

HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT OF 2010: POLICY CONSIDERATIONS

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Introduction:

Health Insurance Exchanges (HIE) are the centerpiece of the private insurance reform of the Patient Protection and Affordable Care Act of 2010 (ACA). It is anticipated that once the ACA becomes fully operational in 2014, exchanges may well play a major role in the marketing, purchasing, and standards for the private and subsidized insurance market. They will serve as the rule-setter for the small-group and nongroup market: oversee the standardization of benefits; and administer the tax credits for lower and middle-income people that are outside employer-sponsored coverage. If the HIE work as expected, they could expand coverage, improve quality, and perhaps even lower costs. The challenge will be to make them “work properly”.

Although the theory behind exchanges is sound, the reality is that prior experience has been checkered at best with decidedly mixed results. It will be essential that states understand the pit falls exposed by earlier experiences and understand the options and opportunities offered by the ACA.

Presumably the HIE could offer the benefits of large employer pools with a broad based risk pool and the ability to minimize adverse selection.

Although the ACA goes to great length toward achieving these goals, the decisions made by states in the process of establishing the HIE will be a major determinate in determining their ultimate success. The initial burden of creating a successful HIE will fall to the federal government, since numerous regulations and guidelines are yet to be determined. However, in the end, the final responsibility for making an HIE functional and beneficial will fall to the states, the final decision maker. Thus, the following key issues must be understood and addressed:

- 1. Adverse Selection**
- 2. Number of Participants**
- 3. Market Coverage and Structure**
- 4. Consumer Choice**
- 5. Transparency and Disclosure**
- 6. Competition**
- 7. Administrative Costs**
- 8. Market Regulation**
- 9. Subsidies and Mandates**

10.State, Regional or National Exchange**11.Governance****12.Relationship With Employers****13.Cost Control****#1: ADVERSE SELECTION**

The Issue: When any purchasing entity is unable to capture a large enough share of the healthy population, it becomes susceptible to adverse selection. This has been the single most important reason why purchasing groups or exchanges have failed. Frequently the altruistic purpose of the exchange has trumped the “good business” decisions necessary to stay in business. The exchanges have offered better coverage or more affordable coverage or less underwriting. The result is a group with unfavorable risk profiles, higher costs, and the inability to attract enough healthy individuals due to the cost structure. As long as competitive large group, small group, or individual coverage is available outside the HIE at a cheaper rate, there is a potential for healthy individual to seek coverage elsewhere. Of particular concern are self-insured/ employer-sponsored groups that will exist outside the reach of the HIE due to ERISA restrictions. These groups may turn to the HIE only if the overall health of their group deteriorates. If the exchange turns into a high risk pool, it will be doomed to eventual failure or prolonged government subsidy.

The ACA: It is important to understand the ACA does not eliminate the potential for adverse selection, but it does go a long way to provide rules and tools to limit its impact on the HIE.

1. The amended IRS code will require all individuals to have “minimal essential coverage”. Although the play or pay provision has few “teeth”, it will help to encourage individuals not to stay out of the marketplace.
2. Most insurance reforms imposed by the ACA will apply to plans both inside and outside the exchange. This is absolutely essential.
 - Banning lifetime or annual limits
 - Requiring plans to permit members’ participation in approved clinical trails
 - Allowing premium variation based only on age, geographic region, individual or family coverage, or tobaccos use. Rating based on health status will be prohibited.
 - Issuance and renewability of coverage will be guaranteed.

