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BUILDING A MARKET-BASED HEALTH-INSURANCE EXCHANGE IN NEW YORK

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The Patient Protection and Affordable Care Act (ACA) requires that every state establish a health-insurance exchange by 2014. The exchange will serve as a marketplace in which individuals and small businesses can shop for coverage. The ACA's controversial mandate provision requires every individual to purchase qualified insurance or face a financial penalty. Ideally, the range of plans available on the exchange—combined with subsidies that help in their purchase—would lead to the reform law's goal of universal coverage as well as a slowing of long-term growth in overall health-care costs.

The idea of the exchanges has, like the ACA more generally, prompted disparate views about their value and expected range of offerings. Proponents believe that the exchanges have the potential to inject much-needed consumer choice and competition into the markets for individual and small-group health insurance, improving the coverage, the cost, and even the care. By creating large, predictable markets for buyers and sellers, exchanges could bring much-needed stability to the small-group and individual sectors, where administrative costs are higher than for large groups and where premiums tend to fluctuate widely as people drop into and out of coverage.

Critics (including some opponents of the ACA who nevertheless support the concept of insurance exchanges) are concerned that the exchanges may become overly bureaucratic and impose excessive regulatory or benefit requirements that will restrict consumer choice and drive up costs. They also point to the enormous discretion that the federal government reserves to certify the exchanges, potentially restricting state options in design and implementation. These are legitimate concerns. Overly restrictive exchanges may fail to attract enough insurers to offer consumers and small businesses a wide variety of affordable plans that meet their needs. If an exchange offers only a handful of very expensive options, it may fall short of signing up a critical mass of healthy enrollees, leaving it with a population of very sick (and thus very expensive) subscribers. Over time, that imbalance could make the exchange financially unsustainable.

The New York Landscape

Some of these feared outcomes are the present realities of the New York insurance landscape. New York is home to one of the most expensive individual and small-group insurance markets in the country, largely as a result of its 1992 community-rating/open-enrollment law. The law imposes "guaranteed issue" provisions that require insurers to offer coverage to all applicants, including those who are already sick, although it does allow plans to impose some limitations on preexisting conditions. And it employs "community rating" regulations that require plans to offer the same price to all applicants regardless of age or health status.

Additional regulations under the 1995 point-of-service law further restricted the types of plans available in New York and required insurers to offer a very generous package of minimum benefits and services (tied to limits on maximum co-pays and deductibles).

As a result of high costs, the market for individuals in the state has been in sharp decline for years. As recently as 2001, more than 128,000 individuals were enrolled in HMOs in the direct-pay market. By 2010, enrollment had plummeted to just 31,000. Premiums approximately tripled during this period. In all, about 15 percent (2.6 million) of New York's residents are uninsured, a group that is largely young (about half are aged eighteen to thirty-four), in good health, and without dependents.

The danger is that the premiums of these plans will be off-putting to budget-conscious consumers, even with federal subsidies defraying some of the cost. And because the penalties for not buying insurance, in many cases, are not that painful, it is reasonable to conclude that many younger, relatively healthy individuals and households will choose to remain uninsured. This outcome will put great financial strain on the exchange system, which will be left to serve an increasingly high-risk subscriber pool. Eventually, the exchange could collapse, leaving the state in the same position it was before the Affordable Care Act passed.

Accordingly, we recommend that New York policymakers construct an exchange featuring:

- **Competition among All Qualifying Health Plans.** The exchange should primarily be a clearinghouse for insurance competition based on the ACA's minimum standards.
- **Flexibility in Insurance Design.** New York should allow insurers to experiment with a wide range of co-payment and deductible designs, including Health Savings Accounts and other high-deductible plans.
- **Affordable Insurance Options for Younger and Healthier Enrollees.** New York should expand the state's age-banding rules to the ACA allowed 3-1 premium ratio (a reform that would require legislative action).
- **Freedom from Political Influence.** The exchange should be chartered as a quasi-independent public authority or chartered nonprofit rather than housed in an existing state agency, such as the Department of Insurance or Health.
- **Defined Contribution Plans for Small Businesses.** The state's small business exchange should include a defined contribution option for small businesses, combined with a premium aggregator function to help many more small businesses and their employees find affordable health-insurance options.

Barriers at the State Level

On the state level, legislation would likely be needed to permit plans to offer a wider range of deductibles and co-pays and fewer benefits in return for lower premiums. (The Affordable Care Act allows HSAs to be sold on the state exchanges; if state law conflicts with the ACA, it may require the state to offer HSAs.)

HSAs have been criticized as vehicles for the "healthy and wealthy" to skimp on coverage and maximize their tax-deferred savings, leaving higher costs for patients who need more coverage. Another criticism is that HSAs force consumers to skip critical preventive or routine health-care services, saving money in the short term but leading to higher costs down the road.

The evidence undermines those arguments. One recent study found that "a wide range of preventive-care services counts toward plan deductibles (or are covered on a 'first-dollar' basis) under most HSA-qualified policies…. [T]he rates at which enrollees in HSA-qualified plans draw on preventive care or rely on treatment of chronic illness are roughly equal to the rates shown by policyholders in comprehensive plans." Another analysis found that "necessary care was received in equal or greater degrees relative to traditional plans." Though HSA enrollees in the past tended to be of higher income, most of the income differences were not present in 2010, a survey by the Employee Benefit Research Institute (EBRI) found.

Meanwhile, the raison d'être for HSAs—curbing costs—continues to exist, since traditional plans have failed to control health-care inflation. Ironically, many more expensive HMO/PPO plans now have deductibles that approach those of HSA-qualified high-deductible plans. However, higher-deductible or catastrophic plans continue to exhibit cost trends significantly below those of traditional plans.

Much of the savings can be traced to those who enroll in HSA high-deductible plans. The 2010 EBRI survey found that enrollees "were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors," including asking for a generic drug prescription instead of a branded product and discussing care options and costs with their physician.

Issues on the Federal Level

Under the terms of the new federal law, five benefits packages must be on the ACA's exchange menu, in descending order of cost and coverage: platinum, gold, silver, bronze, and catastrophic. HSAs are allowed on the exchange, but making them more attractive for consumers will require that ACA rules be interpreted in ways that will help keep them

more affordable than traditional plans. The problem is that ACA rules could put high-deductible plans and HSAs at a disadvantage. The rules are still evolving, and the situation may well change. But for now, the issues are twofold:

Actuarial Values. Actuarial values define the percentage of expected health-care costs that will be covered by a given plan. The minimum actuarial value for plans on the exchange is set at 60 percent for bronze coverage (the top value is 90 percent for platinum). But HSAs typically have an actuarial value below 60 percent, before any insurer or employer contributions to the savings account are taken into consideration. If the federal government does not count those contributions in calculating the actuarial value, the premium costs of HSA-eligible high-deductible plans may increase significantly because coverage would have to increase. The rise in premiums would make this hybrid coverage less attractive compared with traditional plans.

Medical Loss Ratios. The MLR requires insurers to spend at least 80 percent of plan premiums on health benefits and services, with the remainder for administrative costs and profits. Minimum MLR requirements may encourage carriers to offer fewer high-deductible plans because the high-deductible feature, by definition, means that the plans will be processing fewer claims relative to their (low) premiums compared with higher-cost plans. To meet the minimum MLR, carriers offering HSA-qualified plans would have to blend spending across all their products within the individual, small-group, and large-group markets in each state. Carriers with relatively more HSAs might find themselves penalized and required to offer rebates to policyholders. Such a requirement would, again, diminish the attractiveness of HSA plans, notwithstanding their potential for increased cost savings.

The Market for Small Business

New York's small-group market is not as dysfunctional as the market for individual coverage, partly because of the wider range of insurance products, including HSAs, that are already available to small groups and sole proprietors. But the state is still among the most expensive small-group markets in the nation, partly because it does not allow rates to vary by age or health status.

Since many of the uninsured work at small firms, expanding affordable insurance options for small employers and their employees should be a priority for New York policymakers. According to one estimate, a properly configured New York exchange could enroll up to 120,000 small firms and cover up to 1.2 million employees and their dependents.

New York would benefit by borrowing some elements for its small-business exchange from one established in Utah in 2009, before the ACA was passed. The Utah Health Exchange was created to address escalating premiums and an accelerating decline in employer-based coverage, especially among small employers. Although the state had a lower uninsured rate (10.6 percent) than the national average, policymakers still believed that the rate was too high and that incentives in the system were not aligned to provide consumers with cost-effective, high-quality, affordable insurance. Less than half of Utah's small businesses offered insurance to their employees.

Because policymakers were focused on the small-group market, the exchange incorporated several features designed to make insurance more affordable for employees of small businesses, including a premium aggregator to bundle contributions from multiple employer sources. The exchange also functions as a defined contribution market, in which employers give employees a predetermined level of funding to purchase coverage, akin to a voucher system.

Another innovative mechanism that the exchange is testing is an all-payer database, which allows researchers to analyze all statewide health claims to better measure the effectiveness of disease prevention and wellness initiatives, among other things.

After a yearlong pilot program, the state opened the exchange to all small employers, and 3,000 people are now receiving coverage. A similar private insurance exchange, New York's HealthPass, covers more than 30,000 enrollees in New York City, Long Island, and the mid-Hudson Valley.

About the Author

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Paul Howard

I: INTRODUCTION

State-based health-insurance exchanges are one of the two linchpins of health-care reform under the Patient Protection and Affordable Care Act (ACA), along with a large expansion of the joint state-federal Medicaid insurance program to cover low-income uninsured individuals. Beginning in 2014, the ACA requires every state to have an operational electronic health-insurance exchange (hereafter, "exchange") offering what the ACA defines as "qualified" health-insurance plans for the individual and small-group markets.[1] The exchanges will have many responsibilities, but their central obligation is certifying that plans for sale on the exchange meet existing state regulations and federal insurance requirements under the ACA.

Proponents believe that exchanges have the potential to inject much-needed consumer choice and competition into the individual and small-group (firms with two to fifty employees) health-insurance markets, changing health insurance—and perhaps even health care—for the better. Ideally, insurers will compete on the exchanges to offer high-quality, affordable coverage to individuals and small businesses. By creating large, predictable markets for buyers and sellers, exchanges could bring much-needed stability to premium pricing in the small-group and individual health-insurance markets, where administrative costs are higher than for large groups and where premium prices tend to fluctuate widely as people drop into and out of coverage.

However, critics (including some opponents of the ACA who nevertheless support the concept of insurance exchanges) are concerned that the exchanges may become overly bureaucratic and impose excessive regulatory or benefit requirements that will restrict consumer choice and drive up health-insurance costs—causing young and healthy applicants to avoid buying coverage on the exchanges. They point to the enormous discretion that the federal government reserves to certify the exchanges (potentially restricting state options in exchange design and implementation), as well as ACA insurance-market reforms that may restrict consumer choice and drive up premiums. States can also restrict the number and type of insurance plans available on the exchanges, potentially reducing competition and driving up insurance costs.

Overly restrictive exchanges may fail to attract enough participating insurers to offer consumers and small businesses a wide variety of attractive and affordable plans—including Health Savings Accounts (HSAs)[2]—that meet their needs. If the exchange offers only a handful of very expensive insurance options, it may fail to attract a critical mass of healthy enrollees, leaving the exchange with a population of sicker (and more expensive) enrollees. Over time, the exchange may become financially unsustainable for both taxpayers and the very individuals and small businesses that it is meant to help.

New York's current individual and small-group market largely justifies these concerns. The state's current individual and small-group insurance markets are heavily regulated and, as a result, extraordinarily expensive. This is particularly the case for individuals seeking unsubsidized coverage in the individual (or "direct-pay") market—where only two comprehensive insurance plans are available, and families can pay $1,000 or more a month for coverage. If New York's exchange merely mirrors the state's current high-priced insurance options, it may fall victim to the same forces that have crippled the state's individual insurance market.

Accordingly, this paper recommends that state policymakers embrace the exchange requirements of the ACA as a unique opportunity to make more affordable and innovative insurance options available for non-Medicaid-eligible individuals and small businesses through a competitive, market-oriented exchange. A transparent exchange that allows consumers to quickly and effectively compare a wide variety of innovative and affordable plans for the individual and small-group markets would meet the coverage goals of the ACA while helping to control health-care costs and improve health-care quality.

