2010, http://www.ama-assn.org/ama/pub/news/news/health-insurance-competition.shtml.

above competitive levels.[45] In 2004, the joint report of the Department of Justice and Federal Trade Commission expressed skepticism as to whether market concentration was a significant factor affecting competition in most markets.[46] As a matter of economic theory, the market power of insurance intermediaries may have offsetting benefits, such as improved efficiencies resulting from economies of scale and scope and the ability to exercise countervailing power to reduce provider payments.[47] At the same time, there is evidence that reduced competition owing to insurance market concentration bears some of the responsibility for the increasing cost of health insurance.

Several studies show correlations between increasing concentration and premium levels,[48] while others supply evidence that insurers are able to exercise market power vis-a-vis employers[49] or physicians.[50] Quantifying the magnitude of insurer market power, one recent study found that consolidation in the insurance industry caused a seven percent increase in premiums between 1998 and 2006.[51] Others rely on anecdotal evidence to suggest that high premium pricing by dominant insurers is not effectively countered by smaller rivals, which are instead content to engage in "shadow pricing."[52] However,

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45. *Examining Competition in Group Health Care Before the S. Comm. on the Judiciary*, 109th Cong. (2006) (statement of Stephanie Kanwit, Special Counsel, America's Health Insurance Plans) ("[T]here are multiple competing health plans . . . in every major metropolitan area in the United States, each offering multiple products to consumers and employers . . . . [T]here are 16 HMOs in Los Angeles, 20 in Miami, 12 in Boston, 13 in Baltimore, 14 in Philadelphia, and 11 in Pittsburgh.").

46. FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 1 (2004) (acknowledging lingering skepticism about the role of market concentration in competition, but also examining its profound effect).

47. Leemore Dafny et al., *Paying a Premium on your Premium? Consolidation in the U.S. Health Insurance Industry* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 15434, 2009) ("From a theoretical standpoint, both the sign and the magnitude of the effect of concentration on insurance premiums are ambiguous. On the one hand, increases in market concentration may allow health insurers to raise their markups, leading to higher premiums. On the other hand, increases in market share may strengthen insurers' bargaining positions vis-a-vis healthcare providers, leading to reduced outlays and lower premiums. In addition, there are many potential sources of efficiency gains from consolidation, including economies of scale in IT investing and disease management programs, which would also reduce costs and optimal premiums.").

48. *See, e.g.*, James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 HEALTH AFF. no. 6, 11 (2004).

49. *See, e.g.*, Leemore S. Dafny, *Are Health Insurance Markets Competitive?*, 100 AM. ECON. REV. 1399 (2010).

50. *See, e.g.*, Dafny et al., *supra* note 47.

51. *Id.* at 33.

52. JOHN HOLOHAN & LINDA BLUMBERG, URBAN INST. HEALTH POLICY CENTER, CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH REFORM? 3 (2008), *available at* http://www.urban.org/UploadedPDF/411762_public_insurance.pdf ("[S]mall insurers do not aggressively compete over price. Rather, rising premiums and increased profitability of nondominant firms provide indirect evidence of shadow pricing by smaller insurers; that is, smaller insurers do not seem to compete on premiums to gain market share but rather seem to follow the pricing of the dominant insurer.").

the effect of insurance industry consolidation should not be overstated. The empirical study by Leemore Dafny and her co-authors found that the extent to which premium price increases are attributable to insurance plan market power constitutes only a small proportion of the overall price escalation.[53] The authors point out that the seven percent increase caused by insurance industry consolidation "pales in comparison to the [sixty] percent increase in average, inflation-adjusted premiums observed for the average firm" in the study during that time.[54] Put another way, increased insurance industry concentration explained only two percent of the increases in premiums. Responsibility for much of the remaining increment must be placed at the door of provider market power.

However, an important questions remains: how should we evaluate the "balance of power" between hospitals and insurers?[55] That is, does the increasing concentration of insurers create offsetting power that mitigates, to some degree, the price effects of hospital concentration? Indeed, several studies indicate that increased insurer market power can reduce hospital prices and improve access.[56] The limited economic research on this issue suggests a rather intricate relationship between hospitals and insurers. While high concentration undoubtedly enables hospitals to command higher prices from insurers, increasing insurer market power can ameliorate hospitals' power where payers can threaten network exclusion or bargain effectively through other means.[57] However, when insurer market concentration exceeds that of the hospitals, insurers "can mark up the lower prices they obtain from hospitals and retain the difference as profit with little fear of losing enrollees to other insurers."[58] Moreover, where dominant insurers face dominant providers, the preferred strategic response may entail understandings that divide the gains of the parties' market power. For example, in several recent antitrust cases, bargaining between dominant hospitals and insurers appears to have produced reciprocal understandings that have resulted in reduced competition in both markets. A notorious example involved the so-called "market covenant" between the CEOs of Partners Health Care, the dominant hospital system in Massachusetts, and the state's largest insurer, Blue Cross Blue Shield of Massachusetts ("BCBSM").[59] In this covenant, BCBSM agreed to a major

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53. Dafny et al., *supra* note 47, at 33.

54. *Id.*

55. *See* Austin Frakt, *The Future of Health Care Costs: Hospital-Insurer Balance of Power*, NAT'L INST. FOR HEALTH CARE MGMT. (Nov. 2010), http://nihcm.org/pdf/EV_Frakt_FINAL .pdf.

56. *See, e.g.*, Roger Feldman & Douglas Wholey, *Do HMOs Have Monopsony Power?*, 1 INT'L J. HEALTH CARE FIN. & ECON. 7 (2001); Laurie J. Bates & Rexford E. Santerre, *Do Health Insurers Possess Monopsony Power in the Hospital Services Industry?*, 8 INT'L J. HEALTH CARE FIN. & ECON. 1 (2008).

57. *See* Frakt, *supra* note 55.

