



Active or Passive: The Role of a New Jersey Health Insurance Exchange

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Executive Summary

Health insurance exchanges are intended to organize the health insurance marketplace for the benefit of individuals and small businesses, a marketplace that many find confusing and increasingly expensive. New Jersey has two decades of experience with efforts to bring efficiency and transparency to this market. The Affordable Care Act (“ACA”) envisions Exchanges with powers and duties that go beyond New Jersey’s existing Individual Health Coverage Program and Small Employer Health Benefits Program. How much further the Exchange’s powers and duties ought to go is politically and practically contested. In particular, there is sharp dispute in New Jersey and elsewhere over the degree to which Exchanges should be active purchasers, directly bargaining with carriers to give consumers the bargaining clout enjoyed by large employers, or open marketplaces, arming consumers and small businesses with information to empower them to choose from among the array of products offered by willing insurers.

This Brief will provide information and analysis to help assess the costs and benefits of New Jersey’s options. It will describe time frames for decision, and the options for New Jersey to build its own Exchange, leave the task to the federal government, or act in partnership with the federal government. It will describe past and pending New Jersey legislation and gubernatorial response, and decisions made in other states grappling with the role of their Exchange. After the Supreme Court’s decision largely upholding the ACA and the reintroduction of the Exchange bill in the New Jersey Legislature, the issue of New Jersey’s Exchange is back on the public agenda.

There are four domains of tasks for which the Exchange will be responsible; within each domain are tasks that the ACA requires, and tasks that New Jersey can assign to the Exchange at its option. The four domains are:

1. **Information**: providing or facilitating the provision of coverage information to consumers through hotlines, on-line calculators, and Navigator services.
2. **Eligibility and enrollment**: facilitating or accomplishing the enrollment and reenrollment of consumers in public and private insurance plans.

3. **Financial management:** maintaining a self-sustaining income stream, maintaining accurate accounting of activities, granting exemption from individual responsibility for coverage, and assessing and transferring to the Secretary of the Treasury information on individual exemptions and employers whose employees were eligible for an unaffordability exemption or a tax credit because the employer did not provide minimum essential coverage.
4. **Private plan selection and management:** screening plans in and out of the Exchange market, and overseeing the activities of Exchange plans.

The first three domains are important, but it is the fourth – plan selection – that dominates the active/passive debate.

Unpacking the active/passive debate begins with recognizing the complexity of the distinction. First, no Exchange under the ACA can be entirely passive – indeed, New Jersey’s existing exchange-like programs for small group and individual insurance go beyond pure clearinghouse status, imposing plan standardization and transparency requirements on carriers. At a minimum, an Exchange will require that consumer information, plan design, and cost-sharing provisions conform to uniform, consumer-friendly formats. At the other extreme, “active” exchanges can follow a variety of strategies, from selective contracting, to soliciting bids, to imposing terms and conditions on carriers beyond those required in State law or the ACA. Three common models along the active/passive continuum can be represented as follows:

Clearinghouse Model	Active Regulatory Model	Active Purchaser Model
<ul style="list-style-type: none"> • Empowered to perform information, enrollment, and financial tasks • Reviews insurance plans for compliance with required terms of ACA and state insurance law • Makes all insurance products available for purchase 	<ul style="list-style-type: none"> • Empowered to perform information, enrollment, and financial tasks • Requires plan terms and conditions beyond those in ACA for entry into Exchanges • Offers only those plans that comply with more restrictive terms and conditions 	<ul style="list-style-type: none"> • Empowered to perform information, enrollment, and financial tasks • Directly engages carriers in negotiations or bidding process • Attempts to obtain through negotiation or bidding process favorable terms on issues including price, quality, and plan design • Offers only those plans that succeed in the negotiation or bidding process

As states have adopted Exchange legislation, they have considered the lessons to be drawn from Utah and Massachusetts, where Exchanges predated the adoption of the ACA. Utah has a clearinghouse model Exchange. Massachusetts has two; its Exchange for residents eligible

for subsidized coverage is an active purchaser, and its Exchange for unsubsidized individuals and small businesses is an active regulator. Post-ACA state laws fit into to five categories in active/passive terms:

- **Active purchasers** – empowered to negotiate with or solicit bids from carriers;
- **Active regulators** – empowered to add terms and requirements for products in the Exchange beyond those required by state law or the ACA;
- **Clearinghouse models** – charged with admitting all qualified products to Exchange;
- **Starter Exchanges** – empowered to create the infrastructure for an Exchange, with active/passive decision put off to future; and
- **Maryland’s Exchange** – power to select plans phased in; for first two years, to act as active regulator, with potential for shift to other model in 2016.

The Secretary has faced the active/passive issue for federally-operated Exchanges. The ACA charges the Secretary with creating federally-operated Exchanges in states that choose not to run their own Exchanges (either on their own or in partnership with the federal government). The federal strategy will be similar to that adopted by Maryland: Federally-facilitated Exchanges will certify all qualified plans in the first year, but leave open the possibility of more active plan management in the future.

The New Jersey Legislature passed an Exchange bill that was vetoed by the Governor and has been reintroduced. That bill opted to create an Exchange in the second listed category with respect to plan management: not an “active purchaser,” but an “active regulator.” That is, the Exchange was not empowered to negotiate with carriers directly, but was empowered to set terms and conditions for the offering of plans beyond the minimum required by law. As New Jersey revisits the creation of an Exchange, it will grapple with the active/passive issues anew, and can benefit from the work of other states’ legislatures and executives that have similarly weighed their many options. One that bears attention – and therefore is singled out in this Brief – is Maryland’s. Maryland has been quite deliberate in its examination of the costs and benefits of different Exchange activities. After substantial consultation with a range of stakeholders, Maryland’s Legislature acted in two stages. First, it adopted Exchange legislation that left largely open the question of how directly the Exchange should intervene in the insurance market, and charged the Exchange with rounds of consultation and study. Following much deliberation, and the production of a comprehensive report to the Legislature, the statute was amended. It empowered the Exchange to impose terms and conditions on plan entry, but not to negotiate with or solicit bids from carriers. It also charged the Exchange to evaluate its experience in two years, to further study the costs and benefits of Exchange power, and inform the Legislature of its conclusions. The final decision on future Exchange activity was therefore left to the Legislature.

New Jersey's decision-making process is enriched by the variety of analysis and action that has already taken place. Resolving the active/passive question will necessitate the juxtaposition of the merits of two visions of consumer protection: expansive consumer choice in an open market, and bargained-for price reductions or improvements in terms and conditions offered in a more constrained product market. It will take into consideration the concentration of New Jersey's individual and small group insurance market, and that concentration's effect on the leverage an Exchange could apply to negotiation and market-shaping activities. It might consider the benefits of phasing in its decisions as to the degree of active purchasing the Exchange may undertake, as did Maryland. Finally, it should consider the broad range of activities beneficial to New Jersey's individuals and small businesses that an Exchange might undertake regardless of its orientation along the active/passive continuum.

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I. Introduction and Context

State health insurance exchanges are slated to begin facilitating coverage for individuals and small groups on January 1, 2014.¹ In anticipation, some states have adopted Exchange legislation, reflecting varied views of the place Exchanges may play in states' health insurance marketplaces. Subject to some general federal requirements, states have wide discretion in designing their exchanges. The debate on how that discretion should be used often turns on whether one believes the Exchanges should operate as an "active purchaser," driving hard bargains for the best deals possible, or as a "clearinghouse," a passive portal through which insurers offer varied products, allowing choice from a wide variety of plan permutations according to their perceived needs and capacities to pay. This Brief will examine the "active/passive" issue in New Jersey. It will survey the requirements of the ACA, the response of New Jersey's Legislature and Governor, and the United States Supreme Court's ruling on the ACA's constitutionality.² It will then discuss the categories of tasks the ACA puts to the Exchanges, and the tasks within those categories that are mandatory under the law. In particular, it will examine the private plan selection and management tasks that are the focus of the active/passive debate. It will review Exchanges created in other states, and assess the extent to which states have selected active or passive modes of operation. It will then discuss factors that may inform New Jersey's way forward: timing issues and the potential for putting off some decisions on how New Jersey's Exchange will regulate plan entry; the constraints New Jersey's marketplace for individual and small group insurance places on the choice of an Exchange design; and the opportunities for improvements in that marketplace regardless of whether New Jersey adopts an active or passive Exchange.

The ACA intended a state's health insurance exchange to serve as a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By

¹ See 45 CFR 155.105(a).

² *National Federation of Independent Businesses v. Sebelius*, ___ U.S. ___ (June 28, 2012) available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>. (hereafter, *NFIB v. Sebelius*)

pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.³

Exchanges⁴ are prominent pillars of the ACA's plan to expand access to private insurance to individuals and small businesses.⁵ State-run Exchanges⁶ must be prepared by January 1, 2013 to demonstrate to HHS that they will be ready to perform the functions required of an Exchange under the ACA by January 1, 2014.⁷ Exchanges must be self-financing by January 1, 2015.⁸ HHS has published an Exchange Blueprint against which states' readiness for Exchange operation will be assessed.⁹ States electing to create a State-based Exchange or a State Partnership

³ Initial Guidance to States on Exchanges (HHS/CMS/CCIIO Nov. 23, 2010)), available at http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html.

⁴ The ACA contemplates the creation of an exchange for individual purchasers (an "American Health Benefits Exchange") and one for small businesses (a "Small Business Health Options Program"), which may be operated separately or together. See 42 U.S.C. 18031(b). This paper refers to the exchanges collectively as the "Exchange" or "Exchanges" for ease of reference.

⁵ See Preamble to Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 FR 18310, 18311 (March 27, 2012).

⁶ The federal government is charged with creating an exchange in states that fail or decline to create their own exchange. 42 U.S.C. 18041(c). The Centers for Medicare and Medicaid Services ("CMS") has issued guidance on the range of relationships that might exist between a state and the federal government in the operation of an exchange, ranging from largely autonomous management of the exchange by the state, to a "partnership" arrangement in which the state and the federal government (through the Center for Consumer Information and Insurance Oversight ("CCIIO") within CMS), to federal creation and operation of an exchange within a state. See CCIIO, *General Guidance for Federally-facilitated Exchanges*, (May 16, 2012) available at http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf. See generally Deborah Bachrach and Patricia Boozang, *Federally-Facilitated Exchanges and the Continuum of State Options* (Robert Wood Johnson Foundation and the National Academy of Social Insurance, December 2011), available at <http://www.rwjf.org/files/research/73741.nasi.12.20.11rpt.pdf>. This paper addresses the State's options should New Jersey determine to run its own exchange.

⁷ 45 CFR 155.105(a). If a state is unable or unwilling to run their own exchanges, HHS is prepared to stand up an exchange, HHS is prepared to implement a "Federally-facilitated Exchange" (FFE), or, as an intermediary step, to work with the state to create a "State Partnership Insurance Exchange." See *infra* Part _____. See 77 FR 18317-18 (response to comments in adoption of final Exchange regulations). See also Timothy Jost, *Implementing Health Reform: State-based, Partnership, and Federally Facilitated Exchanges* Health Affairs Blog, May 12, 2012, available at <http://healthaffairs.org/blog/2012/03/13/implementing-health-reform-a-final-rule-on-health-insurance-exchanges/>; Policy Brief, *Overview of Final Exchange Regulations* RWJF State Health Reform Assistance Network April 2012, available at <http://www.rwjf.org/files/research/74165.5784.overviewoffinalexchange.20120321.pdf>. As the time for implementation grows short, the State Partnership Exchange option may become more attractive to states. See *Establishing Health Insurance Exchanges: An Overview of State Efforts* (Kaiser Family Foundation March 2012) available at <http://www.kff.org/healthreform/upload/8213-2.pdf>. States may also begin their Exchanges in the Partnership model, with substantial federal involvement, but move over time to more state control, eventually converting to a State-based Exchange. See Deborah Bachrach and Patricia Boozang, *Federally-Facilitated Exchanges and the Continuum of State Options* (National Academy of Social Insurance December 2011) available at <http://www.rwjf.org/files/research/73741.nasi.12.20.11rpt.pdf>.