The insurance-exchange concept is not new. Some private and public exchanges, such as the Federal Employees Health Benefits Program (FEHBP), actually predate health-care reform by decades. The basic concept is elegant in its simplicity: an organized marketplace where consumers and small businesses can compare competing health-insurance plans and, if so desired, purchase coverage. However, until now, health-insurance exchanges have been relatively limited in size—with a few notable successes and many outright failures.[3]

This paper includes a review of several exchange and exchange-like programs and includes a number of lessons learned and recommendations that can help policymakers structure an effective market-based exchange in New York that can help consumers and small businesses choose from a wide range of flexible and affordable health-insurance options. In brief, policymakers should build an insurance exchange that:

- Maximizes the ability of individuals and small businesses to choose from a wide variety of plans that fit their specific needs
- Streamlines or removes costly regulatory or benefit requirements for insurers that drive up health-insurance costs, specifically for young and healthy enrollees
- Creates a level playing field for insurers (including provider-sponsored plans)[4] to compete inside and outside the exchange based on benefit design, network coverage, price, and quality
- Offers a small-business exchange utilizing a "defined contribution" mechanism as well as a premium aggregator.[5]

- Protects the exchange from political pressures to pick winners and losers from among competing insurers and plans

This approach will maximize competition within the exchange while minimizing the likelihood of unintended consequences from well-meaning regulations that undermine the exchange's effectiveness at controlling costs or improving quality for consumers and small businesses.

The range and cost of insurance options allowed on the exchange (defined as "qualified health plans") may be affected by the final benefit package that the federal government requires of all individual and small-group plans and by how existing state laws and insurance regulations interact with the ACA. More arcane regulatory decisions by the Department of Health and Human Services (HHS)—including rules relating to the actuarial value of high-deductible health plans—may affect the cost and types of plans available on the exchange. This paper will discuss these issues in later sections, but in general recommends that the state request waivers from the federal government or amend its own laws or regulations to the extent that they inhibit robust insurance competition on the exchange.

The remainder of this paper will discuss the new market regulations under the ACA; the challenges of creating a successful exchange; New York's current individual and small-group insurance markets and opportunities for reform; and several current models of exchanges for individuals and small businesses. It will conclude with lessons learned and recommendations for structuring New York's individual and small-group exchange.

II. ACA: NEW SUBSIDIES, COSTLY REGULATIONS, AND THE ROLE OF THE EXCHANGES

The ACA creates a dramatic—and controversial—new set of insurance subsidies, mandates, and regulations that will expand nearly universal (95 percent) insurance coverage to American citizens. However, many regulatory changes will impose new cost pressures on health insurance that may undermine the exchanges' ability to offer more affordable insurance options, such as HSAs. Without more affordable options, the ACA may not meet its coverage goals, and the exchange could collapse entirely.

The ACA mandates that most uninsured buy qualified health insurance or pay a (modest) penalty. The mandate is offset by generous premium tax credits for the uninsured to purchase private health insurance, as well as expanding eligibility for Medicaid coverage for low-income Americans (to 133 percent of the federal poverty level [FPL]).

Premium tax credits and cost-sharing subsidies (for deductibles and co-payments)[6] are available to uninsured individuals and families making up to 400 percent of the FPL, currently $88,000 for a family of four (by 2016, this FPL will likely rise to close to $100,000). Premium costs are also capped as a percentage of income (see below). Tax credits and subsidies are available only through the exchange.

Income	Premium Cap
<133 percent FPL	2 percent
133–150 percent FPL	3–4 percent
150–200 percent FPL	4–6.3 percent
200–250 percent FPL	6.3–8.05 percent
250–300 percent FPL	8.05–9.5 percent
300–400 percent FPL	9.5 percent

The ACA creates new limits on insurance cost-sharing—the total amount that policyholders have to pay out of pocket for health care, not including premiums.[7]

The primary role of the exchange is to decide which plans are "qualified" for participation in the exchange.[8] The ACA standardizes coverage on the exchange through five available benefit packages, based on the percentage of expected medical costs that insurers must pay for policyholders.[9] Bronze plans pay 60 percent of costs, silver 70 percent, gold 80 percent, and platinum 90 percent. "Catastrophic" plans with

high deductibles will be available to individuals under thirty or applicants who cannot find an affordable health-insurance option on the exchange.

Tax credits and subsidies on the exchange won't cover 100 percent of insurance costs, so consumers will at least have some incentive to choose lower-cost plans. This is because the premium tax credit will be pegged to the second-lowest-cost (silver) plan available on the state health-insurance exchange. Individuals who choose lower-premium silver plans or bronze plans can keep the savings. This assumes that there will be many lower-cost plans available from which to choose. That may not be the case. Rich tax credits and subsidies will encourage at least some individuals and families to bid up to more expensive silver-level coverage.

Insurance policies will be significantly more expensive than most small-group or individual policies sold today.[10] This is because the ACA requires insurers to cover more of an enrollee's costs, and some additional benefits.[11] (States can require even more minimum benefits for plans sold on the exchanges—although the state will be required to pay the added cost.) Insurers are required to spend more of every premium dollar that they collect on medical services.[12] If they do not meet these new federal minimum spending requirements (the minimum "medical loss ratio" standard, or MLR), companies will have to rebate the difference to policyholders. Pumping more money into the health-care system is likely to drive up insurance costs.

Additional federal regulations may hamstring insurers' ability to offer significantly cheaper bronze or silver plans, including HSAs. Insurers who offer low-premium HSAs may be penalized because they don't cover enough health-care costs. HSAs typically cover less than 60 percent of health costs, before any insurer, employee, or employer contributions to the plans' savings account are taken into consideration. But federal regulations require bronze plans to cover a minimum of 60 percent of costs—raising the question of whether they would even qualify as bronze plans or potentially forcing HSAs to cover more services but also raise their premiums. This would be a case where the letter of the law kills its spirit because the savings accounts associated with HSAs often raise their value to at least 60 percent. Whether federal regulators will recognize this value is an open question.[13]

HSAs are designed to make more careful health-care consumers through their high-deductible feature. But the high deductible makes it harder for insurers to meet the ACA's minimum spending requirements.[14] Carriers with relatively more HSAs may find themselves at a disadvantage versus carriers that offer more traditional—but more expensive—plans.[15] Most important, the ACA requires companies to issue plans to all applicants, regardless of their health status (called "guaranteed issue") and charge the same price to all applicants, after taking into account a few variations for factors such as age (called "modified community rating").[16] Community rating lowers prices for sicker or older enrollees but also raises the cost of health insurance for younger and healthier applicants.[17]

If there aren't enough low-cost options available on the exchanges, consumers (and taxpayers) will be exposed to higher premium costs—giving younger and healthier consumers an incentive to pay the penalty for going without coverage and to wait to buy insurance in the event of a serious illness. Over time, this would leave the exchange with a sicker and older population, driving up prices even further—potentially leading to the collapse of the exchange.[18] Building more flexibility and competition into the exchange (while minimizing the costs associated with new regulations) will be the key to preventing this outcome.

III. THE CHALLENGE OF MAINTAINING A SUCCESSFUL AND AFFORDABLE EXCHANGE

The ACA gives states substantial flexibility in the initial organization and operation of the exchanges[19] —including the option of allowing the federal government to operate the exchange on the state's behalf.[20]

New York policymakers will have to decide whether they should create a single statewide exchange or several smaller regional exchanges (e.g., upstate and downstate), or even whether to join a multistate exchange compact. Policymakers will have to decide whether to place the exchange within an existing state agency (such as the Department of Insurance), create a new public authority, or contract with a non-profit organization to run the exchange. Within the exchange, policymakers also have the option of merging the small-group and individual health-insurance exchanges (and merging the two risk pools).

States with poorly designed exchanges may fail to achieve their goal of delivering affordable coverage or controlling health-care costs.[21] Over time, these exchanges may collapse as insurance (or the subsidies required to support exchange-based coverage) costs become unaffordable.[22]

All these decisions will affect New York's exchange and require careful consideration. But no decision is likely to prove more important than the basic role of the exchange in certifying the eligible health plans for sale within the exchange, i.e., deciding what types of plans should be available and how "qualifying" plans are admitted into the exchange. Here, the critical question is whether the exchange should act as an intermediary and actively screen plans for inclusion in the exchange (an active-purchaser exchange) or let in all plans that meet minimum standards (a market-organizer or clearinghouse exchange) and let consumers and small business pick the plans that best meet their individual needs and preferences.

Answering this question requires a better understanding of the problems that exchanges are designed to address and the potential benefits that they can bring to the individual and small-group markets.

First Principles: What Is an Exchange, and What Should It Attempt to Achieve?

The basic concept of an exchange is relatively simple: an organized marketplace for consumers that "facilitates the buying, selling or administration of private health insurance" (Chambless 2007).[23] Current examples of exchanges include the Federal Employees Health Benefits Program (FEHBP), New York's HealthPass, the Massachusetts Connector, and the Utah Health Exchange. The Medicare Part D drug program has many elements of an exchange.

As noted above, exchanges can encompass everything from "clearinghouses" (such as the Utah Health Exchange) to active-purchaser models (such as the Massachusetts Connector), which screens and contracts with plans for the exchange. Under the ACA, each state will have the responsibility for creating a state exchange that fits the unique needs and preferences of state residents. Both types of exchange share common goals.

What Problems Should an Exchange Address?

There is bipartisan support for the creation of exchanges because of long-standing and well-recognized problems in the small-group and individual health-insurance markets. Among the most serious problems in these markets are:

High Administrative Costs. The individual and small-group health-insurance markets have higher administrative costs because it is more difficult for insurers to market plans to, and collect premiums from, many disaggregated individuals and small firms than from one centralized entity (such as the human-resources department of a single large employer). These factors produce higher administrative costs that increase premium pricing.

Medical Underwriting. In almost all states (New York is one of the few exceptions), individuals with preexisting conditions who aren't offered group coverage are subject to medical underwriting based on prior health experience, which can expose them to substantial premium increases above standard rates.[24] Other individuals may be denied coverage outright. Although insurance experts disagree on the number

of Americans who are denied coverage or are offered coverage only at higher than standard rates (or with coverage exclusions for preexisting conditions), the lack of affordable health insurance, and thus access to care, can lead to worsening health.[25]

Expensive State Regulation. Self-funded group health plans (in which the employer pays all its employees' claims costs) are regulated by the Employee Retirement Income Security Act of 1974 (ERISA) and are generally not subject to state insurance regulations. Unlike ERISA-regulated health plans, health insurance purchased in the individual and small-group insurance markets is regulated by the states and is subject to extensive provider and benefit mandates that can drive up prices by 10 percent to 50 percent, depending on the state and the number and type of mandates that are enforced.[26] Regional or national insurers also incur the additional administrative costs associated with fifty-one state regulatory regimes (fifty states plus the District of Columbia).[27] Allowing the interstate sale of health insurance (or perhaps through interstate compacts, as the ACA permits) is one potential solution to the problem of states using what are essentially unfunded mandates to extend coverage to certain provider groups or services. This approach would make the cost of such mandates (and the cross-subsidies that they imply) highly visible to consumers and would thus force policymakers to consider the costs of such mandates before applying them.[28]

Adverse Selection. Adverse selection is a phenomenon largely created by regulatory policies (like community rating) that limit insurers' ability to charge low-risk individuals correspondingly low prices. Medical underwriting allows insurers to impose actuarially fair premiums that take into account expected health-care utilization (and thus older and sicker policyholders will pay somewhat higher premiums than younger and healthier policyholders).[29] If insurers lose the ability to offer to lower prices to lower risks, younger and healthier policyholders will drop out of the market, and the risk pool will tip toward sicker, higher-cost policyholders and premiums rise, leading to significant further premium increases for the remaining members. Over time, this can lead to a "death spiral," where the risk pool—and the market—collapses entirely (as it has in New York).[30] Maintaining a large, stable risk pool—with affordable options for healthy enrollees —should help smooth out premiums in an actuarially efficient manner, including for older, sicker policyholders.

What Are the Potential Benefits of an Exchange?

If an insurance exchange can attract a large-enough pool of lives in a given market to create stable risk pools for participating insurers, it may be able to reduce or eliminate some of the most serious problems associated with the small-group and individual markets.[31] For instance:

- By pooling large numbers of purchasers, exchanges may be able to lower administrative, marketing, and transaction costs for insurers (or at least distribute these fixed costs over a larger number of covered lives).
- A transparent insurance market can provide consumers with the ability to easily and confidently compare plan price, benefits, and network coverage terms to find affordable, high-quality plans that meet their specific needs.
- By creating a larger risk pool with more healthy policyholders, exchanges can stabilize expected premium increases and reduce adverse selection pressures common to the small-group and individual markets. To the extent that insurers currently screen risks out, insurers can instead focus on managing risks.[32]
- Exchanges may be able to encourage insurer competition based on innovative benefits and services, potentially raising the quality of health care received by policyholders.
- Less efficient benefit or network designs should exit the market over time as consumers select more high-quality plans that control costs more efficiently. Ideally, this would improve the efficiency of health-care markets overall.

- Small employers who do not currently offer coverage may be able to find more affordable plans on the exchange.[33]

Achieving these outcomes will require careful consideration of how insurance regulations and insurance costs can encourage (or deter) younger and healthier enrollees from obtaining insurance in any market or exchange. New York's current individual and small-group insurance markets are testimony to the unintended effects of well-meaning regulations designed to address problems of high costs and medical underwriting of older and sicker consumers that exposes them to potentially high or unaffordable insurance costs. Unfortunately, the cure may be worse than the disease.