58. *Id.*

59. Scott Allen & Marcella Bombardieri, *A Handshake that Made Healthcare History*, BOS.

payment increase for Partners who in return received higher payments from BCBSM.[60] In addition, Partners promised to "push for the same or bigger payment increases" from other insurers.[61] Recently, the Third Circuit reinstated an antitrust claim by an insurer concerning the leading insurer in western Pennsylvania, which had allegedly reached an anticompetitive understanding with the dominant hospital system in the market.[62]

A further issue to consider is whether the ACA will induce more vibrant competition and entry into new markets by insurers in the future. On the one hand, the availability of some twenty million new customers and the reduction of risks of adverse selection should encourage insurers to expand into new markets. On the other hand, reform may eliminate some carriers whose business model in the past has depended entirely on risk selection and those that offer low benefits and are unwilling to undertake the new law's ban on lifetime limitations and minimum loss ratio requirements.[63] Ultimately, the capacity of the new law to stimulate competition in insurance markets depends on the design of the new markets and the success of regulatory measures designed to mitigate market imperfections and channel insurers' energies to competing on price and quality.

In sum, the economic literature offers compelling evidence that dominant providers are a major cause of health cost inflation as they generally exercise market power by raising prices that are then reflected in higher premiums. Insurer concentration may temper hospital monopoly power up to a point, but when it too becomes excessive, insurers are likely to take monopoly profits and reach accommodations with dominant providers. This phenomenon leant support to injecting a "maverick" competitor into the insurance market in the form of a "public option plan" that might counteract the power of dominant providers, but not yield to the temptation to cooperate with other insurers or charge supracompetitive premiums.[64] The impetus for empowering exchanges to play an active role in promoting competition among insurers is rooted in the same concerns about market power among providers and insurers.

GLOBE, Dec. 28, 2008, at A1.

60. *Id.*

61. *Id.*

62. W. Penn Allegheny Health Sys., Inc. v. UPMC, 627 F.3d 85, 109–10 (3d Cir. 2010).

63. TIMOTHY STOLTZFUS JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: EIGHT DIFFICULT ISSUES 29 (2010) [hereinafter JOST, EIGHT DIFFICULT ISSUES] ("[S]mall 'bottom-feeder' insurers who currently thrive in the market by picking off low-risk individuals or groups (often by offering high cost-sharing, limited-benefit plans) will probably disappear once they are required to meet statutory minimum loss ratios. The ACA bar on lifetime and annual limits will also eliminate many low-cost, low-value plans.").

64. *See* HOLOHAN & BLUMBERG, *supra* note 52, at 5.

C. Dealing with the Bête Noire of Adverse Selection

Adverse selection has been cited as "[t]he single most important reason why exchanges have not succeeded in the past."[65] Consequently, the drafters of the ACA devoted considerable efforts at curbing its effects. The reason adverse selection plays such an important role can be traced to the uneven distribution of health care needs. With the sickest one percent of the population accounting for nearly twenty five percent of all health spending and the sickest ten percent accounting for two thirds of healthcare spending, insurers have quite rationally focused their competitive strategy on seeking out the healthier tiers of the population. [66] Even if premiums match the relatively higher costs (which they tend not to in a fluctuating market), the threat of attracting ever worse risks is evident, as higher premiums drive out the marginally healthier populations.[67] Thus, the impulse to chase good risks—i.e., the healthiest half of the population that accounts for only three percent of spending[68]—is strong absent regulatory restrictions that reduce that incentive.

The risk selection imperative arising from adverse selection also affects market entry and the competitiveness of insurance markets. Entry is made riskier for insurers because even those that manage care successfully can fall victim to a pool of high risks. Incentives to enter markets are lessened if an insurer cannot successfully compete in chasing good risks. Historically, insurers have had free reign to engage in practices designed to select risks, and therefore, have directed their efforts to marketing and underwriting. Thus, the ACA's numerous provisions aimed at reigning in insurer risk selection can be seen as an effort to correct a market failure and redirect competition toward managing care for greater value and quality.[69]

Mindful of these problems, Congress undertook extensive efforts to minimize risks of adverse selection when drafting the ACA. First, the

65. TIMOTHY STOLTZFUS JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 3 (2010) [hereinafter JOST, KEY POLICY ISSUES]; *see* Micah Weinberg, *The California Health Benefit Exchange,* NEW AM. FOUND. (Aug. 20, 2010), http://health.newamerica.net/blogposts/2010/in_the_states_the_california_health_benefit_exchange-35848 ("The difference between the products offered inside and outside of the exchange was one of the main reasons that [California's] own small business exchange failed. Businesses with older or sicker workers went into the exchange, while good risks stayed out, creating a classic adverse selection problem.").

66. *See* BLUMBERG & POLLITZ, *supra* note 4, at 2.

67. *Id.*

68. *Id.*

69. Jon Kingsdale, former executive director of the Massachusetts Health Connector, summarized the need to reorient the energies of the health insurance industry: "[F]rankly, a lot of competition among health plans is [based] on risk selection rather than socially more useful ends, such as service and benefits and value." Jon Kingsdale, The Role of Exchange in California's Implementation of National Health Reform 5 (Oct. 21, 2010) (transcript available at http://www.chcf.org/~/media/Files/PDF/S/PDF%20Sacto10212010HealthBenefitExchangeTranscript.pdf).

individual mandate requires, with limited exceptions, that everyone purchase insurance.[70] Additionally, the law makes federal subsidies available only through the exchange.[71] Together, these provisions serve to enlarge the overall pool for the individual market in the exchanges and reduce risks to plans. Second, the ACA applies many of the same market rules to plans inside and outside the exchange. For example, it assures that premium rates are the same inside and outside the exchange,[72] provides for guaranteed access to all plans,[73] prohibits ratings based on health status,[74] prohibits preexisting condition exclusions,[75] prohibits waiting periods of longer than ninety days,[76] and places limitations on out-of-pocket costs.[77] Importantly, under the ACA, plans inside and outside the exchange are in a single risk pool.[78] The ACA allows plans to adjust premiums from fixed community rating to recognize variation in health usage based on age, family composition, tobacco use, and location of the insured.[79]

Third, the law establishes minimum essential health benefits ("EHB"), to be defined by the Secretary of HHS.[80] An important feature curbing the ability of insurers to frame benefits to attract favorable risks is the Act's mandate that the essential health benefit requirements apply to markets inside and outside the exchange.[81] Undermining this provision however, the law does not restrict the opportunity of plans to enhance the prescribed EHB package by offering additional benefits or benefit enhancements. Finally, the law requires risk adjustment and applies it to plans inside and outside the market.[82] This policy enhances competition by reducing entry barriers by reducing one important source of business uncertainty (selection risk) and also makes it less risky for carriers—both new and incumbent players—to test innovative benefit designs.