⁸ 42 U.S.C. 18031 (d)(5).

⁹ Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, HHS/CMS/CCIIO (August 14, 2012) available at <http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf>. See 45 CFR 155.105(c).

Exchange¹⁰ must submit a Declaration Letter no later than November 16, 2012, although early submission of the letter is encouraged.¹¹

The Declaration Letter signifying a state's intention to create a State-based Exchange must be signed by the governor and should include an indication of the state's intentions to create an Exchange. It should include an indication as to its intent (or not) to administer risk adjustment, reinsurance, and subsidy determination tasks. The Letter must also designate a primary point of contact between the state and HHS for Exchange approval purposes.¹² The Blueprint itself is intended to be completed electronically, and includes more detailed information permitting HHS to assess the state's readiness to operate an Exchange.¹³

The New Jersey Legislature passed a bill on March 15, 2012 to create the New Jersey Health Benefit Exchange.¹⁴ The bill would have enabled the creation of a quasi-public ("in but not of") Exchange compliant with the ACA's requirements for a state-run Exchange, with specific goals to:

- reduce the number of uninsured New Jerseyans by creating an organized, transparent marketplace for the people of this State to: purchase affordable, quality health care coverage; claim available federal tax credits and cost-sharing subsidies; and meet the personal responsibility requirements imposed by the federal act;
- strengthen the health care delivery system in this State;
- guarantee the availability and renewability of health care coverage in New Jersey through the private health insurance market to eligible persons and participating employers;
- require that health benefits plans and health insurers issuing coverage in the individual and employer markets in this State compete on the basis of price, quality, and service, and not on risk selection; and
- meet the requirements of the federal act.¹⁵

The bill would have enabled the Exchange to undertake operational steps to allow for consumers to obtain coverage,¹⁶ and to take steps to hire staff and obtain consulting

¹⁰ The Declaration Letter may also indicate that the state declines to form an Exchange, either as state-run or in partnership with HHS. In that event, or should a state not submit a Declaration Letter, HHS will "plan to implement a Federally-facilitated Exchange" for that state. Blueprint *supra* at 7-8.

¹¹ If the Declaration Letter is submitted more than 20 business days before the submission of the Exchange Blueprint (also due on November 16, 2012), the state may request a consultation with HHS to get assistance in completing the Exchange Blueprint. Blueprint, *supra* at 4.

¹² Blueprint, *supra* at 6-7.

¹³ Blueprint, *supra* at 10-45.

¹⁴ New Jersey Assembly Bill 2171 (2d Reprint 2012) ("A2171"), available at http://www.njleg.state.nj.us/2012/Bills/A2500/2171_R2.PDF.

¹⁵ A 2171 § 2.

¹⁶ A2171 § 6(d).

resources.¹⁷ Most significantly for purposes of this Brief, the bill also described the means by which the Exchange would be empowered to select the carriers permitted to offer plans through the Exchange, requiring, among other things, that the Exchange only accept plans that “offer the optimal combination of choice, value, quality, and service.”¹⁸

Governor Christie vetoed the bill on May 10, 2012. His veto message made four essential points. First, it recounted efforts made by the Legislature and Administration to study the best way to achieve compliance with the terms of the ACA.¹⁹ Second, it expressed the Governor’s view that the Exchange legislation was untimely in light of the challenges to the ACA’s constitutionality then pending before the United States Supreme Court.²⁰ Third, it took issue with three specific provisions of the bill. Most significantly for purposes of this Brief, it expressed the view that “the bill’s mechanism for certifying health plan participation in the exchange limits the pool of plan participants, which will likely reduce options and increase costs.” That is, it objected that the bill created an “active” exchange.²¹ Finally, the message indicated a commitment to continued preparations for implementation of those portions of the ADA ultimately upheld by the Court.²²

On June 28, 2012, the United States Supreme Court ruled on challenges to the constitutionality of the ACA.²³ The principal issues before the Court were the constitutionality of the individual mandate, which requires most individuals to have insurance coverage beginning in 2014,²⁴ and the constitutionality of the expansion of the Medicaid program to include most individuals with incomes less than 133 percent of the federal poverty level.²⁵ The Court, construing the individual mandate provision to be tax obligation, found it to be within Congress’s taxing power.²⁶ The Court also upheld the constitutionality of the Medicaid

¹⁷ A2171 § 6(e).

¹⁸ A2171 § 7(a)(1).

¹⁹ Veto Message to Assembly Bill 2171 (2d Reprint) (“Veto Message”) at 1 (May 10, 2012) available at http://nj.gov/governor/news/news/552012/pdf/A-2171_AV.pdf.

²⁰ Veto Message at 2.

²¹ Veto Message at 3. The other two provisions singled were that the Exchange, in conjunction with the New Jersey Department of Human Services, was charged with creating a “Basic Health Plan,” *see* A2171 § 6(b) (*see generally* Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States* (State Coverage Initiatives March 2011), and that comprising the Exchange’s governing board with with members that do not “represent[] ... all stakeholders,” and authorizing that the directors receive \$50,000 per year in compensation, *see* A2171 § 5(a) – (c).

²² Veto Message at 4 (“My Administration will continue [its preparatory] work and stands ready to implement the Affordable Care Act if its provisions are ultimately upheld.”).

²³ *NFIB v. Sebelius*, *supra*.

²⁴ 26 U.S.C. § 5000A(a) (“An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for each month.”).

²⁵ 42 U.S.C. § 1396a(10)(A)(viii).

²⁶ *NFIB v. Sebeius*, *supra*, Opinion of Roberts, C.J. for the Court, *slip op.* at 38 (“Our precedent demonstrates that Congress had the power to impose the exaction in § 5000A under the taxing power, and that § 5000A need not be read to do more than impose a tax. That is sufficient to sustain it.”). Chief Justice Roberts, with the support of four

expansion, but held that the ACA's Medicaid expansion is "a shift in kind, and not degree,"²⁷ and that the Medicaid provision empowering the Secretary to "withhold *all* 'further [Medicaid] payments . . . to the State' if she determines that the state is out of compliance with any Medicaid requirement, including those contained in the expansion"²⁸ could therefore not be used to penalize states declining to adopt the ACA's Medicaid expansion.²⁹ The majority of the Court, then, upheld the private insurance market provisions of the ACA in their entirety, and struck only the enforcement provision with respect to Medicaid expansion. Following the Court's decision, the vetoed bill was reintroduced.³⁰ Governor Christie has been quoted as indicating that he is considering the State's options with respect to Exchanges and other aspects of health reform.³¹ The nature of a New Jersey Exchange (if any) is therefore back on the state's agenda.

II. Active or Passive: Choices along a Continuum

The concepts of passive and active Exchanges have taken on well-accepted meanings. A passive Exchange is thought of as a centralized market for health coverage shopping. An active Exchange is thought of as a purchaser negotiating directly with carriers over price and non-price terms, or as a regulator setting terms and conditions beyond those required by the ACA in order to narrow the number of plans offered, and to encourage carriers to shape their offerings consistent with the Exchange's vision of coverage.³² One source describes the "passive market organizer approach" to Exchange activity as one in which,

Any health plans meeting minimum ACA standards for insurers and products could participate; the exchange would act as an impartial source of information on health plans available in the market, providing the structure and tools that

other Justices, rejected the argument of the United States that the mandate is also valid under the Commerce Clause (*slip op.* at 27) or the Necessary and Proper Clause (*slip op.* at 29) of the Constitution.

²⁷ *NFIB v. Sebeius*, *supra*, Opinion of Roberts, C.J. for the Court, *slip op.* at 53.

²⁸ *NFIB v. Sebeius*, *supra*, Opinion of Roberts, C.J. for the Court, *slip op.* at 56, quoting 42 U.S.C. § 1396c (emphasis in original).

²⁹ *Id.*

³⁰ Senate Bill 2135 (June 28, 2012), available at http://www.njleg.state.nj.us/2012/Bills/S2500/2135_I1.PDF. See Beth Fitzgerald and Colleen O'Dea, *What the ACA Ruling Means for New Jersey*, NJSpotlight, June 29, 2012, available at <http://www.njspotlight.com/stories/12/0629/0010/>.

³¹ See, e.g., Fred Mogul, *With Health Care Law Upheld, Christie Talks Options for NJ*, (New Jersey Public Radio, July 3, 2012) available at <http://www.wnyc.org/articles/new-jersey-news/2012/jul/03/christie-no-medicare-maybe-federal-insurance-exchange/>.

³² See Micah Weingberg and Leif Wellington Haase, *State-Based Coverage Solutions: The California Health Benefits Exchange* at 8 (Commonwealth Fund Issue Brief, May 2011) available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/May/1507_Weinberg_california_hlt_benefit_exchange_ib.pdf; Deborah Bachrach and Patricia Boozang, *Federally-Facilitated Exchanges and the Continuum of State Options* at 28 (National Academy of Social Insurance December 2011) available at <http://www.rwjf.org/files/research/73741.nasi.12.20.11rpt.pdf>.

enable consumers to compare health plans and purchase coverage, and undertaking basic administrative functions for health plans and consumers.³³

An “active purchaser model,” on the other hand, is described as one which would,

Attempt to use its leverage – much as a large employer would – to get the best price through a competitive procurement, or attempt to influence the market by contracting with a select group of health plans or by setting health plan requirements that exceed the minimum standards of the ACA.³⁴

As even these short definitions suggest, it is difficult to cleanly separate the operations of Exchanges into active or passive models. Either model is, as is more fully described below, required to undertake *some* tasks in order to comply with the ACA. An “active” exchange could literally be a “purchaser,” bargaining with plans and selecting and rejecting products after negotiating over price and non-price terms, or it could be a market regulator, sharpening the criteria for participating plans beyond those required by the ACA for the benefit of purchasing individuals and small businesses. At one extreme, an Exchange attempts to adopt a mode of operation similar to the business plan of the travel website Travelocity by acting, within the minimum constraints of the ACA, to provide an information-laden clearinghouse for purchasers. At the other, an Exchange would use all of the tools available to it under federal and state law to achieve optimal plan selection in terms of price and non-price criteria for individual consumers and small businesses.³⁵

While the labels have some value in organizing the debate, neither an extreme version of a passive exchange, in which the state’s market for individual and small group coverage remains the same, with Exchanges simply providing a Travelocity-like informational and coordinating function, nor an extreme version of an active exchange, in which Exchanges mimic a purchasing manager for a firm’s health benefits plan, is a realistic option for states. The purely passive, clearinghouse model is unrealistic because the ACA sets out some requirements for Exchanges that go beyond merely serving as a conduit to private insurers.³⁶ And a very active Exchange, mimicking the aggressive conduct of a firm’s benefits manager, is unrealistic due to practical constraints faced by any Exchange attempting to accomplish the tasks facing it.³⁷ Instead (assuming they wish to create an Exchange), states will examine the categories of tasks

³³ Peter Newell and Robert L. Carey, *Passive/Active: Defining the Role for a Health Benefit Exchange in the Interests of New Yorkers* at 1 (United Hospital Fund 2011) available at <http://nyshealthfoundation.org/uploads/resources/passive-active-health-benefit-exchange-december-2011.pdf>.

³⁴ *Id.*

³⁵ *Id.* at 1.

³⁶ *See infra* at § III.

³⁷ *See infra* at § V(B).

Exchanges must or may take on, and express their preference for light or heavy state market participation by defining the manner in which required and optional tasks will be carried out.³⁸

Whether conceived as a choice between a market facilitator or market maker, an active or passive model, or a light or heavy regulatory model, it is clear that the choices presented are not bimodal, but rather fall on a spectrum. In unpacking the choices to be made, it is useful to examine the tasks that Exchanges must and may employ to achieve the goals created for them, and to assess which of those are essential to a state's discussion of the choice between a more or less active Exchange.