New York's Small-Group and Individual Insurance Markets Today

About 15 percent (2.6 million) of New York residents are currently uninsured, representing a diverse population that is largely young (about half are aged eighteen to thirty-four), in good health, and without dependents. About one-third of New York's uninsured make over $50,000 per year (Bragdon 2007).

The decision not to purchase insurance coverage (or, in the case of small businesses, not to offer coverage) is heavily influenced by the high cost of insurance. New York has one of the most expensive individual and small-group insurance markets in the country, largely as a result of its 1992 community-rating/open-enrollment (CR/OE) law.[34] The law imposes guaranteed-issue provisions that require insurers to offer coverage to all applicants, including those who are already sick,[35] and community-rating regulations that require plans to offer the same price to all applicants regardless of age or health status.[36] Additional regulations under the 1995 point-of-service law further restricted the types of plans available in the market (to an HMO and a more expensive point-of-service, or POS, plan that included out-of-network coverage), as well as specifying a very generous package of minimum benefits and services that must be covered by insurers (as well as limits on maximum co-pays and deductibles). The mandated minimum insurance package (as well as the absence of more limited but more affordable insurance plans) has driven up private unsubsidized (known as direct-pay) insurance premiums to the extent that only very sick (and affluent) consumers can afford them.[37]

More affordable insurance options, such as HSAs combined with high-deductible health plans or limited benefit plans, are not currently available in the individual direct-pay, unsubsidized insurance market. As a result of its high cost, the individual, direct-pay market in the state has been in sharp decline for years. As recently as 2001, more than 128,000 individuals were enrolled in HMOs in the direct-pay market. By 2010, enrollment had plummeted to just 31,000. Premiums have approximately tripled during the same period. The New York Times noted: "New York's insurance system has been a working laboratory for the core provision of the new federal health-care law—insurance even for those who are already sick and facing huge medical bills—and an expensive lesson in unplanned consequences. Premiums for individual and small-group policies have risen so high that state officials and patients' advocates say that New York's extensive insurance safety net … is falling apart."[38]

A 2009 survey by America's Health Insurance Plans (AHIP) found that New York has the highest annual average premiums for individual health insurance in the country, over twice the national average. The increase in costs has led to an "adverse selection death spiral" where healthy, price-sensitive policyholders abandon the market because the cost of benefits far exceeds the value of the coverage—essentially transforming the market into an extraordinarily expensive high-risk pool. One consumer advocate told the Times that New York's mandates make insurance "accessible in theory, but not in practice, because it's too expensive…. [W]hat you get left clinging to the life raft is the population that tends to have pretty high health needs."[39]

Although New York's small-group market is not as dysfunctional as its individual counterpart (partly because of the wider range of insurance products available to small groups and sole proprietors, including HSAs), New York is still among the most expensive small-group insurance markets in the nation. According to a 2008 AHIP survey of small-group premiums by state, New York was the eighth most expensive in the nation. AHIP attributed at least part of the high cost of coverage in New York to the fact that "states that do not allow rates to vary by health status generally have higher average rates. In these states, small firms with relatively healthy employees are not eligible for any health-status related premium reductions, and they may choose to forgo coverage. As a result, average rates for firms remaining in the small-group pool rise."[40]

To compensate for the collapse of the individual insurance market, the state has expanded public programs like Medicaid and subsidized private coverage through programs like Healthy NY. Today, more than 20 percent of New Yorkers are enrolled in the state's Medicaid program, which is the most expensive in the nation. Governor Cuomo has called the Medicaid program unsustainable, given its current size and rate of growth.

Federal insurance subsidies under the ACA may appear to offer the state a windfall, allowing it to expand insurance coverage at relatively low cost to the state. The individual insurance mandate under the ACA is designed to solve the problem of the individual insurance market death spiral by requiring all residents to purchase qualified insurance plans, increasing the number of healthy policyholders.[41] According to one estimate, nearly 700,000 uninsured will be eligible for premium subsidies to purchase coverage through the newly created state health exchange (another 340,000 will be able to purchase coverage without subsidies).[42] Hundreds of thousands of residents who currently qualify for Medicaid coverage but who are not enrolled may also enroll in Medicaid through the exchange to comply with the individual mandate.

However, if the only insurance offerings on the exchange are expensive, heavily regulated, comprehensive insurance plans, the insurance exchange may replicate the flaws of New York's existing individual and small-group insurance market—and small businesses and individuals will be unable to find affordable coverage that meets their needs. As an example of the costs that consumers may face on an exchange with a relatively narrow menu of expensive plans, see Table 1.

In Table 1, we present new estimates of premium increases on a hypothetical New York State individual insurance-exchange market. The HSA plan shown on page 9 is based on a high-deductible plan, with the high-deductible structure allowed under the ACA, with a preventive-care rider included (which covers ACA-required preventive services at no cost to the policyholder).

The other three health-plan options correspond to the Massachusetts gold, silver, and bronze options.[43] (These options were modeled because HHS has not yet defined the "essential benefits" that all qualifying health plans must cover, both inside and outside the exchanges.)

The high-deductible plan is assumed to have a much lower rate of premium increase—3 percent—given the demonstrated cost savings accruing to catastrophic health plans. The other plan designs have year-over-year increases in premium costs that average about 8 percent. This estimate is consistent with the Congressional Budget Office estimates of insurance premium increases under the ACA. Family coverage is much more expensive than single coverage because of the assumption that the policy covers at least one additional adult and/or child.

Of the health-plan options presented, the platinum PPO with a very generous benefit design gets very expensive quickly, mostly because of its higher starting premium. The bronze PPO option increases at nearly the same rate but is not nearly as expensive by 2014 or 2020 because of a lower starting premium. The high-deductible plan remains

Table 1. New York Health-Insurance Exchange Options*

Individual Market	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Family Coverage**										
Bronze–Catastrophic	$11,343	$11,983	$12,642	$13,322	$14,021	$14,742	$15,484	$16,249	$17,036	$17,847
Bronze–EPO	$10,802	$11,767	$12,808	$13,933	$15,147	$16,459	$17,876	$19,406	$21,058	$22,843
Silver PPO/POS	$12,603	$13,711	$14,908	$16,201	$17,597	$19,104	$20,733	$22,491	$24,391	$26,442
Gold–PPO/POS	$14,403	$15,655	$17,008	$18,469	$20,046	$21,750	$23,590	$25,577	$27,723	$30,041
Platinum PPO	$16,204	$17,600	$19,108	$20,737	$22,495	$24,395	$26,447	$28,662	$31,055	$33,640
Single Coverage										
Bronze–Catastrophic	$5,083	$5,536	$6,002	$6,482	$6,977	$7,486	$8,010	$8,551	$9,107	$9,681
Bronze–EPO	$4,841	$5,329	$5,855	$6,423	$7,037	$7,700	$8,416	$9,190	$10,025	$10,927
Silver PPO/POS	$5,648	$6,200	$6,796	$7,440	$8,135	$8,886	$9,697	$10,572	$11,518	$12,540
Gold–PPO/POS	$6,455	$7,072	$7,737	$8,456	$9,233	$10,071	$10,977	$11,955	$13,012	$14,153
Platinum PPO	$7,262	$7,943	$8,679	$9,473	$10,331	$11,257	$12,258	$13,338	$14,505	$15,766
			Income	$55,000	$56,650	$58,350	$60,100	$61,903	$63,760	$65,673
			Maximum Contribution	$4,675	$4,815	$4,960	$5,108	$5,262	$5,783	$6,345
			Silver Premium	$16,201	$17,597	$19,104	$20,733	$22,491	$24,391	$26,442
			Subsidy	$11,526	$12,781	$14,145	$15,624	$17,230	$18,608	$20,097

* Estimates are based on national premium projection data that have been calibrated to the New York insurance market.
**Family of four with income just above 250% of the FPL (currently around $55,000): in 2014, the maximum premium contribution will be 8.1 percent of income.

an attractive option throughout the period because of lower premium increases because the consumer is bearing more out-of-pocket risk.

In 2014, when most of the ACA comes into full effect, the catastrophic option is about 17.4 percent less expensive than the PPO medium plan (the silver benefit level under the ACA) for individual coverage and 13.5 percent less expensive for family coverage. Purchasing a silver plan beginning in 2014 could require a contribution of $4,615, compared with the maximum penalty that year of $95 per household member (up to three) or 1 percent of household income (whichever is greater). The penalty increases to $325 per member in 2015, or 2 percent of income, and is capped at $695 per member, or 2.5 percent of income, beginning in 2016.

Two major findings are highlighted in Table 1's illustration of the impact of the subsidy structure on a family at 250 percent of the FPL. The first finding is that, unless a variety of more affordable plans are available on the exchange, a budget-conscious consumer may have a significant incentive to opt out of coverage and pay the penalty for failure to comply with the ACA's individual mandate provision rather than purchase health insurance, even with a very substantial premium subsidy. Specifically, a potential (capped) $4,675 premium payment for a silver-level plan is over eight times the maximum individual mandate fine in 2014—underscoring the need for more affordable HSA and bronze coverage options (including flexibility in network design for all exchange plans, which can help control premium costs).

The second notable finding is the steadily escalating federal subsidy costs (assuming medical inflation at 8 percent) for nearly every health-plan design compared with a consumer's underlying wealth growth of only 3 percent a year. As a result, from 2014 to 2019, the federal outlays for a family in Table 1, opting to purchase a silver-level plan, increases from $11,526 to $20,097—a nearly twofold increase per insurance contract. Given other uncertainties associated with the ACA—including the possibility that large employers will dump low-wage employees into the exchanges—escalating exchange subsidies may threaten the financial viability of the ACA.

Van de Water (2010) raises similar concerns, noting that moderate- and upper-income consumers will see substantial out-of-pocket costs on the exchanges even in 2014 and that such costs will rise rapidly within just a few years of the ACA going into effect:

> From 2015 through 2018, the premium credits [on the exchanges] will increase annually at the same rate as average premiums in the exchanges, so that families at each income level (computed as a percentage of the poverty level) will pay the same *share of their insurance premium* as a comparable family paid in 2014. But since health insurance premiums are projected to grow more rapidly than incomes, *low- and moderate-income families will thus be required to spend an increasing share of their income on health insurance each year*. [emphasis in original]
>
> After 2018, the premium credits will only increase at the same rate as consumer prices, which are projected to grow less rapidly than premiums. From that point on, families at each income level will pay a growing share of their insurance premium each year—and *an even more rapidly increasing share of their income* on health insurance. [emphasis in original]
>
> Moreover, even in 2014 … the amounts that these low-income families would have to pay themselves are substantial. Consider a family of four with income just above 250 percent of poverty (currently around $55,000): in 2014 the required premium contribution will be 8.1 percent of income, or about $4,500 at today's income levels, for a policy that would carry a quite high deductible and require substantial co-payments.

Van de Water's concern is that even the existing subsides may be inadequate; but the point can equally be made that the exchanges must maintain affordable coverage options that will remain attractive to healthy families and individuals who will still bear substantial annual premium costs. As noted earlier, the penalty under the ACA for refusing to purchase health-insurance coverage is relatively modest (the eventual maximum penalty is 2.5 percent of income, or just over $2,000) and is waived entirely for individuals and families who can't find "affordable" coverage.[44]

Many families and individuals who can't find affordable options on the exchanges are likely to decide that high-priced coverage is simply not worth it, especially when guaranteed-issue plans are available in the event of a serious illness. In these circumstances, many uninsured New Yorkers may elect to go without coverage or seek coverage outside the exchange—transforming the exchange into a de facto high-risk pool. Avoiding this outcome will require policymakers to understand how empowered consumers—and market competition—can help control costs and make more affordable insurance options available in the individual and small-group markets.

IV. MAKING THE CASE FOR CONSUMER-DRIVEN INSURANCE EXCHANGES

As discussed in the previous section, New York policymakers face two basic exchange options. First, the state can take a more selective stance toward plan certification (as, for instance, the Massachusetts Connector does). This approach could involve a number of different strategies. The exchange could require that plans qualified for sale on the exchange offer more benefits than are mandated by federal regulations. The exchange could selectively contract with plans to offer coverage on the exchange, perhaps through a competitive bidding system. States can even opt to launch a "public plan" option to compete against private insurers on the exchange.

The emphasis in this active-purchaser model is ensuring that there is no wrong option for plan choice within the exchange, even if restrictions on insurer participation limit competition and consumer choice within the exchange. By screening out what regulators consider low-value plans and requiring qualified plans to cover a wide range of services and benefits, regulators hope to offer consumers a few high-quality

choices that are attractive to consumers and small businesses while controlling increases in health-care costs. This may seem to balance choice with important consumer protections. However, policymakers should ask the most basic question of any system that relies on an intermediary to make choices on behalf of a third party: Who gets to choose, and why?

