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Insurance Exchanges

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Insurance Exchanges

POINT: Health insurance exchanges are essential to ensure that individuals have access to a choice among affordable health plans and to transparent information regarding the costs and quality of alternative coverage. They also help effectuate insurance market competition on the basis of price and quality, rather than on favorable risk selection.

COUNTERPOINT: Health insurance exchanges are insufficient to solve the major problems in American health insurance markets; they may well add complexity, not reduce it; they will not dampen rising premiums, which are driven by health care inflation, and they will introduce new opportunities for adverse risk selection to undermine the major coverage expansion goals of the Patient Protection and Affordable Care Act.

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Introduction

Two perennial and interrelated concerns with the U.S. health care system have been the continuing increase in the number of Americans without health insurance and the rising costs of health care coverage. According to the U.S. Bureau of the Census, in the first decade of the new millennium, the number of persons without health care coverage increased from 36.7 million persons in 2000 to 49.9 million in 2010, or from 13.1 percent to 16.3 percent of the population. Over a similar period, data from the Kaiser/HRET Survey of Employer Sponsored Benefits reveal that health insurance premiums for employer-sponsored family coverage increased by 131 percent, from $5,791 in 1999 to $13,375 in 2009, with employee contributions increasing by 128 percent (from $4,247 to $9,860). The pronounced change in premiums over this period is certainly indicative of the increasing difficulty some Americans have in affording coverage during a period of relatively stagnant earnings. At the same time, attention has also focused on whether the behavior of insurers—especially a tendency to avoid offering coverage to high-risk individuals—has led to the failure of insurance markets to fulfill their important social role of protecting individuals against financial loss through risk pooling.

In the context of health-reform efforts, two reactions to the above concerns have emerged. On the one hand, some believe that insurance markets need to be purposefully organized and managed to ensure that consumers have transparent information on health plan costs and quality, a choice among competing and affordable health plans, and an ability to participate in markets with rules that constrain the favorable selection practices of insurers

These advocates have envisioned the use of state or regional health insurance exchanges (HIEs) as a vital organizing structure to achieve such objectives. Alternatively, others believe that HIEs are unnecessary to oversee the dissemination of expanded consumer information on health plans, assure sufficient health plan choices, and promote efficient market competition. Instead, such individuals believe that state regulation of insurance markets, especially in the small-employer group and individual markets, prohibitions on the interstate selling of health plans, and state mandated health insurance benefits have stymied what otherwise could be effective insurance market competition that would yield access to affordable coverage. These advocates of a minimal regulatory approach argue that imposing the cumbersome and potentially costly administrative structure and rules necessitated by an insurance exchange will only discourage insurers from participating in an HIE and otherwise stifle effective market competition.

Barring repeal of the 2010 Patient Protection and Affordable Care Act (ACA), health insurance exchanges will become a reality in 2014. Although advocates of the HIE approach remain confident that implementation will achieve the goals necessary for insurance markets to enhance social welfare, among other observers the prospect of broad HIE implementation has raised numerous policy concerns. This chapter identifies several issues critical to the implementation of HIEs and uses these issues to stimulate a debate over the merits and shortcomings of such a policy approach. In doing so, Alan C. Monheit offers arguments in support of HIEs as a framework for organizing health insurance markets, while Joel C. Cantor takes the contrary view. Underlying this debate is a long-standing conflict between reform advocates who emphasize the need for regulation and government intervention and those that believe that the goals of reform can best be achieved by relying on the performance of relatively unconstrained private markets.

Point

Alan C. Monheit

Ensuring access to affordable health insurance coverage and encouraging effective competition among health insurers has been a long-standing goal of health reform. To that end, reformers have proposed health insurance exchanges (HIEs) as a way to create organized health insurance markets that encourage the efficient and equitable provision of coverage. Among the goals of an HIE are to provide individuals with a choice among health plans, convey transparent information on health plan price and quality, effectuate health plan enrollment regardless of individual health status and ability to pay, and ensure health plan competition on the basis of cost and quality. Beginning in 2014 HIEs will play a prominent role in the implementation of the 2010 Patient Protection and Affordable Care Act (ACA).