D. Options For States To Deal With Adverse Selection

The ACA is not airtight concerning adverse selection issues. The Act leaves open means by which plans might design or market their policies in ways that secure favorable risks. For example, while the law requires plans to meet thresholds of actuarial value within the precious metal categories, it does

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70. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, sec. 5000A, 124 Stat. 119, 242–49 (2010).

71. *Id.* § 1401, 124 Stat. at 213–24 (adding a new section to the Internal Revenue Code).

72. *Id.* § 1301(a)(1)(C)(iii), 124 Stat. at 163.

73. *Id.* § 1201, sec. 2702, 124 Stat. at 156.

74. *Id.* § 1201, sec. 2704(a), 124 Stat. at 154.

75. *Id.*

76. *Id.* § 1201, sec. 2708, 124 Stat. at 161.

77. *Id.* § 1302(c), 124 Stat. at 165–67.

78. *Id.* § 1312(c), 124 Stat. at 182.

79. *Id.* § 1201, sec. 2701, 124 Stat. at 155.

80. *Id.* § 1302(a)–(b), 124 Stat. at 163–65.

81. *Id.* § 1302(b)(1), 124 Stat. at 163.

82. *Id.* § 1341, 124 Stat. at 208; § 1343, 124 Stat. at 212.

not standardize the cost sharing options offered by plans within the same tier. Thus, two plans might offer radically different proportions of co-pay and deductibles and still fall within the bronze actuarial value requirement. For example, one plan might have a large deductible and no or low copayments and the other might have low deductibles and high co-payments. In addition, the law empowers the Secretary to specify minimum benefits, but does not prohibit plans affording additional benefits. This may enable plans to add benefits that may attract a healthier population. Other avenues for favorable risk selection, such as marketing, branding, and other subtle manipulations, are familiar tactics that plans may employ to target healthy populations. Finally, the ACA's ultimate backstop against risk selection, mandatory risk adjustment, may not prevent risk selection owing to various shortcomings in the methodology likely to be employed.[83]

Moreover, although many regulations apply to the individual and small group markets, whether they are inside or outside the exchange, other significant groups escape regulation. So-called "grandfathered plans" and large group plans are not covered by essential benefit requirements.[84] Likewise, risk adjustment mechanisms do not apply to large groups or self-insured plans.[85] Further, self-insured plans escape most state regulation because of ERISA. Often overlooked is the fact that many small employers (sometimes employers with as few as ten employees) are now opting for self-insurance owing to controversial court decisions finding that the purchase of large "stop loss" policies does not affect their "self insured" status.[86]

A particularly serious risk for exchanges is the possibility that employers will implement what Professor Amy Monahan terms a "dumping strategy," designed to induce their less healthy or "high risk" employees to opt out of their employer-sponsored coverage and instead purchase insurance through individual markets in the exchange.[87] Self-insured plans remain relatively unregulated and as a result have considerable latitude in designing their plans. Some employers may find it financially attractive to amend their plans to appeal to young healthy employees (e.g., with generous wellness benefits) and unappealing to high-risk employees. The strategy can be a win-win, as high-risk employees will have the option of purchasing an individual policy on the exchange. The employer can defray much of that cost by paying into a health account, while saving considerably on the cost of care for the remainder of its

83. *See generally* Hall & Schneider, *supra* note 24 (explaining the limitations of the healthcare marketplace to control risk selection).

84. § 1201, sec. 2707(a), 124 Stat. at 161 (stating that only individual or small group market plans need include essential health benefits required under § 1302(a)).

85. *Id.* § 1343, 124 Stat. at 212.

86. JOST, LEGAL AND POLICY ISSUES, *supra* note 3, at 17.

87. Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 128 (2011).

employees.[88] These gaps create a risk that plans may be designed to encourage less healthy employees to opt for coverage under the exchange. Moreover, it has been suggested that "small businesses with healthy employees [might] remain 'self-insured' until the health of their pool deteriorates and then join the exchange [so that] premiums within the exchange will increase and the exchange will become less viable."[89]

In designing the rules governing exchanges, states have the potential to mitigate or exacerbate adverse selection problems in the market. If insurers will be allowed to sell plans both inside and outside the exchange, the risk of adverse selection is two-fold. First, there is a risk that the exchange will suffer adverse selection, as insurers may seek to encourage healthier individuals and small employers with healthier members to choose plans outside the exchange. Second, selection may occur within the exchange if carriers are able to structure or market their plans in a manner that attracts a more healthy set of enrollees. State regulation itself may enable adverse selection to the extent it regulates unevenly, for example, imposing stricter marketing regulations on plans inside the exchange than on those outside the exchange, or permitting insurers to offer only low cost plans outside the exchange likely to attract healthier beneficiaries. Given the limited protections afforded by the ACA, states may be well advised to adopt additional protections.

California serves as an example of these additional protections. To combat the problem of adverse selection, it has adopted the following steps: (1) all insurers must offer all four of the "actuarial equivalent" benefit plan levels (bronze through platinum) for each product sold on the exchange;[90] (2) the sale of catastrophic coverage plans is restricted to plans that participate in the exchange, outside the exchange;[91] (3) participating plans may sell to persons not otherwise eligible to purchase through the exchange;[92] (4) fair and affirmative marketing (where exchange-participating insurers are encouraged to "fairly and affirmatively" market and sell any plan offered in the exchange outside of the exchange);[93] (5) permissive standardization of products which allows the Exchange Board to standardize benefits for products offered through the exchange, if the exchange does so, insurers in the non-exchange market must offer at least one standardized plan at each of the four benefit levels (bronze through platinum);[94] (6) selective contracting which permits the Exchange Board to develop additional criteria that may help to prevent adverse

88. *See id.* at 158–63.

89. JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 19–20.

90. *See* CAL. HEALTHCARE FOUND., CALIFORNIA'S HEALTH INSURANCE EXCHANGE: EXPERTS TACKLE THE BIG QUESTIONS 5 (2010).

91. *Id.* at 6, 11.

92. *Id.* at 8.

93. CAL. HEALTHCARE FOUND., HEALTH BENEFIT EXCHANGE: CALIFORNIA VS. FEDERAL PROVISIONS: A COMPARISON OF CALIFORNIA LEGISLATION AB 1602/SB 900 WITH THE U.S. PATIENT PROTECTION AND AFFORDABLE CARE ACT (AMENDED) 5 (2011).

94. CAL. HEALTHCARE FOUND., *supra* note 90, at 11.

selection;[95] (7) exchange marketing which permits the exchange to market its services directly to consumers.[96]

IV. THE STATES' TOOL KIT FOR IMPROVING MARKET COMPETITION

Besides taking steps to deal with selection problems, states establishing exchanges have a host of options that may serve to improve competition in their insurance markets. While federal rules will set standards, offer recommendations, and provide technical assistance, states are empowered to make many important decisions. There are a host of approaches states can adopt to encourage entry and foster rivalry based on value and encourage informed product comparisons such as:

- Whether the exchange will be an "active purchaser" in selecting plans eligible to be offered
- Whether to use a competitive bidding process for plans or negotiate informally with plans
- Whether to condition certification of QHPs on meeting demanding specified competition-favoring criteria
- Whether to expand the scope of the exchange by:
    - Including large employers
    - Requiring health insurers to participate in the exchange
    - Forming regional exchanges or establishing interstate coordination for certain functions
- Whether to require or prohibit additional benefits in the Exchange beyond the essential health benefits
- Whether to extend some or all regulations applicable to plans offered in the exchange to plans offered outside insurance market[97]

It should be obvious that in making these determinations, states need to weigh a number of sometimes competing objectives. First is the desirability of promoting wide participation of insurers in the exchanges in order to ensure adequate geographic coverage and give consumers both value and variety in their choices. Thus, exchanges must be run efficiently and must offer an attractive alternative to the market outside the exchange. Second, because a broader pool of insured individuals will attract new entry by enabling carriers

95. *Id.* at 4, 10.

96. CAL. HEALTHCARE FOUND., *supra* note 93, at 7

97. *See generally* U.S. DEP'T HEALTH & HUMAN SERVICES, INITIAL GUIDANCE TO STATES ON EXCHANGES (2010).

to enjoy economies of scale and scope and minimize random risks, the exchanges will benefit from expanding their reach beyond individuals and small groups. Third, assuring a level playing field with options outside the exchange will serve to promote stability and prevent migration of plans and customers. Fourth, exchanges are expected to serve a regulatory function, assuring, for example, that plans provide high quality service, adequate information, timely payments to providers, and processes for redress of consumers' grievances. Finally, exchanges carry the promise of promoting cost control and efficiency and thus should be designed to reduce transaction costs for plans and consumers.

The foregoing catalogue of goals and responsibilities indicate that exchanges, whether active or passive, will inevitably shape small group and individual insurance markets. Given that information deficits, agency issues, and other market failures may persist even with well-functioning exchanges, merely affording a well organized set of choices will not assure that individuals and small groups will realize the full benefits of market competition. Accordingly, many believe it is essential that the exchange take on the role of a surrogate purchaser, i.e., an informed buyer that does the initial comparative shopping on behalf of the consumer.

A. Active Purchaser or Market Facilitator?

A key decision that will shape the competitive interaction of insurance plans is whether to adopt what HHS refers to as an "active purchaser" model, in which the exchange may negotiate directly with potential participants concerning the terms and prices of their offerings. The alternative approach is the "open marketplace" model, in which the exchange serves as a market facilitator or clearinghouse, but is generally passive as to the pricing or content of options offered by plans other than assuring compliance with the requirements of the ACA and HHS regulations.[98]

There are a number of reasons why states may prefer an active purchaser model. Exchanges might be analogized to large employers that perform what economist Henry Aaron refers to as the "industrial purchasing" function: assembling and interpreting the vast amount of information necessary to make an informed comparison among plans based on cost, quality, and service.[99]

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98. *See id.* ("States have a range of options for how the Exchange operates from an 'active purchaser' model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an 'open marketplace' model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. In both cases, consumers will end up with options, and States should provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences.").

99. Henry J. Aaron, Commentary, *A Funny Thing Happened on the Way to Managed Competition*, 27 J. HEALTH POL. POL'Y & L. 31, 33 (2002).

This role, widely acknowledged as a strength of employer-based insurance system, permits large employers to aggregate data, develop expertise, and bargain efficiently on behalf of their employees. In addition, adoption of the active purchaser model finds support in behavioral economics, which suggests that individuals are prone to making suboptimal choices in purchasing health insurance. Richard Frank and Richard Zeckhauser describe how exchanges may address shortcomings in individual decision-making:

> The rationale for an exchange is that consumers are rarely well equipped to deal with markets offering large numbers of complex, expensive, hard-to-evaluate products—products that, as in the case of health insurance policies, may nonetheless be critical to their well-being. Consumers facing complex, high-stakes choices are prone to predictable errors.[100]

As discussed in the following sections, there are two prerequisites for exchanges to be effective as active purchasers: (1) they must have some amount of leverage in the market and (2) they must exercise that leverage effectively. That is, with a sufficiently large and attractive pool of potential customers, exchanges can elicit concessions from insurers that would be unavailable to individual buyers. It should be emphasized that the potential uses of buyer leverage extend well beyond negotiating for lower premiums. Exchanges can seek to restructure underlying conditions that have thwarted effective competition, for example, by insisting on conditions that can serve to correct market failures. Thus, exchanges might require insurers to offer some plans that pay providers on other than a fee-for-service basis or insist that all plans disclose information about provider reimbursement.