Regulators inevitably bring their own biases and preferences to plan design and selection, leading to constrained competition and winners who tailor their plans to meet regulators' (as opposed to consumers') preferences.[45] Special interests will bring their full weight to bear on exchange administrators to ensure that favored services and providers are included in the basic package (and thereby subsidized by consumers who might be otherwise unwilling to pay for such services), driving up costs.

But there are deeper underlying challenges. Even the most sophisticated active-purchaser model will be dependent on the consistent ability of a relatively small number of exchange administrators to select plans that reflect the real (and shifting) preferences of consumers; adapt to rapid changes in health-care services and technologies; and incorporate novel network or benefit designs that have the potential to improve health while lowering (or slowing the rate of growth of) health-care costs.

Regulators that adopt a year-to-year exchange-contracting process—potentially shifting eligible plans frequently—will risk bouncing consumers from plans that they like into plans that they may not like and may undermine insurers' incentives to offer innovative wellness programs, since healthier enrollees could be lost to a competitor during the next contracting or selection process. Adopting multiyear exchange contracts with carriers risks forgoing real opportunities for market innovation that exist during the period when other carriers are barred from entering the exchange.

In short, no active-purchaser model is apt to be as flexible, innovative, or competitive as an open market where consumers can vote with their feet and where every open enrollment season carriers are at risk for losing enrollees to new market entrants or new plan designs that offer better value. This does not imply that the opposite approach—an open exchange that does not screen plans beyond basic minimum regulatory standards—lacks appropriate safeguards to ensure that consumers can find and consistently select high-quality health plans.

The second option, a clearinghouse or consumer choice exchange, will have minimal insurance regulation. Instead of achieving value and cost control through regulation, in the consumer choice exchange value and cost control are achieved by competition among carriers offering a wide variety of network and benefit designs at a variety of prices. One criticism of this model is that insurers will offer a confusing array of low-value plans that may offer low premiums but little financial protection in the event of a serious illness. Critics allege that a blizzard of plans will mean that even diligent consumers will struggle to find high-value plans that reflect their real needs. The end result is that healthy consumers will gravitate toward cheap plans that don't offer real protection against catastrophic illness, and sicker enrollees will face ever-escalating premiums for comprehensive coverage.

These concerns should be taken seriously, especially in opaque markets where it can be difficult for consumers to compare costs and quality across competing providers and health insurers—as it is in health-care markets today. However, these concerns can be addressed through a variety of different exchange mechanisms—some of which are incorporated into the ACA. First, the ACA envisages electronic exchanges that offer meaningful cost and quality information on health plans to consumers. New York's exchange should incorporate a web-portal search mechanism that allows consumers to create their own template for insurance coverage, based on a variety of basic but important metrics, such as age (if the state expands age-rating to the ACA-allowed 3-1 rating), tolerance for financial risk (balancing lower premiums versus higher out-of-pocket costs), and preference for more or less extensive benefits or provider networks.[46]

By helping consumers identify key plan components, many potential choices can quickly be narrowed to a few high-value ones based on the consumers' (or small businesses') needs and preferences. Particularly industrious consumers could use even more sophisticated search tools to home in on specific plan features or access additional information. Risk-adjustment mechanisms[47] in the small-group and individual insurance markets (mandated by the ACA) will help ensure that plans that attract sicker enrollees do not suffer adverse consequences; in fact, some risk adjustment designs could encourage plans to seek out such enrollees for targeted and cost-effective disease-management plans.

Beyond the requirements of the ACA, the exchange should work with providers and carriers to create a transparent and effective provider quality database that encourages consumers to select low-cost plans with the most cost-effective providers. (Carriers should even be able to offer financial incentives for consumers who participate in wellness plans or who utilize more cost-effective providers, particularly for high-volume, relatively low-risk, services that can be standardized—such as hernia surgery or MRIs.)

In the clearinghouse model, choice is left in the hands of the informed consumer, driving carriers and providers to compete on the exchange and shift plan offerings and services to control costs and meet consumers' real preferences. The flexibility of the clearinghouse model provides the best opportunity for insurers to navigate around minimum ACA requirements and find more innovative ways to contain costs and improve quality.

Health Savings Accounts: The Role for Consumer-Driven Plans on New York's Health-Insurance Exchange

There is no single right choice of insurance coverage for every individual, family, or small business. And insurance providers continue to experiment with novel network and benefit designs (such as value-based insurance)[48] that have the potential to improve health-care outcomes at lower cost. Some insurers have even begun offering consumers financial incentives for shared savings from the use of high-quality, low-cost health-care providers.[49] As the market evolves to meet new demands for innovative, high-quality health-insurance options, New York's health-insurance exchange should embrace an open-door policy to new entrants and novel insurance designs.

However, HSAs linked to a high-deductible health plan (known as "consumer-driven health plans," or CDHPs) are not currently allowed in New York's individual, direct-pay market, and it is not entirely clear whether New York's exchange will be required to permit them in the individual exchange, even though the ACA ties maximum out-of-pocket limits to current HSA standards. Some policymakers and community groups in New York view HSAs and other CDHPs with suspicion, believing that they are merely vehicles for the "healthy and wealthy" to skimp on insurance coverage and maximize their tax-deferred savings, leaving higher costs for patients who need more comprehensive ("first dollar") insurance coverage. Another frequent criticism is that CDHPs force consumers to skip critical preventive or routine health-care services that may save money in the short term but lead to higher health-care costs in the long run when consumers develop more serious (untreated or undiagnosed) health complications.

These concerns can be addressed through a number of CDHP designs, and a growing body of evidence suggests that CDHPs offer consumers protection from catastrophic health costs (and achieve similar or better health outcomes) at lower cost than traditional HMO plan designs. CDHPs offer higher deductibles in return for lower premiums, seeking to empower consumers to become more efficient and effective shoppers in the health-care marketplace. The higher initial deductible does not mean that consumers necessarily face higher out-of-pocket costs than with traditional plan designs in the event of a serious or chronic illness. Indeed, CDHPs compatible with HSAs must annually limit

out-of-pocket expenses for benefits covered by the plan to no more than approximately $6,000 for single coverage and $12,000 for families. These limits must apply to all covered benefits, including prescription drug expenses, which are not typically included in out-of-pocket limits under traditional plans.

The rationale for CDHPs stems from the fact that traditional plans have failed to control health-care inflation. Proponents of CDHPs believe that their design (which forgoes first-dollar health-care coverage) can drive consumers to seek better value by selecting more cost-efficient health care goods and services. The high deductible isn't the only feature of HSAs that seems to encourage more price-sensitive consumer behavior, since many HMO/PPO plans now have deductibles that approach those of HSA-qualified high-deductible health plans: CDHPs exhibit cost trends significantly below those of traditional health-insurance plans, while offering comparable—or, in some cases, even better—performance on metrics like the use of generic drugs.

To date, the evidence for CDHPs is mostly positive. Zycher (2009) found that HSA-eligible high-deductible plans had premiums that were 10–40 percent less expensive than traditional plans and that "a wide range of preventive-care services counts toward plan deductibles (or are covered on a 'first-dollar' basis) under most HSA-qualified policies." He noted that "the rates at which enrollees in HSA-qualified plans draw on preventive care or rely on treatment of chronic illness are roughly equal to the rates shown by policyholders in comprehensive plans." A 2009 meta-analysis of CDHP research by the American Academy of Actuaries found that several well-designed studies showed that first-year savings in CDHPs ranged from 4 to 15 percent, compared with control populations in traditional plans that experienced cost increases of 8 to 9 percent (putting total cost savings at 12 to 20 percent in the first year).

The reviewed studies found that "necessary care was received in equal or greater degrees relative to traditional plans" and that there was a "significant increase" in the use of preventive services by CDHP-enrolled members. Levels of recommended care for chronic conditions in CDHPs were comparable with those of enrollees in traditional plans. While the actuaries noted that employers can use CDHPs to shift more costs to consumers (as employers can through traditional plan designs), "most employers are not doing so, and might even be reducing employee cost-sharing under certain circumstances."[50]

A 2010 survey from the Employee Benefit Research Institute (EBRI) found that "individuals in CDHPs were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors," including asking for a generic drug prescription instead of a branded product; discussing care options and costs with their physician; and comparing prices before accessing care. Enrollees in CDHPs were more likely than participants in traditional plans to "report that they had the opportunity to fill out a health risk assessment, and equally likely to report that they had access to a health promotion program … and were more likely than traditional plan enrollees to take advantage of the health risk assessment and the health promotion program." They were more likely to "report that they would be interested in using select networks of high-quality doctors when combined with lower cost sharing."[51] (Notably, enrollees in CDHPs were "significantly less likely" to smoke and were less likely to be obese.) In the past, CDHP enrollees tended to be of higher income, but most of the income differences were not present in 2010, although CDHP enrollees did have higher educational levels.

An earlier (2006) EBRI survey found that enrollees in CDHPs and HDHPs (high-deductible health plans) were less satisfied with the quality of care than enrollees in traditional plans; by 2010, EBRI found that the "gap in satisfaction disappeared because quality satisfaction increased significantly among those with CDHPs," although it remained for enrollees in HDHP plans. The survey attributed the differences in plan satisfaction to consumers' uneasiness with higher out-of-pocket costs.

Rowe et al. (2008) compared the use of preventive services for cancer and diabetic screening between continuously enrolled CDHP members (for three years) with a matched group of PPO enrollees, and found no difference between the plan types.

Overall, data reported to date—through peer-reviewed studies as well as self-reported data from insurers offering CDHPs—should give New York policymakers confidence that CDHPs provide a valuable form of insurance coverage that may offer significant cost advantages over traditional plan designs without compromising quality. These concerns should be further assuaged in a competitive, transparent insurance-exchange environment where consumers will have the ability to easily compare and choose among different plan designs based on cost and quality metrics—including accountable care organizations (ACOs) and medical home-based insurance products.

If New York's health-insurance exchange is to offer more affordable coverage options that will be attractive to a large number of individual enrollees and small businesses—representing a wide variety of ages, preferences, and potential health risks—policymakers must ensure that consumer-driven plans and other innovative designs are widely available on the exchange.

V. CURRENT EXCHANGE MODELS AND LESSONS LEARNED

Building an effective, efficient, and affordable health-insurance exchange in New York will require careful consideration of the strengths and weaknesses of existing exchange models for the individual and small-group markets. In this section, we will consider several such models: the Massachusetts Connector; the Utah Health Exchange and New York's HealthPass; and Medicare Part D and the Federal Employees Health Benefits Program (FEHBP). We will conclude with some lessons learned that should inform New York's exchange implementation and design.

Massachusetts Connector. The Massachusetts Connector was the centerpiece of 2006 bipartisan health-reform legislation developed by Massachusetts's then-governor, Mitt Romney, a Republican, and the state legislature, dominated by Democrats. The legislation included an individual mandate for all state residents to carry "minimum creditable coverage" and a mandate for employers to offer coverage or pay a fine; and it required the merger of the small-group and individual insurance markets. Massachusetts's reforms were the template for what eventually became the ACA.

Beginning on October 1, 2006, the Massachusetts Connector began offering heavily subsidized or free coverage to residents with incomes of up to 300 percent of FPL through the Commonwealth Care program. In May 2007, the Connector began offering Commonwealth Choice for the sale of unsubsidized insurance to individuals; small employers couldn't purchase from the program until the end of 2008. Since health-reform implementation began in 2006, Massachusetts has been successful in extending coverage to more than 400,000 previously uninsured residents, lowering the state's uninsured rate to about 5 percent—less than one-third of the current national average of 17 percent.[52] About half of the newly insured have enrolled in Commonwealth Care or other subsidized programs; only a small fraction of newly insured residents purchased new, unsubsidized coverage through Commonwealth Choice. The remainder received employer-based coverage.

The increase in coverage, however, has not slowed the unsustainable rate of increase in state health-care costs. Lischko and Manzolillo (2010) report that in 2000, Massachusetts's per-capita health-care expenditures were 24 percent above the national average; in 2007, post-reform, they were 30 percent greater than the national average. Total government spending (federal and state) rose 27 percent from 2005 to 2007, growing faster than employer or individual spending. Premiums

for employer-based coverage (for individuals and families) continue to rise faster than the national average, although the trend rate is below that of the pre-reform average. Lischko and Manzolillo caution that national premium trends slowed in 2007–09, indicating that "it is difficult to attribute the slowing pace of premium increases observed in Massachusetts to health care reform."[53]

The one notable *decrease* in premiums came in the unsubsidized, non-group market with a nearly 40 percent decrease in individual premiums and a 21 percent decrease in family premiums from 2006–07 to 2009.[54] However, Massachusetts non-group premiums are still among the highest in the nation. Lischko and Manzolillo attribute this decrease to the merger of the small-group and individual markets, and they note that the deceleration in premium trends may be ending, with small employers, in particular, reporting significant premium increases in 2010.[55]

Massachusetts reforms seem to have been most effective in extending insurance coverage to individuals making up to 150 percent of the FPL, who are not responsible for any premium cost-sharing. Bronze plans remain the most popular choice on Commonwealth Choice, with 41 percent of enrollees, indicating the importance of maintaining more affordable plan options on the exchange.[56] The ability of consumers to compare costs effectively on the exchange has led to increasing market share for one of the state's smaller insurers, Neighborhood Health Plan (from July 2008 to July 2010, NHP increased its enrollment by about 20 percent). As of July 2010, NHP had the second-highest enrollment, 24 percent, behind Harvard Pilgrim Health Care.