The Conceptual Basis for HIEs

It is well established that health insurance markets enhance social welfare. They do so by creating the opportunity for risk-averse individuals to spread the potential financial loss associated with unexpected and costly medical events through the pooling of risks. In an ideal, efficient health insurance market, risk pools would have homogeneous actuarial risk profiles. As a practical matter, creating such risk pools is not possible because, compared to insurers, individuals know far more about their health status, past health problems, and perhaps even their genetic predisposition to illness. Such informational disparities put insurers at a disadvantage, leading to high-risk individuals being inappropriately grouped with those who have standard health risks. Over time, insurers lose money on such adverse health risks, and those in the insurance pool with more favorable risk profiles face rising premiums as the increased costs of insuring poor risks are realized. In the extreme, such asymmetric information between insurers and potential enrollees can threaten the stability of health insurance plans.

In response to the threat of such adverse selection in their health plans, insurers, particularly those in the individual and small-group markets, have sought ways to evaluate the health risk of potential enrollees. At best, they have applied tools such as medical underwriting to assign premiums and preexisting-condition exclusions or limitations on plan benefits to lessen the consequences of obtaining a "bad draw" from the pool of potential enrollees. At

worst, insurers have been found to engage in more pernicious behavior that has included the redlining of industries and occupations perceived to be high risk; rescinding insurance contracts when claims are made; substantially increasing premiums when individuals or small groups file claims; imposing lengthy waiting periods prior to the onset of benefits; and favorably selecting enrollees through more subtle means such as excluding specific health benefits, strategically locating providers in areas less accessible to those likely to be health risks, and by selectively marketing to low-risk demographic groups.

The need to address the failures of health insurance markets to achieve an actuarially fair outcome is a prominent policy concern. However, some would go further, arguing that health insurance mechanisms should be explicitly designed to transfer resources from the well to the sick, regardless of differences in underlying health status. Adherents to this "social insurance" model argue that public policy intervention is needed to overcome the incentives of private markets that undermine the ability of health insurance to achieve this explicit transfer.

Whether directed at improving actuarial fairness and market efficiency or achieving a more egalitarian vision of the distribution of health care resources, state policymakers have spawned a patchwork of legislation to address exclusionary behavior by insurers. Such state legislation has been implemented in small-group and individual insurance markets and typically includes the following provisions: the guaranteed issue of health plans to all potential enrollees and the guaranteed renewal of coverage for those enrolled, constraints on premium variation by enrollee health status (through the use of full or modified community rating of premiums or narrowly defined premium rating bands), and limitation on the aggressive use of lengthy waiting periods before benefits become effective for those with preexisting health conditions. In voluntary health insurance markets, however, these efforts have not achieved the goals of enhancing enrollment, stabilizing premiums, or creating a more progressive distribution of resources.

A Framework for HIEs

HIEs are largely a response to exclusionary practices used by insurers to avoid adverse risk

plans. This objective is to be accomplished through a number of provisions consistent with the managed-competition model of a health insurance market envisioned by Alain Enthoven. In this setting, insurer behavior is overseen by a "sponsor." The key responsibilities of the sponsor include establishing rules to govern access to the insurance market, such as by specifying open-enrollment periods, eliminating enrollment exclusion due to preexisting conditions, establishing premium-setting rules, guaranteeing continuous coverage, and determining which insurers can participate in the market. Within this framework, subsidies are available to ensure that individuals have access to the lowest-cost health plan, and the sponsor actively manages the enrollment process and administers enrollment changes. To further strengthen the environment for competition, the sponsor prepares information about health plan features and makes quality-related information available to enrollees. Finally, the sponsor addresses possible favorable risk selection by insurers by coordinating enrollee plan choice, communicating such choices to health plans, implementing risk-adjusted premiums, and monitoring enrollment patterns. Key features of this conceptual framework have been incorporated in the HIEs sanctioned under the ACA.

Historical Precedents

Although HIEs are a critical component of the ACA, they and their managed competition framework are not recent insurance-market innovations. Instead, both have historical antecedents, having served as the foundation for insurance-market reform in a number of policy proposals. Such proposals include Enthoven's own consumer-choice health plan proposal of the early 1980s, the health-reform proposals of the Jackson Hole group in the early 1990s, President Bill Clinton's 1993 proposed Health Security Act (where health insurance purchasing cooperatives were to act as regional HIEs) and more recently in Senators Ron Wyden and Robert Bennett's Healthy Americans Act (with Health Help Agencies taking on the role of HIEs). HIEs are presently a source of coverage for state employees in the California Public Employees Retirement System (CALPERS), for federal government employees and members of Congress in the Federal Employees Health Benefits Program (FEHBP), and are perhaps most prominent as the Commonwealth Health Connector, an essential component of health reform implemented in Massachusetts in 2006. The

health plans in the Medicare Prescription Drug program and in the Medicare Advantage program.