III. Exchange Task Overview

The ACA sets out a number of tasks for individual and small group Exchanges, and the Secretary has provided some detail with respect to the means by which these tasks must be pursued. It is clear, however, that states retain substantial discretion in fulfilling the ACA's requirements. They may tailor Exchanges' means of undertaking the mandatory tasks to the state's own circumstances, and they may charge Exchanges with additional tasks consistent with the states' own regulatory judgment. The tasks associated with the Exchanges³⁹ under the ACA can be grouped within the following four domains:

1. **Information:** providing or facilitating the provision of coverage information to consumers through hotlines, on-line calculators, and Navigator services.⁴⁰
2. **Eligibility and enrollment:** facilitating or accomplishing the enrollment and reenrollment of consumers in public and private insurance plans.⁴¹
3. **Financial management:** maintaining self-sustaining income stream, maintaining accurate accounting of activities, granting exemption from individual responsibility for coverage, and assessing and transferring to the Secretary of the Treasury information on individual exemptions and employers whose employees were eligible for an

³⁸ See Eva H. DuGoff and Jonathan Weiner, *A White Paper Prepared for the Executive Board of the State of Maryland Health Benefit Exchange* (Maryland Citizens' Health Initiative/Johns Hopkins Bloomberg School of Public Health, 11/14/11) available at <http://healthcareforall.com/wp-content/uploads/2011/11/Active-Purchasing-and-HIEs-White-Paper-MCHI-TAC-Final-11-14-11.pdf>.

³⁹ As Professor Jost has pointed out, the ACA assumes the continuing predominance of state Departments of Insurance over the regulation of insurance companies, and reposes some of the tasks related to individual and small group market reform with those state agencies. See Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* at 20-21 (Commonwealth Fund, July 2010) available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf.

⁴⁰ See, e.g., 42 U.S.C. 18031(d)(4)(C), (G), and (K) 45 CFR 155.205 and 155.210.

⁴¹ See, e.g., 42 U.S.C. 18031(d)(2) and 18031(d)(4)(F); 45 CFR 155.310, 315, 320, 335, and 345, 155.400-430, and 155.700-730.

unaffordability exemption or a tax credit because the employer did not provide minimum essential coverage.⁴²

4. **Private plan selection and management:** screening plans in and out of the Exchange market, and overseeing the activities of Exchange plans.

There are required tasks within each of the domains. The required tasks within the first domain (information) comprise tasks devoted to providing consumers with assistance in making coverage choices. These required tasks include

- Establishing a toll-free call center;
- Maintaining an Internet web site displaying evaluative and comparative information on Qualified Health Plans;⁴³
- Providing consumer education on coverage issues; and
- Establishing a Navigator service to help consumers make coverage choices.⁴⁴

These tasks are intended to create efficiency within the market for individual and small group health insurance; their implementation appears not to affect the extent to which an Exchange is a passive or active purchaser.

The second domain (eligibility and enrollment) also includes mandatory tasks. Within this domain, the ACA requires that Exchanges (either themselves or through partner organizations) maintain a “no wrong door” approach to evaluating and enrolling consumers in appropriate public insurance, or facilitating their enrollment in private plans.⁴⁵ These functions are intended to increase the likelihood that consumers will locate and obtain the appropriate coverage, rather than suffer the confusion and frustration of bouncing between programs attempting to locate the coverage for which they are eligible.⁴⁶ The federal standards and

⁴² See, e.g., 42 U.S.C. 18031(d)(4)(H), (I), and (J), and 18033(a); 45 CFR 155.200(b) and (c), and 155.340.

⁴³ New Jersey now maintains web sites containing some of the required information on health plans offered in both the individual (see http://www.state.nj.us/dobi/division_insurance/ihcseh/shop_ihc.htm) and small group (see http://www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm) markets.

⁴⁴ See 45 CFR 155.205-210. See also Deborah Bachrach and Patricia Boozang, *Federally-Facilitated Exchanges and the Continuum of State Options* (National Academy of Social Insurance December 2011), *supra*, at 8; Eva H. DuGoff and Jonathan Weiner, *Demystifying Active Purchasing: Tools for State Health Insurance Exchanges* (Maryland Citizens’ Health Initiative/Johns Hopkins Bloomberg School of Public Health 11/14/2011), *supra* at 8.

⁴⁵ See 45 CFR 300-355; 400-430; and 700-730. See also Deborah Bachrach and Patricia Boozang, *Federally-Facilitated Exchanges and the Continuum of State Options* (National Academy of Social Insurance December 2011), *supra*, at 8; Eva H. DuGoff and Jonathan Weiner, *Demystifying Active Purchasing: Tools for State Health Insurance Exchanges* (Maryland Citizens’ Health Initiative/Johns Hopkins Bloomberg School of Public Health 11/14/2011), *supra* at 8.

⁴⁶ See Michael Birnbaum, *A Conversation with Donald Berwick on Implementing National Health Reform*, J. HEALTH, POL., POL’Y & LAW 709, 712-13 (2012). Dr. Berwick, then CMS Administrator, this task as follows:

[O]ne of the ACA’s core design concepts is seamless integration between Medicaid and the exchanges. In Washington we’re calling it “no wrong door,” and it’s an absolutely crucial concept. There should be no wrong door for accessing coverage. If you call, then you will be guided through what is a pretty complex architecture of potential supports, all the way from Medicaid,

funding are intended to guide these consumer-service functions, but here also, requiring enrollment coordination services does not render an exchange more or less “active.”

The third domain (financial management) also includes ACA-mandated tasks. The mandatory tasks largely concern evaluation, administration, and information transfer with respect to individuals’ premium assistance, cost-sharing subsidy, and individual responsibility status,⁴⁷ aggregating and transmitting billing information to participating employers,⁴⁸ reporting to the IRS information regarding employee and employer participation,⁴⁹ and, by January 1, 2015, maintaining a revenue stream allowing financial self-sufficiency.⁵⁰ These tasks can be accomplished by Exchanges at any point in the active/passive continuum.

It is the fourth domain, private plan selection and management, that squarely raises concerns regarding the active nature of Exchanges – and rightfully so. It is Exchanges’ role in selecting health insurance products for inclusion in the Exchanges’ individual and small group marketplaces, and the exclusion of other products, that has most prominently raises concerns of critics of active Exchanges,⁵¹ who prefer an Exchange that does not perform any narrowing function, but rather leaves to consumers the choice among all plans licensed by state regulators and meeting the requirements in the ACA for Qualified Health Plans.⁵² New Jersey’s vetoed bill would have empowered the Exchange to certify only “those plans that it determines offer the optimal combination of choice, value, quality, and service to enrollees,” implicitly empowering it to reject those plans it determined would not offer such benefits.⁵³ In his veto message, Governor Christie argued that this provision “limits the pool of plan participants, which will likely reduce options and increase costs.”⁵⁴

Preferences for active or passive exchanges often turn on one’s views of the general efficacy of free market competition and regulatory oversight as forces to improve choice, quality, and cost in the health insurance marketplace. On one hand, health care and health insurance markets are generally agreed to be deeply flawed, for a variety of reasons,⁵⁵ and many economists (and others) argue that health insurance markets will fail without substantial

to premium subsidies through the exchange, to unsubsidized coverage purchased through the exchange. People need help, so what you really want is one door, one point of entry.

⁴⁷ 45 CFR 155.340.

⁴⁸ 45 CFR 155.705(b).

⁴⁹ 45 CFR 155.720(c).

⁵⁰ 45 CFR 155.160(b).

⁵¹ See T.R. Goldman, *Colorado’s Health Insurance Exchange: How One State Has So Far Forged A Bipartisan Path Through The Wilderness*, 31:2 HEALTH AFFAIRS 332, 336 (2012).

⁵² See 42 U.S.C. § 300gg-91; 45 CFR § 155.1000.

⁵³ A2171 § 7(a)(1).

⁵⁴ Veto Message at 3.

⁵⁵ See generally, Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFFAIRS 24 (Supplement 1993); Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Health Care*, 53 AMER. ECON. REVIEW 941 (1963); Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, 20 KAN. J. LAW & PUBLIC POL. 237 (2011).

regulatory intervention.⁵⁶ Others, without denying that some regulation is appropriate, argue that state intervention in health insurance markets should err on the side of guaranteeing substantial market freedom.⁵⁷

Professor Timothy Jost has astutely observed that Exchanges will inevitably exercise, to some extent, a regulatory role in the health insurance marketplace, even if they only undertake the tasks required of them by the ACA. A key policy choice, he argues, is “whether to pursue this role aggressively or minimally.”⁵⁸

On the one hand, exchanges could allow every insurer in the state or region to participate, so long as it minimally complied with statutory requirements. On the other hand, exchanges could limit participation to a few high-value plans, either by applying restrictive certification requirements, using a bidding process, or negotiating with plans. Maximizing participation might increase competition and innovation, while asserting regulatory authority or using a bidding or negotiation might increase value and consumer protection.⁵⁹

In connection with plan selection, as with other tasks, the ACA accords states a great deal of flexibility. It is useful to review how early models of state legislation and executive orders reflect states’ choices regarding their Exchanges’ adoption of active or passive regulatory strategies.

IV. State Action: Choices for Active/Passive Exchanges

A. The Precursors: Massachusetts and Utah

Two states created Exchanges prior to the passage of the ACA. Massachusetts, as part of its broad 2006 health reform law, created the Commonwealth Health Insurance Connector.⁶⁰ The Connector manages two exchanges: Commonwealth Care (“CommCare”), for people with incomes below 300% of the federal poverty level and who therefore are eligible for a state-run subsidy program, and Commonwealth Choice (“CommChoice”), for people and small businesses

⁵⁶ See, e.g., Sherry A. Glied, *Health Insurance and Market Failure Since Arrow*, in PETER J. HAMMER ET AL., EDS., *UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE* 103 (2003).

⁵⁷ See, e.g., DAVID A. HYMAN ET. AL., *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* (Federal Trade Commission and United States Department of Justice, July 2004).

⁵⁸ Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* at 20 (Commonwealth Fund, July 2010) available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf.

⁵⁹ *Id.* at 19.

⁶⁰ See Mass. L. 2006 c. 58, codified as amended at Mass. Gen. Laws 176Q § 1 *et seq.*

not eligible for subsidies.⁶¹ Utah created the Utah Health Exchange in 2008 and 2009.⁶² The Utah Health Exchange was designed as a portal for the exchange of information, organized so as to permit residents and businesses to purchase coverage from licensed Utah insurers.⁶³ It was and is pointed to as a model for a clearinghouse Exchange, for which the goal is to gather, sort, and provide information, and to facilitate the purchase of coverage from any willing, licensed carrier. The Massachusetts Exchanges, on the other hand, have a more complex provenance. They are part of a comprehensive health insurance reform measure that mandated that most Commonwealth residents obtain health coverage, and that provided subsidies for those with income below 300% of the federal poverty level.⁶⁴

Created prior to the ACA's passage, the Utah Exchange was envisioned as a true portal, with no authority to bargain with carriers or set terms and conditions on plan offer beyond those already set by state insurance law.⁶⁵ In addition to its portal services for individuals, it has created a defined contribution plan to facilitate the expansion of coverage in the small business market – with limited success.⁶⁶ Its powers have been modestly augmented over the years. In 2010, for example, insurers offering coverage through the Exchange were required to treat enrollees in the that product as a single risk pool, whether they enrolled through the Exchange or outside of it.⁶⁷

The Massachusetts Exchanges both involve themselves more actively in the market than does Utah's. CommCare – the program that subsidized enrollees must use to get coverage – has engaged in a bidding process to encourage carriers to reduce premiums. Two mechanisms have encouraged carriers to provide bids that have moderated price increases. First, enrollees in CommCare who do not designate a plan are enrolled in the lowest-cost qualifying plan. Second, enrollees are required to pay the difference between the price of the lowest-cost plan and the plan they select.⁶⁸ Carriers therefore see a direct benefit in submitting a low bid.

CommCare has had considerable success, and is enrolling an increasing number of individuals (up to 173,476 in March 2012⁶⁹). CommChoice, the Exchange for unsubsidized

⁶¹ See Sabrina Corlette et al., *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned* at 4 (Georgetown University Health Policy Institute, March 30, 2011)(hereafter, "*Lessons Learned*") available at <http://www.rwjf.org/files/research/72105massutah201103.pdf>.

