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ARTICLES

USING THE FLEXIBILITY OF THE AFFORDABLE CARE ACT TO REDUCE HEALTH DISPARITIES BY CREATIVELY STRUCTURING HEALTH INSURANCE EXCHANGES

KIMBERLY COGDELL BOIES*

INTRODUCTION

The Patient Protection and Affordable Care Act will decrease financial barriers to health care access; however, it may do little to eliminate health disparities.¹ Massachusetts implemented sweeping health care reform in 2006.² The Affordable Care Act has many of the same provisions as the Massachusetts health care reform, including an individual mandate and health insurance exchanges.³ The purpose of this article is to present a novel strategy to increase health equity through health insurance exchanges. First, the problem will be presented using a study of the existence of health disparities following Massachusetts' major health care reform. Next, the causes of health disparities and some issues related to health disparities will be presented. Then, examples of health insurance exchanges will be presented using states that have exchanges that pre-date the Patient Protection and Affordable Care Acts, and proposals from other interest groups about creating new exchanges will be discussed. Finally,

* Kimberly Cogdell Boies, JD, MPH, Assistant Professor, Director, Biotechnology and Pharmaceutical Law Institute, North Carolina Central University School of Law. I would like to thank my research assistant Obieze Mmeje for his help on this research.

¹ The disparities addressed in this article are health disparities between racial minorities and majority groups, specifically blacks and Hispanics.

² See GREG DEBOR & FRAN TURISCO, THE MASSACHUSETTS HEALTH CONNECTOR: LESSONS LEARNED FROM THE BUILDERS OF THE HEALTH INSURANCE EXCHANGE 1 (2010), http://assets1.csc.com/health_services/downloads/CSC_Massachusetts_Health_Connector_Lessons_Learned.pdf.

³ See Jane Zhu, Phyllis Brawarsky, Stuart Lipsitz, Halden Huskamp & Jennifer Haas, *Massachusetts Health Reform and Disparities in Coverage, Access and Health Status*, 25 J. GEN. INTERNAL MED. 1356, 1356 (2010).

the article concludes with recommendations about the required characteristics and the format the exchanges must have to achieve the goal of reducing health disparities.

I. MASSACHUSETTS STUDY OF HEALTH DISPARITIES

Massachusetts enacted broad health care reform legislation in 2006, overhauling the health care system there.⁴ The legislation required universal insurance coverage.⁵ In a study of health disparities comparing Massachusetts to other New England states, although access to care increased, health disparities did not decrease.⁶ A result of the reform efforts in Massachusetts was that by 2008, two years after the health care overhaul, nearly 98% of the population was insured.⁷ However, the study showed that having insurance did not equate to access to care.⁸ It is also important to note that this study used self-reported data; in other words, study participants were asked questions about their own health status.⁹ Key findings of the study include: 1) black and Hispanic adults were still less likely to be insured than whites; 2) there was no decline in financial barriers to physician services for blacks and Hispanics; 3) there was no significant increase in access to a personal doctor for blacks and Hispanics; and 4) self-reported health status did not improve for blacks or Hispanics.¹⁰

⁴ See Christie L. Hager, *Massachusetts Health Reform: A Model of Shared Responsibility*, 29 J. LEGAL MED. 11, 11 (2008).

⁵ DEBOR & TURISCO, *supra* note 2, at 1 (This provision required everyone to purchase health insurance coverage that could afford it. There is also a mechanism for waiving insurance coverage, as well as providing free and low cost insurance to those who meet certain income and resource eligibility requirements.).

⁶ Zhu et al., *supra* note 3, at 1356. Here, access to care refers to the availability of affordable insurance coverage. As a result of the legislation, a larger percentage of the population is insured and should therefore have decreased barriers to accessing health care.

⁷ *Id.* The actual figure was 97.7% in 2008, which was an increase from 94.7% in 2006. The average insurance coverage in the other New England states was approximately 92%. *Id.*

⁸ *Id.*

⁹ *Id.* The study involved Massachusetts adults, ages 18-64, who self-identified as non-Hispanic white, non-Hispanic black or Hispanic. There were 36,505 individuals included in the sample from Massachusetts, and 63,263 individuals from the other New England states of Connecticut, New Hampshire, Vermont, Rhode Island, and Maine. *Id.* The study indicated that one limitation was the use of self-reported data, and that patterns of self-reporting may vary by race/ethnicity. *Id.* However, any biases related to this data should be consistent over time.

¹⁰ *Id.* at 1358. The study noted significant increases in insurance coverage for Hispanics, which represented a significant improvement in the Hispanic-white disparity as compared to other New England states. There was also a significant increase when comparing non-Hispanic blacks in Massachusetts with blacks in New England. *Id.* However, there were no significant improvements to the Hispanic-white disparity in Massachusetts or the non-Hispanic black-white disparity in New England because of a similar increase in coverage of whites in Massachusetts. *Id.* The study found that for whites, there was a decline in financial barriers to physician services from 5.9% to 4.5%, but no change for blacks and Hispanics. *Id.* Regarding access to a personal doctor, blacks reported being more likely than whites to have access to a personal doctor in 2006. *Id.* Access to a personal doctor did not improve

By creatively structuring components of the Act, namely health insurance exchanges, health disparities can be directly addressed.¹¹ State insurance exchanges must select insurance plans that ensure members have actual access to care. State exchanges must be actively involved in selecting plans that will not only promote access, but also will incentivize improving the health status of their members and providing prevention programs. Without requiring the included plans to address health disparities, there will be a subpopulation of individuals who have health insurance but still lack health care. The Affordable Care Act provides an outer framework for the structure of state exchanges, but states have flexibility over the model, governance, and performance measures of the exchanges.¹² It will be through these decisions by states that regulation can impact health disparities through the exchanges.

Cost is a major barrier to obtaining health care; and without health insurance, many individuals are left to seek their health care needs in the emergency room. Also, without insurance, there is little preventive care, treatment of chronic conditions, and general maintenance of health status. For those who have insurance, access is often limited by pre-existing condition exclusions and benefit maximums. While safety net programs such as Medicaid exist for individuals who are extremely poor, there is a significant population of the United States, classified as the working poor, who do not have insurance provided by their employers, but make too much money to qualify for Medicaid to finance their health care needs. The Affordable Care Act provides a solution to many of the financial barriers to access to health care.

Reducing health disparities will be beneficial to the economy and the health care industry. By significantly reducing health disparities, preventable hospital stays can be greatly reduced, saving billions of dollars on health care costs each year.¹³ To achieve the goal of significantly reducing health disparities, targeted programs must be implemented to address vulnerable populations.¹⁴

significantly for any racial/ethnic group. *Id.* Also, fair to poor health status was reported more often in blacks and Hispanics than in whites. *Id.*

¹¹ See generally HEALTHCARE.GOV, HEALTH DISPARITIES AND THE AFFORDABLE CARE ACT, <http://www.healthcare.gov/law/infocus/disparities/index.html> (last visited Oct. 3, 2011).