Observers such as Timothy Jost have noted that, to date, experience with HIEs has not been encouraging. HIEs, with few exceptions such as the FEHBP and CALPERS, have not successfully controlled rising health insurance costs, and efforts by some states to establish exchanges have not met with sustained success. The challenge for health reform is thus to create a viable exchange model that can meet a variety of objectives that include encouraging enrollment by diverse health risks, sustaining plan participation, controlling health plans costs, and addressing the objectives noted below.

Health Insurance Exchanges in the ACA

State and regional insurance exchanges are essential components of the ACA. In this context, their purpose is essentially two-fold: first, to create organized health insurance markets that promote effective competition among insurers and create transparency for consumers regarding the price and benefits of coverage; and second, to ensure affordable coverage with a baseline of essential health benefits for eligible individuals seeking insurance in the individual and small-group insurance markets. HIEs—in concert with strict market conduct and premium rating rules in the ACA—play a direct role in assuring that insurer competition is not based on favorable risk selection, but rather on competition that seeks to attract enrollees through lower health plan costs and enhanced quality.

Persons eligible to obtain coverage through HIEs include U.S. citizens and legal immigrants and those without access to affordable employer-sponsored insurance and who are ineligible for Medicare. The framework for managed competition noted earlier serves as the foundation for the operation of HIEs. The HIE's sponsor must be a state or nonprofit entity established by a state or by the federal government should a state fail to set up an exchange before 2014. The sponsor can establish separate exchanges for the individual and small-employer markets, a combined exchange serving both, or a regional exchange. The sponsor can also allow multiple exchanges to operate within a state, provided that each serves a distinct geographic area. Participating plans must be certified as “qualified,” defined as

those with significant health needs), ensuring a sufficient choice of providers (including those serving individuals with low income), being accredited on clinical quality measures, and using a standard format for presenting health benefits. In addition, qualified plans must abide by regulations relating to guaranteed issue, risk-adjusted premiums, and prohibitions on preexisting-condition exclusions.

The ACA mandates that most individuals obtain health insurance either through direct purchase or through their employers. Additionally, employers face a “play-or-pay” mandate that requires eligible employers to either provide coverage or face a financial penalty. Because such a requirement may create financial hardship for some workers and their families, HIEs assume the essential role of administering new income-related tax credits for premiums and cost-sharing subsidies for medical-care spending for those with HIE coverage. Exchanges also provide tax credits to eligible small employers that purchase HIE coverage, and will assist eligible individuals to enroll in expanded Medicaid coverage. Beginning in 2014, states will be required to establish HIEs for individual coverage, and for small employers with up to 100 employees through separate State Health Options Program (SHOP) exchanges. Prior to 2016, states can limit the SHOP exchanges to employers with fewer than 50 employees, and by 2017 can permit employers with more than 100 employees to obtain exchange coverage.

In addition to these activities, the exchange sponsor will monitor premium increases; require plans to provide a variety of information such as claims payment policies, denied claims, rating practices, financial status, and cost-sharing provisions for in- and out-of-network providers; rate each plan on the basis of their quality and price of benefits; and make available standardized comparison information, uniform enrollment forms, and a standardized presentation of health plan options. The sponsor will also inform individuals about their eligibility for public programs, coordinate enrollment with such plans, and engage in outreach to promote public knowledge about the exchange.

Finally, HIEs will offer four types of health plans (Bronze, Silver, Gold, and Platinum) that will provide specified “essential benefits” but differ with regard to coverage protection (e.g., the Bronze plan provides 60 percent of the benefit costs, and the Platinum 90 percent). HIEs will

Management, a response to the elimination of a public health plan as an option in the exchanges. HIEs will offer a catastrophic plan in the individual market for persons under age 30 and for those who qualify for an "affordability exemption" from the individual-coverage mandate, and states have the option to create a basic health plan for individuals who would be eligible for subsides through the HIE because their incomes are between 133 and 200 percent of the federal poverty line (FPL). For those with income between 100 and 400 percent of the FPL, the HIE will make available refundable and advanceable income-related premium credits.

Currently, a number of states have either implemented or are in the process of developing HIEs. To assist in these efforts, the federal government makes grants available to states. To date, 49 states and the District of Columbia have received planning grants, with Alaska the only state not to apply for such funds. According to the Center for Budget and Policy Priorities, as of November 8, 2011, ten states have enacted laws to fully establish exchanges, four states and the District of Columbia have legislation pending, and nine states have issued executive orders establishing or stating an intent to establish an HIE. Seven other governors have ordered the creation of exchange study commissions.

