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## It's a Mistake: Insurer Cost Cutting, Insurer Liability, and the Lack of ERISA Preemption Within the Individual Exchanges

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# IT'S A MISTAKE: INSURER COST CUTTING, INSURER LIABILITY, AND THE LACK OF ERISA PREEMPTION WITHIN THE INDIVIDUAL EXCHANGES

CHRISTOPHER SMITH\*

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In today's society, most people receive their health insurance through their employers.<sup>1</sup> If their employment-based insurer engages in cost cutting that leads to patient injury, Employee Retirement Income Security Act of 1974 ("ERISA") preemption means that these people have no state tort-based recourse against their insurers.<sup>2</sup> ERISA is a federal statute that regulates employee benefit plans, and the Supreme Court has interpreted the ERISA statute to preempt most beneficiary state tort claims against an employment-based insurer.<sup>3</sup> In other words, even if the insurer, and not the doctor, caused the patient's harm, the patient with employment-based insurance can only sue their health care provider for medical malpractice, with very limited federal remedies available against the insurer. However, when the Affordable Care Act ("ACA") individual exchanges come into play in 2014, the number of individuals with non-employment-based insurance will likely expand and so will their remedies for insurer cost cutting that results in patient harm.

Imagine it is 2014 and Bill Smith does not have employment-based insurance, so he buys insurance from a Health Maintenance Organization ("HMO"), XYZ Insurance Company, through his State's individual exchange. XYZ is concerned about high costs within the individual exchange, so they have set up incentives or bonuses for general practitioners in their network to keep patients in-house, if at all possible, instead of referring them to specialists. Bill Smith goes to see Dr. Jones, a general practitioner in XYZ's network, for treatment for a skin lesion. Dr. Jones is eager to receive his bonus, concerned that excessive referrals might cause him to be terminated from XYZ's network, and believes that the lesion is a simple cyst that he can dispose of without referral to a specialist. Accordingly, Dr. Jones treats the cyst in-house. Unfortunately, the cyst is actually a virulent form of cancer that requires highly skilled treatment from a dermatologist and/or oncologist. Due to the delay in receiving specialty care, Bill dies and his estate sues Dr. Jones for malpractice and XYZ under theories of corporate negligence and apparent agency.

Since Bill is buying his insurance through the individual exchange and not receiving his insurance through his employer, ERISA preemption does not apply,

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<sup>1</sup> CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011, at 21 (Sept. 2012), available at <http://www.census.gov/prod/2012pubs/p60-243.pdf> (finding that 55.1% of Americans receive their health insurance through their employer, whereas only 3.6% directly purchased their insurance coverage).

<sup>2</sup> Robert A. Schapiro, *Not Old or Borrowed: The Truly New Blue Federalism*, 3 HARV. L. & POL'Y REV. 33, 46-47 (2009) (noting that the Supreme Court has interpreted ERISA to preempt State law claims against employment-based HMOs without providing a federal substitute remedy).

<sup>3</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (holding that the ERISA enforcement scheme is the exclusive remedy for plan participants and beneficiaries and "that varying state causes of action for claims within the scope of [the ERISA enforcement scheme] would pose an obstacle to the purposes and objectives of Congress").

and therefore his tort claim against XYZ is a viable claim.<sup>4</sup> On the surface, equity favors providing an individual exchange beneficiary with recourse for insurer wrongdoing, especially when compared to the lack of remedies available to beneficiaries with employment-based insurance. However, the situation is not so simple and raises a troubling dilemma. While the lack of ERISA preemption opens up a new damage recovery source for individual exchange beneficiaries, it hinders the ability of individual exchange insurers to engage in cost cutting measures that eliminate waste and fight potentially high costs within the exchanges.<sup>5</sup> High costs, in turn, will likely be passed along to beneficiaries in the form of higher premiums. Given the impacts of the lack of ERISA preemption within the individual exchanges, to quote “Men at Work,” insurers will “not be the only one[s] saying it’s a mistake.”<sup>6</sup>

This Article seeks to address this dilemma in an effort to balance beneficiary access to damages when insurer cost cutting causes harm and properly incentivize insurers to engage in beneficial cost cutting and to keep down exchange costs, so that the exchanges can thrive. Section I starts by outlining insurance coverage access problems for high-risk individuals prior to the passage of the ACA, and the ACA’s efforts to expand coverage access. Section II addresses concerns that the ACA access expansion provisions may lead to adverse selection and high costs with regard to the individual exchanges. Section III outlines how insurers may respond to adverse selection and high costs within the individual exchanges through cost cutting measures. Section IV discusses insurer tort liability, the operation of ERISA preemption, and the impact of the lack of ERISA preemption on the individual exchanges. Finally, Section V outlines potential solutions to the ERISA problem with a proposal for a no-fault insurer liability fund solution.