¹² See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, INITIAL GUIDANCE TO STATES ON EXCHANGES, http://cciio.hhs.gov/resources/files/guidance_to_states_on_exchanges.html (last visited Oct. 3, 2011) [hereinafter CCIIO INITIAL GUIDANCE TO STATES].

¹³ See CTRS. FOR DISEASE CONTROL & PREVENTION, CDC HEALTH DISPARITIES & INEQUALITIES REPORT PRESENTATION 4 (2011), <http://www.cdc.gov/minorityhealth/reports/CHDIR11/Presentation.pdf>.

¹⁴ See *id.* at 5.

II. HEALTH DISPARITIES

Health disparities persist between racial minorities and their majority counterparts, even after controlling for socioeconomic status and other confounding factors. This phenomenon has been studied extensively, yet disparities continue. While, at first glance, the remedy would seem to come from the public health or medical community, because of the structure of the health care system in the United States, these fields have not been able to adequately address the issue. For this reason, a legal solution may augment the efforts by medical and public health professionals to address health disparities prevalent among racial minorities. In order to change the structure of the health care system, and address these issues, major reform is required. After years of debate, and many failed proposals, the Affordable Care Act was passed in 2010. The cause of health disparities addressed by the Affordable Care Act is access to affordable health care, which will be achieved through a variety of mechanisms, including health insurance exchanges.

Individuals who work for small employers or employers that do not provide insurance are not well served by the existing insurance market.¹⁵ This group lacks bargaining power and pays much higher prices for health insurance.¹⁶ They are less likely to have health insurance, and therefore, less likely to receive adequate health care.¹⁷ If access to health care is improved through the Affordable Care Act, disparities that exist between this population and others outside of this demographic may be reduced.

Several federal organizations study health disparities. The Department of Health and Human Services' Office of Minority Health presents data on health disparities and African Americans related to cancer, diabetes, heart disease, HIV/AIDS, immunization, infant mortality, and stroke.¹⁸ Healthy People 2020 suggests that disparities related to health care access are caused by barriers to services, such as high costs, limited availability of providers, and lack of insurance.¹⁹ The Centers for Disease Control

¹⁵ See Elliot K. Wicks, *Building a National Insurance Exchange: Lessons from California*, CAL. HEALTHCARE FOUND. 3 (2009), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingANationalInsuranceExchange.pdf>.

¹⁶ See *id.* at 5.

¹⁷ See AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., IMPROVING HEALTH CARE FOR RURAL POPULATIONS (1996), <http://archive.ahrq.gov/research/rural.htm>.

¹⁸ See OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., AFRICAN AMERICAN PROFILE (2009), <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=51>.

¹⁹ HEALTHYPEOPLE.GOV, ACCESS TO HEALTH SERVICES, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1> (last visited Oct. 3, 2011).

published the first CDC Health Disparities and Inequalities Report (CHDIR) on January 14, 2011.²⁰ This report summarizes issues related to health disparities, and categorizes these disparities by sex, race, ethnicity, income, education, disability status, and other social characteristics.²¹

III. HEALTH INSURANCE EXCHANGES

A. Overview

Health insurance exchanges will provide access to health care for individuals who buy their insurance on the open market and not through their employer.²² Buying insurance without the benefits of employer subsidies is generally much more expensive.²³ Individuals who buy this type of insurance are likely to choose a high deductible health plan or health savings account to have coverage but also reduce costs.²⁴ While many individuals who do not have employer-sponsored coverage and do not qualify for Medicaid choose not to purchase insurance at all. This population has difficulty obtaining health care and is unlikely to have a primary care provider. Poor minorities make up a disproportionate share of this medically underserved group.²⁵ This group experiences health disparities that are caused by lack of access to care and other factors.²⁶ By offering a centralized location to purchase health services at an affordable rate and mandating individual coverage, the Affordable Care Act addresses some of these issues.

The Department of Health and Human Services defines health insurance exchange as a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.²⁷ Exchanges should pool resources, increase

²⁰ See CTRS. FOR DISEASE CONTROL & PREVENTION, CDC HEALTH DISPARITIES & INEQUALITIES REPORT (CHDIR) (2011), <http://www.cdc.gov/minorityhealth/CHDIRReport.html>.

²¹ *Id.*

²² See The Henry J. Kaiser Family Foundation, *Explaining Health Care Reform: What are Health Insurance Exchanges?*, FOCUS ON HEALTH REFORM 1, May 2009, <http://www.kff.org/healthreform/upload/7908.pdf>.

²³ See Lisa Dubay, John Holahan & Allison Cook, *The Uninsured and the Affordability of Health Insurance Coverage*, 26 HEALTH AFFAIRS 1, Nov. 30, 2006, <http://content.healthaffairs.org/content/26/1/w22.full.pdf+html>.

²⁴ *Id.*

²⁵ See Lesley Maloney, Kasey Thompson & Hanna Vanderpool, *ASHP's Role in Eliminating Health Disparities*, 62 AM. J. HEALTH-SYS. PHARMACY 1871 (2005).

²⁶ *See id.*

²⁷ See CCIIO INITIAL GUIDANCE TO STATES, *supra* note 12 (The exchanges are helpful because the

transparency, and reduce health care transaction costs.²⁸ The Kaiser Foundation suggests five general functions of health insurance exchanges including: 1) offering consumers a choice of health plans and focusing competition on price; 2) providing information to consumers; 3) creating administrative mechanisms for enrollment; 4) moving toward portability of coverage; and 5) reforming the insurance market.²⁹

There are three basic types of insurance exchanges: 1) active purchaser model; 2) passive clearinghouse; and 3) hybrid market organizer.³⁰ An example of the active purchaser model is the way that large employers negotiate with and select insurance plans based on benefits and price in exchange for the insurance plan having access to a large number of enrollees.³¹ The passive clearinghouse accepts all plans, and consumers compare price, quality, and services offered by the included plans to make a selection without the preliminary filter seen in the active purchaser model.³² The level of activity of the hybrid market organizer exchange is between the active purchaser and the passive clearinghouse.³³ It does not directly negotiate, but it may require certain benefit minimums.³⁴

B. Exchanges and the Affordable Care Act

Health insurance exchanges are a major component of the Affordable Care Act.³⁵ According to the Act, health insurance exchanges must be established in each state by 2014.³⁶ Suggested benefits of these exchanges

individual and small group markets traditionally suffer from high adverse selection and high administrative costs. The exchanges will create economies of scale and allow this market to benefit from features already enjoyed by the large group market).

²⁸ See *id.* (noting that pooling resources, reducing costs, and increasing transparency will allow exchanges to increase efficiency and competition).