HIEs and Insurance-Market Competition

Current insurance markets lack an essential element for effective competition: transparency for consumers regarding the value and quality of coverage, out-of-pocket costs of coverage, and scope and breadth of benefits across plans. HIEs overcome these deficiencies by certifying plans as qualified to participate in the exchange; requiring plans to provide information on performance measures such as enrollment, denied claims, cost sharing, and rating practices among other information; requiring a baseline level of minimal health benefits and indicating the benefit costs that will be covered; rating each plan on the basis of quality and price of coverage; risk-adjusting premiums to reduce market risk segmentation; and reducing enrollment costs through a uniform enrollment form. By monitoring health plan enrollment practices and maintaining state insurance market rules regarding guaranteed issue and renewal, risk adjusting premiums and establishing temporary reinsurance protection during initial period of exchange implementation, HIEs will ensure

that health plans compete on the basis of price and quality and not through favorable risk selection.

Consumer Choice

A frequent criticism of the predominately employment-based system of health insurance has been the limited choice of health plans typically available to employees within a given firm. Such a limitation has been alleged to compromise the ability of individuals to select health plans that are consistent with their preferences for coverage and out-of-pocket costs, thus compromising consumer satisfaction and welfare. By contrast, the individual-insurance market has been viewed as providing potential enrollees with a broad array of health plan choices that more effectively accommodate enrollee preferences. A fundamental purpose of HIEs is to more broadly apply this perceived advantage of the individual market in an environment of managed competition, and by doing so not only enhance consumer satisfaction but also encourage greater quality and cost competition on the part of insurance plans seeking to make their coverage more attractive to enrollees.

As discussed earlier, HIEs will present consumers with a broad array of health plan options. Such an expansion of health plan choices, together with more transparent information on plan costs and quality, will provide the basic elements for improved enrollee health plan selection. To ensure that an expanded choice of health plans also leads to more effective plan competition, HIEs will provide constraints on the favorable-selection practices by guaranteeing the issuance and renewal of plans, risk-adjusting premiums and constraining premium variation, and monitoring the enrollment practices of insurers. These measures, in tandem with more transparent information on insurance costs and quality, will contribute to the creation of a competitive health plan marketplace.

Finally, there remains the possibility—one that was rejected in congressional negotiations leading up to the passage of the ACA—that enrollee choice and health plan competition could be further enhanced through a publicly sponsored health plan. Such an option could re-emerge if private plans fail to provide effective price and enrollment competition. Apart from offering greater consumer choice—particularly for those who have had poor claims

honest and exert downward pressure on health plan costs. Proponents argue that this is the case because a public plan need only be self-sustaining, is not accountable to shareholders, may achieve economies in health plan administration, is exempt from state premium taxes, will have lower costs of capital than private plans, and exhibit greater bargaining power with providers, among other advantages.

Flexibility

Under the ACA's insurance mandate, HIEs will provide coverage to the employees of small firms, as well as to those seeking individual health insurance. Because those from small firms are actively working, such potential enrollees may be in better health than those who would obtain coverage from the individual market. Establishing an HIE that merges these disparate groups into a single market could have important consequences for the costs of coverage faced by each group. In particular, in a merged market, premiums for those in the small-group market will rise while premiums for those in the individual coverage market will fall, with the magnitude of the change depending on the representation of each type of enrollee in the merged market. As a result, the welfare of the relatively healthy employees in small groups may be reduced as they face higher premiums and indirectly subsidize the lower premiums faced by those with individual coverage.

To more closely conform to the principle of actuarial fairness, HIEs will have the flexibility to determine the market arrangement most appropriate to the risk profile of its enrollees. Under rules established by the ACA, states have the option of implementing a single HIE to accommodate both small businesses and individuals, or forming a separate small-business exchange (the SHOP exchanges noted earlier) and individual exchanges (the American Health Benefit Exchange). Such flexibility will enable states to determine whether enrollee welfare is best served by combined or separate exchanges and will thus help mitigate any unintended cost consequences and perceived inequities that may arise when groups with potentially disparate risk profiles are combined.