The active purchaser model can take many forms that will enable it to be selective, including requiring formal competitive bidding, setting specific and demanding standards for certification, or negotiating with each carrier regarding the cost and characteristics of its plans. Choosing any of these options is likely to prove highly contentious, as most insurers would prefer an open market, free of regulatory requirements or having to negotiate with the exchange administrators and will surely exercise their political clout to prevent adoption of this model. For their part, states will have to weigh a variety of factors in deciding whether to adopt an active purchaser model and, if so, how to structure it.

B. Leverage

At the outset, states face the question of whether some form of selective

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100. Richard G. Frank & Richard J. Zeckhauser, *Health Insurance Exchanges—Making the Markets Work*, 361 NEW ENG. J. MED. 1135, 1135 (2009).

contracting by the exchanges will work in their markets. Whether done through negotiation, competitive bidding, or some combination of those methods, the exchange must have some degree of market leverage for selective contracting to be beneficial to a state. The degree to which leverage exists depends in part on the number and market power of insurers willing to participate in the exchange. Assessing this condition is complicated by the fact that it will be impossible to predict with confidence what that number will be. The individual and small group markets will surely be more attractive in some respects, as millions of new customers, aided by subsidies, enter the market. Moreover, the ACA seeks to encourage entry of new plans, making available loans and start-up costs for Consumer Operated and Oriented Plans ("Co-op plans")[101] and mandating inclusion of at least two multi-state plans by each exchange.[102] However, there are reasons to doubt that Co-op plans or small insurance plans unaffiliated with national brands can become a significant participant in most areas of the country. As discussed above, local health insurance markets have remained highly concentrated because new entrants are impeded by the difficulty of obtaining discounts from providers.[103]

Nevertheless, states are not without power to augment their buying power. As discussed in detail below, states can structure their insurance markets to encourage or even mandate broad participation by insurers in their exchanges.[104] Although this strategy is not without risk, expanding the pool of buyers and limiting access to external markets can serve to encourage insurers to participate in the exchange and invigorate competition among them. Combining the purchasing power of the exchange with other purchases of health insurance for which the state is responsible might enhance leverage. For example, California evidently envisions using the power of the exchange to effect delivery system reform and doing so in conjunction with the other state purchasing responsibilities:

> The ACA provides opportunities for purchaser collaboration, including the Exchange, Medi-Cal, Healthy Families and CalPERS, to advance the goals of improved care, improved quality and lower costs. Such collaborations could focus on delivery system improvement such as reducing infections in inpatient facilities or health status improvements such as better birth outcomes or diabetes prevention. Implementation of the Exchange offers a new opportunity for the State to exhibit leadership in cross purchaser

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101. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1322, 124 Stat. 119, 188 (2010) (to be codified at 42 U.S.C. § 18042); *see generally* OFFICE OF CONSUMER INFO. & INS. OVERSIGHT, CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM ADVISORY BOARD EXECUTIVE SUMMARY (Jan. 13, 2011), http://www.hhs.gov/ociio/initiative/executive_summary_faca.pdf.

102. § 1322, 124 Stat. at 187; § 1334, 124 Stat. at 902–03.

103. *See supra* Section III.B.

104. *See infra* notes 120–22 and accompanying text.

collaboration intended to drive delivery system change and improve health outcomes.[105]

In this connection, it should be noted that states may achieve significant efficiencies by coordinating certification and requirements for quality, coverage and network adequacy among Medicaid, the exchanges, and other state insurance programs.

C. Standard Setting, Bidding, or Negotiation?

States choosing to be active purchasers will need to determine whether their exchanges should rely on competitive bidding, negotiation, or standard setting (or some combination of these strategies). Of course, underlying this choice is the threshold issue of what goals should guide administrators. While the ACA charges exchange administrators with the responsibility of assuring that plans comply with the requirements of the statute and regulations promulgated by the Secretary of HHS[106] and that the plans offered in the exchange are in the interest of the consumer,[107] prioritizing the importance of key factors such as competition, access, and quality is left to the discretion of each state. Whether establishing a competitive insurance market will satisfy other goals of the exchange is a philosophical question that will likely influence the choice of whether to design exchanges as active purchasers and if so what preferences should guide its purchasing decisions.

Perhaps the most politically attractive selective purchasing option for many states will be to set demanding standards for certification using clearly stated, objective criteria. If done through a consensus-building regulatory process, it can serve to afford applicants advance notice of what will be required while giving regulators the opportunity to ascertain in advance the market response of potential applicants. The process might enable exchanges to set clear priorities for insurers on matters of particular concern to the state. For example, it has been suggested that exchanges might require plans to participate in Medicaid, serve particular regions, or offer specific benefits of particularly importance to the communities they serve.[108] Standard setting can

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105. CALIFORNIA HEALTH & HUMAN SERVICES AGENCY, IMPLEMENTATION OF THE AFFORDABLE CARE ACT IN CALIFORNIA: A WINDOW OF OPPORTUNITY FOR STATE POLICY MAKERS 7 (2010), http://www.chcf.org/~/media/Files/PDF/I/PDF%20ImplementationACACaliforniaCHHS.pdf.

106. § 1311(e)(1)(A), 124 Stat. at 178.

107. *Id.* § 1311(e)(1)(B), 124 Stat. at 178 (exchange may certify plans only if it "determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates").

108. *See* Ken Terry, *Don't Look Now, but State Health-Insurance Exchanges Are Gathering Steam*, BNET (Mar. 17, 2011), http://www.bnet.com/blog/healthcare-business/don-8217t-look-now-but-state-health-insurance-exchanges-are-gathering-steam/2592 (describing approaches to integrating Medicaid into state-run exchanges).

serve important pro-competitive ends as well. As noted above, conditions might be attached that are aimed at improving the competitiveness of provider markets, such as requiring insurers to contract on other than a fee-for-service basis with a certain percentage of their insured.