²⁹ See The Henry J. Kaiser Family Foundation, *supra* note 22, at 1-2. In addition to the general functions of the exchange, the report lists key questions about insurance exchanges, including: 1) who has access to the exchange; 2) how is the exchange structured; 3) how should the exchange be governed; 4) how much purchasing authority should the exchange have; and 5) what benefits should be offered in the exchange. *Id.* at 2-3. The recommendations at the end of this article answer these questions.

³⁰ See Wicks, *supra* note 15, at 1-2.

³¹ See *id.* at 1 (identifying the PAC Advantage plan of California is an example of this type of exchange).

³² See *id.* (listing the Federal Employees Health Benefit Program is an example of this type of exchange).

³³ See *id.* at 2.

³⁴ See *id.* (explaining that the hybrid market organizer plan indirectly encourages health plans to offer high value coverage).

³⁵ The Patient Protection and Affordable Care Act is often referred to as the Affordable Care Act and will be referenced as such in this article.

³⁶ See COLORADO MEDICAL SOCIETY, 2014 MAJOR PROVISIONS – PPACA, <http://www.cms.org/strategic-priorities/practice-viability/practice-evolution/timeline/2014-major-provisions-ppaca> (listing

are lowering costs, providing necessary services through one mechanism, and expanding benefits and protections.³⁷ The Act also calls for the creation of Small Business Health Options Program (SHOP), exchanges where small businesses with up to one hundred employees can obtain health insurance for their employees.³⁸ A state may choose to create an exchange that services both individual buyers and small employers, or two different exchanges.³⁹ If the state creates its own exchange, it can choose a single state option or to participate in a regional or geographic exchange.⁴⁰ The state may also opt for the federal government to run the exchange.⁴¹ Additionally, the state may select whether to run the exchange by a federal agency, state agency, or private entity.⁴²

Section 1311 of the Affordable Care Act requires states to establish American Health Benefit Exchanges and provides guidelines for insurance exchanges.⁴³ Health insurance exchanges required by the Affordable Care Act are set for open enrollment in 2013.⁴⁴ In order for a health plan to be included in the exchange, it must be certified by the exchange and meet the requirements set by the Secretary of the Department of Health and Human Services.⁴⁵ The plan must also meet specific requirements to be classified as a qualified health plan.⁴⁶ The minimum benefits required include: ambulatory care, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, laboratory services, preventive

the various procedures that must be in place by January 1, 2014) (last visited Oct. 4, 2011).

³⁷ See HEALTHCARE.GOV, HEALTH INSURANCE EXCHANGES: STATE PLANNING AND ESTABLISHMENT GRANTS (2011), <http://www.healthcare.gov/news/factsheets/esthealthinsurexch.html> (describing the benefits of the exchanges).

³⁸ See STATE HEALTH ACCESS DATA ASSISTANCE CENTER, HEALTH INSURANCE EXCHANGES: IMPLEMENTATION AND DATA CONSIDERATIONS FOR STATES AND EXISTING MODELS FOR COMPARISON 1 (2010), www.rwjf.org/files/research/70588.pdf [hereinafter HEALTH INSURANCE EXCHANGES].

³⁹ See *id.* at 2 (noting that “generally, this will be feasible only if the states choose to combine these markets outside the exchange as well”).

⁴⁰ See *id.* (stating that exchanges can be structured as single-state exchanges or subsidiary exchanges).

⁴¹ See *id.* at 3.

⁴² See *id.* at 3 (“Exchanges may be operated by a federal agency (if states cede control over exchange design and implementation), by state government or quasi-public agency, or by a private and most likely nonprofit entity.”).

⁴³ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311, 124 Stat. 119 (2010) [hereinafter PPACA].

⁴⁴ See CCIIO INITIAL GUIDANCE TO STATES, *supra* note 12 (“Beginning with an open enrollment period in 2013, Exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices.”).

⁴⁵ See PPACA § 1311(c)(1) (“The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans.”).

⁴⁶ See PPACA § 1301 (outlining the various requirements for a qualified health plan).

services, and pediatric services.⁴⁷ These benefits should mirror employer-based plans, but can be expanded beyond these basic services at the exchange's discretion.⁴⁸

The model for the exchange selected will dictate the amount of control the state has over the plan.⁴⁹ Although the Affordable Care Act outlines certain structural aspects of state insurance exchanges, several critical decisions are left to the discretion of the states.⁵⁰ Section 1321 of the Affordable Care Act gives states flexibility in the operation and enforcement of exchanges.⁵¹ In addition to this flexibility, the Affordable Care Act allows states to obtain a waiver of the exchange requirement and to establish their own programs beginning in 2017.⁵² Because the states are required to have an exchange by 2014, a state would have to create an exchange and then dismantle it to create a new program when the waivers are available in 2017.⁵³

In order to promote the establishment of the exchanges, in January 2011 the federal government gave small planning grants.⁵⁴ A total of \$49 million of funding was available in grants of up to \$1 million each to states establishing health insurance exchanges.⁵⁵ There are two levels of grants available, one for states that are early in the planning process of creating an exchange, and another for states that have met specific criteria, such as having a governance structure or a budget, and a consumer assistance plan in place for the exchange.⁵⁶ These grants are used to determine state legislative requirements to create an exchange, determine the organizational structure of the exchange, and explore how the exchange will work with other existing programs, among other goals.⁵⁷

In addition to these grants, Early Innovator grants were awarded to six

⁴⁷ PPACA § 1302(b)(1).

⁴⁸ PPACA § 1311(d)(3)(B)(i) ("[A] State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits . . .").

⁴⁹ Exchanges can be run by a private entity, a state agency, or the federal government. *See* PPACA § 1311.

⁵⁰ *See generally* HEALTH INSURANCE EXCHANGES, *supra* note 38.

⁵¹ *See* DEMOCRATIC POLICY COMMITTEE, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, available at <http://dpc.senate.gov/healthreformbill/healthbill53.pdf>.

⁵² *See id.*

⁵³ *See* Memorandum from Jennifer Staman, Legislative Attorney, to Senator John Cornyn, Legal Analysis of Section 1311(e)(1)(B) of the Patient Protection and Affordable Care Act (Sept. 24, 2010), http://assets.opencrs.com/rpts/M20100924_20100924.pdf.