HIEs and Employer-Sponsored Insurance

In order to effectively compete in the labor market, and because it remains a valued employee benefit, employers will want to continue to provide health insurance to their employees. By offering their own coverage rather than steering employees to a state or regional HIE, employers can exercise greater control in tailoring benefits to the needs of their specific work force, and may be able to better monitor those health care costs that are unique to their workers. Under the ACA, employers will have the option of retaining health coverage that was in effect on March 23, 2010. Though such "grandfathered" plans must comply with certain ACA provisions, they are exempt from providing minimum essential health benefits, coverage of preventive services without cost sharing, and review of premium increases in excess of 10 percent, among other provisions. Employers will have to weigh the advantages of grandfathering prior coverage against the constraints imposed on those plans by the ACA in regards to adjustments to coinsurance, deductibles, employer contributions, and other plan features. To discourage employers from steering specific, high-risk employees to the HIEs, ACA imposes penalties on employers with more than 50 employees who encourage their workers to seek coverage and premium tax credits from the exchanges. Moreover, oversight by the HIE will identify whether employers are engaging in such selective behavior.

Finally, apart from the issue of penalties, the question remains whether large self-insured firms will cease providing health insurance benefits to their employees, thus adversely affecting the provision of employer-sponsored insurance (ESI). The plan benefit and premium rating requirements for HIEs, as well as the inclusion of required state-mandated benefits, could substantially alter the nature of health benefits and costs to such firms and their employees. Moreover, to the extent that large self-insured firms employ high-wage workers, many such employees may not be eligible for cost-sharing subsidies or premium tax credits. The prospect of having to abide by a specific new set of rules governing health insurance might compromise the value of this benefit to workers of self-insured firms, affect worker morale, and potentially create some workforce instability as some workers decide to seek alternative employment. However, projections by independent analysts suggest that any change in ESI enrollment in response to the ACA will be relatively moderate. In a survey of such estimates, Avalere Health LLC reports that compared to baseline projections of ESI

ranging from a 0.3 percent decline to an 8.4 percent increase. Additionally, they note that surveys generally show employers are committed to the continued provision of ESI.

HIEs and State Insurance Regulations

HIEs' goals of access to affordable coverage and efficient market competition are consistent with the aims of current state small-group and individual-market regulations. Key ACA provisions (such as guaranteed issue and renewal, and limits on premium variation and the use of preexisting condition exclusions) are already in place in many states so that the transition to such requirements may be relatively costless with only modest changes required to some existing state regulations. For example, existing premium rating rules could be made consistent with the risk-adjusted premiums in the HIE. Under the ACA, states can also maintain existing benefit mandates in their HIE-sanctioned plans, many of which are likely to be valued by consumers. Because some states already provide Web-based information on benefits and premiums in their regulated markets, HIEs may avoid the unnecessary duplicative expense of disseminating such information to potential enrollees (although some start-up costs will necessarily be incurred). Consequently, HIE administrative costs may be mitigated to the extent that states already require private health plans to make such information available, as they also do information on enrollee satisfaction and the number and resolution of claims disputes.

HIEs and Risk Selection

The ACA requires all eligible individuals to purchase health insurance and helps offset some of the costs of coverage by providing premium tax credits for those with incomes between 133 and 400 percent of the federal poverty line. With such a mandate in place, HIEs can avoid the adverse selection problem that arises for private health plans when individuals seek coverage because they are sick. As a result, plans within the HIE should not disproportionately enroll poorer health risks than do plans of comparable benefits issued outside the HIE. Because all qualified plans require a minimum set of essential benefits both inside and outside the HIEs, and because state benefit mandates are to be included in

encourage favorable selection and avoid adverse selection will be minimized. Requirements of guaranteed issue and renewal, the use of age, location, and tobacco use to define permissible premium variation, reinsurance, and assessments on plans with a relatively large proportion of low-risk enrollees will also serve to ensure that plans with higher risks are compensated for disproportionately drawing high-cost enrollees, thus limiting incentives for favorable selection. The latter provision will apply to “nongrandfathered” plans and insurers, with high- or low-risk classification based on the average risk profile of all group health plans in the state that are not self-insured. Risk adjustment will be applied to plans both inside and outside of the HIE, and risk-adjustment methodology must be federally certified (either through the method developed by the federal government or through one devised by a state). Finally, oversight by the HIE's managing authority regarding enrollment patterns and plan switching should sound an early alert that will mitigate any systematic favorable risk selection by health plans.