⁶² See Ut. L. 2008, c. 283 and Ut. L. 2009 c. 12, codified as amended at Ut. St. § 63M-1-2504 et seq.

⁶³ See Ut. St. § 63M-1-2506. See also *Lessons Learned* at 4.

⁶⁴ See Sharon K. Long, *Massachusetts Health Reforms: Uninsurance Remains Low, Self-Reported Health Status Improves As State Prepares To Tackle Costs*, 31:2 HEALTH AFFAIRS 444, 444 (2012).

⁶⁵ See Ut. St. §§ 63M-1-2504 – 2506.

⁶⁶ See *Lessons Learned* at 6.

⁶⁷ Sharon Silow-Carroll et al., *Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection* (Commonwealth Fund 2011).

⁶⁸ *Lessons Learned* at 10.

⁶⁹ See Commonwealth Connector minutes, March 8, 2012, available at <http://archives.lib.state.ma.us/bitstream/handle/2452/118419/ocm71834631-2012-03-08.pdf?sequence=1>.

individuals and small business, has a lower enrollment – 38,747 in March 2012.⁷⁰ It does not solicit bids; rather it is a “price taker.”⁷¹ That is, while it engages in activity that could be characterized as “active purchasing,” such as standardization of products and evaluation of quality, it does not negotiate over price.

The explanation for CommChoice’s decision not to bargain directly with carriers appears to be two-fold.⁷² First, CommChoice, unlike its sister Exchange, does not have a captive population; rather, individuals and businesses are free to purchase inside and outside the Exchange. It is unable, then, to assure carriers that significant volume will follow from premium price concessions. Second, Massachusetts law requires that premiums for products be the same inside and outside the Exchange, requiring a carrier to lower prices for all enrollees if it grants a discount in the Exchange. Carriers agreeing to price reductions for a product in return for CommChoice business would thereby be agreeing to price reductions for *all* enrollees in that product – in or out of the Exchange. Combining these factors, carriers may regard price concessions in return for CommChoice volume as too risky a proposition to accept.

How have these models fared? Massachusetts has the nation’s lowest uninsurance rate: in 2010, non-elderly residents of Massachusetts had a 6% uninsured rate, compared with a national rate of 18% and a rate in Utah of 15%.⁷³ The comparison between Massachusetts and Utah cannot be attributed, however, only to the distinction between an active and passive exchange. It is unclear how much of the gain in Massachusetts could have been achieved without an individual mandate, and the subsidies and new public coverage available to the poor and near-poor.⁷⁴ It is impossible to gauge the effect of the Utah Exchange on insurance rates, as the passive portal by its nature does not enroll people in coverage, but rather provides information on available coverage. The signature program begun by Utah in 2009, which creates a defined contribution plan for small businesses, had only 2880 covered lives after two years.⁷⁵

These two early adoptors showcase a range of Exchange philosophies. Utah’s Exchange functions primarily as a passive portal, with a small experimental small employer defined

⁷⁰ *Id.*

⁷¹ See Sabrina Corlette and JoAnn Volk, *Active Purchasing for Health Insurance Exchanges: An Analysis of Options at 7* (Georgetown University Health Policy Institute, June 3, 2011) available at <http://www.rwjf.org/files/research/72457healthexchange201106.pdf>.

⁷² See *Lessons Learned* at 10.

⁷³ See Kaiser Family Foundation, StateHealthFacts.Org, comparing 2010 uninsured rates of Massachusetts and Utah, available at <http://www.rwjf.org/files/research/72457healthexchange201106.pdf>.

⁷⁴ In addition to the Exchanges, the 2006 reform included an expansion of Massachusetts’ Medicaid program, which was projected to add about 92,000 enrollees. See Kaiser Family Foundation, *Massachusetts Health Care Reform Plan* (April 2006) available at <http://www.allhealth.org/briefingmaterials/Kaiser-MAHealthCareReformPlan-240.pdf>.

⁷⁵ John Buntin, *A Closer Look: Utah’s Health Insurance Exchange* (Governing: the States and Localities, April 26, 2011) available at <http://www.governing.com/topics/health-human-services/closer-look-utah-health-insurance-exchange.html>.

contribution program. Should it determine to create a state-based Exchange compliant with the ACA Utah will have to modify its Exchange law to permit it to undertake many of the ministerial tasks it does not now provide, but Utah will retain the discretion under the ACA to remain a largely passive clearinghouse. Massachusetts, on the other hand, provides examples of two more active Exchange models. CommCare is actively engaged in striking prices for coverage by engaging in a bidding process with carriers, and steering enrollees to coverage on the basis of the resulting bids. CommChoice, on the other hand, does not engage in price negotiations, but instead engages in information gathering, plan standardization, and quality rating activities. It could fairly be said that CommChoice is on the spectrum of active and passive Exchanges between Utah's Exchange and CommCare. It is more than a passive portal as it enforces uniformity and information disclosure in the insurance market, but it does not bargain directly with carriers.

B. State Laws Since the ACA

Many states have moved forward with legislation creating Exchanges, although the pendency of *NFIB v. Sebelius* slowed down state action. A recent survey counts ten states and the District of Columbia as having adopted Exchange legislation since the passage of the ACA, three states creating Exchanges through executive order, two states (Massachusetts and Utah) having legislation predating the ACA, and several other states with formal planning processes for the creation of Exchanges.⁷⁶ There have been attempts to categorize state actions as creating "active" or "passive" exchanges,⁷⁷ although these labels fit imperfectly, both because the Exchanges (other than Massachusetts' and Utah's, discussed above) have not yet begun to operate, and because the language in the statutes seems to place the state efforts at various places along the active/passive spectrum.

⁷⁶ See National Conference of State Legislatures, *State Actions to Address Health Insurance Exchanges*, at <http://www.ncsl.org/issues-research/health/state-actions-to-implement-the-health-benefit-exch.aspx>. The National Conference of State Legislatures ("NCLS") maintains on its website a frequently cited compendium on state developments in health reform. See also Sara Rosenbaum *et al.*, *State Health Insurance Exchange Laws: The First Generation* (The Commonwealth Fund, July 2012) available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Jul/1616_Rosenbaum_state_hlt_ins_exchange_laws_ib.pdf.

Many other states have spoken with various degrees of formality to refuse to take action to comply with terms of the ACA. See NCLS, *State Legislation and Actions Challenging Certain Health Reforms, 2011-2012*, available at <http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-aca.aspx>.

⁷⁷ See National Conference of State Legislatures, *State Actions to Address Health Insurance Exchanges*, *supra*; Mark Hall and Katherine Swartz, *Establishing Health Insurance Exchanges: Three States' Progress* (Commonwealth Fund, July 2012) available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Jul/1611_Hall_establishing_hlt_ins_exchanges_three_states_progress.pdf.

1. Exchanges Empowered to Actively Negotiate with Carriers

Some states' legislation appears to permit their Exchanges to engage in active negotiations with insurers. As is true with almost all state Exchange statutes, California's law directs its Exchange board to require that all plans participating in the Exchange meet the minimum ACA "standards and criteria" for such plans, a requirement any state Exchange must meet regardless of whether it is otherwise "active" or "passive." The law goes beyond ACA obligations, however, and empowers selective contracting:

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 service.⁷⁸

In addition, the California law requires that all carriers participating in the Exchange offer all five levels of coverage,⁷⁹ and requires a carrier offering plans outside the Exchange to offer in its non-Exchange business all plans offered inside the Exchange.⁸⁰

Rhode Island created its Exchange not by legislation but by executive order.⁸¹ The executive order empowers the Exchange to

Determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers. The [Exchange] shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service. In selecting products that provide value to consumers and small businesses, the [Exchange] shall seek to promote cost containment and quality improvement. . . .⁸²

Rhode Island, then, has also empowered its Exchange to negotiate with carriers. The District of Columbia similarly empowered the Executive Board of its Health Benefit Exchange to "limit the number of plans offered in the exchanges using selective criteria or contracting; provided, that individuals and employers have an adequate number and selection of choices."⁸³

How will this active purchasing language play out in practice? A recent analysis of California's and other states' developments since passage of their Exchange law passage points out that it remains uncertain how far Exchanges such as California's will go in selective contracting, as the desire to be a force for organizing and/or driving the market for individual

⁷⁸ Cal. Gov. Code § 100503(c).

⁷⁹ Cal. Gov. Code § 100503(e). That is, each carrier must offer all four "metal" levels of coverage and the catastrophic plan. See 42 U.S.C. 18022(d) and (e).

⁸⁰ Cal. Gov. Code § 100503(f).

⁸¹ R.I. Executive Order 11-09, *Establishment of Rhode Island Health Benefits Exchange* (September 19, 2011) available at http://www.governor.ri.gov/documents/executiveorders/2011/Executive_Order_11-09.pdf.

⁸² *Id.* at 5-6.

⁸³ D.C. St. § 31-3171.06(g).

and small group insurance may be constrained by circumstances beyond Exchange boards' control.⁸⁴ Similarly, the Rhode Island Exchange's "active purchasing" power is subject to the provision in the executive order that Exchange activity alone will not solve the health care cost crisis; rather, it notes that,

increases in health insurance premiums. . . are primarily caused by underlying medical cost trends [and] an Exchange will not be able to offer affordable products over the long term in the absence of payment reforms and innovative benefit design. . . .⁸⁵

2. Exchanges Empowered to Limit Plans by Imposing Criteria and Standards beyond Those Required by ACA

Some Exchanges, not empowered to selectively negotiate with carriers or plans, are nevertheless empowered to limit the number of participating plans by imposing criteria for a plan's entry into the Exchange that are not required by the ACA. The ACA requires each state's Exchange, prior to allowing a plan to be offered through the Exchange, to consider whether offering the particular plan "is in the interests of qualified individuals and qualified employers in the State or States in which the Exchange operates[.]"⁸⁶ Formally, then, an Exchange may not simply offer in the Exchange all state-licensed plans. Rather, the Exchange, even in a state adopting a clearinghouse model, must exercise some discretion in review plans seeking certification. Some states' Exchange legislation goes beyond that recitation of federal law, and adds substantive standards and criteria to plans' terms of entry into an Exchange.

Vermont's Exchange law,⁸⁷ for example, requires the Commissioner of the Vermont Department of Health Access (*not* the Exchange), in determining a plan's eligibility to be offered in the Exchange, to:

consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate.⁸⁸

In addition, a certified plan "must meet the following minimum prevention, quality, and wellness requirements:"

⁸⁴ See Mark A. Hall and Katherine Swartz, *Establishing Health Insurance Exchanges: Three States' Progress* at 6 (Commonwealth Fund Issue Brief, July 2012) available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Jul/1611_Hall_establishing_hlt_ins_exchanges_three_states_progress.pdf.

⁸⁵ *Id.* at 2.

⁸⁶ 42 U.S.C. 18031(e)(1)(B).

⁸⁷ Vt. Law 2011, No. 48 (July 1, 2011), codified at 33 Vt. St. §§ 1801 *et seq.*

⁸⁸ 33 Vt. St. § 1806(a).