- Prohibiting pre-existing condition exclusions.
 - Prohibiting waiting periods of longer than 90 days.
3. Individual and small group plans, both within and outside the HIE, must cover “essential health benefits”, with a scope equal to a typical employer health plan. In 2014, out-of-pocket expenditures, both outside and inside the exchange cannot exceed those allowed for high-deductible plans linked to health savings accounts. It is the hope that plans outside the HIE can not attract younger healthier individuals by offering higher cost sharing or by excluding benefits.
 4. Health insurance issuers must treat all individual enrollees as a single pool (grandfather plans are excluded) and all enrollees in small groups as another pool. If the state elects, the HIE may treat both pools as a single pool. Issuers of health plans must agree to charge the same premium for plans inside and outside the HIE.
 5. The ACA has three risk adjustment programs (two transitional and one permanent) to reduce adverse selection. The first permanent risk adjuster will be administered by states and apply to health plans inside and outside the HIE but not to self insured or grandfathered plans. It will allow an assessment of plans with low risk enrollees to make payments to plans with high-risk enrollees. Second, from 2014 to 2016, a transitional reinsurance plan, implemented by states through contracts with private re-insurers, will be established. Since the high-risk pool will terminate in 2014, it is anticipated that the HIE will attract most of these individuals. Early on this will place the HIE at a decided disadvantage. The re-insurance program will help to medicate this problem. One needs to recall that the healthy individual mandate penalties do not phase in until 2017. Unhealthy individuals may well be over-represented in the HIE until that time. It would be wise to assume that this will occur and be surprised if it does not. Lastly, from 2014 till 2016, a risk-corridor program would be available for qualified health plans in the individual and small group market.
 6. With out question the most important protection against adverse selection is the ACA’s premium assistance credits and cost-sharing reduction payments available only to individuals enrolled in health plans provided through the HIE. These subsidies will be offered to households with incomes up to 400% of the FPL (nationwide: 19 million). It will be based on the income level and the total amount spent on health coverage. The lower the income and the higher the cost, the more the subsidy. There may well be a deflection point,

where even with the subsidy, a family could buy minimal coverage outside the HIE cheaper than in the HIE.

7. Small business tax credits will be available only through the exchange for the first two years. Hopefully, this will move additional people into the HIE earlier.
8. States that mandate the coverage of certain benefits that are not included in the federal essential benefit package, will be required by the ACA to cover the cost only if they are provided by qualified health plans. This could pose a problem and lead to adverse selection. Only “qualified health plans” can be sold through the HIE. These qualified plans must comply with all the requirements of the ACA and any additional state requirements. The plans found within the HIE could well be more expensive, making them more difficult to market and sell. If mandated additional benefits were imposed on plans both in and out of the HIE, the overall cost of health insurance would rise but the migration based on benefits would be minimized.
9. Insurance companies must sell gold and silver coverage within the HIE before they can offer bronze. However, they may choose to remain outside the HIE and sell bronze high-cost-sharing or catastrophic plans. Self-insured plans have even less restrictive requirements. Healthy individual will therefore have options for lower cost coverage that could potentially enhance adverse selection.

State Options:

- The ACA does not allow states to require individuals to purchase coverage through the exchange. It does preempt all state laws that would “prevent the application” of the intent of the ACA. It is silent on the option that states could pass laws to more tightly regulate the insurance market place outside the HIE. Self-insured companies covered under ERISA would be the only exception.
- States could: (a) prohibit the sell of insurance outside the exchange; (b) require all plans to be “qualified health plans”; (c) Require all insurers that sell outside the HIE to comply with requirements applicable to plans sold in the HIE; (d) Prohibit insurers that sell within the plan form having an affiliate that sells outside the plan; (e) Prohibit insurers from selling only bronze plans outside the HIE; (f) Prohibit insurers from offering benefit structures or using marketing practices to attract healthy individuals or discouraging unhealthy

individuals; (g) Implement monitoring practice to make sure that grandfathered plans are not encouraging high cost enrollees to leave their coverage and joining the HIE; and (h) Prohibit brokers from collecting higher commissions for selling plans outside the HIE.

#2: NUMBER OF PARTICIPANTS

Issue: The success of a HIE, at its core, is a numbers game. Absent a large enough pool, the HIE will not be able to attract enough health insurance companies; will not be able to negotiate favorable rates; and eventually have an unfavorable risk pool. If the participant numbers are too small then the anticipated economies of scale will not materialize.