Conclusion

By drawing upon well-regarded principles of managed health plan competition, HIEs represent a unique opportunity to achieve greater efficiency, transparency, and equity in the provision of health care coverage. HIEs will ensure the efficient provision of health plans to consumers by expanding their health plan choices; disseminating information on health plan benefits, costs, and quality; shielding insurers from the consequences of adverse enrollment selection through risk-adjusted premium provisions; monetary transfers to plans that draw high-cost enrollees; and close monitoring of enrollment and disenrollment patterns across plan types. As a consequence of such provisions, HIEs also will minimize health plan competition based on favorable risk selection, thus encouraging plans to seek enrollees through price and quality competition. The ACA's individual mandate along with tax credits to smaller firms will yield enrollment sufficient to achieve economies of scale in administration. Administrative costs will be further reduced through HIE measures such as uniform enrollment forms, taking responsibility for marketing, eliminating medical underwriting, and by simplifying the enrollment process. Recognizing that an individual mandate will cause financial hardship for some families, HIEs will provide tax credits for

HIEs will also be able to build on many existing state insurance market reform provisions. Finally, HIEs are unlikely to threaten the viability of the existing employment-related health insurance system, thus preserving a primary and long-standing source of coverage for most Americans.

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The purpose of this chapter is to debate the merits of organizing health insurance markets into state and regional health insurance exchanges (HIEs) consistent with the principles of managed competition. This counterpoint will demonstrate that HIEs—as currently conceived in the Patient Protection and Affordable Care Act (ACA)—will not be effective in creating market competition that will enhance consumer welfare through meaningful health plan choice and access to affordable coverage. As will be shown, the transition from current insurance markets to the structure imposed by an HIE will not be seamless or costless. Rules must be developed and administrative and informational structures and costs will be imposed on states, and in doing so, perverse incentives will be created that subvert the aims of the HIE. These incentives may constrain participation by insurers and cause some employers, especially those with bad risks, to drop coverage or steer their high-cost employees to the HIE, potentially undermining the composition of the exchange risk pool and significantly raising HIE premiums. The development of essential health benefits and possible addition of state-mandated benefits will do little to ensure that affordable coverage is available through the HIE, especially when the cost of medical care more generally continues to rise. At best, the HIE model will largely preserve and extend a cumbersome and inefficient regulatory structure for the provision of health insurance that has been unsuccessful in achieving reform objectives and controlling health insurance costs.

The goals of creating affordable coverage will require a stronger government hand than is contemplated in the ACA. Under current rules, HIEs are a halfway technology that will not solve, and may exacerbate, current flaws in health insurance markets. The strategy embedded in the ACA of preserving existing employer-sponsored coverage arrangements outside of exchanges while establishing HIEs only for the niche of families without access to adequate and stable employer-sponsored coverage which is offered mainly by large, high-wage firms, is fraught with risks. Single-payer advocates argue that the only way to eliminate the private insurance market's high overhead and risk-avoidance behavior is to eliminate private insurance in favor of a Medicare-like plan for everyone. Of course, a government-sponsored single payer for the United Statesis politically well out of reach at a time of

structure and regulate private insurance to eliminate risk-avoidance behavior and tackle health care cost control. Achieving the goal of efficient administration of health coverage and broad risk pooling will require eliminating opportunities for individuals and firms to opt out of coverage and risk pools. Creating such a structure would be a significant departure from the managed competition paradigm that drove the design of HIEs under the ACA.

HIEs and Insurance Market Competition

That HIEs will see only limited participation by private insurers compromising the goal of effective insurer competition. The requirements for HIE plan certification and the cost of meeting information requirements unique to the HIE (such as information on plan quality and service-specific cost-sharing provisions) will discourage entry by insurers. Despite the requirements of open enrollment, limits on health-related premium variation by insurers, and efforts to monitor insurer behavior, entry by previously "uninsurable" individuals (e.g., from the ACA's temporary high-risk pools) will cause insurers to continue favorable-selection practices. Because HIEs will be responsible for checking the legal residency status of all participants and querying payroll databases for applicants for tax credits and subsidies, they will be unattractive to many market participants and may engender political backlash. Moreover, the high degree of complexity and short timeline available for states to tackle the technical challenges of establishing HIEs under health reform may serve to further undermine public confidence.

Ensuring sizeable enrollment is essential if HIEs are to capture the benefits of reduced administrative costs that can translate into lower premiums for consumers. Despite individual mandates, "pay-or-play" mandates for employers, and tax credits to encourage participation by small employers, the voluntary nature of insurer participation and the ability of individuals and employers to obtain coverage outside the exchanges can threaten the ability of HIEs to obtain significant administrative economies. The start-up administrative costs of HIE implementation are significant—including those associated with securing the necessary data to establish risk-adjusted premiums, developing the mechanisms to collect information on plan quality and consumer satisfaction, and assessing eligibility for tax credits and cost-sharing subsidies and overseeing their distribution, as well as other provisions

and will result in additional costs imposed on participating health plans, offsetting the administrative economies from increased enrollment.