## I. INSURANCE COVERAGE ACCESS

### A. Pre-ACA Insurance Access Problems

Prior to the ACA, many individual consumers without employment-based health insurance—especially those who were high-risk—had difficulty procuring affordable or, in some cases, any health insurance.<sup>7</sup> The culprits behind these access problems have been adverse selection and insurer efforts to combat adverse selection. Adverse selection is the tendency of high-risk, costly consumers to seek out health insurance coverage, more so than low-risk, less costly consumers.<sup>8</sup> The former are more motivated to seek out insurance because they have superior knowledge about their

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<sup>4</sup> 29 U.S.C. § 1144(a) (2006) (ERISA preempts State law as applied to employee benefit plans).

<sup>5</sup> Thomas R. McLean & Edward P. Richards, *Health Care’s “Thirty Years War”: The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 316-17 (2004) (arguing that ERISA preemption has allowed managed care to be more ruthless in its cost cutting strategies).

<sup>6</sup> MEN AT WORK, IT’S A MISTAKE (Epic 1983).

<sup>7</sup> Stewart Jay, *On Slippery Constitutional Slopes and the Affordable Care Act*, 44 CONN. L. REV. 1133, 1139 (2012) (noting that historically, health insurance has been unaffordable and unavailable to those that do not have Medicaid, Medicare, or receive insurance through their employer).

<sup>8</sup> Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1235-37 (2004).

risk level than insurers do.<sup>9</sup> As more and more high-risk beneficiaries seek out coverage, insurance rates rise to cover the costs of the high-risk population and more and more low-risk enrollees drop coverage.<sup>10</sup> The result is a death spiral, as premiums continue to rise and more and more healthy consumers drop coverage.<sup>11</sup>

In the pre-ACA world, insurers used a variety of tools to combat adverse selection, including pre-existing condition exclusions, experience rating, waiting periods, and rescission based on nondisclosure of pre-existing condition.<sup>12</sup> However, insurers focused these efforts primarily on the individual market because the large group and self-insured markets<sup>13</sup>—which were mostly large group employers—were thought to function well without much adverse selection.<sup>14</sup> Moreover, ERISA and the Health Insurance Portability and Accountability Act (“HIPAA”) limited the ability of employment-based insurers and self-insured employers, but not individual insurers, to use such tools.<sup>15</sup> Accordingly, the primary focus of insurer favorable selection measures, such as cherry-picking, experience rating, pre-existing condition exclusion, and rescission, was the individual market.<sup>16</sup>

While favorable selection measures can keep down insurance costs, they obviously hinder access for high-risk beneficiaries. Hence, the pre-ACA access problems for high-risk individuals.<sup>17</sup> Insurers used favorable selection tools to screen out or price these individuals out of the market, keep costs down, and avoid the

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<sup>9</sup> *Id.* at 1223 (describing adverse selection as a process whereby enrollees “utilize private knowledge of their own riskiness when deciding to buy or forgo insurance”).

<sup>10</sup> Ronen Avraham, *The Economics of Insurance Law: A Primer*, 19 CONN. INS. L.J. 29, 44 (2012).

<sup>11</sup> *Id.*

<sup>12</sup> Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 134-35 (2011) (explaining that insurers have rescinded coverage for even innocent omissions or misstatements on policy applications); Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. HEALTH POL. POL’Y & L. 175, 179-80 (2000) (explaining that individual insurance markets collapse unless insurers can use pre-existing condition exclusions and waiting periods to combat adverse selection).

<sup>13</sup> Self-insured plans are those in which the employer pays out employee insurance claims directly and no insurer is involved.

<sup>14</sup> Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps & Border Crossing Techniques & How to Address Them*, 5 ST. LOUIS U.J. HEALTH L. & POL’Y 27, 29 (2011).

<sup>15</sup> *Id.* at 29-30.

<sup>16</sup> Monahan & Schwarcz, *supra* note 12, at 176 (describing individual health insurance markets as dysfunctional for both low-risk and high-risk enrollees, subjecting both “to significant risks associated with unanticipated coverage restrictions, rescissions, non-renewals, large rate increases, and preexisting condition exclusions”).