⁵⁴ *See* HEALTHCARE.GOV, HEALTH INSURANCE EXCHANGE ESTABLISHMENT GRANTS FACT SHEET (2011), <http://www.healthcare.gov/news/factsheets/exchestannc.html>.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

states and a multi-state conglomerate to develop an information technology infrastructure to operate the exchanges.⁵⁸ The states that received this award are Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a multi-state consortium⁵⁹ led by the University of Massachusetts.⁶⁰

The Kansas Health Authority launched its planning of the Kansas Health Insurance Exchange on January 27, 2011 at a small function lead by insurance commissioner Sandy Praeger.⁶¹ In order to avoid having the federal government run the exchange, Kansas will develop its own exchange.⁶² It is estimated that over 500,000 individuals will get their insurance through the exchange.⁶³ Kansas intends to lead the development of the state exchanges, following California, which was the first state to pass exchange legislation in response to the Affordable Care Act.⁶⁴ Kansas is using its Innovator grant to create working groups and a steering committee to develop the state's exchange plan.⁶⁵

Health Care for All New York (HCFANY) is a statewide coalition of health care organizations that advocates for five standards for the New York Health Exchange. The five standards the organization recommends are: 1) there should be one combined state exchange for the individual market and the small group market; 2) health plans must provide quality benefits by setting high minimum standards and must limit the ability for plans to charge different prices and offer different options outside of the exchange; 3) the exchange must be easy to navigate for consumers; 4) the exchange should explore using existing public programs to create a public insurance option; and 5) the exchange should support principles of health equity and should also cover immigrants and reproductive health services.⁶⁶ These principles are somewhat different than the other

⁵⁸ See HEALTHCARE.GOV, STATES LEADING THE WAY ON IMPLEMENTATION: HHS AWARDS "EARLY INNOVATOR" GRANTS TO 7 STATES, <http://www.healthcare.gov/news/factsheets/exchanges02162011a.html> (last visited Oct. 4, 2011) [hereinafter STATES LEADING THE WAY ON IMPLEMENTATION].

⁵⁹ States included in the consortium include Connecticut, Maine, Massachusetts, Rhode Island, and Vermont.

⁶⁰ STATES LEADING THE WAY ON IMPLEMENTATION, *supra* note 58.

⁶¹ See Mike Shields, "Kickoff" for a Kansas Health Insurance Exchange, KAN. HEALTH INST. NEWS SERV., Jan. 27, 2011, <http://www.khi.org/news/2011/jan/27/process-begins-developing-kansas-health-insurance-/>.

⁶² See *id.* (announcing that the federal government will run exchanges in states that choose not to run their own).

⁶³ See *id.* (stating that at least 500,000 Kansas residents are expected to participate and get their insurance through the exchange).

⁶⁴ See *id.* (noting that California became the first state to pass exchange legislation after the federal health reform law was approved in March 2010).

⁶⁵ See *id.* (explaining that the grant would be guided by a steering committee of up to 40 people and would be a front runner state in developing an exchange).

⁶⁶ See HEALTH CARE FOR ALL NEW YORK, COMMUNITY CATALYST, FIVE STANDARDS FOR THE

proposals, especially because this proposal includes a recommendation to establish a state-run health plan.

Several organizations have proposed legislation about the creation of health insurance exchanges. The National Association of Insurance Commissioners created an American Health Benefit Exchange Model Act.⁶⁷ The Model Act gives general parameters for state legislation to comply with the Affordable Care Act, but does not provide guidance on the model and governance of the exchange.⁶⁸

The Oregon Health Policy Board provided a report to the Oregon legislature on recommendations for creating the Oregon health insurance exchange.⁶⁹ The report highlights value for individuals and group consumers, employers, health plans and other stakeholders, touting simplicity, convenience, choice, and service.⁷⁰ The recommendation is that of an active purchaser model, which can set standards and negotiate rates.⁷¹

The Center for Health Policy at Indiana University created a proposal to direct discussion of the creation of a health insurance exchange as mandated by the Affordable Care Act.⁷² The proposal suggests that Indiana creates its own exchange, rather than allowing the federal government to run the exchange, in order to allow the state to promote alternative goals such as improving the state population's health.⁷³ Participating in a regional exchange at some point later to increase the risk pool and decrease the possibility of adverse selection within the exchange is also discussed.⁷⁴ The model for governance of the exchange suggested by the proposal is a quasi-independent state agency to be controlled by the Hoosier Health

NEW YORK INSURANCE EXCHANGE, http://www.communitycatalyst.org/doc_store/publications/five_standards_for_NY_exchanges_HCFANY.pdf (last visited Oct. 4, 2011). Health Care For All New York's founding members are the American Cancer Society, Center for Working Families, Children's Defense Fund – NY, Citizen Action of New York/Public Policy and Education Fund, Community Service Society, Metro New York Health Care for All Campaign, New Yorkers for Accessible Health Coverage, and New York Immigration.

⁶⁷ NAT'L ASSN. OF INS. COMM'RS, THE AM. HEALTH BENEFIT EXCHANGE MODEL ACT 1 (2010), http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

⁶⁸ See generally *id.* (containing sections for general requirements, duties of exchange and regulations, but not providing any sections regarding guidance).

⁶⁹ See OR. HEALTH POLICY BD., OR. HEALTH AUTH., BUILDING OREGON'S HEALTH INSURANCE EXCHANGE: A REPORT TO THE OR. LEGISLATURE (2010), available at <http://www.oregon.gov/OHA/action-plan/exchange-report.pdf?ga=t>.

⁷⁰ See *id.* at 7-8.

⁷¹ *Id.* at 3.

⁷² CTR. FOR HEALTH POL'Y, IND. UNIV. CTR. FOR HEALTH POL'Y PROPOSAL FOR A "HOOSIER HEALTH INSURANCE EXCHANGE" 1 (2010), available at <http://www.healthpolicy.iupui.edu/PubsPDFs/CHP%20Proposal%20for%20a%20Hoosier%20Health%20Insurance%20Exchange.pdf>.

⁷³ See *id.* at 4.

⁷⁴ See *id.* at 4-5.

Commission.⁷⁵ Finally, the proposal suggests the use of an active purchaser model coupled with consumer protection regulations both inside and outside the exchange.⁷⁶

C. Existing Models

Health insurance exchanges, sometimes called health benefit exchanges, existed prior to the Affordable Care Act.⁷⁷ For example, Massachusetts and Utah have health insurance exchanges that predate the Act.⁷⁸

a. Massachusetts

Massachusetts enacted major health reform in 2006.⁷⁹ The reform included an individual mandate for health insurance coverage, a health insurance exchange, regulations regarding employer-based coverage, and an expansion of low-income coverage.⁸⁰ The low-income coverage expansion is called Commonwealth Care.⁸¹ This program covers individuals with income up to 300 percent of the federal poverty guidelines.⁸² The health insurance exchange is the Commonwealth Health Insurance Connector.⁸³ The Massachusetts Health Connector includes two exchanges – one exchange for subsidy-eligible individuals (Commonwealth Care) and a separate exchange for small group and unsubsidized non-group health insurance (Commonwealth Choice).⁸⁴ The combined exchange is referred to as the Massachusetts Health Connector Commonwealth

⁷⁵ See *id.* at 5.

⁷⁶ See *id.* at 13.