However, this approach entails several risks. First, it may be difficult to prescribe ex ante what criteria to impose. The relative importance of fixed criteria may change over time, requiring revisiting the standards frequently. A demanding set of criteria may deter participation in the exchange, such as risking the creation of concentrated market structures in the exchange and encouraging plans to form outside the exchange. In addition, strict quality or process-focused criteria may result in an excessive focus on non-price variables and the sacrifice of price competition.

The second method of selective contracting is to require competitive bidding to determine which plans are offered in the exchanges. Under certain conditions, economic theory predicts that bidding can produce competitive outcomes even with a small number of sellers.[109] However most of those conditions—winner take all, no incumbency advantage, easy entry—are not present in health insurance exchange bidding.[110] Bidding also runs the risk that some needs may not be satisfied; hence, some detailed specifications are commonly required. Nevertheless, a bidding process has the advantage of compelling prospective insurers to focus on price and value.[111]

The third option is to engage in negotiations with carriers, enabling exchange administrators to tailor their requirements with respect to individual proposals by carriers. This approach gives exchange administrators flexibility to weigh and prioritize different variables in the selection process and ensure variety and choice. In this regard, it may be important to empower the governing body of the exchange with broad powers to set and negotiate terms with applicants.[112] Where multiple bidders are available, there is some

109. Paul Klemperer, *Bidding Markets*, 3 J. COMPETITION L. & ECON. 1, 6 (2007).

110. *See id.* at 4–9.

111. The Centers for Medicare and Medicaid Services has experience with bidding markets in the Medicare Advantage plans where plans bid against an established benchmark. *See* Berenson et al., *supra* note 36, at 704–05 (process has been complicated by issues regarding the developing an appropriate benchmark).

112. To enable individualized negotiations, it will be necessary to give exchange administrators room to negotiate specific terms while setting forth generalized criteria. Ambiguous language in California's statute, which adopts an active purchaser model, may be read to limit such flexibility. CAL. GOV'T CODE § 100503 (West Supp. 2011) (empowering the governing board to "[d]etermine the minimum requirements a [health] carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. *The board shall consistently and uniformly apply these requirements, standards, and criteria to all carriers.* In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and

evidence that individual negotiations can be successful in inducing concessions from sellers. For example, CMS has asserted that its recently acquired power to negotiate aggressively with Medicare Advantage plans enabled it to obtain premium reductions for 2011.[113] The Federal Employee Health Benefit Plan and the Commonwealth Choice exchange in Massachusetts have also employed use of the negotiation power, albeit with a light hand.[114]

To drive good bargains while preserving choice and innovation, states will need to construct a regulatory regime that offers insurers both flexibility in the selection process and poses a credible threat of exclusion. These considerations probably counsel an approach that combines features of bidding, negotiation, and standard setting. In any event, states wanting to act as active purchasers face a number of vexing problems. There is an inherent tension with selective purchasing in that at some point, whittling down the number of plans becomes antithetical to the purpose of an exchange: offering multiple and perhaps somewhat differentiated plans.[115] If a single or few plans are chosen and there are advantages to incumbency,[116] it may be difficult to get plans to enter or reenter markets in subsequent years.[117] In the end, vesting in exchange administrators discretion to use all three tools seems best designed to enable them to react to changing and unpredictable market forces while adhering to the goal of promoting rivalry among insurance plans.

D. Scope and Design of Benefits

States have authority to influence the scope and design of benefit options that may be offered through the exchanges. It is clear that the exchanges will play an important role in facilitating comparison shopping for coverage in their

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service.") (emphasis added).

113. *See* Mike Lillis, *CMS: Medicare Advantage Enrollment to Jump Next Year, Premiums to Fall*, HEALTHWATCH: THE HILL'S HEALTHCARE BLOG (Sept. 21, 2010, 10:48 AM), http://thehill.com/blogs/healthwatch/medicare/119977-cms-medicare-advantage-enrollment-to-jump-next-year-premiums-to-fall (quoting the head of CMS, Donald Berwick, "The Affordable Care Act gave us new authority to negotiate with health plans in a competitive marketplace. As a result, our beneficiaries will save money and maintain their benefits.").

114. *See* JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 28 (characterizing the FEHBP model as "something of a hybrid, negotiating with plans that request participation, but taking a generally permissive and inclusive approach.").

115. Selectivity is the exchange's only real tool to get carriers to serve its customers better, but it is not a power that any government would want to use lightly. *See* Rachel Brand, *Jon Kingsdale: A Q and A on Health Insurance Exchanges: October/November 2010*, NAT'L CONF. ST. LEGIS., http://www.ncsl.org/?tabid=21406 (last visited Apr. 4, 2011) (quoting Jon Kingsdale, "I believe it is unwise to either prohibit or force selectivity, but it is wise to give the exchange some flexibility to negotiate. The trouble with having no ability to select plans is that the exchange becomes an automated yellow pages.").

116. *See* Frank & Zeckhauser, *supra* note 100, at 1136 (stating the "status quo basis" which makes consumers reluctant to switch plans has historically been prevalent in health insurance markets).

117. *See* JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 29.

display and comparison of health plans' premiums, benefit levels, provider networks, and other features. More controversial, however, is the question of whether state laws should restrict the scope of benefits and limit the range of options in the features that plans offer. The behavioral economics literature shows that too much choice can impede the efficiency of markets. Consumers encountering a large number of health plans can be subject to "inertia due to numbers"—a reduced willingness to switch plans.[118] Research has also demonstrated that where consumer decisions are adversely affected by excessive options among health plans, the outcome can be large variations in plan pricing in the market which suggests that many are not taking advantage of plans with more favorable terms.[119] At the same time, one must remember that choice has real economic value: it both encourages plans to innovate and provides sizeable economic benefits to consumers.[120] Further, choice is constrained in the employer-sponsored market: the vast majority of small employers offer only one plan and the majority of large employers offer only two plans.[121]

In enacting laws governing exchanges, states may decide to restrict consumer choice in a number of ways, such as limiting the number of insurance plans offered in the exchange, prohibiting carriers from offering plans outside the exchange, standardizing benefits by prohibiting an addition to EHBs or requiring a premium add-on for such benefits, and limiting variation in co-payments and deductibles. However, there are other means to mitigate the effects of too much choice. For example, exchanges will rate plans, conduct consumer satisfaction surveys, and provide on-line tools for comparative shopping. Other sources, including brokers and consumer groups, may also supply information and guidance that can lessen search frictions.