HIEs and Employers

Given the likelihood that health care costs and insurance premiums will continue to increase faster than will the ability of businesses to pay, employers can be expected to seek ways to reduce their commitment to provide coverage to their employees. Individual coverage available through HIEs provide an alternative to employer-sponsored coverage, and some employers will steer their employees in that direction. Employers with fewer than 50 full-time-equivalent (FTE) workers are not subject to penalties for dropping coverage, and tax credit "carrots" are too weak to induce them to begin and continue to support coverage for their workers.

In addition, some employers subject to penalties for not providing coverage under the ACA may find it advantageous to drop coverage and have their employees obtain individual coverage through the HIE. The structure of ACA employer penalties makes this especially true for employers just above the 50-FTE threshold. Specifically, employers who do not offer creditable coverage and who have at least one worker receiving an exchange tax credit will be subject to a penalty of $2,000 per FTE, minus the first 30 workers. So an employer with 75 workers in this circumstance would face a penalty of $90,000, a sum that would cover the average employer-paid single premium for fewer than 25 workers. Other employers with high-cost employees may encourage such workers to obtain coverage through the HIE if they perceive that the cost savings associated with dropping coverage, not providing new coverage, or sending some employees to the HIE will exceed the penalties they will face for doing so. Other employers may find the minimum requirements for "qualified essential benefits" under the ACA to be prohibitively costly and encourage their employees to obtain insurance through the HIE. Small employers at the lower end of the firm-size requirement to offer coverage (50 employees) may adjust their number of full-time equivalent employees (e.g., by using more part-time labor) in order to fall below the size threshold. Additionally, some low- and moderate-income employees will find the premium tax credits available by obtaining coverage through the exchanges to be more attractive than employer

contributions to their coverage. On this basis, they may opt for individual coverage through the exchanges, creating further incentives for employers to avoid providing coverage.

Such responses can crowd out available employer-sponsored insurance, thus threatening the viability of the employer-based insurance system. The pooling of health insurance risks is one of best-functioning features of the U.S. health care system, with low administrative costs, virtual elimination of adverse risk selection, and responsiveness to the needs of insured workers and their families.

HIEs and State Insurance Market Reforms

Although state insurance market reforms developed for the small-group and individual health insurance markets are to be integrated into HIEs, relying on such regulations to support reform goals will be insufficient and likely mimic the poor experience of states to date. Existing research on state regulation suggests that reform of the small-group and individual insurance market has not been effective in achieving the goal of affordable coverage. Instead, key provisions to be applied to HIEs—guaranteed issue and renewal and constraints on premium variation among others—have had the unintended effect of raising the risk composition of insurance markets and increasing premiums.

For instance, since the early 1990s, New Jersey has required guaranteed issue and used some form of community rating in its nongroup health insurance market, which has experienced premium increases in its standard health plans well above national averages and precipitous erosion in enrollment. Although such effects may be mitigated by the ACA's individual mandate and premium tax credits, these key elements of state reform legislation features could significantly affect the risk composition and costs of coverage provided through the HIE. Moreover, in the past, many states have relied on insurers to self-regulate their adherence to rules for these markets. Though doing so has raised issues in regard to effective enforcement, under the new regime these responsibilities would likely shift to the HIE sponsor, adding additional administrative costs that might translate into higher premiums.

Because private insurers are not compelled to participate in HIEs, some carriers with relatively healthy enrollees may choose to stay outside the exchange. As a result, plans within the HIE may disproportionately take on greater health risks. This may be exacerbated by the elimination, in 2014, of ACA-sanctioned high-risk pools, whose enrollees will have to seek coverage through the HIEs. Eligible individuals of modest incomes (low income often reflects poor-health status) who can obtain HIE subsidies and face more favorable premiums also may be drawn to exchanges rather than to insurers who remain outside the HIE. Some small employers required to provide insurance may stop offering coverage so that their older and potentially sicker workers will have to obtain HIE coverage.