<sup>17</sup> JULIE PEPPER ET AL., WAKELY CONSULTING GROUP, ACTUARIAL ANALYSIS: IMPACT OF THE AFFORDABLE CARE ACT (ACA) ON SMALL GROUP & INDIVIDUAL MARKET PREMIUMS IN OREGON 26 (July 31, 2012), available at [http://www.wakely.com/wp-content/uploads/2012/10/OR\\_ACA\\_Market\\_Premium\\_Impact\\_wletter\\_20120731.pdf](http://www.wakely.com/wp-content/uploads/2012/10/OR_ACA_Market_Premium_Impact_wletter_20120731.pdf) (finding a 25% insurance denial rate in Oregon’s individual market).

death spiral. Consequently, prior to the ACA, not much of an individual health insurance market existed, especially not for those considered to be high-risk.<sup>18</sup>

*B. ACA Insurance Access Expansion and the Benefit to High-Risk Beneficiaries*

The ACA transforms the existing health insurance market by expanding insurance access for all, but particularly for high-risk beneficiaries. Broadly, it does so through a voluntary Medicaid expansion,<sup>19</sup> the creation of insurance exchanges,<sup>20</sup> and various prohibitions against favorable selection tools within the individual insurance market.<sup>21</sup> With these changes, individual high-risk consumers who previously did not have access to insurance should have access to a new marketplace for insurance.

To illustrate the drastic change, in 2009, the individual insurance market covered only 16.7 million people or 6% of the insurance market.<sup>22</sup> By 2020, the individual exchange market is predicted to grow to 26.9 million, or even as much as 65.3 million, if employers drop employment-based coverage and shift employees onto the individual market.<sup>23</sup> These numbers could be even higher, as the Congressional Budget Office has predicted that the now optional nature of the Medicaid expansion will grow the exchanges further.<sup>24</sup>

A number of ACA reforms are directly aimed at improving insurance access for high-risk beneficiaries both inside and outside of the exchanges. Such regulations include the guarantee access and renewability requirements,<sup>25</sup> the prohibition against premiums based on health status,<sup>26</sup> the prohibition against discrimination based on

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<sup>18</sup> Martha B. Coven, *The Freedom to Spend: The Case for Cash-Based Public Assistance*, 86 MINN. L. REV. 847, 885-86 (2002) (arguing that cash-based assistance to individuals to purchase health insurance is not sufficient to expand coverage because of the lack of robust individual health insurance markets in the United States).

<sup>19</sup> 42 U.S.C.A. § 1396(a)(10)(A)(i)(VIII) (West 2013).

<sup>20</sup> *Id.* § 18031.

<sup>21</sup> *Id.* §§ 300gg-300gg-7 (provisions prohibiting preexisting condition exclusions, requiring modified community rating, requiring guaranteed availability and renewability of coverage, prohibiting discrimination based on health status, providing for Essential Health Benefits coverage, and prohibiting excessive waiting periods).

<sup>22</sup> PAUL H. KECKLEY ET AL., DELOITTE CTR. FOR HEALTH SOLUTIONS, THE IMPACT OF HEALTH REFORM ON THE INDIVIDUAL INSURANCE MARKET: A STRATEGIC ASSESSMENT 4 (2011), available at [https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Reform%20Issues%20Briefs/us\\_chs\\_HealthReformAndTheIndividualInsuranceMarket\\_IssueBrief\\_101011.pdf](https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Reform%20Issues%20Briefs/us_chs_HealthReformAndTheIndividualInsuranceMarket_IssueBrief_101011.pdf).

<sup>23</sup> *Id.* at 7-8.

<sup>24</sup> CONG. BUDGET OFFICE, ESTIMATES FOR INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 12 (July 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf> (predicting that the Supreme Court decision on the Medicaid expansion will grow the exchange rolls by 3 million by the year 2022).

<sup>25</sup> 42 U.S.C.A. §§ 300gg-1(a), -2(a) (West 2013).

<sup>26</sup> *Id.* § 300gg(a).

health status,<sup>27</sup> the prohibition against preexisting condition exclusions,<sup>28</sup> and the prohibition against waiting periods of longer than ninety days.<sup>29</sup> Each of these requirements and prohibitions is aimed at practices that insurers previously used to screen out high-risk beneficiaries, keep costs down, and avoid adverse selection.

Similarly, the ACA's Essential Health Benefits ("EHBs") requirement benefits high-risk beneficiaries by mandating that small group and individual insurers, both inside and outside of the exchanges, guarantee beneficiaries access to certain EHBs,<sup>30</sup> such as hospitalization and emergency services.<sup>31</sup> Moreover, insurers must cover at least 60% of the actuarial value of EHBs.<sup>32</sup> In other words, an insurer cannot eliminate or limit a particular essential benefit for a high-risk group of beneficiaries just because it would be too expensive to provide such coverage for those beneficiaries. The ACA also prohibits insurers from offering EHBs in such a way as to discriminate against individuals on the basis of age, disability, or life expectancy.<sup>33</sup> In a similar vein, insurers are prohibited from denying EHBs to beneficiaries on the basis of age, life expectancy, present or predicted disability, dependency, or quality of life.<sup>34</sup>

The ACA EHB requirement also aims to level the playing field of coverage content between employment-based coverage and individual coverage, such that those with employment-based insurance do not have a wider scope of coverage for essential benefits than those who obtain insurance through the exchanges.<sup>35</sup> The EHB requirement provides that small group and individual insurers must ensure that the essential benefits offered are equal in scope to those offered under a typical employer plan.<sup>36</sup>

## II. HIGH COSTS, ADVERSE SELECTION, AND THE ACA COVERAGE ACCESS EXPANSION

If all of these ACA access expansion provisions applied equally inside and outside the exchanges, then costs associated with increased access for high-risk beneficiaries could be spread across the entire industry. However, the regulatory structure of the ACA tends to treat some insurers differently than others, and as a result, will tend to push high-risk beneficiaries into the individual exchanges.