Early on, the number of enrollees will be an enormous issue. With risk profile of the covered population being the most important consideration, it has been estimated that between 75,000 and 100,000 participants will be necessary. However, after several years, risk-status underwriting will be eliminated, universal mandates for the purchase of insurance will begin, and reinsurance and risk-adjustment have been implemented, the risk faced by a single insurer will be considerably lessened. There are two ways to look at the “numbers”: (1) either the absolute number of enrollees or (2) the percent of the total market covered. It has been shown that in a small state the percent covered may well be more important than the absolute number to reduce the risk of adverse selection. Using this logic, it is easy to see why attracting small business early on is so important.

The ACA: The HIE must understand the importance of the subsidies and tax credits to attract individual enrollees and small businesses early in the process. The mandates will also help. It is necessary to remember that businesses with greater than 100 employees may not utilize the exchange initially. After 2017, states may opt to open the exchange to this segment of the market. Including large employers has pro and con considerations. While they will rapidly increase the enrollee base, they may also have a less healthy population and could skew the risk profile.

State Options: The most obvious option for states would be to use the state employee, teachers, and retiree pools that currently exist to rapidly expand the participant pool within the HIE. Prior to 2017, states could establish an exchange identical to the HIE and run the two in parallel. This would

immediately increase market share and give credibility to the exchange process. After 2017 the two exchanges could be merged.

#3: MARKET COVERAGE AND STRUCTURE

The Issue: How many risk pools are best to insure the survival of the exchange and best serve the population? Should the ultimate goal be separate risk pools with separate pools for individuals, small businesses, and any other entities that join the exchange? Does the exchange opt for less volatility and more stability with one large pool or regulatory complexity and possibly increased complexity with multiple pools?

A single exchange might offer more choices while multiple pools might be each uniquely tailored to service their designated population. An additional consideration is whether a pool would be regional or statewide. Since Arkansas's population is not evenly dispersed, regionalization may be difficult. Additionally, the risk profile of regional exchanges would most assuredly be different. The last consideration would be to consider a multi-state or bi-state pool, especially if a metropolitan area spanned the state line. The ACA requires insurers to pool individual members into one pool and small business into another, but the law also gives states the option to combine risk pools. Although there may be sound business reasons to separate pools, the overriding key to long term viability will be to have a pool large enough and risk diverse enough to survive. Regional exchanges remain an option to be reviewed later. The ACA provides enough flexibility to states, that policy makers can tailor the exchange to their needs.

#4 MAXIMIZING CHOICE

The Issue: What does "choice" means? Each participant in an exchange might answer differently. It could mean different insurers, premium levels, benefits, cost-sharing options, or provider networks. Exchanges do have a good track record in addressing options and choice. Too much choice can be confusing and counterproductive. The HIE can and should streamline and standardize plan options, concentrating on key features with broad based appeal, like price, benefits, and cost-sharing.

The ACA: The main question will be if the premium subsidies, inherent in the ACA, will be adequate to entice a large enough market to bring insurers

into the exchange, despite the additional requirements involved in participation. Options will increase as plan participation increases. The ACA will define coverage using an “actuarial valve” methodology (the average % medical costs covered by a health plan); Bronze-level = 60%; Silver-level=70%; Gold-level=80%; and Platinum-level=90%. Catastrophic policies are available only to those under 30 or to those that cannot find affordable coverage or suffer a hardship in buying coverage. Participating plans must offer at least one silver and one gold plan. Nothing in the law prohibits states from requiring plans within (or outside) the exchange from further standardizing plans: for example—restricting the number of deductible options, requiring copayments rather than coinsurance. A state could even establish a standard plan at each tier to provide a benchmark for consumers. States need to understand that standardization of benefits and cost-sharing may well deter the use of these variables to risk-select populations.