⁷⁷ See Emily Adron, Krista Harrison & Gerard Anderson, *Health Insurance Exchanges*, HEALTH POL'Y MONITOR (2009), http://www.hpm.org/en/Surveys/Johns_Hopkins_Bloomberg_School_of_Publ_H_USA/14/Health_Insurance_Exchanges.html.

⁷⁸ See AMERICAN ACADEMY OF FAMILY PHYSICIANS, HEALTH INSURANCE EXCHANGES: VARIATION IN STATE EFFORTS (2011), http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/state/statehcr/aafpexchangesbrief.Par.0001.File.tmp/AAFP%20Exchanges%20--%20March%202011.pdf.

⁷⁹ Adron et al., *supra* note 77.

⁸⁰ *Id.*

⁸¹ See Regina S. Rockefeller, *Massachusetts Take-Away Messages for National Health Care Reform*, EMERGING ISSUES LAW CMY. (2008), <http://www.lexisnexis.com/Community/emergingissues/blogs/spotlightonhealthcarereform/archive/2010/11/08/massachusetts-take-away-messages-for-national-health-care-reform.aspx>.

⁸² See *id.* (explaining that legal residents who are not eligible for other public or employer sponsored health care can receive a completely subsidized comprehensive coverage package for their children if they earn up to 300 percent the poverty level).

⁸³ See *id.*

⁸⁴ See HEALTH INSURANCE EXCHANGES, *supra* note 38, at 3 ("Commonwealth Care is a separate exchange for subsidy-eligible individuals; Commonwealth Choice is combined exchange for small group and unsubsidized nongroup health insurance.").

Choice.⁸⁵

Because the Massachusetts exchange has been in existence for several years, pilot programs are being implemented to improve wellness in the state.⁸⁶ One such program is the Small Group Wellness Incentive Program.⁸⁷ This program is administered by the board of the exchange to implement evidence-based programs aimed at improving wellness, decreasing costs, and increasing productivity.⁸⁸ This program is targeted at small employers that purchase insurance through the exchange.⁸⁹ Employers can receive tax credits through the Affordable Care Act for participation in this program.⁹⁰ The exchange is responsible for creating regulations for this program.⁹¹

Individuals who have employer-sponsored coverage in Massachusetts are also interested in purchasing insurance through the exchange.⁹² For example, Daniel and Diane Provencal sued the Commonwealth Health Insurance Connector Authority, its executive director, and the chairperson of the board, because they were deemed ineligible to participate in Commonwealth Care, the state's insurance exchange.⁹³ The connector is governed by a ten-member board, which determines eligibility and can adopt regulations to operate and regulate the connector.⁹⁴ In *Provencal v. Commonwealth Health Insurance Connector*, the issue was whether the connector was required to consider a request for a waiver of the employer-sponsored insurance exclusion.⁹⁵ The Provencals were in a precarious position for several reasons: 1) they received health insurance through Mr.

⁸⁵ See *id.* at 5 (stating that the Massachusetts Health Connector Commonwealth Choice is synonymous with the combined exchange).

⁸⁶ MASS. GEN. LAWS ANN. ch. 176Q, § 7A (West 2001) (noting one specific pilot program that is effective as of July 1, 2011).

⁸⁷ *Id.* at § 7A(a) ("There shall be a small group wellness incentive pilot program to expand the prevalence of employee wellness initiatives by small businesses.").

⁸⁸ See *id.* at § 7A(b)(3) (discussing that in order to be eligible for the program a small group must offer evidenced-based, employee wellness programs that meet specific criteria). The small groups that do participate in the program would receive from the connector an annual subsidy not to exceed five percent, and technical assistance in order to maximize the federal grant provided for the establishment of wellness initiatives by small employees. *Id.* at § 7A(c).

⁸⁹ *Id.* § 7A(a).

⁹⁰ *Id.* at § 7A(b)(2).

⁹¹ *Id.* at § 7A(a).

⁹² See *Provencal v. Commonwealth Health Ins. Connector Auth.*, 924 N.E.2d 689 (Mass. 2010).

⁹³ *Id.* at 690.

⁹⁴ *Id.*

⁹⁵ *Id.* at 693-94. Two provisions of the eligibility criteria for the connector are relevant to this question: (1) the individual's or family member's employer has not provided health insurance coverage in the last 6 months for which the individual is eligible and for which the employer covers at least 20 per cent of the annual premium costs of a family health insurance plan; and (2) the individual has not accepted a financial incentive from his employer to decline his employer's subsidized health insurance plan. These two criteria must be met to be eligible. *Id.* at 693 n. 9.

Provencal's employer; 2) the employer met the minimum coverage requirements of an employer-sponsored plan; 3) Mrs. Provencal could not work because of numerous health conditions; and 4) they could not afford the \$196.52 bi-weekly premiums required for the employer-sponsored plan on Mr. Provencal's salary of \$24,239 per year.⁹⁶ Because of the employer-sponsored coverage, they were ineligible for the connector.⁹⁷ The ineligibility exists despite the fact that Mr. Povencal's salary was 177% of the federal poverty level, substantially less than the 2007 income eligibility cap of \$41,076 for participation in the exchange.⁹⁸ The court reasoned that because of the use of the language "may waive" by the legislature, the connector has discretionary power and is entitled to substantial deference.⁹⁹ For this reason, the court did not grant a right to waiver to the Provencals.¹⁰⁰ The court suggested that the legislature could create an economic hardship exemption. However, because no such exemption currently exists, the determination of waiver of the employer-sponsored insurance exclusion is left to the discretion of the board of the connector.¹⁰¹ This case gives a powerful example of the ability of health insurance exchanges to allow individuals with specific challenges, both financial and non-financial, to seek access to affordable health care. It is a testament to the Massachusetts system that individuals outside of the exchange see the exchange as an option for the purchase of affordable health care.

b. Utah

The Utah Health Exchange was created in 2009 as a portal for employees of small businesses to use their employer-defined contribution to shop for and purchase insurance online.¹⁰² The Exchange was launched on August 19, 2009 for employer enrollment, and coverage became effective on January 1, 2010.¹⁰³ Through the Health Exchange, small employers can choose not to select a health care plan for all of their

⁹⁶ *Id.* at 691.

⁹⁷ *Id.* at 691-92.

⁹⁸ See *Provencal v. Commonwealth Health Ins. Connector Auth.*, 924 N.E.2d 689, 691 (Mass. 2010).

⁹⁹ See *id.* at 694.

¹⁰⁰ See *id.* at 696.

¹⁰¹ See *id.*

¹⁰² Press Release, Governor's Office of Economic Development, State of Utah, Governor's Office of Economic Development to Launch the Utah Health Exchange (Aug. 19, 2009), *available at* <http://www.exchange.utah.gov/images/stories/PDFs/Health20Exchange20Launch208.09.pdf>.