However, outside heavily subsidized plans in Commonwealth Care, insurance for individuals and small-groups remains expensive, and pre-reform cost pressures remain (notwithstanding the merger of the small-group and individual markets). Lischko (2011) notes: "The Connector has been less successful at enrolling nonsubsidized individuals and businesses. Improving the insurance market by changing how insurance is purchased and putting the consumer in control of insurance decisions does not appear to have been a priority.… As a result, officials have not seen a dampening of premium costs, and the affordability of insurance is becoming a serious concern for an increasing number of individuals and small businesses."[57]

Excluding Young Adult products (which are only available on the Connector), Connector Choice has fewer than 20,000 non-group purchasers—less than half of those newly purchasing insurance in the individual market. If the Commonwealth Choice were providing superior value for this market, most new purchasers would seek coverage through the Connector. Lischko reports that, as of February 2011, only 164 employees were enrolled in the Connector's small-employer program (the Contributory Plan, currently closed to new enrollees), and fewer than 2,300 employees were enrolled in a newer program, Business Express. Lischko attributes the failure of the Connector to attract more small businesses and their employees to several factors:

- The Contributory Plan option limited employees to choosing from among plans within a tier chosen by their employer (with a fixed plan contribution based on the employer's choice of tier). Because the employee couldn't pick a plan outside the employer's choice (and thus capture more of the plan savings), "the result was that a single 25-year-old was essentially forced to purchase coverage similar to a 55-year-old with four kids."
- Employers choosing plans within the Connector had to meet the same standards as outside the Connector, paying at least 50 percent of the premium and meeting minimum employer participation rates. Many smaller employers simply can't afford to meet these requirements.
- Only twenty brokers in the state were licensed to sell the Contributory Plan, restricting access to the plan.

Despite high approval ratings from the employers and employees in the Contributory Plan option, the program is currently closed to enrollment. In its place, the state opened a new program, Business Express, which offers lower administrative fees for enrolled small businesses but does not allow employees any choice of product, despite the fact that Contributory Plan members identified choice as one of the most important parts of the program. Business Express lacks participation from any of the state's major insurance carriers. Lischko offers a number of recommendations for improving the Connector's value proposition for small employers, including:

- Allowing employers to use a defined contribution mechanism
- Allowing employee choice across all tiers, maximizing employee choice, and allowing additional savings from more frugal plan selections
- Adding a premium aggregator to collect premiums from multiple small employers
- Eliminating minimum participation and contribution requirements
- Opening the program to all brokers and all small employers

Post-reform, Commonwealth Choice basically offers the same high-priced small-group products that were available pre-reform (except for Young Adult products). Lischko notes that carriers have been reluctant to innovate around lower-cost select or tiered hospital- and provider-networks, at least partly because the Connector has sharply limited the number of products that could be sold by each carrier and required standardization of all products, two restrictions that inhibit plan innovation.[58]

In short, although Massachusetts has been successful in extending heavily subsidized insurance coverage, many of the pre-reform challenges (including limited choice and high costs) remain for unsubsidized individuals and small businesses seeking more affordable coverage options. In early 2011, Romney's successor, Democrat Deval Patrick, announced his intention to overhaul how the Commonwealth pays for care for the 1.4 million residents who receive state-subsidized care, including switching to a global payment plan for providers. The Connector announced plans to reduce payment rates to plans receiving state subsidies and to increase the use of limited network plans.[59] The ultimate effect of these reforms will not be known for several years.

Utah Health Exchange and New York's HealthPass: The Defined Contribution Option for Small Employers. Small businesses are a central engine of job creation and innovation, in New York and nationally. However, small businesses pay close to 20 percent more for premiums compared with larger groups. When health-insurance costs rise, small businesses are the first ones to drop coverage or to pass those costs along to their employees. Higher premium costs make small businesses less competitive relative to larger firms in labor markets (since large firms can spread higher insurance costs over many more employees) and in product markets (as larger firms spread the costs of increased coverage to a larger customer base).

Since many of the uninsured work at small firms, expanding affordable insurance options for small employers and their employees should be a priority for New York policymakers. According to one estimate, a potential New York state Small Business Health Options Program (SHOP) exchange could enroll up to 120,000 small firms and cover up to 1.2 million employees and their dependents.[60]

The Utah Health Exchange and New York's HealthPass provide two examples of exchanges that attempt to offer a wider range of affordable choices to small employers and their employees using a defined contribution mechanism.[61] Prior to passage of the ACA, the Utah Health Exchange was created to address escalating insurance-premium costs and a growing decline in employer-based coverage in the state, especially among small employers. Although the state had a lower uninsured rate (10.6 percent) than the national average, policymakers still believed that the

rate was too high and that incentives in the system were misaligned to provide consumers with cost-effective, high-quality, affordable health insurance.

Analysis of Utah's uninsured population found that a majority were employed but worked part-time. Many held more than one part-time position. Most were "young immortals" (aged eighteen to thirty-four), who often place a low value on insurance coverage. Fewer than 50 percent of Utah's small businesses offered health insurance to their employees. In 2009, the state launched the Utah Health Exchange to allow consumers to compare, shop, and enroll in a health plan. Because policymakers were focused on the small-group market, the exchange incorporated several features designed to make health insurance more affordable for employees of small businesses, including a premium aggregator to bundle contributions from multiple employer sources. The exchange also functions as a defined contribution market, where employers give employees a predetermined level of funding with which to purchase coverage—in effect, the defined contribution acts like a voucher that employees can use to purchase health insurance on the exchange.

An insurance risk-adjuster board was established to prevent adverse risk selection against plans in the defined contribution market. (Basically, risk adjustment is a mechanism whereby premiums are shifted from plans with healthier enrollees to plans with sicker enrollees. It is challenging to do well but is required by the ACA both inside and outside the exchanges in the small-group and individual insurance markets. The states are currently awaiting additional guidance from the federal Department of Health and Human Services on how to design appropriate risk-adjustment mechanisms.) Three carriers announced that they would participate in the exchange during its limited pilot for small employers (with two to fifty employees) in 2009 to test the underlying technology.

Problems were identified during the limited launch relating to risk-rating rules inside and outside the exchange. Employers who shifted to defined contribution plans were rated as seeking new coverage and experienced significant premium increases as a result. Plans sold inside and outside the exchange were sold at different prices. Utah enacted legislation to address these problems, including requiring health insurers to apply the same risk-rating rules inside and outside the exchange and to offer the same prices for plans offered in the defined contribution or defined benefit markets.

In April 2010, Utah opened an exchange pilot for large employers (with fifty or more employees) with the potential to enroll 50,000 members when the program goes "live" in 2013. In August 2010, the state opened the exchange to all small employers, which now covers 3,000 members. Another mechanism that the Utah Health Exchange is testing is an all-payer database, where researchers can analyze complete episodes of care from all statewide health-insurance claims to better measure (among other things) the effectiveness of disease prevention and wellness initiatives, health differences among various demographic groups, and the effectiveness of care received from both commercial and public insurers. Ultimately, it may become a powerful tool for measuring quality in health care and provide an additional mechanism for steering enrollees to more cost-effective providers.

Utah's Health Exchange is focused on the state's core problem (uninsured individuals in the small-group market) and is designed to address problems in that market by: simplifying benefits management for employers; giving them predictable costs (through a defined contribution mechanism); enabling the bundling of premium contributions for individuals with more than one employer; and expanding portable, tax-free health-insurance options for employees.

New York offers a private small-business exchange, HealthPass, which shares many of the features of the Utah Health Exchange. HealthPass is a private health-insurance exchange started in 1999 as a joint collaboration between the Northeast Business Group on Health, the New York City mayor's office, and

private health insurers. Its purpose was to expand insurance access for small firms and reduce the number of "working uninsured." Like the Utah Health Exchange, Medicare Part D, and the FEHBP, HealthPass operates as an employee-choice, defined contribution model with a fixed-dollar contribution, albeit under existing New York state insurance regulations.[62]

HealthPass serves the city of New York, as well as Long Island and the Mid-Hudson Valley, and covers more than 30,000 enrollees. It offers a wide range of plans (twenty to thirty) and benefit designs. The value that it offers to small firms lies in simplifying administration of health benefits (with a one-page employer and employee enrollment form) and a robust customer-service center. It offers a range of ancillary services (such as dental benefits) that improve the ability of small firms to compete for labor. Employees can choose any plan with their defined contribution, freeing the employer from trying to find a one-size-fits-all plan that may or may not serve the needs of its employees.

HealthPass sees its central value as streamlining administration for both the employer and the insurer, including a premium aggregator service; bundling multiple employee contributions for payment to the insurer; monthly consolidated billing for the small employer; and facilitating the setup of Section 125 plans for employees (which employees can use to set aside tax-free funds to purchase health insurance). The ACA supports the concept of employee choice, but New York's small-group exchange could allow firms to designate plans for their employees. This could be considered part of a continuum of choice in a competitive labor environment as businesses compete for labor using a variety of health-insurance benefit designs.

Medicare Part D and the Federal Employees Health Benefits Program (FEHBP): Two Defined Contribution Programs Built on Consumer Choice. The Medicare Part D prescription drug program offers government-subsidized coverage for enrolled seniors through private plans. Low-income seniors can qualify for coverage that pays almost all their costs, and higher-income seniors pay somewhat more.

Premiums and co-pays vary based on the types of drugs (branded as opposed to cheaper generics) that are covered by the plan. In general, plans that cover more new drugs will be more expensive than a plan that covers more generics. Seniors can enroll in a drug plan of their choosing when they first become eligible for Medicare; late enrollees pay a penalty. The penalty encourages healthy seniors to enroll when they are first eligible, keeping overall premium costs down for all enrollees.

Medicare Part D was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the first significant change in Medicare benefits in thirty-five years. It is an exchange-like program that helps seniors find affordable prescription drug coverage that fits their needs. Medicare Part D receives extremely high satisfaction ratings from enrollees and has come in under project budget projections for each of the four years for which CMS has reported data (through 2009).

In a 2009 survey,[63] 88 percent of seniors with a Medicare Part D prescription drug plan reported satisfaction with their coverage (including 89 percent of seniors in New York). More than 80 percent of seniors said that their premiums and co-pays were affordable and represented "good value," and 80 percent said that their plan covered all medicines that their physician prescribed.

Average monthly premiums in 2010 were just $2 above 2009 levels, and 2009 costs were $35 billion lower than projected. Overall, 2009 Part D costs to taxpayers were 40 percent lower than originally estimated. Plan choice is extraordinarily wide. Across the country, seniors can choose from more than 2,000 plans, offered by a range of sponsors, including stand-alone prescription drug plans and Medicare Advantage plans. Seniors can opt for low-cost plans that emphasize generic coverage

and mail-order prescriptions, or plans with greater access to branded drugs (but higher premium costs). Finally, seniors can choose plans with (generic drug) coverage in the "doughnut hole," and thus no gap in prescription drug coverage.

Part D shows that a national, consumer-choice-based health plan can offer effective insurance choices, achieve high levels of enrollee satisfaction, and achieve some degree of cost control (at least compared with original plan projections). Part D also benefits from: the lack of heavily entrenched incumbents that can pressure regulators to shield them from competition; the fact that seniors generally choose lower-cost plans (although not always the lowest-cost plans); and a bidding system for the program (along with a capped subsidy of about 75 percent—seniors pay about 25 cents on the dollar) that ensures that consumers always have some incentive to choose cost-effective plans.

The success of the program is attributable to many different factors, including robust competition among private plans; increased competition between brand-name and generic drugs; and subsidies targeted at the highest-need seniors. Part D also contains a risk-adjustment mechanism to adjust plan payments based on factors including demographics, claims-based medical data, and institutional status—so that plans that enroll seniors with higher prescription drug costs are not at a financial disadvantage.

The FEHBP has a long track record of providing federal employees with a wide variety of high-quality health-insurance choices, protection from catastrophic health expenses, and (until relatively recently) providing good value to taxpayers. The program acts like a defined contribution program or voucher program that allows enrollees to select from a menu of choices. Enrollees can opt for more expensive plans and pay added costs out of pocket, or opt for less expensive plans and keep more of the savings. The government's contribution is close to that of Part D (72 percent). The FEHBP has an open enrollment season, with dozens of regional plans from which to choose.