- (1) standards for marketing practices, network adequacy, essential community providers in underserved areas, appropriate services to enable access for underserved individuals or populations, accreditation, quality improvement, and information on quality measures for health benefit plan performance, as provided in Section 1311 of the Affordable Care Act and any more restrictive requirements provided by 8 V.S.A. chapter 107;
- (2) quality and wellness standards, including a requirement for joint quality improvement activities with other plans, as specified in rule by the secretary of human services, after consultation with the commissioners of health and of banking, insurance, securities, and health care administration and with the advisory committee established in section 402 of this title; and
- (3) standards for participation in the Blueprint for Health as provided in 18 V.S.A. chapter 13.⁸⁹

Connecticut similarly endowed its Exchange with selective contracting authority.⁹⁰ Connecticut's Exchange board has the legislative power to "Limit the number of plans offered, and use selective criteria in determining which plans to offer, through the exchange, provided individuals and employers have an adequate number and selection of choices"⁹¹ and to "[s]eek to include the most comprehensive health benefit plans that offer high quality benefits at the most affordable price in the exchange".⁹² Oregon has empowered its Exchange to set selective plan criteria, and to limit the number of plans each carrier may offer.⁹³

Vermont's, Connecticut's, and Oregon's Exchange laws, then, do not empower their Exchanges to negotiate directly with insurers over price or non-price terms of an offered plan. In this sense, they are less "active" than is Massachusetts' CommCare program, which is the Exchange for Massachusetts residents eligible for subsidies. They are, rather, more like the Massachusetts CommChoice program, which is the Exchange for Massachusetts residents not eligible for subsidies, and Massachusetts small businesses. They are empowered to shape the market for health insurance by imposing terms and conditions on products to be offered, over and above the conditions required by their state (or District) insurance law, or the ACA's terms of certification.

⁸⁹ 33 Vt. St. § 1806(c).

⁹⁰ Conn. Pub. Act 11-53 (2011), codified at Conn. Gen. St. §§ 38a-1080 *et seq.*

⁹¹ Conn. Gen. St. § 38a-1083(c)(16).

⁹² Conn. Gen. St. § 38a-1084(24).

⁹³ Ore. Rev. St. §§ 741.310(3) and (4).

3. Clearinghouse Exchanges

There are states that have adopted laws that seem to incline their Exchange toward the clearinghouse model. Colorado's Exchange law⁹⁴ fits this description. The legislative declaration of purpose recites that, "The exchange shall foster a competitive marketplace for insurance and shall not solicit bids or engage in the active purchasing of insurance. All carriers authorized to conduct business in this state may be eligible to participate in the exchange."⁹⁵ The Exchange board (perhaps in consideration of the ACA's requirement that boards consider the best interests of individuals and small businesses when selecting plans for the Exchange⁹⁶) is also required to "[c]onsider the affordability and cost in the context of quality care and increased access to purchasing health insurance."⁹⁷ The statute's language is not a model of drafting clarity; it is clear enough, however, that the Colorado Legislature intends the Exchange to act as a market facilitator and not as an active purchaser, or even an active regulator, of the individual and small group markets in that state.

Hawai'i's Exchange also has restricted powers. The Exchange, denominated the "Hawai'i Health Connector" is charged to "serve as a clearinghouse for information on all qualified plans and qualified dental plans listed or included in the connector."⁹⁸ Although it creates an Exchange board, it leaves with the Commissioner of the Department of Commerce and Consumer Affairs the power to select plans to be included in the Connector's offerings, and limits the Commissioner's power:

The commissioner shall determine eligibility for the inclusion of insurers and plans; provided that all qualified plans and qualified dental plans that apply for inclusion shall be included in the connector.⁹⁹

In both Colorado and Hawai'i, then, it is clear that the Exchange is charged with serving as a clearinghouse that permits all products that satisfy the terms of the ACA and preexisting state insurance law to be offered.

4. Starter Statutes

Several states have passed Exchange laws that set out some organizational structure, and create the means by which planning for a fuller Exchange program can be developed.¹⁰⁰ In adopting its Exchange law, for example, Washington¹⁰¹ stated its intent in the following terms:

⁹⁴ Co. Laws 2011, No. 246 (2011), codified at Co. Rev. St. 10-22-101 *et seq.*

⁹⁵ Co. Rev. St. § 10-22-104.

⁹⁶ See 42 U.S.C. 18031(e)(1)(B).

⁹⁷ Co. Rev. St. § 10-22-106(1)(j).

⁹⁸ Hawai'i Rev. St. § 435H-2(c).

⁹⁹ Hawai'i Rev. St. § 435H-6.

¹⁰⁰ See Sara Rosenbaum *et al.*, *State Health Insurance Exchange Laws: The First Generation* (The Commonwealth Fund, July 2012) *supra*, at pp. 4-5.

¹⁰¹ Wa. Law 2011, c. 317 (2011) codified as amended at Rev. Code Wa. 43.71.0001 *et seq.*

The legislature finds that the affordable care act requires the establishment of health benefit exchanges. The legislature intends to establish an exchange, including a governance structure. There are many policy decisions associated with establishing an exchange that need to be made that will take a great deal of effort and expertise. It is therefore the intent of the legislature to establish a process through which these policy decisions can be made by the legislature and the governor by the deadline established in the affordable care act.¹⁰²

Much of the power granted to the Exchange in the law is to engage in planning to produce a working Exchange.¹⁰³ It is tasked, in partnership with other state entities, with producing “a broad range of options” for the Governor and the Legislature on issues including the proper means for “[c]ertifying, selecting, and facilitating the offer of individual and small group plans through the exchange....”¹⁰⁴

West Virginia’s law¹⁰⁵ contains no such specific planning language, and is light on details of how the Exchange is to behave. Other than locating the Exchange within the state Department of Insurance, and identifying the ex officio members of the board and the appointment powers for the public members, the law does not describe in any detail how the Exchange’s duties are to be carried out. Nevada’s law¹⁰⁶ is similarly slight. It describes as the Exchange’s general purpose to “[p]rovide a transparent marketplace for health insurance and consumer education on matters related to health insurance... .”¹⁰⁷ With respect to the Exchange’s methods of deciding which health plans should be offered, it requires the Exchange to “[m]ake qualified health plans available to qualified individuals and small employers on or after January 1, 2014.”¹⁰⁸ Each of these states will clearly have to speak with greater specificity as they gear up their Exchange functions.

5. Maryland

In some ways, Maryland stands apart among the states in Exchange planning. As Mark Hall and Katherine Swartz have recently noted, “Maryland has been on a fast track since spring 2011 to implement the state’s health insurance exchange.”¹⁰⁹ Maryland’s original Exchange legislation¹¹⁰ contained language regarding the Exchange’s obligations to screen plans,

¹⁰² Rev. Code Wa. 43.71.005(1).

¹⁰³ See Rev. Code Wa. 43.71.005.

¹⁰⁴ Rev. Code Wa. 43.71.040(2)(a)(e).

¹⁰⁵ W.Va. Acts 2001, c. 100 (2011) codified at W.Va. Code §§ 33-16G-1 *et seq.*

¹⁰⁶ Nev. L. 2011, c. 439, codified at Nev. Rev. St. §§ 695I.010 *et seq.*

¹⁰⁷ Nev. Rev. St. § 695I.200(4).

¹⁰⁸ Nev. Rev. St. § 695I.210(1)(c).

¹⁰⁹ Mark A. Hall and Katherine Swartz, *Establishing Health Insurance Exchanges: Three States’ Progress* at 6 (Commonwealth Fund Issue Brief, July 2012), *supra*, at 8. Maryland’s law is Md. Acts 2011, c. 1 (2011), codified as amended at Md. Insurance 31-101 *et seq.*

¹¹⁰ Md. Acts 2011, c. 2 (2011) codified at Md. Ins. §§ 31-101 *et seq.*

requiring (as required by the ACA) that they be “in the interest of qualified individuals and qualified employers, as determined by the Exchange” and that they “meet any other requirements established by the Exchange under this title.”¹¹¹ The original Exchange law also included a requirement that the Exchange, in consultation with advisory committees created by the law, consider the “feasibility and desirability” of the Exchange undertaking a more active role in plan screening, specifically by considering whether it should engage in,

selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care by certifying only those health benefit plans that meet certain requirements such as promoting patient-centered medical homes, adopting electronic health records, meeting minimum outcome standards, implementing payment reforms to reduce medical errors and preventable hospitalizations, reducing disparities, ensuring adequate reimbursements, enrolling low-risk members and underserved populations, managing chronic conditions and promoting healthy consumer lifestyles, value-based insurance design, and adhering to transparency guidelines and uniform price and quality reporting. . . .¹¹²

The Exchange board undertook that consultation, and reported to the Governor and Legislature on December 23, 2011.¹¹³ That report describes the result of an extensive consultative process on active purchasing. The report defined “active purchasing” broadly:

Active purchasing includes a menu of tools that states can use in contracting with issuers in the Exchange. These tools include developing additional criteria that issuers must meet beyond the Affordable Care Act minimum, selectively contracting with certain issuers, or requiring issuers, as a condition for contracting in the Exchange, to participate in quality improvement programs. Active purchasing may allow the Exchange to manage competition, negotiate product offerings with insurers, improve quality, and achieve specific longterm goals.¹¹⁴

The Exchange engaged in a process by which it examined, first, whether there is value in engaging in active purchasing as defined above; second, and if so, which of the types of active purchasing should be adopted for the Exchange’s initial period of activity beginning in 2014;

¹¹¹ Md. Acts 2011, c. 2, § 1, adding Md. Ins. §§ 31-109(b)(7) and (9).

¹¹² Md. Acts 2011, c. 2, § 5(1).

¹¹³ Maryland Health Benefits Exchange, *Recommendations for a Successful Maryland Health Benefits Exchange: A Report to the Governor and Maryland General Assembly* (December 32, 2011)(hereafter, “Maryland Exchange Recommendations”) available at http://dhmh.maryland.gov/exchange/pdf/HB0166_MHBE-Report_of_2of2_12-23-11_OGA_1204.pdf. See Mark A. Hall and Katherine Swartz, *Establishing Health Insurance Exchanges: Three States’ Progress* at 6 (Commonwealth Fund Issue Brief, July 2012), *supra*, at 8.

¹¹⁴ *Id.* At 4.

and, third, whether the Exchange should have the flexibility to consider alternative active purchasing activities in future years.¹¹⁵ The Exchange forwarded two recommendations in this regard:

- The Exchange should have the flexibility to set minimum standards for qualified health plans above the requirements of the Affordable Care Act.
- The Exchange should have the flexibility to modify its approach to contracting over time.¹¹⁶

The first recommendation goes to the ability of the Exchange to set criteria and conditions for participating plans that go beyond the ACA's – as, for example, does Massachusetts' CommChoice. It did not recommend, however, that the Exchange be empowered initially to negotiate directly with carriers – as does, for example, Massachusetts' CommCare. The second recommendation asks that different contracting tools be held in reserve, allowing for reconsideration of expanding (or contracting) the powers of the Exchange after it has had some experience. Maryland's legislature and governor responded to these (and other) recommendations by enacting amendatory legislation in June 2012¹¹⁷ that added specificity to the active purchasing steps the Exchange may take during two periods: in 2014-2015, and beginning in 2016. The amended law addresses the Exchange's plan-selection power in the following terms:

(d) Beginning January 1, 2014, the Exchange:

(1) shall allow any qualified plans that meet the minimum standards established by the Exchange under this title to be offered in the Exchange; and

(2) may exercise its authority under . . . this title to establish minimum standards for qualified plans in addition to those required by the Affordable Care Act.

(e) [After giving the Legislature at least 90 days advance notice], beginning January 1, 2016, in addition to establishing minimum standards for qualified plans, the Exchange may employ alternative contracting options and active purchasing strategies, including:

(1) competitive bidding;

(2) negotiation with carriers to achieve optimal participation and plan offerings in the Exchange; and

¹¹⁵ *Id.*

¹¹⁶ *Id.* at 6.

¹¹⁷ Md. Acts 2012, c. 152 (June 1, 2012).

(3) partnering with carriers to promote choice and affordability for individuals and small employers among qualified plans offering high value, patient-centered, team-based care, value-based insurance design, and other high quality and affordable options.¹¹⁸

Maryland, then, decided to empower its Exchange to be an “active purchaser” to the extent that it can impose supra-ACA criteria and conditions on plans as a condition of entry into the Exchange marketplace. It has not – yet – empowered the Exchange to bargain directly with carriers over price and non-price terms, but has left that issue open for reconsideration in 2016 and beyond.