¹⁰³ News Release, Governor's Office of Economic Development, State of Utah, Utah Health Exchange Reaches Launch Goal Early, <http://www.exchange.utah.gov/images/stories/PDFs/Utah20Health20Exchange20Reaches20Launch20Goal20Early.pdf> (last visited Oct. 8, 2011).

employees, but can instead provide a specific contribution towards the purchase of health care, which the employee can then supplement with the employee's own money and shop on the Health Exchange to purchase the amount of coverage the employee selects.¹⁰⁴ The Utah Health Exchange calls itself an information portal and lacks many of the formalities of the Affordable Care Act insurance exchange requirements.¹⁰⁵ The Utah Exchange aims to connect consumers to existing information in a standardized format, which will empower consumers by giving them a single source for information and purchase of health insurance.¹⁰⁶

The Utah Health Exchange expanded its pilot exchange to include large employer groups in 2010.¹⁰⁷ Some statistics from the Exchange were published in the Salt Lake Tribune, including that 400 individuals are receiving insurance through the exchange, and some of the 66 plans are reporting costs up to 130% higher under the plan.¹⁰⁸ Currently in Utah, House Bill 128 makes significant changes to the Utah Health Exchange.¹⁰⁹ The new legislation allows contracts with private entities to administer the exchange, establish a call center, and remove the large employers from the exchange.¹¹⁰ The bill creates a health system reform task force which will review and make recommendations on the health insurance exchange regarding the governance structure, operations, and which market regulatory functions should be given to the exchange.¹¹¹

The New York Times quoted the speaker of the Utah House of Representatives as saying, "[i]n our exchange, the government is a market facilitator, not a contracting agent. We believe in the invisible hand of the marketplace rather than the heavy hand of government."¹¹² This ideology marks a major difference between the Utah exchange and the

¹⁰⁴ See UTAH CODE ANN. § 31A-30-204(3) (2011).

¹⁰⁵ See UTAH HEALTH EXCHANGE, EXCHANGE FREQUENTLY ASKED QUESTIONS, <http://www.exchange.utah.gov/learn-more/exchange-frequently-asked-questions> (last visited Oct. 8, 2011).

¹⁰⁶ See *id.*

¹⁰⁷ See News Release, Governor's Office of Economic Development, State of Utah, New Groups to be Included in Utah Health Exchange's Large Group Pilot Project (Apr. 28, 2010), http://www.exchange.utah.gov/images/stories/PDFs/UHE20large20employers_round202.pdf.

¹⁰⁸ See KAISER HEALTH NEWS, UTAH TRIES TO IMPROVE STATE HEALTH INSURANCE EXCHANGE; MICH. PLANS FOR DOCTOR SHORTAGE (2010), <http://www.kaiserhealthnews.org/Daily-Reports/2010/February/17/State-Policy-Developments.aspx>.

¹⁰⁹ See generally 2011 Utah Laws 128.

¹¹⁰ See *id.* (noting that the revisions to the bill relate to Utah's health system, and that the revisions reform the Health Code, the Insurance Code, and the Governor's Programs).

¹¹¹ *Id.* ("The committee and the department shall report to the Legislature's Health System Reform Task Force . . .").

¹¹² Robert Pear, *Health Care Overhaul Depends on States' Insurance Exchanges*, N.Y. TIMES, Oct. 23, 2010, at A23.

Massachusetts exchange.¹¹³

The Utah exchange was created, and is governed, by the Office of Consumer Health Services, which was created by the Health System Reform Act.¹¹⁴ The legislation requires that the exchange provides access to health insurance websites, provides comparisons for health benefit plans, and includes enrollment for government assistance programs.¹¹⁵ However, the Office of Consumer Health Services is strictly prohibited from regulating health insurers, health insurance plans, or health insurance producers.¹¹⁶ It also may not adopt administrative rules or act as an appeals entity for resolving disputes.¹¹⁷

c. Comparisons

The Massachusetts exchange is the largest, and most closely resembles the American Health Benefit Exchanges required by the Affordable Care Act.¹¹⁸ The Utah and Washington exchanges are administered by public agencies, the Connecticut exchange is a private not-for-profit entity, and the Massachusetts exchange is a semi-independent public entity.¹¹⁹

The Utah exchange relies on the market to drive competition.¹²⁰ The Massachusetts exchange exerts much more control over the plans included in the exchange, playing an active role in increasing competition.¹²¹ Although both states have health insurance exchanges, there are stark differences between health care coverage in Utah and Massachusetts.¹²² The Utah and Washington exchanges serve as market organizers, the Massachusetts exchange is an active purchaser, and the Connecticut

¹¹³ See *id.* (“Massachusetts and Utah provide a glimpse of the future, and they offer radically different models for other states.”).

¹¹⁴ UTAH CODE ANN. § 63M-1-2504(1) (2011) (“There is created within the Governor’s Office of Economic Development the Office of Consumer Health Services.”).

¹¹⁵ See *id.* at § 63M-1-2504(2) (“The office shall . . . create a Health Insurance Exchange that: (i) is capable of providing access to private and government health insurance websites and their electronic application forms and submission procedures; (ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange . . . ; and (iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs . . .”).

¹¹⁶ See *id.* at § 63M-1-2504(3)(a)(i) (“The office may not: (i) regulate health insurers, health insurance plans, health insurance producers . . .”).

¹¹⁷ See *id.* at § 63M-1-2504(3)(a) (“The office may not: ii) adopt administrative rules . . . or iii) act as an appeals entity for resolving disputes between a health insurer and an insured . . .”).

¹¹⁸ HEALTH INSURANCE EXCHANGES, *supra* note 38, at 7 (*finding that the Massachusetts Health Connector most closely aligns with the new federal law*).

¹¹⁹ *Id.* at 9.

¹²⁰ See Pear, *supra* note 112 (discussing Utah’s belief in the invisible hand of the marketplace rather than the heavy hand of government).

¹²¹ See *id.*

¹²² See *id.* (referring to the radically different models of the two states as bookends for other states).

exchange has a hybrid role in plan selection.¹²³ Benefit options within each exchange vary by the number of plans offered as well as the number of options within each plan.¹²⁴

D. Other State Approaches

California is the first state to establish an exchange that implements the requirements of the Affordable Care Act.¹²⁵ California's exchange is a quasi-independent body that has the ability to make policy decisions about the exchange.¹²⁶ The legislation to create the exchange was signed on September 30, 2010.¹²⁷ This exchange will take a more active role, mirroring the Massachusetts Connector more than the Utah exchange. The California exchange is regulated by a five-member Oversight Board.¹²⁸

California has attempted versions of health insurance exchanges in the past with its Health Insurance Plan of California.¹²⁹ This exchange was set up under the active purchaser model.¹³⁰ The major problem cited with this exchange was that because the exchange was not the exclusive source of coverage, competition problems arose when competing for the same customers inside and outside the exchange.¹³¹ Two side effects of this problem were that higher risk enrollees bought insurance from the exchange and participating health plans chose to give lower prices outside of the exchange.¹³²

Several other states are at various stages in creating exchanges. Because much of the background work being done to develop the exchanges

¹²³ See HEALTH INSURANCE EXCHANGES, *supra* note 38, at 9 (characterizing the particular exchange role that Massachusetts, Utah, Connecticut, and Washington each play in health plan selection).