Any qualified plan may be selected within the exchange by participating individuals. Premium credits are keyed to the silver level (70%). The ACA does not prohibit an individual from selecting a more generous plan and paying the difference or selecting a less generous and paying less. However, the cost-sharing subsidy is available only to those persons who select a silver-tiered plan, as the subsidies are intended to raise the actuarial value of the silver-plan. If an employer contributes to the purchase of coverage through the exchange, the employee may enroll in any qualified plan in the tier of coverage selected by the employer. By using this policy, the ACA can both expand and channel choices. Choices can also be tailored by the state by setting limits and requirements for participation by plans.

#5 TRANSPARENCY AND DISCLOSURE

The Issue: One of the principle benefits of an HIE is the power to require all plans to fully disclose the terms and conditions of the policies offered, thus eliminating the “fine print”. If consumers are to embrace the exchange it will be important that they easily understand options of choice, alternatives, costs, and have the ability to communicate concerns and questions without excessive paperwork or complexity. The exchange must offer timely objective assessments of the quality and efficiency of plans offered.

The ACA: The ACA is rife with numerous transparency and disclosure requirements intended to expand the amount of information available to consumers. The act requires the Secretary and the National Association of Insurance Commissioners to develop standards for ALL group plans (inside and outside the exchange and self-insured plans) to provide summaries of all benefits and coverage explanations. All state standards are preempted. There are separate disclose requirements for those plans to be sold within the exchange.

In addition, the exchange must report and rate all participating plans on quality and price and to measure plan member satisfaction. All data must be reported in a standardized form on a regular basis.

#6 COMPETITION

The Issue: In many areas of the United States true competition between plans is not available. Most local markets are highly concentrated and noncompetitive. A major hope for the exchange is to lure addition plans into a market and make choices more focused on price, value, and quality. There are several secondary or downstream benefits of competition. First and most importantly, competition would increase in market efficiency and lower costs. Second, it would be possible for local and regional integrated health plans to compete with large carriers.

The ACA: Subsidies to low and middle income Americans and to small employers should attract considerable numbers to the exchange. Individual mandates and associated penalties for nonparticipation will also move populations to the exchange. Subsidies and mandates will increase the exchange participant numbers. Guaranteed issue, guaranteed renewal, prohibition on health related underwriting, guaranteed benefits, classification of all plans into tiers, disclosure and transparency, and favorable risk allocation should keep consumers in the exchange and focus competition on price and value.

Enhanced competition is a principle goal of the ACA. Several options exist for states to ponder. First, interstate plans as well as plans offered by cooperatives and “qualified direct primary medical homes” may well enhance competition. But first, they have to be incorporate into the exchange structure. Second, multistate plans offered through the office of Personnel Management may be offered. The extent that these options will enhance competition remains to be seen. Although interstate plans may increase

competition, they may also distort the market since state regulation and requirement may differ significantly. Healthy individuals may opt for a low cost low value insurance policy from a lightly regulated state leaving the higher risk population to the risk pool of their home state. Another likely scenario concerning multistate competition is the reality that only the Blues are currently positioned to do this and it is not likely they will choose to compete against themselves. The last option to enhance competition is for the state to create a public plan to compete. This is not prohibited as long as the plan meets all requirements demanded by the private plans. The predictable objections from those opposed to public intrusion into the marketplace will have to be considered.

#7 ADMINISTRATIVE COSTS

The Issue: Administrative costs, along with underwriting, have long been the “black boxes” of health insurance premiums. Even brokerage costs may add 10% of the cost of a policy in the first year. The exchange could perform a host of administrative functions, such as processing applications, billing enrollees, financial reconciliation, paying commissions, marketing and outreach, and even human resource training. Centralized enrollment offers a real opportunity to save. The potential to lower administrative costs is one of the real benefits of the exchange. With greater required transparency and the modification or elimination of risk based underwriting, the exchange has the tools to alter the overhead structure of health insurance. The track record of exchanges in reducing costs has been mixed to date. If an exchange is to compete in the overall marketplace, it must rapidly and efficiently address the cost issue.