6. Federally-Facilitated Exchanges

The Secretary has recognized that not all states will have Exchanges ready for business on January 1, 2014.¹¹⁹ In some such cases, a state will choose to initiate an Exchange, but will not be ready by the deadline to undertake all necessary tasks. Under those circumstances, the Secretary will partner with the state, providing technical, administrative, and operational assistance, but will defer to the state with respect to policy choices in plan management.¹²⁰

Other states will decline altogether to create state-run Exchanges, even with federal partnership assistance. Under those circumstances, the Secretary will create a “Federally-facilitated Exchange” through the Center for Consumer Information and Insurance Oversight (“CCIIO”) within CMS. CCIIO will be responsible for answering the active/passive question: will a Federally-facilitated Exchange adopt a clearinghouse, an active purchaser, or some intermediate plan management strategy? In its Guidance on such Exchanges, CCIIO has announced two-phased strategy similar to that adopted by Maryland:

To ensure a robust QHP market in each State where an FFE operates, and to promote consumer choice among QHPs, at least in the first year HHS intends to certify as a QHP any health plan that meets all certification standards. In future years, HHS will analyze the QHP certification process and may identify improvements or changes to this process.¹²¹

CCIIO will, then, welcome all qualifying plans initially, leaving its options open for more aggressive plan management in the future.

¹¹⁸ Md. Acts 2012, c. 152 § 3, codified at Md. Ins. §§ 31-110(d) and (e).

¹¹⁹ See CCIIO, *General Guidance for Federally-facilitated Exchanges*, (May 16, 2012) available at http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf, at 3.

¹²⁰ *Id.* at 5.

¹²¹ *Id.* at 8 (footnotes omitted).

7. New Jersey

The Exchange bill approved by the New Jersey Legislature, vetoed by the Governor, and now reintroduced fits most naturally in the second category of state Exchange bills described above. That is, the bill did not empower the exchange to negotiate directly with carriers on price and non-price terms and conditions or to solicit competitive bids, but it did include the following mandate:

The exchange shall offer to enrollees only health benefits plans that have been certified by the board, approved for issuance or renewal in this State by the commissioner, and underwritten by a carrier. The board shall certify those plans that it determines offer the optimal combination of choice, value, quality, and service to enrollees, so as to provide an appropriate range of health care coverage choices within the exchange that achieves the purposes of the federal act, including, in each region of the State, a choice of qualified health benefits plans in each of the benefit categories required under the federal act.¹²²

This language is similar to that contained in the California law¹²³ to the extent it empowers the Exchange to set terms and conditions beyond those required by the ACA, but it is different in that it does not permit the Exchange to negotiate directly with carriers. Rather, like the Massachusetts CommChoice Exchange,¹²⁴ and the Connecticut,¹²⁵ the District of Columbia,¹²⁶ and Maryland (prior to 2016) Exchanges,¹²⁷ the New Jersey Exchange would be empowered to an “active purchaser” to the extent it can specify terms and conditions for the plans it will accept. Were the reintroduced bill to be passed by the Legislature and signed by the Governor, then, New Jersey’s Exchange would not be empowered either to bargain directly with carriers over price and non-price terms, or to engage in a bidding process to force down premiums. It would, however, be more than a clearinghouse, as it would be empowered to set additional terms and conditions for products offered in the Exchange. In other words, the reintroduced bill inhabits a middle ground in the continuum between active and passive Exchange models.

As New Jersey and other states consider their options along the active/passive continuum, there are several factors they might consider – factors not always raised in discussions of active purchasing. These factors are described in the following section.

¹²² A2171 § 7(a)(1).

¹²³ Compare Cal. Gov. Code § 100503(c).

¹²⁴ See Sabrina Corlette *et al.*, *The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned*, *supra* at 7.

¹²⁵ Conn. Gen. St. § 38a-1083(c)(16).

¹²⁶ D.C. St. § 31-3171.06(g).

¹²⁷ Md. Ins. § 31-110(d).

V. Going Forward: Timing, Constraints, and Opportunities

A. Timing

The Secretary's regulatory philosophy with respect to Exchanges permits a state to adopt Exchange statutes that specify precisely how active its Exchange will be, or to put off some of the hard decisions to another day. The Executive Summary of the Secretary's rules proposal for Exchanges explained the regulatory intent in the following terms:

The intent of this proposed rule is to afford States substantial discretion in the design and operation of an Exchange. Greater standardization is proposed where required by the statute or where there are compelling practical, efficiency or consumer protection reasons.¹²⁸

As is described above, some states have responded to this freedom by adopting active Exchanges in various permutations, and others have opted for more passive Exchanges. But several have opted to either put off the extent to which their Exchanges will actively negotiate with carriers or actively regulate entry into the Exchange marketplace, or to phase in the degree to which such activity will be undertaken.

A recent analysis has noted this diversity in state responses:

States whose initial laws are more detailed in scope can be thought of as having initiated the difficult job of policy translation, providing state implementers with more specific regulatory guidance. * * * States whose laws are drafted broadly and with limited detail essentially opt to implement their exchange operations through greater use of "downstream" policymaking tools, such as regulations, guidelines, contracts, and other mechanisms.

* * *

As exchange implementation proceeds, all states can be expected to issue implementing guidance. This is particularly true in states whose initial laws are silent on major implementation matters. In both cases, however, states will establish implementing regulations, guidelines, and other downstream policies.¹²⁹

Phasing in of a regulatory strategy could occur in several ways. First, and regardless of the authority granted an Exchange by its enabling legislation, it is likely that the Exchange board

¹²⁸ United States Department of Health and Human Services, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule, 76 FR 41866, 41867 (July 15, 2011), adopted as amended 77 FR 18310 (March 27, 2012).

¹²⁹ Sara Rosenbaum et al., State Health Insurance Exchange Laws: The First Generation at 4-4 (Commonwealth Fund, July 2012) available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Jul/1616_Rosenbaum_state_hlt_ins_exchange_laws_ib.pdf 9 (citations omitted).

and managers would proceed cautiously. That is, the Exchange could stand up the structures required to initiate its essential functions of connecting consumers and small businesses to public and private coverage, and only after learning from its own experience and that of other states' Exchanges would it consider moving forward more aggressively in its relationship with carriers.

Second, a legislature could create an Exchange empowered only to undertake the essential functions of connecting consumers and small businesses to public and private insurance, and only after a period of gaining experience through its Exchange and those of other states expand the Exchange's authority. And third, a legislature could create an explicit phasing of the Exchange's activities, as did Maryland's legislature with that state's Exchange. A legislature could empower the Exchange to undertake essential activities and additional activities as to which there is a consensus in the state, but create a timed trigger pursuant to which the Exchange could exercise more active responsibilities, but subject to a period of notice to the legislature, during which the legislature could consider whether to intervene and revoke the power to act as a more active purchaser.¹³⁰

Under any of these options, it might be possible to put off a decision on a divisive issue until resolution of that issue is ripe. As was the case in Colorado, it may be that consensus can be reached only as to the essential functions required by the ACA.¹³¹ Or, as was the case in Maryland, there may be consensus that some degree of "active purchasing" in the form of adding terms and conditions beyond those required by the ACA is appropriate, but that greater power should be withheld pending more experience.¹³² Should any of these strategies to phase in Exchange power be adopted, the chances for political consensus increase, and the resolution of divisive issues could await the day.¹³³

B. Practical Constraints on Active Purchasing

Much of the active/passive discussion occurs at the level of important regulatory and political principle. Not to be neglected, however, are two practical factors that might impede the implementation of active purchasing efforts. The first is the complexity of the trade-off between cost and choice in an active purchaser Exchange, and the second is the concern that active purchasing tools are comparatively ineffective to the extent the market for individual and small group health insurance is concentrated in the state in which the Exchange is to operate.

¹³⁰ See Md. Ins. § 31-110(e).

¹³¹ See T.R. Goldman, *Colorado's Health Insurance Exchange: How One State Has So Far Forged A Bipartisan Path Through The Wilderness*, *supra*, 31:2 HEALTH AFFAIRS 332 (2012).

¹³² See Md. Ins. §§ 31-110(d) and (e).

¹³³ See Rosemarie Day and Pamela Nadash, *New State Insurance Exchanges Should Follow The Example Of Massachusetts By Simplifying Choices Among Health Plans*, 31:5 HEALTH AFFAIRS 982, 985 (2012) (arguing that Massachusetts' CommChoice Exchange achieved success in part because the reforms it embodies took place incrementally).

1. The Choice/Price Trade-Off

As is described above, advocates of active purchasing models hope to obtain for the benefit of individual and small employers the selective contracting tools used by large employers' purchasing managers. Purchasing managers use these tools in furtherance of "industrial purchasing" to produce either low-cost coverage, or the lowest-cost coverage at a particular quality level, for employees of the purchasing firm.¹³⁴ But one criticism of this industrial purchasing model has been that it limits employees' choice among plans – a limitation that both reduces the value of such offerings to individual employees (who may have good reasons to prefer an offering not selected by their employer) and reduces that aspect of competition by which many individual choices among plans can drive incremental quality improvements and cost savings. It is in part this criticism of industrial purchasing that gave rise to the Managed Competition movement - a movement whose theories are thick in Exchange discussions.¹³⁵

Choice in health plans is argued to be a good in its own right, as consumers may have different preferences, and clearly prefer a wider over a narrow range of plan choices.¹³⁶ If consumers can choose from among plans, there is an opportunity for their individual choices to combine to create pressure on carriers to improve the quality, cost, and consumer service aspects of their offerings. But choice alone is clearly not enough to drive improvement in a complex market such as health insurance. To serve the interests of consumers, and to drive competitive pressures toward beneficial change, the marketplace must facilitate *informed* choice. As one commentator has said, "Too much or the wrong kind of choice can be counterproductive . . . by making insurance shopping more complex. Choice is optimized if it focuses the enrollee's attention on the salient features of the health plans."¹³⁷ The founding Executive Director of the Commonwealth Health Insurance Connector Authority has suggested that consumer choice should be supported by several factors: standardization of plans to permit ready comparison, clear evaluation of and transmission of evaluative information to consumers, and consumer-friendly Web services to permit consumers to access and understand the information gathered.¹³⁸ Managed competition, and market improvement by consumer choice, has always been driven by a preference for *informed* consumer choice. Further, the extent to which consumers actually prefer a wide range of plans (as opposed to a wide range of

¹³⁴ See Henry J. Aaron, *A Funny Thing Happened on the Way to Managed Competition*, 27 J. HEALTH POL. POL'Y & LAW 31, 33 (2002); Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, *supra*, at 254-55.

¹³⁵ See Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OREGON L. REV. 811, 826 (2011). See generally Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFFAIRS 24 (Supplement 1993); James Maxwell, *Managed Competition versus Industrial Purchasing of Health Care Among the Fortune 500*, 27 J. HEALTH POL. POL'Y & LAW 5 (2002).

¹³⁶ See Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, *supra* at 12.

¹³⁷ *Id.*

¹³⁸ John Kingsdale, *Health Insurance Exchanges – Key Link in a Better-Value Chain*, 362 NEW ENG. J. MED. 2147, 2149 (2010).

health providers) is factually contested.¹³⁹ A clearinghouse model, augmented by plan standardization and consumer information, then, may provide a form of consumer protection through regulated competition.

Exchange negotiation with plans, on the other hand, could achieve consumer value that is difficult to obtain through the accretion of many individual purchasing decisions. Exchange negotiators could follow the well-traveled path of offering increased volume to a small number of qualified plans that offer the lowest price. While it is clear that most of the future progress in health care cost-containment will be accomplished elsewhere in the health care system (though more coordination of care, for example),¹⁴⁰ there are surely gains to be had at the margins in bargaining with carriers on price. Such bargaining may serve a broader cost-containment goal, as it is hoped that “insurers struggling to lower their prices and control utilization” will bargain more aggressively with the providers in their networks to retain their margin of return.¹⁴¹ Active purchasing, then, could serve consumers by employing the tools of value maximization employed by employers’ benefits managers in their dealings with carriers. These two visions both strive to serve consumers’ interests, but approach the maximization of consumer value from very different perspectives.