¹²⁴ See *id.* (listing the different plans available by state and including the number of options available for each of those plans).

¹²⁵ See ROBERT WOOD JOHNSON FOUNDATION, STATE OF THE STATES 2 (2011), <http://www.rwjf.org/files/research/71835summary.pdf> (noting that in September 2010, "California became the first state to pass legislation to establish an exchange" following the enactment of the Patient Protection and Affordable Care Act).

¹²⁶ See *id.* (stating that California established "a quasi-independent governing board with broad latitude to shape the policy decisions of the exchange").

¹²⁷ See Pear, *supra* note 112 (explaining that on September 30, 2010, California's governor "signed two bills establishing the California Health Benefit Exchange, with broad powers to 'negotiate on behalf of the public' and select qualified health plans").

¹²⁸ See California Healthline, California Becomes First State to Create Health Benefit Exchange (Oct. 1, 2010), <http://www.californiahealthline.org/articles/2010/10/1/california-becomes-first-state-to-create-health-benefit-exchange.aspx> (noting that the California exchange will be overseen by "an independent, five-member board").

¹²⁹ Wicks, *supra* note 15, at 1.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

happens in legislatures, information is not readily available at this time about the status of new exchanges. Often the exchanges do not have a website because they have not been officially created. There may be legislation pending, or the legislation may still be at the committee level, or it is being drafted. States are actively pursuing the creation of insurance exchanges and overall health care reform. For example, Oregon began creating its exchange prior to the passage of the Affordable Care Act.¹³³ Illinois created the Illinois Health Care Reform Implementation Council, which recommended that the Illinois exchange adopt an active purchaser model.¹³⁴ Vermont has yet to create its exchange, but has even greater reform plans, lead by Governor Peter Shumlin, to eventually move the state to a single payer system.¹³⁵ In a memorandum from the Congressional Research Service addressed to Senator John Cornyn, legislative attorney Jennifer Staman gives a legal analysis of Section 1311 of the Affordable Care Act regarding the creation of a public option as the only health care plan within a state exchange.¹³⁶

IV. OPPOSING PERSPECTIVES

If the health care market is not regulated, both inside and outside of the exchange, and there are not sufficient numbers of individuals enrolling in insurance plans through the exchange, the active purchaser model may not be the best option.¹³⁷ In order to compete with plans outside of the exchange in an unregulated environment, the exchange should be set up as either a market organizer or a passive clearinghouse.¹³⁸ The amount of regulation required to induce insurance plan enrollment may be seen as negative to those who favor a strict market-based approach. Although the states have wide latitude in creating and regulating the exchanges, the

¹³³ Joe Rojas-Burke, *Health Reform: Oregon Among Leading States in Effort to Start Health Insurance Exchanges, Receives \$48 Million From Obama Administration*, THE OREGONIAN, Feb. 16, 2011, available at http://www.oregonlive.com/health/index.ssf/2011/02/health_reform_oregon_among_lea.html.

¹³⁴ See Patrick Yeagle, *Planning a One-Stop Shop for Health Insurance*, ILLINOIS TIMES, Feb. 10, 2011, <http://www.illinoistimes.com/Springfield/article-8343-planning-a-one-stop-shop-for-health-insurance.html>.

¹³⁵ See *Administration Lays Out Vt. Health Reform Plan*, ASSOCIATED PRESS, Feb. 8, 2011, <http://news.yahoo.com/administration-lays-vt-health-reform-plan-20110208-122540-598.html>.

¹³⁶ See Staman, *supra* note 53 (stating that there is no language in the PPACA that would prohibit an exchange from denying certification to every private plan that applies if it determines that every plan is not in the "interest of plan participants").

¹³⁷ See Wicks, *supra* note 15 (explaining that an active purchaser model will have a difficult time achieving its objectives if insurers are able to compete for the same customers outside the exchange market).

¹³⁸ See *id.*

federal government is still mandating state action. States that would otherwise choose not to reform health care are required to do so by the Affordable Care Act. Some states that oppose the health care reform believe that the federal government does not have the authority to enforce the individual mandate and the requirement to create a health insurance exchange. While these questions exist, states are moving forward with plans to create exchanges within the parameters of the Affordable Care Act. Calls have been made to return federal funding for the creation of the state exchange in an effort to oppose the Affordable Care Act.

V. INSURANCE EXCHANGES AND HEALTH DISPARITIES

Health insurance exchanges can reduce health disparities by: 1) increasing competition among insurance companies for spots in the exchange; 2) creating a data clearinghouse at the state level; and 3) requiring insurance plans included in the exchange to provide certain resources and benefits. Health insurance exchanges can decrease health disparities by increasing competition and ensuring meaningful coverage.¹³⁹ Meaningful coverage requires that plans provide a certain amount of coverage, so that the sickest individuals do not all end up in one plan.¹⁴⁰

The process of creating health insurance exchanges involves a balance of inducing insurance companies to want to participate in the exchange and provide the best benefit plans at the best prices for consumers.¹⁴¹ If no insurance companies include plans in the exchange, the exchange will fail. If there are either too many plans in the exchange, or the plans do not provide benefits needed, they will not be as effective for consumers. Using the Affordable Care Act as a guide, states must use the flexibility included in the Act to create exchanges that not only address access issues and increase the purchasing power of small employers and individuals, but also address important concerns such as reducing health disparities.

Health insurance exchanges can increase competition among health insurance companies based on the requirements of the exchange. If health insurance exchanges include a limited number of plans and there is an

¹³⁹ See Linda J. Blumberg & Karen Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, URBAN INST., Apr. 2009, at 8, available at <http://www.rwjf.org/files/research/qsexchangefinal.pdf> (concluding that without a well-designed exchange, a patchwork of new agencies would be required to achieve the nation's health reform goals).

¹⁴⁰ See *id.* at 2.

¹⁴¹ See Wicks, *supra* note 15, at 2 (explaining that because insurers would be required to offer standardized health plans, which individual employers could choose every year, they would be forced to compete on the basis of price, quality, and service – an approach known as “managed competition”).

incentive for companies to participate, plans will vie to have one of their plans included in the exchange.¹⁴² An additional benefit to limiting the number of plans included in the exchange is that with fewer choices, consumers will better understand the choices and can more easily compare the similarities and differences between the plans.¹⁴³ If there are a limited number of plans within the exchange and insurance companies have an incentive to participate, consumers will have the benefit of several options at different cost sharing points, without being overwhelmed by too many choices.¹⁴⁴ The variety will not be overwhelming because the number of plans is not open-ended.