The ACA: The bill allows for federal grants to assist in the formation of the exchange. This federal assistance will terminate as of 2015. From that point, the exchange will need to be self-sufficient, supported by fees imposed on insurers. The exchange will have responsibilities that go beyond a typical insurance carrier. In addition to collecting, creating, managing, and distributing information about participating plans, the exchange will be required by statute to enroll persons eligible for Medicaid, CHIP, and any other state program. It will need to contract with “navigators”, organizations designed to inform the public about state or federally available financial options.

Brokerage commissions, a major additional cost in the current system, will not be eliminated but can be negotiated. Brokers may assist in recruiting clients into the exchange and in assisting in the application for tax credits. The ACA seems to allow participants the option of paying their premium directly to the insurance carrier or the exchange. This will include any premium assistance payments and cost-sharing payments. A key will be to coordinate with the plans to avoid the expensive duplication of services. The cost for health status underwriting should be greatly reduced since underwriting is eliminated. Insurers will still be able to rate age, geography, and tobacco. This saving may be offset by the additional costs of transparency and reporting requirements.

On a different note, the new medical loss ratio provisions of the ACA may well encourage health plans to use the exchange. By statute, if an insurer spends less than 80% of premium income on payment for clinical services or activities that improve quality of care, the difference must be rebated to the enrollees. The plans may exclude federal and state regulatory fees from the denominator. If exchange fees can also be excluded, this will alter the ratio in favor of the insurers. The exchange will need to be vigilant to monitor or at least pay close attention to any manipulation of ‘gaming’ of the medical loss ratio calculation.

#8 MARKET CREATOR OR MARKET REGULATOR

The Issue: Fundamentally, for an exchange to achieve its objective of creating a well-functioning and efficient insurance market, it must be proactive and take on regulatory functions. Exchanges can or may require: A) insurers to provide standardize disclosure of policy terms; B) guarantee issue of policies; C) uniform open enrollment periods; D) minimum benefit packages with cost-sharing in standardized tiers; E) insurers to provide information and data that can be released to consumers; F) limit participation to insurers that comply with exchange requirements; and G) negotiate premiums with insurers or define premium limitations. It is essential to note that the current operating exchanges (FEHBP and CalPers) do negotiate with insurers but not very aggressively.

The ACA: While it is clear that the primary role of the HIE under the ACA is to be a market creator, the regulator responsibilities, as outlined above, are considerable. Since the HIE can offer only qualified plans and premium-assistance tax credits and subsidies can be used only to purchase such plans, the exchange must assume the responsibility and oversight that all

participants are playing by the rules. The HIE cannot impose premium cost controls but it can require a plan to post on its web site justification for its pricing or any cost increase. The exchange may exclude a plan if the costs are felt to be excessive or if the justification for the pricing is not felt to be valid.

Almost at its inception the exchange will need to make an important policy decision; whether or not to pursue a regulatory role aggressively or minimally. The exchange could allow every qualified plan (state or regional) to participate, as long as they meet qualifications. The other option would be to limit participation to a few limited high value plans selected by a competitive process. This could be accomplished by either by using restrictive certification requirements or using a bidding process. There may be a tradeoff between maximal plan participation with enhanced competition and innovation, versus restricting plan participating with maximal consumer protection and likely value. It will be difficult at best to reverse the initial course the exchange selects. The state will, through the HIE, will need to implement a model to follow one course or the other.

It may be a bit odd, but the HIE will regulate the plans offered and direct the market, but will not have all regulatory responsibilities. The new statutes imposed by the ACA will be enforced by the state insurance department or HHS if the state cannot or will not assume the responsibility. All risk-adjustment and reinsurance programs will be administered outside the exchange.