The ground of discussion is not a bimodal one, however, as the middle ground is quite rich. First, there is broad agreement that consumer choice, to be effective, must be assisted by substantial market organizing. For example, it is important to create “apples to apples” standardization of plans, as New Jersey already does in the individual and small group markets.¹⁴² Second, the ACA requires that all Exchanges produce substantial quality and consumer satisfaction information on plans offered through a Web site, a call center, and in cooperation with a Navigator program, and consumer choices are therefore likely to be well-informed.¹⁴³ And third, there are, as has been described above, *degrees* of active purchasing. Even an Exchange that is an active negotiator with plans can select more rather than fewer products. Further, Exchanges can permit all qualified products to be offered, but add additional

¹³⁹ See Jeanne M. Lambrew, “Choice” in *Health Care: What Do People Really Want?*, (Commonwealth Fund, September 2005) available at http://www.commonwealthfund.org/usr_doc/lambrew_853_choice_ib.pdf.

Consumers appear to be at risk of “information overload” and to value choice among a relatively small number of selected plans than from a wide array of dissimilar plans. See Rosemarie Day and Pamela Nadash, *New State Insurance Exchanges Should Follow The Example of Massachusetts By Simplifying Choices Among Health Plans*, 31:5 HEALTH AFFAIRS 982 (2012); Richard Frank and Karine Lamiraud, *Choice, Price Competition and Complexity in Markets for Health Insurance*, NBER Working Paper No. 13817 (February 2008).

¹⁴⁰ See R.I. Executive Order 11-09, *supra* at 2 (“increases in health insurance premiums for consumers and small businesses are primarily caused by underlying medical cost trends, [and] an Exchange will not be able to offer affordable products over the long term in the absence of payment reforms and innovative benefit designs. . .”).

¹⁴¹ See Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, *supra* at 28. The ability of an Exchange to bargain for price may be limited by the degree of concentration in the health insurance market, as is discussed in the following section.

¹⁴² See N.J.S.A. 17B:27A-2 *et seq.* (individual markets), and N.J.S.A. 17B:27A-17 *et seq.* (small group markets).

¹⁴³ See 45 CFR 155.205.

terms and conditions to those required by the ACA as bases for qualification – as does Massachusetts’ CommChoice and Maryland’s Exchange (at least for its first two years of operation).

Choice and selection have a complex relationship. Consumers value some range of choice, but benefit from choice most if they confront choices among standardized product descriptions (“apples to apples comparisons”), and are provided with assistance in their decision-making. Selection can narrow the range of choices; if it does so while still leaving sufficient choices, it does not frustrate consumers’ desire to express different preferences; if it does so while reducing prices and/or improving value, it adds obvious consumer benefits. This relationship can be seen as a recapitulation of the general relationship between active and passive Exchange models, or as a tension point that must be addressed whatever the underlying philosophy of Exchange design. However conceived, the relationship requires close examination, and deserves to be discussed fully as the design process proceeds.

2. Market Concentration

In discussions of active or passive Exchanges, insurance market concentration is the elephant in the room. Discussion of Exchanges using selection powers to improve value for consumers and small businesses assumes a range of products from which the Exchanges may select. It is clear, however, that insurance markets are very concentrated in many states.¹⁴⁴ As one analysis of active purchasing stated,

If an exchange wishes to contract selectively with plans or negotiate with them on price and quality, it needs to attract a reasonable mix of carriers with products that consumers and small businesses want to buy. If the exchange sits in a market that is highly concentrated, this approach to active purchasing is likely to be unsuccessful.¹⁴⁵

Even a state with an inclination toward active purchasing has been advised that the concentration in its individual and small group market counsels against adopting a strategy of actively negotiating with carriers:

In 2010, the dominant insurer [in the individual market] controlled 72 percent of the market and only two other health plans accounted for more than 5 percent of the individual market. In the small group market, the dominant insurer controlled 46 percent of the market and only three other health insurers accounted for more than 5% of the market. . . . * * * Given Maryland’s level of

¹⁴⁴ See Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, *supra*, 89 OREGON L. REV. at 841-42; Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, *supra* at 15.

¹⁴⁵ Sabrina Corlette and JoAnn Volk, *Active Purchasing for Health Insurance Exchanges: An Analysis of Options*, *supra* at 13.

market concentration, the largest insurers will have significant leverage compared to the Maryland Exchange in a negotiation. * * * In the early years of the program, policymakers may want to consider focusing on growing the marketplace.¹⁴⁶

This concentration matters because “[n]ormally, less concentrated markets lend themselves to more active exchange functions.”¹⁴⁷

New Jersey’s small and individual health insurance markets are very concentrated. In the individual market, one firm has over 75 percent of the market share, a second has about 17 percent, and a third has about 6 percent; no other firm has more than 2 percent of the market.¹⁴⁸ In the small group market, one carrier has over 59 percent of the market share, a second just over 16 percent, and a third has about 9.5 percent; no other carrier has even 1 percent of the market.¹⁴⁹ This market concentration does not rule out an active Exchange strategy, but it renders success difficult.

There is some dispute as to the economic effect of insurer concentration on health care markets; while increased concentration is associated with higher health care costs, it appears that the large majority of health cost increases in recent years is traceable not to dysfunction in the insurance market, but to trends in the health care delivery system.¹⁵⁰ Nevertheless, even if health cost inflation is only affected by health insurer concentration at the margins, those margins matter. As Exchanges are charged with reviewing Qualified Health Plans through the lens of the interest of consumers and small businesses,¹⁵¹ it is within their charge to consider the possibility of constraining premiums. The tried and true method for reducing a requested price, of course, is to bargain for a lower one.

The question remains whether Exchanges are likely to be successful in bargaining with insurers in a concentrated market for price and other concessions. The concentration of health carriers matters in this context because, as Professor Greaney has explained,

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

¹⁴⁶ Eva H. DuGoff and Jonathan Weiner, *A White Paper Prepared for the Executive Board of the State of Maryland Health Benefit Exchange*, *supra* at 27-28.

¹⁴⁷ Peter Newell and Robert L. Carey, *Passive/Active: Defining the Role for a Health Benefit Exchange in the Interests of New Yorkers*, *supra* at 6.

¹⁴⁸ New Jersey Department of Banking and Insurance, Individual Health Coverage Program: Enrollment Report (First Quarter 2012) available at http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/1q12ihccarriers.pdf.

¹⁴⁹ New Jersey Department of Banking and Insurance, Small Employer Health Benefits Program: Enrollment Report (First Quarter 2012) available at http://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/1q12sehcarriers.pdf.

¹⁵⁰ Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, *supra* at 246-47, and sources cited therein.

¹⁵¹ See 42 U.S.C. 18031(e)(1)(B).

exists depends in part on the number and market power of insurers willing to participate in the exchange.¹⁵²

The importance of market concentration in this regard is clear. Bargaining will be less effective to the extent the Exchange needs a dominant carrier to attract subscribers, as the dominant carrier can be confident that the Exchange will be viewed as comparatively unattractive if it cannot offer products from the state's dominant carrier. In negotiations with such carriers, the Exchange may be regarded as lacking the ability to "walk away" from the table; it will be seen as having little leverage.¹⁵³ In addition, Exchanges may be inhibited from aggressive negotiations by the fear that year-to-year shifts in successfully bidding carriers could disrupt patient-physician relationships. Past experience with markets in which carriers moved in and out of markets suggests that the human cost could be high. When shifts in the level of premium support for Medicare+Choice HMOs dropped following the passage of the Balanced Budget Act of 1997, for example, there were widespread reports of consumers dislocated from relationships with caregivers as Medicare enrollees had to shift plans.¹⁵⁴ The consumer-protection mission of Exchanges might, then, lead paradoxically to some reluctance to trade market share for premium reductions if such a trade could cause dislocations in caregiving relationships.

It is likely that dominant carrier will be in a very strong bargaining position, at least as an Exchange is in the process of opening for business. Dominant plans will have the greatest name recognition, and will likely have a more robust statewide provider network than smaller carriers. And the stakes for insurers agreeing to price concessions with an Exchange are amplified by the provision of the ACA that requires carriers to treat all enrollees of an individual or small group plan to be members of the same risk pool, whether they are in or out of the Exchange.¹⁵⁵ This provision – included in the Act to counter adverse selection effects on Exchange plans – means that a carrier agreeing to reduce premiums for Exchange enrollees in a particular individual or small group product must equally reduce its premiums for non-Exchange enrollees in the same product.

Active purchasing is not impossible in the face of carrier market concentration in the individual and small group markets. It may be that the new business available in the Exchanges will have sufficient scale to give the Exchanges some leverage with carriers even in a concentrated market. New Jersey's individual market is currently quite small, counting only

¹⁵² Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, *supra* at 256.

¹⁵³ See Eva H. DuGoff and Jonathan Weiner, *A White Paper Prepared for the Executive Board of the State of Maryland Health Benefit Exchange*, *supra* at 21.

¹⁵⁴ See Jule A. Schoenman *et al.*, *Impact of HMO Withdrawals on Vulnerable Medicare Beneficiaries*, 26:3 HEALTH CARE FINANCING REVIEW 5 (2005).

¹⁵⁵ 42 U.S.C. 18032(c).

about 136,000 enrollees.¹⁵⁶ Of that number, approximately 91,000 are in Basic and Essential plans – which are likely not to be available after the ACA is effective¹⁵⁷ – and only about 45,000 are in “standard” plans. It is estimated that the total number of enrollees in private individual plans will grow after 2014 to approximately 571,000,¹⁵⁸ “with two-thirds of new enrollees coming from among currently uninsured individuals who will be eligible for subsidies.”¹⁵⁹

If the private individual coverage market experiences growth approaching this predicted magnitude, and if a large percentage are receiving federal subsidies, then the Exchange will have a substantial “captive” population of enrollees both in absolute terms and in comparison to the residual, non-Exchange individual market. If the Exchange’s individual program does have a large “captive” population – that is, a sizeable group of enrollees who must (because they are receiving federal subsidies) obtain coverage through the Exchange¹⁶⁰ - then the Exchange may, like Massachusetts’ CommCare program, be in a position to exercise some leverage of its own in bargaining with carriers.¹⁶¹ If, then, the Exchange were to experience an influx of a large number of new individual enrollees who are required to purchase through the Exchange, the pool of in-Exchange individual enrollees might dwarf the pool of out-of-Exchange individual enrollees in any product. Carriers may, under those circumstances, be undeterred in negotiations by the fact that price concessions to the Exchange would carry over to non-Exchange business, as non-Exchange individual business may be comparatively negligible.¹⁶²

Perhaps the only thing that is clear about the likely ability of Exchanges to successfully negotiate over price with carriers in New Jersey’s concentrated insurance market is that there are many contingencies whose effect on negotiations are difficult to assess at this point. The leverage that New Jersey’s dominant plans have would render such negotiations difficult; on

¹⁵⁶ New Jersey Department of Banking and Insurance, Individual Health Coverage Program: Enrollment Report, *supra*.

¹⁵⁷ See Joel C. Cantor, *Combining New Jersey’s Individual and Small Group Health Insurance Risk Pools* at 3 (Rutgers Center for State Health Policy, December 2011).

¹⁵⁸ Joel C. Cantor *et al.*, *Health Insurance Status in New Jersey After Implementation of the Affordable Care Act* at 7 (Rutgers Center for State Health Policy, August 2011) available at <http://www.cshp.rutgers.edu/Downloads/8970.pdf>. This total takes into account both individual coverage through the Individual Health Coverage program and coverage through student plans.

¹⁵⁹ *Id.* at 6. These estimates could be affected by many contingencies, including the question of whether New Jersey implements a Basic Health Program, see 42 U.S.C. 18051. States are permitted but not required to create a Basic Health Program to cover persons with income between 133 percent and 200 percent of the Federal Poverty Level. *Id.* See generally, Stan Dorn, *The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States* (Urban Institute, March 2011) available at <http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-option.pdf>. New Jersey’s adoption of a Basic Health Program could shift tens of thousands of persons out of individual Exchange coverage. See Joel C. Cantor *et al.*, *Health Insurance Status in New Jersey After Implementation of the Affordable Care Act* at 10.