The exchanges must set reducing health disparities as a goal, and must engage insurance companies that provide plans within the exchange to reduce disparities. Insurance companies collect large amounts of data on plan participants. This industry has created several ways to limit patient care to only what is necessary. This is done by requiring a finding of “medically necessary” when determining eligibility for services. Another strategy is to prohibit “experimental” treatment. These practices are intended to reduce overuse of the system and to control costs incurred by the insurance company.

Physicians are often the gatekeepers of the provision of services. Physicians make medical decisions about what care is needed. The same physicians who make these medical decisions are also incentivized by the insurance companies to reduce costs.¹⁴⁵ The insurance industry benefits when people use less health care. Physicians receive incentives and cash payments at the end of the year based on the amount of care that is provided. In the same way that insurance companies have created a system of incentives for reducing costs, there is an opportunity for companies to create programs that address health disparities. If a physician received additional payments for improving the health status of a certain number of patients, the physician may take more ownership of their patients in providing better care.

¹⁴² See *id.* (“Just as large employers do, the exchange would negotiate with health plans, offering contracts to only a selected few plans that offered favorable prices in exchange for a significant market share.”).

¹⁴³ See Richard Frank & Richard Zeckhauser, *Health Insurance Exchanges – Making the Markets Work*, 361 NEW ENG. J. MED. 1135, 1136 (2009), available at <http://www.nejm.org/doi/full/10.1056/NEJMp0906246> (suggesting that one way to enhance the prospect of informed choices is to limit the number of options).

¹⁴⁴ See *id.* (arguing that requiring plans to offer identical features would limit choice of plans).

¹⁴⁵ See Joshua Goldman, *Who’s Paying for Health Care?*, HOUSE CALL, MD, Mar. 24, 2010, <http://www.myhousecallmd.com/archives/1899> (finding that when it comes to complex or advanced diseases, HMOs are incentivized to provide the minimum amount of care necessary to reduce costs).

The Health Insurance Portability and Accountability Act (HIPAA) restricts the transmission of this data to employers and prohibits discrimination based on health status, but the information would not be used for that purpose. Additionally, data provided by insurance companies to the exchange about plan participants can be identified and presented as a statistical report.

VI. RECOMMENDATIONS

A. Format and Governance of the Exchange

State health exchanges should be governed by a state agency or quasi-state agency. This new agency, or sub-agency should be responsible for the selection of insurance plans to participate in the exchange, data collection, operation of the exchange, and administrative decision-making. The agency goals include containing costs, facilitating the provision of quality health care, and eliminating health disparities. Because of the flexibility included in the Affordable Care Act regarding the exchanges, states have the ability to tailor their exchanges to achieve these goals. The agency will be responsible for monitoring the implementation of the Affordable Care Act and generating new strategies for dealing with state-specific issues. This agency should promulgate regulations both inside the exchange and outside the exchange, to facilitate competition.

An active purchaser model should be used by the agency governing the exchange. The exchange should promote competition among insurers to provide the best quality options at affordable prices. The exchange should be limited to a small number of insurers with a limited number of plans. By limiting the number of plans, insurers will work hard to be included in the exchange.¹⁴⁶ In order to promote the effectiveness of the active purchaser model for health insurance exchanges, insurers must be restricted from competing with offerings within the plan. This will allow for collective bargaining within the exchange without the challenge of adverse selection and cherry picking outside of the exchange.

It is to the advantage of insurers to partner with the exchange to reduce health disparities and improve health outcomes for minority populations. Individuals who have better health status require less expensive health services. If a goal of insurance companies is to improve the health of their

¹⁴⁶ See CTR. FOR HEALTH POL'Y, *supra* note 72, at 13 (maintaining that if Connectors are selective on which plans get into the exchange, then insurance providers would be more likely to bargain for higher value and lower premiums).

enrollees, this will cut costs in the long run. The problem with this approach is that financial investment in prevention and improving health status is usually not quickly and easily quantifiable. This is why the law must step in to require that these measures be taken. Through the exchange, insurers will be challenged to create the best practices and become market leaders in the reduction of health disparities. Incentives should be provided by the agency in the form of tax advantages for insurers that can demonstrate improvement in health equity. When insurers have a mandatory stake in reducing disparities, more opportunities for change exist.

The agency should require each insurance organization to submit information about benefits and services offered in their plans. Information provided should include prevention programs, and highlight what aspects of the plan make it a better choice than other plans. This information will be used by the agency to create a report card on each plan. This report card will then be used to select plans for inclusion in the exchange. Report card scores can be provided with the data about each plan to consumers to aid in the decision making process. The agency may decide to rank the plans based on quality or simply assign each plan a score or grade.

a. Director of Diversity and Health Disparities Elimination

Within the new agency, the position of Director of Diversity and Health Equity should be created. There must be one person whose sole responsibility is to address issues of diversity and health equity. The agency has the ability to address the diversity of the medical profession through the director. By partnering with programs that provide scholarships for minority medical students, the director can help to determine where these students practice during their obligatory service period. The director will be responsible for all issues related to health disparities and diversity of the exchange. The director will determine the health disparities rating for the report card of each plan that wishes to participate in the exchange. Additionally, the director will be responsible for making recommendations and assessments of the plans.

B. Incentives and Outcomes

Health Insurance Exchanges are the ultimate data collector. By empowering the exchange agency to regulate which plans participate in the exchange, along with other regulatory and structural mechanisms, insurance companies will be encouraged to reduce health disparities. The

agency should not limit the insurance companies' ability to be innovative in achieving the goal of reducing health disparities. The agency should facilitate the use of identified data collected by the exchange to study disparities and their elimination. Insurance companies should be free to create pilot programs and conduct research using exchange data. In exchange for receiving a high score related to disparities reduction on the report card, the insurance plan would be more likely to be selected by the exchange. Insurance companies will have access to a large percentage, if not all, of the individual and small group market.

For insurance company incentive programs and interventions to be successful, concrete outcome measures must be identified. Preventable hospitalizations can be tracked to determine the effectiveness of a plan's intervention. Data is needed to show whether the cause of the hospitalization is based on access and quality issues, as opposed to other unrelated issues. Information on commonly collected health disparities, such as heart disease, certain cancers, and diabetes, are good measures on which to base performance measures.

Overall, health insurance exchanges provide a ripe area for innovation to reduce health disparities. Despite the fate of the Affordable Care Act, states may still choose to create an insurance exchange. The goal of this article is to suggest a new way of engaging the insurance community to partner with the state on the common goal of reducing health disparities using health insurance exchanges.