#9 ADMINISTERING OF SUBSIDIES AND MANDATES

The Issue: Much of the exchanges power and influence resides in it responsibility to administer the subsidies that assist low and middle income participants. Basically, the mechanism will be to establish eligibility at the time of enrollment and then to direct the payment subsidy to the insurance carrier selected by the individual. The exchange is ideally suited to perform this duty and to monitor its many steps. Likely the exchange will model its role after the Massachusetts program where Medicaid and CHIP eligibility determination are unified. If programs and plans are housed under the same administrative structure, participants can move more easily from one to another. The key will be to manage subsidies, mandates, programs, and plans in a seamless manner.

The ACA: To start, under the ACA, it will be up to HHS to establish a system that will assure an individual applying to the exchange will receive all subsidies or cost reductions that they are qualified to receive. And if eligibility in a state program like Medicaid or CHIP is appropriate, they will be referred accordingly. HHS is also charged with the creation of a single streamlined form that can be used to apply for all state sponsored health programs. Centralization of enrollment for subsidies and standardization of cost sharing through the exchange should facilitate administration and enhance efficiency. The enforcement of the mandate will lie outside the exchange and will be handled by the IRS.

#10 THE EXCHANGE: STATE, REGIONAL, OR NATIONAL

The Issue: If history is the anticipated standard, the state implementation of a federally mandated program like Medicaid, Health Insurance, Portability and Accountability Act (HIPPA), and SCHIP have been at best, awkward and at worse, very ineffectual and expensive. Can a national exchange address some of the inherent problem produced at the state level? By creating large markets, with a diverse risk pool and lower administrative costs, would a national exchange achieve the economies of scale to truly lower costs and achieve high quality?

A state exchange maintains the heritage of keeping insurance regulation within state borders and not passing the responsibility to a regional or federal authority. Many if not most states will actually have higher standards for insurance carriers than the ACA requirements. With a state controlled HIE, the standards would be maintained. Another consideration in favor of state exchanges is the argument that smaller insurers like a HMO would have trouble growing in a national exchange. A state exchange could also be tailored to reflect the desired of state planners. For example, perhaps the state employee/ teacher program could be incorporated into the exchange to immediately give it credibility.

Regional exchanges may offer benefits from both state and national exchanges. While a state may remain mostly in control of its marketplace, regional exchanges may well provide a lower administrative overhead structure even though the risk pool and market is larger. The problem with regional exchanges would be how to reconcile the differences between state insurance regulations. Also, the issue of risk adjustment and allocation would be problematic.

The ACA: Although the HHS secretary will be charged with issuing regulation and standards for the exchange, full implementation will be left to the states. States will have until January 1, 2014 to accept the federal standards for reinsurance, risk adjustment, and other regulations or alter them a petition for acceptance. HHS will provide grants to underwrite full compliance with all regulations and policies. If the state cannot or will not make the decisions necessary to implement and direct the HIE, the ACA directs the HHS to step into the void and establish an exchange that is minimally consistent with the organizational guideline found in the ACA. An exchange established by HHS could be either a local entity of a national exchange. The decision would be made a federal level.

Having said this, it should be noted that the ACA offers two opportunities for states to maximize their flexibility. First, if a state feels it can offer comprehensive coverage and cost-sharing equal to that found in an exchange, it may apply for a waiver from the requirement to form an HIE for the plan years starting in 2017. The second option offered to states (with HHS approval) is the ability to create a “basic health plan” for individuals lacking employer-sponsored coverage. The state would receive 95% of what would have been provided for premium tax credits and cost-sharing payments.