¹⁶⁰ See 26 U.S.C. 36B(b)(2)(A).

¹⁶¹ See *Lessons Learned, supra* at 10.

¹⁶² This scenario, in which the Exchange would gain leverage in relation to negotiations with carriers by virtue of obtaining a large, captive risk pool of subsidized enrollees, seems not to apply to the small group side of Exchange business.

the other hand, it is not far-fetched to suppose that at least the Exchange's individual market will be a sufficiently discrete risk pool to allow the Exchange to have some counterbalancing leverage.

Exchanges' inability to bargain with carriers over price does not mean, of course, that carriers will be unfettered in their ability to raise premiums. First, New Jersey law requires that firms file their rates with the Department of Banking and Insurance,¹⁶³ and recent practice suggests rather searching review of those filings. Second, there is price competition even in concentrated markets such as New Jersey's, particularly as plan standardization allows better "apples to apples" comparisons, and comparison shopping is enabled by the web portal maintained by the boards of New Jersey's individual and small group insurance programs.¹⁶⁴

There is, then reason to be somewhat cautious about the power of a New Jersey Exchange to bargain for price with carriers, although some gains at the margins may be forthcoming. The portfolio of concerns for an Exchange goes beyond price, however. To the extent an Exchange does have the power and inclination to either bargain with carriers or shape the market through the implementation of extra-ACA terms and conditions, it could bargain on non-price terms. For example, Exchanges have an obligation to ensure that plans offer a network of providers adequate to serve the needs of subscribers.¹⁶⁵ Similarly, Exchanges must ensure that plans include sufficient Essential Community Providers to serve the needs of low-income and vulnerable subscribers.¹⁶⁶ Network adequacy is a critical issue; a low price is less beneficial to the extent the plan's providers do not serve the needs of subscribers in a timely and geographically appropriate manner. An Exchange, sensitive to these issues, could go beyond price – and beyond carriers – in attempting to ensure adequate networks, but favoring some plans over others on the basis of the provider networks offered. In this way, even in a concentrated market, an Exchange could bargain for, and regulate toward, the offering of plans likely to serve the needs of subscribers and disfavor those that appear to be good buys, but are likely to fail to deliver satisfying services due to inadequate network composition.

C. Opportunities

This Brief focuses its analysis of the question of whether Exchanges should be active or passive regulators of individual or small group insurance on plan selection, negotiation, and the creation of terms and conditions for health carriers, as that is the major ground of dispute. It is useful, however, to highlight a few of the productive actions Exchanges could undertake

¹⁶³ N.J.S.A. 17B:27A-9 (individual insurance); N.J.S.A. 17B:27A-25 (small group insurance).

¹⁶⁴ New Jersey Department of Banking and Insurance, *Shopping for Health Insurance – Individual Market*, see http://www.state.nj.us/dobi/division_insurance/ihcseh/shop_ihc.htm; *NJ Small Employer Health Benefits Program Buyers' Guide*, see http://www.state.nj.us/dobi/division_insurance/ihcseh/sehguide/index.html.

¹⁶⁵ See 45 CFR §§ 155.1050 and 156.230.

¹⁶⁶ See 45 CFR §§ 156.235.

whether they are active or passive in that narrow (but critically important) sense. As is discussed above, the State and the Exchange may well be up and running for some period before it is practical (assuming that it is wise) for the Exchange to act as an active purchaser. During this interim period, and going forward, there are many other steps the Exchange may be in a position to take that would benefit the insurance market and the people of New Jersey.

1. Recruiting New Carriers to the State

Whether or not the Exchange acts as an active purchaser, consumers would benefit from the entry of new, qualified health carriers into New Jersey. Entry into a new market is often difficult for a carrier. Offering value to consumers depends in part on the ability to obtain favorable prices from health care providers for services. Favorable prices usually follow, however, from the promise of a substantial volume of covered lives. New carriers, then, are faced with something of “circularity problem,” as they can’t obtain substantial enrollees without a robust provider network, but they have difficulty obtaining sufficiently favorable prices from providers without sufficient enrollees to entice the acceptance of discounts.¹⁶⁷

The Exchange cannot short-circuit this particular barrier to entry into New Jersey’s insurance market. It can, however, provide a transparent and reliable platform from which a carrier might anticipate offering coverage, and through which it might connect with ready customers. The Exchange could facilitate entry by building on New Jersey’s current regulatory structure for individual and small group insurance now administered by the boards and managers of the Individual Health Coverage Program and the Small Employer Health Benefits Program. The Massachusetts Connector was able to add to the menu of carriers for the CommCare program through such efforts,¹⁶⁸ and the goal of adding to the list of qualified carriers has been embraced elsewhere.¹⁶⁹ Allowing new carriers to develop a degree of confidence that their efforts to offer services in New Jersey will be supported by Exchange infrastructure is a goal that can be embraced by Exchanges along the active/passive spectrum.

2. Quality Improvement and Population Health

As an intermediary between consumers and insurers, Exchanges will occupy a privileged position in the health care system. The Exchange will have a vantage point that will allow it to observe the effects of innovation (and lack thereof) on the health and well-being of consumers. As its activities allow it to develop the confidence of carriers and health care providers, it could serve as a trusted neutral forum for the discussion of systemic improvement. Exchanges will be

¹⁶⁷ See Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, *supra* at 244-45, quoting Christine Varney, then-Assistant Attorney General, Antitrust Division, U.S. Department of Justice, in remarks from May 24, 2010, available at <http://www.justice.gov/atr/public/speeches/258898.pdf>.

¹⁶⁸ See *Lessons Learned* at 10.

¹⁶⁹ See Eva H. DuGoff and Jonathan Weiner, *A White Paper Prepared for the Executive Board of the State of Maryland Health Benefit Exchange*, *supra* at 28.

obliged to collect, gather, analyze, and disseminate plan performance data.¹⁷⁰ They are charged with using this information to facilitate consumer choice. They could use their access to information on quality of care and utilization for other, public health and quality improvement efforts.

Access to such information, and the Exchange's position at the intersection of health finance and care delivery, permit the exchange to be a force for quality improvement.¹⁷¹ The Exchange could pursue quality improvement by facilitating discussion among carriers, providers, and consumers on innovations in care delivery such as patient centered medical homes and open access scheduling. The details of many such innovations are still under development, and the Exchanges could serve as a forum for the dissemination of information about current developments in patient care. The adoption of beneficial modalities of care are often related to reimbursement methodologies; shifting the way health care professionals receive payment often works in tandem with health systems research to improve care quality and enhance public health.¹⁷² The interactive process among consumers, carriers, and health care professionals would benefit from the Exchange taking an active role in exposing promising new means of improving quality, and promoting the adoption of care delivery and reimbursement changes that can ensure the implementation of such promising practices.

3. No Wrong Door: Reducing the Effects of Changes in Program Eligibility

One important role of Exchanges is to facilitate the enrollment of consumers in public and private coverage.¹⁷³ To that end, an Exchange must use a "single streamlined application to determine eligibility and collect information necessary for enrollment" in Qualified Health Plans, federal low-income subsidies for private coverage, and public insurance.¹⁷⁴ The importance of Exchanges' embrace of the task of connecting consumers to the proper source of coverage is difficult to overstate.

Insurance coverage matters; people without health coverage suffer health and financial consequences of their uninsurance.¹⁷⁵ The ACA is intended to create coverage opportunities for many Americans who currently go without coverage. The system created by the ACA, however, comprises a network of varied sources of coverage, including employment-based coverage,

¹⁷⁰ See 42 U.S.C. 10831(c)(3)(4) and (5).

¹⁷¹ See Anne Weiss, *Health Insurance Exchanges: Improving Health Care Access And Quality*, Health Affairs Blog, July 26, 2012, available at <http://healthaffairs.org/blog/2012/07/26/health-insurance-exchanges-improving-health-care-access-and-quality/>.

¹⁷² See 42 U.S.C. 18031(g) (Rewarding quality through market-based incentives); JoAnn Volk and Sabrina Coreltte, *The Role of Exchanges in Quality Improvement: An Analysis of the Options* (Georgetown University Health Policy Institute, September 2011) available at <http://www.rwjf.org/files/research/72851qigeorgetownexchange20110928.pdf>.

¹⁷³ 42 U.S.C. 18031(d)(4)(E) and (F).

¹⁷⁴ 45 CFR § 155.405.

¹⁷⁵ See INSTITUTE OF MEDICINE, *COVERAGE MATTERS: INSURANCE AND HEALTH CARE* (2001).

private individually purchased coverage, Medicare, Medicaid, SCHIP, and the Basic Health Program. Creating opportunities for coverage does not necessarily assure that coverage will be realized. And where there are borders between programs, there are gaps; where there are gaps, there is the danger that people will fall through those gaps, going without coverage due to the complexities of the system.

The gap between eligibility and enrollment seems greatest among the most vulnerable, and in particular children and the poor. In many cases the shortfall in enrollment is due to difficulties in negotiating the initial enrollment process, but more often the problem is the difficulty in negotiating the process for retaining coverage.¹⁷⁶ Advances have been made in creating mechanisms for improving the enrollment and retention process.¹⁷⁷ Exchanges can serve as a hub for activity to employ these mechanisms through the efforts of Exchange personnel directly and in partnership with state agencies charged with public program enrollment and retention. In this regard, the creation of, active support for, and effective partnership with the Navigator programs will be essential.¹⁷⁸ Exchanges must establish a Navigator program that has expertise and commitment to the needs of vulnerable and underserved populations.¹⁷⁹ The location of the Exchange at the hub of coverage activity suggests that it has the potential to close the gap between eligibility and enrollment that has bedeviled many for many years. Successful implementation of a system by which each eligible person is connected to the appropriate source of coverage has been an elusive goal, but one that an Exchange – active or passive – seems uniquely situated to accomplish.

Conclusion

A New Jersey Health Insurance Exchange could provide substantial benefits to individuals and small businesses. It can gather, organize, and disseminate information useful to a complex decision. It can help to streamline enrollment processes for public and private insurance in a state in which many are left without coverage simply because the enrollment and retention systems are too complex. It can serve as a clearinghouse for information that will permit individuals to obtain subsidies for coverage and cost-sharing burdens. And it can serve as an agent for New Jersey's individual and small business insurance purchasers by screening the

¹⁷⁶ *Id.*

¹⁷⁷ See Amanda Cassidy, *Enrolling More Kids in Medicaid and SCHIP* (Health Affairs Health Policy Brief, January 27, 2011) available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_39.pdf; Victoria Wachino and Alice M. Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (National Academy for State Health Policy and the Robert Wood Johnson Foundation, February 2009) available at http://www.nashp.org/sites/default/files/Max_Enroll_Report_FINAL.pdf.

¹⁷⁸ See 42 U.S.C. 18031(d)(4)(K).

¹⁷⁹ 45 CFR § 155.210(b).

insurance products available in the Exchange. How the Exchange is empowered to perform this last function is a terribly divisive issue.

The clearinghouse model of the Exchange has the benefit of supporting a broad choice of insurance products, although it foregoes the possible benefits to be gained by actively bargaining with carriers on behalf of consumers. Active regulator or active purchaser models have the benefit of using the power of numbers to drive a harder bargain with insurers than can individual purchasers, but at the cost of restricting the choice of products available.

New Jersey's decision-makers have the benefit of the experience of state legislators and executive officials who have walked the path of deciding among the options for Exchange design in other states. The decisions do not need to be taken all at once – indeed, there is substantial appeal in putting off decisions that need not be made immediately, and which may be made more easily after the Exchange has developed some experience, has had the opportunity to consult with a range of stakeholders, and has had an opportunity to evaluate the range of options available in New Jersey's highly concentrated insurance market. The proper balance between ensuring broad choice of products on the one hand and advantageous terms of purchase on the other is not easily struck, and need not be decided at the outset of the Exchange's operation. The difficulty of this decision need not obscure the substantial benefits of otherwise moving forward with a New Jersey Exchange.

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