States will therefore confront a delicate "Goldilocks" judgment as to consumer choice: not too much, not too little. From the perspective of promoting competition, the critical issue is how to prevent consumer confusion and promote informed comparisons of plans, while not leaving preferences unsatisfied and stifling innovation in the design of insurance policies. Lessons

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118. *See generally* BARRY SCHWARTZ, THE PARADOX OF CHOICE: WHY MORE IS LESS 18–22 (2004) (stating that consumers, when overwhelmed by the number of options available, choose not to buy a product instead of making the effort to become informed and then making a choice).

119. *See* Frank & Zeckhauser, *supra* note 100, at 1136. (citing Richard G. Frank & Karine Lamiraud, *Choice, Price Competition, and Complexity in Markets for Health Insurance*, 71 J. ECON. BEHAV. & ORG. 550, 561 (2009)).

120. *See* Leemore Dafny, Katherine Ho & Mauricio Varela, *Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange* 28 (Nat'l Bureau of Econ. Research, Working Paper No. 15687, 2010) (estimating median welfare gain from expanding choice at approximately twenty percent of premiums).

121. *See* THE KAISER FAM. FOUND., HEALTH RES. & EDUC. TR. & NAT'L OP. RES. CENTER, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 61 (2010), *available at* http://ehbs.kff.org/pdf/2010/8085.pdf (stating eighty-five percent of small firms offer only one plan type and approximately eighty-nine percent of large firms offer two or fewer plan types).

might be gleaned from the Medicare Part D program, where excessive choice has resulted in confusion and inefficient decision-making.[122] Much of the initial confusion generated by Part D plans appears to grow from the difficulties inherent in making "apples to apples" comparisons of benefits given wide differences in cost sharing. Given the considerable complexity involved in comparing "actuarially equivalent" plans,[123] an important regulatory improvement would be to limit the cost sharing options within each precious metal tier. Whether regulation should prescribe adding benefits to the EHB package is a more difficult issue. Adding new benefits affords plans a means for testing consumer preferences and provides a means of assuring that essential benefit packages do not remain static. For this reason, and because add-ons of benefits will be politically infeasible, a premium surcharge may nevertheless be needed to avoid selection problems discussed earlier.[124] Ultimately, states will need to steer a middle course that standardizes plans but gives sufficient leeway for innovation. Doing so at the outset may prove difficult; as experience with plans develop however, they may use the most popular options for consumers as a guide for standardization.[125]

E. To What Extent Should States Encourage Broad Participation in the Exchange?

There are undoubted benefits to competition in promoting broad participation in the exchanges. First, given the concentration in most individual and small group markets, regulations that encourage entry by new firms would be pro-competitive. Insurers want to be assured of a sufficiently large potential pool of enrollees to justify start up investments in a market and to reduce risks of volatility and destabilization due to large claims.[126] In addition, larger pools reduce the risk of adverse selection, especially if

122. *See* Jason Abaluck & Jonathan Gruber, *Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program*, (Nat'l Bureau of Econ. Research, Working Paper No. w14759, 2009); *see also,* James S. Lubalin and Lauren D. Harris-Kojetin, *What Do Consumers Want and Need to Know in Making Health Care Choices?*, 56 MED. CARE RES. & REV. 67, 83 (1999).

123. JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 29–30 (pointing out that because plans are also able to add additional benefits to the essential health benefits package, comparisons among plans in the same tier will be difficult; "Two silver plans could . . . offer two dramatically different benefit packages (beyond the essential benefits) with significantly different cost-sharing configurations and still have a 70 percent actuarial value (although premium tax subsidies and cost-sharing reduction payments would be pegged to the second-lowest-cost silver plan).").

124. JOST, KEY POLICY ISSUES, *supra* note 65, at 12 (pointing out that because plans are also able to add additional benefits to the essential health benefits package, comparisons among plans in the same tier will be difficult).

125. *See* Jon Kingsdale & John Bertko, *Insurance Exchanges Under Health Reform: Six Design Issues for the States*, 29 HEALTH AFF. 1158, 1160 (2010) (concluding that the Massachusetts Connector has found a "happy medium" for standardized benefits according to the types of policies consumers preferred over time).

126. *See* JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 17.

participation outside the exchange is not encouraged due to disparities in regulation. Insurers may also need sufficient presence in the market to negotiate effectively with providers. Second, the efficiency of the exchange will be enhanced with larger pools to share fixed costs, and the administration of the exchanges will likely benefit from broadened populations. It is likely that the American Health Benefit (individual) Exchange will attract the vast majority of individuals in the market since it is the only vehicle for receiving tax credits for which a large proportion of the individual market will be eligible. Unlike the individual exchanges, participation in the small employer exchange will depend on premium levels and regulatory requirements.

There are a number of ways that states might broaden participation in the exchanges. At the outset, they may choose to accept the ACA default standard for small group participation (100 or fewer employees) rather than the lower optional level (fifty employees).[127] In addition, states can open their exchanges to large employers in 2017.[128] States can also undertake more aggressive measures to increase participation in their pools. They might require that all individual policies or all small group policies be sold exclusively through their exchanges. Alternatively, they could condition participation in the exchanges if a carrier desired to offer plans outside the exchange. Further, states have the option of operating a multi-state exchange that serves two or more states.[129]

Broadening participation, however, carries with it risks and tradeoffs. Making the exchange an exclusive distribution channel may undermine the state's ability or willingness to engage in selective contracting. States would face intense political pressure to include all carriers and all plans in the exchange, since it would be the sole outlet for individual and small group sales; states may encounter legal obstacles as well.[130] Paradoxically, states may impair competition by opening up their exchanges to large group employers if those employers are free to go outside the market or self-insure. That is so because of the regulatory treatment afforded to large groups: they are free from the requirement that they offer qualified health plans and insurers of large groups need not include their large group members in a single risk pool outside and inside the exchange.[131] Thus, Tim Jost concludes,

It is therefore very possible—indeed likely—that large groups

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127. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1304(b), 124 Stat. 119, 172 (2010) (to be codified at 42 U.S.C. § 18024).