#11 GOVERNANCE

The Issue: Governance is not only a practical issue but also a perceptual issue. Important considerations include transparency, flexibility, state civil service and public contracting requirements, open record laws, freedom of information laws, salary limitations, and administrative procedure requirements. An exchange could be operated by a state or federal agency or by a private (profit or non-profit) company. Where a governmental entity maybe more transparent, accessible, and accountable; it may not be able to avoid the political infighting that is usually inherent with government. Regardless of the structure, the exchange will need to maintain an open dialogue with the state insurance commissioners, the state consumer protection agency, ombudsman, federal insurance regulators, Medicaid offices, CMS, and others. A regional and a national exchange must in addition meet several states statues, which are likely to significantly differ. This could pose major political problems to balance the needs and expectations of different states. The exchange could be folded into an existing agency like the state employee benefits program or Medicaid.

The ACA: The ACA is somewhat surprising in its silence about governance. Little direction is offered about the construction of the board or the relationship to state government. There are no federal guidelines about state administrative procedure laws, judicial review, freedom of information, or organization outline. All of this is left to the states.

#12 RELATIONSHIPS WITH EMPLOYERS

The Issue: It is clear that the success of the exchange is dependent on ultimately attracting the healthy populations found in many small businesses. This will only be possible if the exchange offers high value and low cost insurance with reduced administrative complexity. Not a small order. If the small business that elects to use the exchange is faced with questions, administrative mistakes, and confusion, their commitment to the exchange will quickly fade.

The ACA: Section 1312(f)(2) of the ACA defines a qualified employer as an employer “that elects to make all full time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through the exchange.” The ACA however sends mixed signals as to how involved the employer needs to be. The employer can (1) allow employees to pay premiums if it contributes something to the cost of insurance, (2) allow employees to pay for insurance outside the exchange, or (3) allow individuals to pay directly to the insurer. One thing that is quite clear is that the employer may not set up a Section 125 (IRS Code) cafeteria plan that permits employees to purchase insurance through the exchange with their own earnings free of taxes.

Even though an employer can be penalized if employees receive premium or cost-sharing subsidies, there is no direct employer mandate in the ACA. Because the ACA prevents some medical underwriting, provides varying subsidies based on household income, limits older employees from higher premium payments, and allows for direct payments the administrative complexity could be overwhelming. This complexity will need to be handled internally by the exchange. If the burden or cost of administration is transferred to the employer, the employer may well opt for other insurance options.

#13 COST CONTROL

The Issue: An accepted driver for health reform has been the realization that the continued excess growth of the cost of healthcare relative to the economy is no longer sustainable. This unavoidable fact coupled with the growing disparity between private sector payment and public sector payments is also equally unsustainable.

The health insurance exchange is one of the few mechanisms in the ACA that attempts to address the growth of private sector spending. The obvious intention is that the exchange will increase competition among insurers and improve quality while addressing cost. A price competitive exchange could potentially permeate the entire supply chain to be more competitive in pricing. Utilization, bargaining, pricing, service integration, and innovative delivery models all could be effected. For the exchange to succeed in lowering prices several features are essential.

1. Adverse selection must be curtained
2. Premium costs and administrative costs need to be reduced
3. A critical mass of participants are essential
4. The exchange must be attractive to employers
5. Utilization of health services need to be appropriate
6. Competition among plans is essential.

The ACA: The law requires premium subsidies to be tied to the difference in cost between percent of gross adjusted household income and the cost of the second lowest cost (silver) plan in the exchange. This requirement will make individuals and families to be very price sensitive in selecting a plan. Although there is not a limit on employer contributions, there is an excise tax on high cost plans. This may well move employers toward a policy of standardized lower share contributions.

As much as cost control is important, if significant requirements are demanded on the plans in the exchange, not required of plans outside, an unacceptable and unsustainable cost structure will be established. If this occurs, the exchange may well fail. On the other, if quality improvement strategies also coordinate care and reduce the use of unnecessary care, cost reductions could result. This is the unrealized expectation for a health insurance exchange.

Sources: Commonwealth Fund; Kaiser Foundation; Patient Protection and Affordable Care Act of 2010; Professor Timothy S Jost, Washington and Lee University School of Law; Heritage Foundation; American Enterprise Institute; Congressional Research Service; CBO

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