Historically, the FEHBP has outperformed Medicare in its cost trend (Francis 2009), but this has changed over the last decade as the federal workforce has aged and premium "conversion" rules have taken effect that allow enrollees to use pretax dollars to purchase richer insurance coverage—substantially reducing the incentive for enrollees to pick less expensive benefit plans. The success of the FEHBP is also attributed to the fact that the federal government has acted more like an employer as it manages the program (i.e., as a tool to attract talent) rather than as the manager of an entitlement program that tries to offer as rich a benefit set as possible but intervenes in the market to set prices for enrollees. (The FEHBP sets the actuarial values of the plans, but insurers are able to offer a wide variety of plan designs, networks, and co-pays, in a highly competitive environment.)

Lessons Learned

What lessons can policymakers draw from these programs? Massachusetts's success is driven by heavily subsidized coverage. Commonwealth Care is clearly responsible for the lion's share of coverage on the exchange (155,000 versus 22,000 in Commonwealth Choice), and coverage is primarily provided through Medicaid managed-care organizations. While costs have been moderated in Commonwealth Care (a 4–5 percent annual premium increase, on average) and the cost of individual insurance has declined in the wake of state reforms, insurance in the small-group market remains very expensive and heavily regulated. Health-care costs in the state continue on an unsustainable trajectory, threatening substantial tax increases or even substantial cutbacks in the program itself.[64]

Policymakers should note that the relatively less generous subsidies under the ACA may expose many individuals and families in other Massachusetts-style exchanges to higher premium costs, leading them to drop coverage or purchase coverage outside the exchange, increasing adverse selection pressures against the exchange.[65]

The Utah Health Exchange emphasizes private market reforms first, focused on the small-group market. The Utah Health Exchange has taken the lead in implementing a risk-adjustment model in the small-group and individual markets both inside and outside the exchange and has managed to create its exchange with minimal funds ($600,000 plus ongoing funding through an annual appropriation and technology fees) and staff (two). The Massachusetts Connector required $25 million in start-up costs and a much larger ongoing staff and funding commitment.

Utah's health exchange is more of a work in progress but is built on strong buy-in from insurers and the business community. It is designed to expand coverage gradually at an affordable cost to taxpayers. Through its defined contribution mechanism, it contains a powerful tool for consumers to seek high-quality, low-cost health plans, thereby incentivizing insurers to design affordable benefit and network packages. If successful on a large-enough scale—and combined with a provider database to help drive enrollees to more cost-effective, quality health care providers—it could be a game changer.

HealthPass, with an enrollment of more than 30,000, demonstrates that a small-business exchange modeled on similar principles could achieve substantial enrollment. The opportunity to expand coverage, however, depends on making more affordable options available to New York's small businesses and their employees. The state may wish to consider designating HealthPass, or other regional private exchanges, as SHOP exchanges, building on its infrastructure and track record of expanding employees' choice of plans while simplifying insurance administration by providing robust back-office services that free up small employers to concentrate on running their business rather than worrying about health-benefits management.

There are obvious difficulties in extrapolating from national programs like FEHBP and Medicare Part D to state-level exchanges, where competitive pressures may be limited by state regulations, different populations, and the constraints of the ACA. But important lessons can still be drawn for state policymakers. Both programs underscore the importance of consumers voting with their feet as they seek more affordable insurance options. Competition in both programs depends on offering a wide range of plans to meet consumer preferences and giving plans the flexibility to adapt rapidly to changing market demands. Both programs suggest that defined contribution plans drive cost-conscious consumer behavior but that this behavior can be undermined, based on how the contribution is designed (premium conversion severely weakened these incentives in the FEHBP). Insurers must be free to offer less expensive (and thus less generous plan designs) within exchanges to drive more frugal plan selection.

Consumers must be able to capture a significant share of the savings from choosing less expensive plan designs (after premium conversion reforms in the FEHBP, enrollees capture only about 17 percent of the savings from choosing less expensive plans; in Medicare Part D, the enrollee captures about 75 percent). The application of this lesson to exchanges under the ACA is uncertain, since premium subsidies to consumers are pegged to silver-level plans, and the exact benefit package that may be required by state and federal regulators may be very expensive; consumers will also capture a relatively small fraction of the savings from choosing less expensive plans compared with the true, full cost of the plan.

Nonetheless, the FEHBP and Medicare Part D's track record of relatively low-cost coverage, broad consumer choice, and robust competition should reassure policymakers that market-driven competition can help control health-care spending without adverse consequences even for vulnerable populations—provided that it is easy for beneficiaries to compare costs and coverage terms and that consumers have an incentivize to seek more affordable care options.[66]

VI. BUILDING A MARKET-ORGANIZER EXCHANGE IN NEW YORK: KEY PRINCIPLES

Critics traditionally voice concerns that market-based exchanges allow too many choices, either confusing consumers (who pick plans that don't reflect their real needs) or allowing insurers offering bare-bones coverage to "cream skim" healthier enrollees, leading to adverse selection against plans that offer more comprehensive benefits and thus attract sicker enrollees. Arguments like this have shaped the landscape of New York's current insurance market, where plans such as HSAs are unavailable to individuals, and all plans are community-rated and must cover an expensive package of benefits and services.

This approach has not led to a well-functioning and affordable unsubsidized private health-insurance market, and the state has had to bear the brunt of an increasing share of public coverage through its Medicaid program—a strategy that appears to have reached the breaking point. (Notably, despite having a very large and expensive Medicaid program, New York's uninsured rate is just slightly below the national average—15 percent versus 16 percent nationally.)

By contrast, critics of more selective or heavily regulated insurance arrangements contend that such regimes limit consumer choice, are inordinately expensive, and are often captured by incumbent providers or insurers, leading to a long-term decline in competition and unsustainable cost pressures. While the ACA is still the subject of intense partisan debate (and even litigation), it does provide a unique opportunity for New York's policymakers to revisit some core problems afflicting the state's health-insurance markets and to set aside traditional ideological concerns. The ACA sets a new floor for essential health benefits—assuaging liberals' concerns that plans will not cover critical services. It reorders the small-group and individual insurance markets, potentially reducing adverse selection pressures—especially through the creation of a novel risk-adjustment mechanism.

With this safety net in place, New York policymakers should create a market-organizer exchange and embrace deregulation of the state's small-group and individual insurance markets, creating many more affordable and innovative insurance options for New York residents inside and outside the exchange. By offering a variety of plans at affordable rates, policymakers can ensure that the exchange attracts a large risk pool with many young and healthy enrollees—keeping overall rates more stable and affordable, even for older and higher-risk consumers. Key elements of a successful consumer-choice clearinghouse exchange are:

Open Competition among All Qualifying Health Plans. The exchange should primarily be a clearinghouse for insurance competition. Within the context of the ACA, plans should be allowed to compete within each tier (bronze, silver, gold, etc.) based on actuarial value by offering a wide variety of benefit and network designs, rather than having the exchange pick winners and losers for sale on the exchange. As discussed earlier, the floor created by the ACA is an expensive one, but insurers may still be able to find novel ways to offer more affordable insurance options that meet the needs of individuals and small businesses. As in the case of Medicare Part D and the FEHBP, flexibility in insurance design is critical to reducing health-insurance costs to taxpayers and consumers. The state should also resist mandating additional essential benefits for exchange plans. Some consumers may elect to pay a premium for additional services, but this shouldn't prevent other consumers from choosing more affordable stripped-down options. The risk-adjustment mechanism and pooling requirements of the ACA should reassure policymakers that plans that attract healthier enrollees are not cream-skimming, while also encouraging plans to experiment with a variety of innovative disease-management and wellness programs. In every essential respect, there should be a level playing

field among plans offered inside and outside the exchange.

Flexibility in Insurance Design. Through its 1995 POS law, New York standardized coverage in the individual market to a very expensive minimum benefit package and restricted insurers' ability to experiment with various co-payment and deductible designs. While it is unclear how existing requirements will interact with new ACA standards, policymakers should reform regulations based on the 1995 law as needed to allow greater variation in co-pays and deductibles—including allowing HSAs and other high-deductible plans to be sold outside the exchange. They should also allow more limited benefit plans to be sold, allowing consumers to find more affordable coverage options.[67]

Affordable Insurance Options for Younger and Healthier Enrollees. Although the ACA allows New York to maintain its current pure community-rating standards, this regulation is one reason that the state's individual insurance market has become unaffordable for many uninsured individuals and small businesses. By expanding the state's age-banding rules to the ACA allowed 3-1 premium ratio (a reform that would require legislative action), many more affordable policies would become available inside and outside of the state's insurance exchange. Increased enrollment of younger and healthier individuals in the risk pool should help to keep premiums affordable for older enrollees. The state should work with carriers to ensure the creation of an effective risk-adjustment mechanism that encourages insurers to cover and effectively manage patients with higher-cost chronic illness.[68]

Freedom from Political Influence. The exchange should not have responsibility for reviewing the reasonableness of plan rates or for blocking exchange entry to otherwise qualified health plans. (State insurance regulation should remain the responsibility of the state Department of Insurance). The exchanges' function should be limited to serving as an electronic clearinghouse for choice among competing plans and to providing consumers and small businesses with relevant information about competing plans. As such, the exchange should be chartered as a quasi-independent public authority or chartered nonprofit rather than housed in an existing state agency, such as the Department of Insurance or Health. This will maximize the independence of the exchange and reassure participating insurers that the exchange isn't subject to political pressures to pick winners and losers in the exchange market. Locating the exchange outside of a state agency will also maximize the exchange's flexibility in contracting and staffing, freeing it from onerous state contracting and civil service rules. (Of course, the exchange should still—as the ACA requires—be subject to appropriate disclosure of its contracting and hiring practices.)

Defined Contribution Plans for Small Businesses. Defined contribution plans (as in the Utah and HealthPass exchanges) for small businesses, combined with a premium aggregator function, should help many more small businesses and their employees find affordable health-insurance options. To save on exchange implementation and operation costs, the state should consider designating one or more private regional exchanges (such as HealthPass) as the state's small-group health-exchange option.[69]

While not relating directly to exchange administration, we recommend that the state not merge the individual and small-group markets—at least not until the current individual market has stabilized. At that time, the state can perform an analysis to project what the effect of merging the markets would be.[70]

The state has the option of opening the small-group market to employers with up to 100 employees before 2016. We recommend that the state keep the

smaller cap (up to fifty employees) until 2016 to minimize potential disruptions to the small-group market and allow enough time for more "good risks" to obtain coverage. The state should consider the development and implementation of provider cost and quality measurements on the exchange that can be used as a tool to encourage consumers to utilize high-quality, lower-cost providers.

CONCLUSION

The ACA presents New York policymakers with a unique opportunity to reform its individual and small-group insurance markets. However, creating an effective market-based exchange requires policymakers to recognize that simply imposing its current high-cost insurance arrangements on the exchange will lead to the collapse of the exchange over time. Instead, reforms should build on the lessons learned from state exchanges in Utah and Massachusetts, federal programs such as Medicare Part D, and private exchanges such as New York's HealthPass. Creating an efficient, flexible exchange that offers individuals and small groups the maximum number of affordable insurance options will require: a new commitment to consumer choice; openness to innovative provider network and benefit designs; and risk-sharing mechanisms that reward insurers as well as consumers for producing improved health outcomes at lower cost.

Many aspects of the ACA may inhibit state innovation in insurance design and consumer choice. New administrative costs imposed on insurers by ACA regulations will drive up insurance premiums. Higher mandatory MLRs and required rate reviews (and potential premium rebates) will put powerful downward pressure on insurers' (already low) profits—and sharply reduce incentives to control health-care costs by experimenting with new benefit or insurance designs that reduce health-care costs.[71]

Insurers could easily be faced with a no-win scenario that reduces them to regulated utilities that merely administer federal subsidies as a pass-through to providers. While this may cheer some industry critics, it is highly unlikely to produce the efficiency gains or the lower costs that defenders of the ACA hope for from the legislation. Still, a market clearinghouse exchange in New York, driven by policymakers who enact needed reforms (or press federal regulators for appropriate waivers) to ensure maximum flexibility and competition inside the exchange, may mitigate some of the most anticompetitive, cost-increasing effects of the ACA and provide more affordable and innovative insurance options for all New York residents.

Appendix A: New Insurance-Market Regulations under the Affordable Care Act

The ACA contains a number of new requirements for insurance offered in the small-group and individual insurance markets, both inside and outside state health-insurance exchanges. Some of these regulations are effective today, and others will be phased in between 2011 and 2014. All health-insurance plans (both self-insured and fully insured) offering coverage must now meet the following requirements:

- No lifetime benefit limits and increasing restrictions on annual benefit limits (minimum annual benefit limits are raised gradually until they are finally phased out in 2014)
- Children can continue on their parents' policies until they are twenty-six years old
- The ACA prohibits cost-sharing for preventive services
- The ACA prohibits preexisting coverage exclusions for children (under nineteen years old)
- No rescissions, except in cases of fraud[72]

The ACA creates a new minimum essential-benefits package that applies to all non-grandfathered[73] insurance plans (including all plans sold on the exchanges). Every plan must cover:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance-abuse disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The exact scope of the essential-benefits package will be determined by the secretary of HHS; in general, it should be equivalent to the "typical" employer-based health plan. (Insurers can also offer benefits beyond this basic package.)