Employers with close to 100 workers are more likely to feel comfortable bearing the financial risk of their health plan offerings, a practice known as self-funding. Significant incentive will exist for employers with disproportionately healthy workforces to pull out of the small-group exchange by self-funding their benefits. This practice will increase average risk and cost within the exchange risk pool, further tempting employers to consider the self-funding option. An adverse risk spiral could be the result.

Another potential danger to the exchange risk pool comes from special provisions in the ACA having to do with adults in their 20s. Under the new law, young adults have two options, either of which may lead them to abandon the standard plan risk pool in the HIE. First, because young adults up to age 30 can obtain less expensive catastrophic coverage from individual insurers within an HIE, some insurers may choose to specialize in such coverage, further concentrating more costly enrollees in the HIE standard plan risk pool. Second, young adults up to age 26 may enroll as dependents on a parent's plan at no cost beyond standard family premiums. Many families attracted to this option are likely to have coverage through large employers outside of HIEs, further draining exchange plans of premiums from this young and comparatively low-risk population. Finally, regardless of the health insurance market environment, the possibility remains that private insurers will find subtle means to practice favorable risk selection. Despite the best intentions of HIE sponsors, risk-adjusted premiums will likely be insufficient to dissuade insurers from risk-selection practices.

HIEs and Rising Premiums

HIEs, as structured in the ACA, will do nothing to address the principle driver of rising premiums: the unchecked rise in the cost of health services. The ACA focuses on reducing the “loading” costs (e.g., the cost of administration, marketing, and profits) added by health insurers over the amount they pay to health care providers. The law does so by imposing minimum-loss ratios and by encouraging states to scrutinize large premium increases. The law also precludes most medical underwriting practices, such as evaluating applicants for preexisting conditions, which should reduce health insurance loading costs. These provisions may have a significant effect on premiums in states that had weak health insurance regulations prior to the passage of the ACA, but any savings will be of the one-time variety. It is clear that even the strongest forms of managed care have been unable to achieve sustained reductions in underlying health care costs, a dynamic that the HIEs are unlikely to change. With the prospect for continuing increases in premiums for plans within HIEs, the cost of federal tax credits and cost-sharing subsidies will also rise, creating a new unsustainable federal entitlement. Likewise, the level of premiums consumers will be required to pay, even after federal tax credits are applied, will continue to rise, over time leading many thousands to be excused from the individual mandate under the ACA's affordability exemption rules. Those applying for exemptions are most likely to be comparatively healthy (with a commensurate lower demand for coverage), which over time will further exacerbate the risk-selection problem discussed above.

Conclusion

HIEs represent a long-standing strategy to ensure access to affordable coverage, provide transparent information regarding health plan costs and quality, and promote effective insurance market competition. Despite the best intention of policymakers, however, HIEs are unlikely to meet these goals. Practical experience with HIEs among large public-employer groups at the federal and state levels, and in recently enacted health reform in Massachusetts, reveals that HIEs have had little success in controlling health care costs. The development of HIEs will place an enormous financial burden on states in order to implement the required administrative structures necessary to certify health plans, disseminate information, and oversee the performance of health plans and their compliance

The implementation of HIEs, as envisioned by the ACA, is not likely to address the serious problem of risk selection in health plans. The voluntary nature of HIE plan participation will create incentives for some health plans to shed high-cost cases to the HIE, and some employers will be willing to incur penalties to remove costly employees from their insurance plans in favor of the HIE. More generally, some employers will cease offering costly coverage should savings for doing so outweigh the penalties. Strategies such as merging the small-group and individual markets sanctioned by HIEs will not yield sufficient economies to compensate for the significant administrative costs, and the individual mandate and phase-out of the ACA's high-risk pool may result in higher-cost cases entering the exchanges, thus offsetting any administrative economies from the increased enrollment.

An effective regime for delivering health insurance with broad risk pools and minimum administrative costs will require stronger incentives for individuals and employers to participate in coverage, and must eliminate opportunities for low-risk persons and groups to exit the pool. Large employers (e.g., those with over 100 workers) achieve these goals, but the ACA does not create an HIE structure that will. It is essential that all individual, small- and medium-group coverage be moved into a single risk pool with no options to select out. Further, creating strict participation rules that do not permit risk segmentation for insurers would go a long way to making the system more equitable and efficient. Health insurance exchanges, as advanced in the ACA, do not adequately address flaws in the U.S. private health insurance system. As such, they are not likely to achieve the desired end. The first priority of health reform ought to be to fix this high-cost, risk-selection-prone system. Only then could a discussion of how to structure optimal health insurance exchanges be fruitful.

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