128. *Id.* § 1312(f)(2)(B)(i), 124 Stat. at 184.

129. *Id.* § 1334, 124 Stat. at 902–03; *see* ROBERT CAREY, ROBERT WOOD JOHNSON FOUND., HEALTH INSURANCE EXCHANGES: KEY ISSUES FOR STATE IMPLEMENTATION 4 (2010) ("Given the administrative and operational responsibilities of the Exchange, it is difficult to envision a scenario in which establishing more than one Exchange in a single state would be an efficient use of resources.").

130. *See* JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 10–11.

131. § 1312(c), 124 Stat. at 182.

> participating in the exchange would offer their enrollees more generous benefits than some large groups that did not participate (although the essential benefit package is supposed to be actuarially equivalent to a typical employment-based plan). Because insurers of large groups do not need to include their large-group members in a single risk pool with exchange participants and do not need to adjust risk between their large-group and exchange plans, it is very possible—indeed likely—that risk selection would occur against the exchange if large groups are allowed to participate. Healthy groups may remain outside the exchange,where leaner benefits are available; unhealthy groups will turn to the exchange for a more generous benefit package or for lower-than-experience-rated premiums.[132]

States seeking to expand participation will need to walk a tightrope as they open their exchanges to large employers while taking measures to protect the exchange against unfavorable selection.

F. Governance, Bureaucracy, and Politics

As the foregoing analysis suggests, exchanges will face difficult tradeoffs under conditions of uncertainty and intense political scrutiny. To best meet this challenge, the administration of exchanges will require expertise, independence, and finesse. States may choose among a variety of organizational and governance models for their exchanges. The ACA requires only that the exchange be "a governmental agency or nonprofit entity established by the State."[133] An important consideration is that exchanges must be self-funding by 2015, relying on user fees or must "otherwise generate funding."[134] Hence, states may elect to operate exchanges as a purely private nonprofit corporation, a unit of state government, or a quasi-governmental entity. A variety of administrative, policy, and legal considerations will determine states' decisions on this issue.[135] This section considers only the possible effects on competition of the several options.

One possibility is to locate the exchange within the state government. For example, the exchange could be under the direct supervision of the state department of insurance, the state HHS, or act as a stand-alone entity within the executive branch. However, direct accountability to the executive and legislative branches raises concerns that an exchange may be subject to political pressures and use its powers to disadvantage private insurers or discriminate unfairly among insurers. Given the multiple functions expected of exchanges it is highly advisable that they be insulated from political

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132. JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 18.
133. § 1311(d)(1), 124 Stat. at 176.
134. *Id.* § 1311(d)(5), 124 Stat. at 177–78.
135. *See* CAREY, *supra* note 129, at 4–6.

influence and have access to the business expertise they need.

Thus, the option of a quasi-governmental entity with authority drawn from both the private sector and the government seems best suited to bringing needed expertise and independence and necessary linkage with state government. To ensure public accountability, it is critically important that the state impose strict conflict of interest rules and transparency requirements on both the exchange and its management. Indeed, the impulse to place insurance industry or broker/agent representatives in governance roles would seem antithetical to implementing effective selective contracting. These issues are familiar to states managing procurement of health insurance benefits for their employees through independent procurement agencies; indeed, combining the functions of the two entities may make sense.

If a state elects to structure its exchange as a private or quasi-governmental entity, the governance structure it chooses will be of considerable importance. Many quasi-governmental entities adopt an "interest group" approach, with board members appointed from consumer, business, and regulatory sectors. Ideally, a governing board so composed could bring business expertise from the insurance and employer sectors along with representation for consumer and public interest issues underlying the purposes of the exchange. A risk identified by some commentators is that even a balanced, politically attuned board will encounter fundamental disagreements over priorities for their constituencies.[136] An exchange electing to adopt a selective contracting approach would benefit from eschewing broad representation on its board in favor of managers that can impartially evaluate and weigh alternatives once priorities are set by legislation or regulation.

V. CONCLUSION

In designing exchanges and structuring insurance markets, states can take a number of steps to promote competition. They can reduce opportunities for adverse selection, encourage new entry by insurers, enhance and exercise exchange leverage, and facilitate effective comparative shopping by individuals and employers. All are worthy undertakings and, in most markets, probably essential for enabling insurance exchanges to ensure meaningful competition among plans. Moreover, exchanges can play a vital role in promoting competition at the provider level, the locus of the most significant obstacles to well functioning health care markets. This Article has offered some caveats, however. Legislation and regulations need to be carefully calibrated to the market conditions in the state and must make calculated guesses about the behavior of carriers in response to the new regulatory regime. Further, much is asked of exchanges. Exchanges are expected to

136. *See, e.g.*, JOST, EIGHT DIFFICULT ISSUES, *supra* note 63, at 7 (warning that interest group boards might degenerate into "political turf wars").

assume a wide variety of roles: gatekeeper, regulator, consumer guardian, promoter, market facilitator, evaluator, and informed shopper. These multiple responsibilities will likely generate conflicting impulses that can weaken exchanges' resolve to promote competition.

Health reform will stand or fall on whether it succeeds in rationalizing care and thereby aligning payment with value. "Fixing" the insurance industry has been at the forefront of the political and legislative debate, but ultimately successful cost control and value maximization depends primarily on changing health care delivery. Health insurance exchanges might play a helpful role in encouraging delivery system reform by placing a thumb on the scale favoring plans that employ integrated delivery systems, bundled payments, and other market improving mechanisms. Like many other aspects of health reform, designing exchanges to take advantage of market forces requires thoughtful and balanced regulation.