The ACA requires insurers to treat all beneficiaries within the individual and small-group markets (respectively) as one risk pool for purposes of setting premiums in those markets. To prevent adverse selection against the exchanges, the ACA sets up a risk-adjustment mechanism in both the individual and small-group insurance markets so that even if plans outside the exchanges attract healthier enrollees, they will still subsidize plans in the exchange, at least to the extent that they are low-actuarial risk plans, and plans in the exchange are high actuarial risk plans, as those terms are defined in the ACA.

Appendix B: Insurance-Exchange Regulations under the ACA

State health-insurance exchanges have a number of responsibilities under the ACA. Foremost among these is certification that plans sold on the exchanges are "qualified" and that they meet state, federal, and exchange requirements, including offering the essential-benefits package (designated by the ACA and the secretary of HHS) and are sold by an insurer in good standing in the state in which the policy is issued.[74]

Any insurer who wishes to offer coverage on an exchange must offer a silver- or gold-tier plan before it can issue any other benefit level (bronze, platinum, or catastrophic). If an insurer offers an exchange plan outside the exchange, it must charge an identical premium in both markets.[75] The levels of coverage available on the exchange are defined by their actuarial value: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). (Actuarial value defines the percentage of expected health-care costs that each plan will cover for the policyholder.)

Catastrophic plans are available to individuals under age thirty and those exempt from the individual mandate because they cannot find an affordable plan.[76] The deductible for catastrophic plans can be equal to the total cost-sharing allowable under the ACA. The ACA defines the small-group market as including one to100 workers, although states may elect to define small groups to include one to fifty workers until 2016.

Exchanges must establish a website, with a standardized format, that will enable consumers to shop for qualified health plans and coverage options, including a rating system to compare plans based on price and quality. In addition, the exchanges will screen individuals to determine eligibility for Medicaid, the Children's Health Insurance Program (CHIP), or any other relevant public programs; enroll eligible individuals in the appropriate public program; and establish applicants' eligibility for premium tax credits and cost-sharing subsidies. For individuals who do not qualify for public programs and cannot find affordable coverage, the exchanges will certify that they are exempt from the individual mandate.[77] Exchanges must establish a navigator program to conduct public education programs on coverage options and tax credits available on the exchanges and to facilitate enrollment.[78]

Two or more states can elect to establish a health-care choice compact, under which individual plans will be available to all members of the compact, although issuers would still be subject to the laws of the purchasers' home state with regard to unfair trade practices and network adequacy.

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Endnotes

1. The ACA designates the individual exchange as the American Health Benefits Exchange (AHBE). The ACA dubs the AHBE's small-business counterpart the Small Business Health Options Program (SHOP) exchange. States have the option of merging the exchanges and merging the markets but are not required to do so. For the purposes of our discussion, we will refer simply to New York's "exchange" except where we are explicitly discussing the SHOP exchange. Notably, the statutory requirements defining the AHBE are much more developed than those for the SHOP exchanges. The ACA does not require individuals or small businesses to purchase insurance through the exchanges, and insurance for those categories of individuals will remain available outside the exchanges.

2. A Health Savings Account is an account into which employers or employees can deposit tax-free funds for paying "qualified" health expenses (these are defined by the IRS). HSAs must be linked to a high-deductible health plan. After the individual or family meets the maximum allowable out-of-pocket expenses under the plan (set by federal regulations), additional costs must be covered 100 percent by the insurer for the remainder of the year in which such costs are incurred. HSAs are currently not allowed in New York's individual direct-pay market, although they are available in the small-group market and through the state-subsidized Healthy New York program, as well as through a private program for freelance employees called the Freelancers Union.

3. For a helpful overview of many key issues and challenges facing insurance exchanges, see Jost (2010). Voluntary insurance exchanges have often failed because businesses can shop for coverage outside the exchange, leading to adverse selection pressures against the exchange, i.e., leaving it with a sicker pool of enrollees and higher costs.

4. The ACA envisages some providers—including physicians and hospitals—offering insurance coverage and competing with insurers on state-based exchanges.

5. We will discuss this model in depth later. A defined contribution plan basically allows an employer to give the employee a fixed, tax-free contribution for the purchase of health insurance. The fixed-dollar nature of the contribution gives employers some protection against insurance inflation and gives the employee more choice in the type of health plan he selects (most small employers offer only one choice of health plan). The defined contribution model can work in a number of ways—ranging from the employer picking a range of plans (or a "tier") that employees can choose from, or allowing complete employee choice for any plan available on the exchange.

6. Cost-sharing subsidies raise the effective actuarial value of the plan to 94 percent of benefit costs for individuals at 100–150 percent of FPL; 87 percent of benefit costs for 150–200 percent of FPL; and 73 percent for 200–250 percent of FPL. The subsidies are effectively phased out for individuals at 250–400 percent of FPL.

7. The ACA limits maximum annual cost-sharing (out-of-pocket expenses including deductibles, co-insurance, or co-payments) to those currently allowed for HSA-qualified high-deductible health plans (currently $5,950 individual/$11,900 family; by 2014, this cap will increase). After 2014, cost-sharing limits are indexed to premium growth. In the small-group market, deductibles are limited to $2,000 for individuals and $4,000 for family coverage, indexed to average premium growth. However, companies may offer plans with higher deductibles if they also provide a flexible spending arrangement to reimburse the difference between the plan's higher deductible and the $2,000/$4,000 limits.

8. For a more detailed description of exchange responsibilities beyond dispensing subsidies and enrolling qualified applicants into public programs like Medicaid, see Appendix B.

9. This percentage, called actuarial value, represents the percentage of covered health-care costs that are paid by the insurer after all relevant co-pays, deductibles, and co-insurance requirements have been met.

10. The Congressional Budget Office (CBO) estimates that non-group premiums would rise significantly after the ACA takes effect: "Average premiums would be 27 percent to 30 percent higher because a greater amount of coverage would be obtained. In particular, the average insurance policy in this market would cover a substantially larger share of enrollees' costs for health care (on average) and a slightly wider range of benefits. Those expansions would reflect both the

minimum level of coverage (and related requirements) specified in the proposal and people's decisions to purchase more extensive coverage in response to the structure of subsidies." CBO also estimates that the net effect of this premium increase would be offset by reductions in insurers' administrative costs and by an increase in the number of young healthy enrollees purchasing coverage, further reducing the average premium. CBO estimates that the net (pre-subsidy) premium will increase by 10–13 percent. However, the CBO also notes that "the effects on the premiums paid by some individuals and families *could vary significantly from the average effects on premiums*" (emphasis added). CBO, "An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act" (November 30, 2009), p. 6, http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

11. For a more extensive list of these requirements, see Appendix A.

12. Effective January 2011, there is a new minimum medical loss ratio (MLR) standard for all plans in the individual and small-group market (80 percent) and large-group market (85 percent). The MLR is the minimum required percentage of every premium dollar that insurers must spend on actual health care or other related medical expenses (like health-care-quality improvement programs). The remainder can be devoted to administrative expenses and profits. The current MLR standard in New York, adopted in 2010, is actually more restrictive, requiring a minimum MLR of 82 percent in the individual and small group markets.

13. Ironically, the ACA also contains a 40 percent excise tax on "Cadillac" health plans that takes effect in 2018. The IRS is instructed to take HSA contributions into account when determining the value of such plans. For the sake of consistency, HHS should apply the same standard in calculating the actuarial value of such plans.

14. Personal communication with Roy Ramthun, resident scholar at the Council on Affordable Health Insurance, April 1, 2011.

15. Although this is a complex issue and the regulations are still evolving, it is possible that minimum MLR requirements will encourage carriers to offer fewer HSAs or other high-deductible health plans because it is harder to meet the minimum MLR standard when a plan pays fewer claims relative to their (low) premiums compared to plans with lower deductibles. The result could be fewer bronze and low-cost silver plans on the exchanges, and more higher-premium HMOs and PPOs with first-dollar coverage for health benefits. An additional hurdle for HSAs may arise with respect to how federal regulators assess the actuarial value of such plans, since they typically fall below the bronze actuarial value of 60 percent. However, if HHS rules that the actuarial-value of HSA plans may include account contributions from employers, employees, and insurers, the actuarial value of the plans would rise and could, in some cases, equal those of traditional plans. The CBO explains:

    > An additional consideration arises when evaluating the actuarial value of consumer-directed health plans. Such plans generally combine a high-deductible health-insurance policy with an account that enrollees may use to help finance their out-of-pocket costs (and which may accumulate balances over time). By design, the high-deductible insurance policy will generally have a lower actuarial value than conventional insurance policies. But the actuarial value of consumer-directed plans would include the expected value of any contributions that an insurer or employer sponsoring the plan would make to an enrollee's account—so that contribution could be set to make the overall actuarial value of the consumer-directed plan equal to the value of a conventional health plan. Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals" (December 2008), http://www.cbo.gov/ftpdocs/99xx/doc9924/Chapter3.7.1.shtml

    For a fuller discussion of these issues, see Ramthun 2010.

16. The ACA allows premiums to be based only on family size, geography (to account for regional differences in health-care costs), age (3 to 1 maximum variation), and smoking status (1.5 to 1 maximum variation). Community-rating rules limit variation in premiums that can be charged to sicker or older enrollees, effectively mandating an "average" price that insurers can charge within a given market.

17. Setting higher than average premiums for higher than average risks is problematic to the extent that such premiums may price high risk individuals out of insurance markets. However, community rating also significantly raises costs for

younger and healthier (and likely less affluent) applicants compared with older, and potentially less healthy (but also more affluent), applicants. Community-rated coverage is much more expensive, leading to a higher rate of uninsurance for (at best) a modest gain in coverage for higher risks. The better policy prescription is to subsidize high risks directly, which obtains the same goal (making coverage more affordable for high risks) without the market distortions associated with community rating. Pauly (2010) explains: "The most serious unintended adverse consequence [of community rating] is that, if it is implemented in otherwise competitive insurance markets without targeted subsidies, insurers are required to underprice … for higher risks and must overprice policies sold to lower risks in order to cover their total cost. The consequence of this price distortion is that lower risks will drop or fail to buy coverage. There is substantial evidence that this is what happens, and to such an extent that community rating actually causes more people to be uninsured, even as it modestly reduces the number of uninsured high risks."

18. This analysis assumes that New York will not elect to have its exchange operated by the federal government. If the federal government were to operate New York's exchange, it would shield the state from potentially significant start-up and operational costs associated with running an exchange. However, New York state policymakers would also cede responsibility for regulating exchange policies to the federal government, limiting the state's ability to affect the quality or diversity of plans available on the exchange. Regulation of individual and small-group insurance plans inside and outside the exchange (recall that the ACA envisions that insurance markets will continue to exist outside the exchanges) will require careful coordination to avoid the risk of adverse selection; ceding such responsibility to the federal government raises the risk of breakdowns in regulatory coordination, since the state Department of Insurance will retain responsibility for regulating plans offered outside the exchange. Since the state Medicaid and Children's Health Insurance Program will coordinate enrollment eligibility with the exchange to offer seamless coverage for beneficiaries, it makes sense for the state to retain authority to run an exchange. Notably, since the exchange will verify eligibility levels for Medicaid enrollment, ceding that responsibility to the federal government would restrict the state's ability to ask for program waivers to help control Medicaid costs.

19. The federal government will continue to issue guidance to the states on a number of exchange-related issues, including the definition of qualified health plans for sale on the exchange; the creation of appropriate reinsurance and risk-adjustment mechanisms required under the ACA; and designing a standardized enrollment form for consumers seeking coverage on the exchanges. However, the Obama administration has signaled that it may be willing to accelerate states' ability to opt out of many core provisions of the ACA, provided that certain benchmarks are met. See Sheryl Gay Stolberg and Kevin Sack, "Obama Backs Easing State Health Law Mandates," *New York Times*, February 28, 2011, http://www.nytimes.com/2011/03/01/us/politics/01health.html?_r=1.

20. Moreover, if on January 1, 2013, the secretary of HHS determines that for a particular state, an exchange will not be operational on January 1, 2014, the federal government is required to operate an exchange on behalf of state residents.

21. This amounts to the same thing, since health-insurance prices are largely driven by beneficiaries' use of health-care goods and services—doctors, hospitals, drugs, etc.

22. For an excellent overview of the central challenges facing exchanges under the ACA, see Jost (2010). For a more market-oriented perspective, see Haislmaier (2011).

23. Chambless (2007) notes: "The concept is compared to a stock exchange or a farmer's market which bring buyers and sellers together. A legal structure is created to act as a clearinghouse for approved health insurance products, to collect and consolidate insurance premiums from individuals and employers, and to forward the payments to the insurance companies. The entity is established to comply with federal tax law … to allow employees to pay health insurance premiums with pretax dollars."

24. Guaranteed-issue (GI) and community-rating (CR) regulations have been one policy response to medical underwriting. GI and CR lower the expected insurance costs for sicker insurance applicants but raise costs for healthier policyholders. As discussed in the previous section, in states such as New York that have both GI and CR, the individual market has collapsed as healthy policyholders have exited the market.

25. In 2008, U.S. uncompensated care costs were estimated at $43 billion—a relatively small fraction of total U.S. health-care costs. Notably, as of March 2011, only 12,000 Americans had enrolled in coverage under the ACA state high-risk insurance pools created as a venue for temporary coverage until the guaranteed-issue and community-rating regulations of the ACA take effect in 2014.

26. Council for Affordable Health Insurance (CAHI) 2010, p. 1. As of November 2010, CAHI estimated that New York had fifty-two such mandates. See Bunce and Wieske 2010, p. 3.

27. This is not to say that federal regulation is the answer to captive state insurance markets; instead, competitive federalism (see Hyman 2008) would be a better way to improve consumer choice and insurance competition across state lines.

28. Allowing individuals to purchase an insurance policy regulated by a different state would create regulatory competition between states to design an optimal "package" of insurance regulation that balanced coverage with costs.

29. As long as insurers can charge actuarially fair premiums, there is no inherent reason that insurers would selectively seek low-risk individuals or screen out higher-risk individuals. A better solution is to directly subsidize high-risk individuals of limited means.

30. Ironically, rating restrictions—such as community rating—have led to the collapse of individual insurance markets. As long as insurers can accurately price insurance to reflect risk, younger and healthier applicants will be able to find affordable policies and remain insured—helping to stabilize the risk pool and even helping to subsidize coverage for older and sicker applicants in the individual market. For a full discussion of effects of risk regulation and pooling issues in current individual insurance markets, see Pauly and Herring 2007.

31. To what extent these benefits are achievable will depend on how effectively the exchange is designed and operated, an issue that we will address shortly. To date, however, Jost (2010) notes that there is limited evidence that exchanges have been able to achieve these goals: "[W]hile a few state-level exchanges have been quite successful, many others have failed. Thus, Congress has built its reform of private health insurance markets largely on what has to date been an experiment with decidedly mixed results" (p. 2). Although Jost is a critic of more market-oriented exchanges, his point that exchange design and implementation should be carefully thought through to ensure exchanges meet their intended goals is well taken.

32. Another feature of the ACA that may reduce adverse selection is the creation of a risk-adjustment mechanism for all small-group and individual plans, inside and outside the exchange (except for grandfathered health plans and self-insured group health plans). This mechanism would transfer funds from insurers with healthier policyholders to plans with sicker policyholders. However, this mechanism will have to be carefully crafted to ensure that insurers retain incentives to improve disease-management and disease-prevention programs. Without these incentives, an insurer that performed these functions very well—and thus improved the health of its policyholders and decreased their actuarial risk—could actually be penalized by a poorly designed risk-adjustment mechanism and lose funds to a less well-managed plan.

33. A 2009 RAND study estimates that up to 2.9 million employers may enroll in SHOP exchanges. Up to 1 million of those employers will be offering coverage for the first time.

34. The law is actually implemented through the New York State Department of Insurance Regulation 145 (11 NYCRR 360).

35. The CR/OE law does, however, allow plans to impose some "preexisting conditions limitations" on plan coverage (to be covered out of pocket) that mirror federal HIPAA regulations. In effect, uninsured individuals with preexisting conditions who have not had creditable coverage must pay for those conditions for up to one year after securing new insurance coverage before that coverage will cover the medical costs associated with the pre-existing condition.

36. Community-rated insurance products in New York include the direct-pay (individual market), Healthy NY (a government-subsidized insurance program for small businesses and sole proprietors), and small- and large-group HMO products. Premiums are allowed to vary based only on plans' cost-sharing requirements, riders (if any), family size, and geographic region. For a full discussion of the history and development of New York's CR and GI provisions, see Newell and Baumgarten (2009).

37. "The end product (Chapter 504 of the Laws of 1995) required HMOs to offer two new managed care products to individuals, one with out-of-network coverage, with benefits modeled on Empire's TraditionPlus packages. Benefits were clearly defined in statute, right down to the levels of co-pays permitted, and the Insurance Superintendent was authorized to promulgate new benefit packages by regulation…. Today, critics of the market are incredulous that New York adopted both community rating and a quality benefit package without an individual mandate, and banned less generous benefits for those who wanted to purchase or could only afford more-limited coverage" (Newell and Baumgarten 2009, p. 115).

38. Anemona Hartocollis, "New York Offers Costly Lessons on Insurance," *New York Times*, April 17, 2010.

39. Ibid.

40. AHIP 2009a, p. 7.

41. The ACA contains a number of insurance-market regulations that essentially mirror New York's current regulatory environment. However, HHS has yet to define the "essential health benefits" required for qualified health plans. States may require additional benefits beyond those defined as "essential" for plans sold on the exchanges, but the state would then be responsible for defraying the additional costs to insurance premiums and cost-sharing requirements for qualified health plans.

42. Boozang, Patricia et al (2010). "Implementing Federal Health Care Reform: A Roadmap for New York State," p. 3. New York State Health Foundation (August).

43. The platinum plan is a no-cost-sharing, national panel PPO health plan that has been tracked through prior analysis from HSI Network LLC and the University of Minnesota.

44. Defined as costing more than 8 percent of family income for an employer-sponsored plan or the lowest-cost bronze plan available on a state's health-insurance exchange.

45. Of course, many of the same criticisms can be levied against the employer-insurance markets, with one central difference: employees who are unsatisfied with employer-provided insurance options can request changes or leave for another firm with better options, and firms that offer unsatisfactory insurance coverage in competitive labor markets will lose valuable labor to competitors whose plans more closely meet employees' preferences. The opportunity for labor to exit unsatisfactory employment arrangements is far from ideal—largely because the tax preference for health insurance is tied to employment—but there are still strong incentives for employers to adopt insurance arrangements that meet employees' preferences, at least compared with regulators who will have to answer to various constituencies.

46. For small employers and some individuals, insurance brokers have traditionally served this role as trusted intermediary. Whether they will continue to serve this role on the state exchanges is an open question, given how the new MLR requirements will, as currently codified, put strong pressures on insurers to reduce or eliminate brokers' commissions. However, by creating new broker reimbursement mechanisms—perhaps based on flat per-member-per-month assessments—brokers can continue to play a valued role on the exchanges. Legislation is currently pending in Congress to address how brokers are treated under the MLR requirements. For a discussion of the issues and an overview of the value that exchanges (particularly private, small-business exchanges) can add to the insurance-selection process, see Analysis of Private Exchange Business Models (Leavitt Partners, 2010).

47. Risk-adjustment mechanisms transfer premium payments from plans with a healthier than average pool of enrollees to plans with more high-cost enrollees.

48. Value-based insurance designs (VBID) use deductibles and co-pays (or even waive them) to encourage consumers to use cost-effective health-care goods and services. One potential VBID offers free generic drugs for treating chronic illnesses such as heart asthma and diabetes, since evidence suggests that even nominal co-pays can lead some patients to avoid taking drugs that can reduce more expensive health complications—such as taking statin drugs to reduce the risk of heart attacks and strokes.

49. E.g., the Compass SmartShopper program in New Hampshire. For more information see http://admin.state.nh.us/hr/Compass_SmartShopper.html.

50. American Academy of Actuaries (2009). "Emerging Data on Consumer Driven Health Plans." P. 1.

51. Fronstin 2010.

52. Kaiser StateHealthFacts.org, accessed April 7, 2011. In some respects, Massachusetts's experience with health-care reform is an anomaly—suggesting that the experience of other states under the ACA is apt to be significantly different. First, Massachusetts differs in many important respects from other states: its rate of uninsured was already significantly lower than the national average, and more firms than the national average offered health insurance. About half of the state's increase in coverage appears to be the result of an expansion of employer-based coverage—perhaps a testament to the state's higher average level of employee compensation.

53. Lischko and Manzolillo 2010, p. 11.

54. Ibid., p. 12.

55. Cogan et al. 2010 suggest that reforms increased premium trends for employer-provided health insurance, particularly for individual coverage and for small businesses. The authors found that "health reform in Massachusetts increased single-coverage employer-sponsored insurance premiums by about 6 percent in aggregate, and by about 7 percent for firms with fewer than 50 employees…. For small employers, the differential Massachusetts/US growth in small-group [family] premiums from 2006–08, over and above the growth from 2004–006, was 14.4 percent" (p. 5).

56. "Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2010." Massachusetts Health Connector.

57. Lischko 2011, p. 1.

58. Ibid., p. 6.

59. Kay Lazar, "Health Insurers Pushed to Cut Rates," *Boston Globe*, February 11, 2011, http://www.boston.com/lifestyle/health/articles/2011/02/11/health_insurers_pushed_to_cut_rates_for_lower_income_residents/?page=1.

60. Presentation by New York HealthPass to a Manhattan Institute exchange conference on March 18, 2011.

61. The defined contribution mechanism allows employers to set a fixed, tax-free contribution for the employee to use to purchase a health-insurance plan of his choosing. If the employee purchases a plan that costs less than the full contribution, he can keep the savings. If he purchases a plan that costs more, he pays the additional cost.

62. New York's HealthPass represents something of a midpoint between a totally open clearinghouse model, such as the Utah Health Exchange, and the Massachusetts Connector. HealthPass does not offer all the plans available in New York's small-group market but a selective representation of those plans.

63. Mary Grealy, "Medicare Part D: A Health Care Success Story," Forbes.com, November 12, 2009.

64. A 2009 RAND report (Eibner et al. 2009) on controlling health-care costs in Massachusetts notes that "continued increases in the cost of health care services threaten the long-term viability of [health-care reform]…. [I]n the absence of

policy change, health care spending in Massachusetts is projected to nearly double to $123 billion in 2020, *increasing 8 percent faster than the state's gross domestic product*."

65. The ACA also contains cost-sharing subsidies.

66. CMS should also be commended for its track record to date of ensuring that private insurers were committed to Medicare Part D and that available plans covered a wide selection of therapeutic products.

67. In New Jersey, Parente and Bragdon (2009) found that since the state allowed limited benefit "Basic and Essential Plans" in 2003, enrollment in the individual market has increased 32 percent, almost all of it due to growth in these plans. The ACA allows young adults (up to age thirty) to purchase catastrophic coverage, but enrollees will eventually age out of these options, which will lead to sticker shock as they are forced to purchase more expensive coverage.

68. Policymakers may wish to experiment with a variety of prospective or retrospective risk-adjustment pilot programs that encourage the cost-effective management of enrollees with chronic illnesses. As noted, if plans are merely compensated for *having* expensive patients, they may have less incentive to maximize the cost-effectiveness of care for such patients. Risk-adjusting payments across plans may minimize this disincentive to control costs; another option would be to designate "special needs" plans within the exchange, allowing patients with chronic illnesses to choose among these plans with special vouchers. As with the FEHBP, any funds retained from selecting plans below the full cost of the voucher could be deposited into an HSA for the beneficiary to use for out-of-pocket health costs.

69. There are good reasons for designating regional small-business exchanges, given regional differences in carriers, demographics, and health-care costs. Regional business associations could play a vital role in marketing exchange products to small businesses. Alternately, the state could create a single web-access portal directing small businesses to regional carriers.

70. It should be noted that individuals and small groups look for different products and have different needs in insurance coverage. There may be a good business case for keeping these markets separate; merging them should not be taken without extensive consultation with the small-business community.

71. HHS does not plan to recognize some critical health IT investments as investments leading to quality improvement for purposes of calculating the MLR. For instance, insurers making the required transition to ICD-10 coding and billing systems, which would allow for a far more granular analysis of claims data to identify best practices that can improve health outcomes or lower costs, cannot count those expenditures in calculating the MLR. The danger is that the new minimum MLR rules could actually *discourage* efforts to reduce wasteful health-care spending.

72. This was essentially the status quo, although cases of abuse by insurers were not unheard of.

73. For additional guidance on the regulations affecting grandfathered plans, as well as the circumstances under which such plans will lose their protected states, see "Fact Sheet: Keeping the Health Plan You Have: The Affordable Care Act and 'Grandfathered' Health Plans," http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

74. Qualified plans can include co-op plans and multistate plans, or coverage offered through a "primary care medical home" plan. Plans offered on the exchange must also be available as child-only plans (up to the age of twenty-one).

75. Plan premiums can vary by up to 3-1, based on an applicant's age, family status, and smoking status (1.5 to 1), and take into account regional variation in underlying health-care costs. Nothing in the ACA abrogates any state requirements that may be stricter than these standards.

76. The affordability exemption for individual coverage is set at 8 percent of income.

77. Exchanges will notify the secretary of the Treasury on exempted individuals, as well as employees who receive subsidies on the exchange and purchase a qualified health plan because their employer has failed to provide qualifying affordable coverage.

78. Funding for the navigator program must be made out of exchange operating funds, not federal funding.

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