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<sup>27</sup> *Id.* § 300gg-4(a).

<sup>28</sup> *Id.* § 300gg-3(a).

<sup>29</sup> *Id.* § 300gg-7.

<sup>30</sup> *Id.* § 300gg-6(a).

<sup>31</sup> *Id.* § 18022(b).

<sup>32</sup> *Id.* § 18022(d).

<sup>33</sup> *Id.* § 18022(b)(4)(B).

<sup>34</sup> *Id.* § 18022(b)(4)(D).

<sup>35</sup> Troy Oechsner & Magda Schaler-Haynes, *Keeping it Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 290 (2011).

<sup>36</sup> 42 U.S.C.A. § 18022(b)(2)(A) (West 2010).

Moreover, there are inherent structural weaknesses in the new health care delivery system created under the ACA, creating a recipe for high costs and adverse selection.

*A. High Costs and the Uneven Regulation of the Exchange Versus Non-Exchange Markets*

The uneven regulatory structure of the ACA is first found in the ACA's more stringent regulation of exchange plans compared to plans sold outside of the exchange. This is not to say that the ACA does not attempt to level the playing field between plans that are offered both inside and outside of the exchanges. For example, as long as a single plan is being offered both inside and outside the exchange, the insurer offering that single plan must treat the beneficiaries within that plan as part of a single risk pool with the same premiums, whether they buy into the plan inside or outside of the exchange.<sup>37</sup> Beneficiaries inside and outside of the exchange are also entitled to the same EHBs, provided they are not part of a self-insured, large group, or grandfathered health plan.<sup>38</sup> These prohibitions try to prevent the insurance exchanges from becoming a dumping ground for costly high-risk individuals.

Despite these efforts, there are still additional regulatory burdens that fall solely upon the shoulders of exchange plans, allowing insurers who choose to offer coverage solely outside of the exchanges to avoid the level playing field requirements.<sup>39</sup> Such additional regulatory burdens include requirements for provider network adequacy, health care quality reporting, grievance procedures, marketing practices, and benefit design.<sup>40</sup> Comparatively lax regulations imposed on plans sold outside of the exchanges allow those plans to design coverage to attract low-risk beneficiaries, while driving costly high-risk beneficiaries into the exchanges.<sup>41</sup> Moreover, even though the ACA requires that insurance plans, whether offered inside or outside of the exchange, fall into one of four decreasing actuarial value categories—platinum, gold, silver, or bronze<sup>42</sup>—a bronze plan sold inside the

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<sup>37</sup> *Id.* § 18032(c) (providing for the single risk pool requirement); *Id.* § 18021(a)(1)(C)(iii) (2010) (requiring Qualified Health Plans to offer the same premium for a single plan regardless of whether it is purchased inside or outside of the exchange). *But see* SARAH LUECK, CTR. ON BUDGET & POLICY PRIORITIES, STATES SHOULD TAKE ADDITIONAL STEPS TO LIMIT ADVERSE SELECTION AMONG HEALTH PLANS IN THE EXCHANGE 4 (2011), available at <http://www.cbpp.org/files/6-28-11health.pdf> (noting that it will be difficult to enforce the single risk pool requirement).

<sup>38</sup> 42 U.S.C.A. § 300gg-6(a) (West 2013); Stacey A. Torvino, *All Illnesses are (Not) Created Equal: Reforming Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 8 (2012) (noting that grandfathered plans, large group plans, and self-insured plans are excluded from the EHB requirement).

<sup>39</sup> Paul Westfall, *Ethically Economic: The Affordable Care Act's Impact on the Administration of Health Benefits*, 14 DEPAUL J. HEALTH CARE L. 99, 129 (2011) (explaining how previous attempts at state-based health insurance exchanges led to cherry-picking, where some insurers would offer cheaper plans outside of the exchanges, which would tend to attract healthier enrollees, leaving the sickest enrollees to seek coverage through the exchanges).

<sup>40</sup> LUECK, *supra* note 37, at 6.

<sup>41</sup> Thomas L. Greaney, *Regulating to Promote Competition in Designing Health Insurance Exchanges*, 20-SPG KAN. J.L. & PUB. POL'Y 237, 252 (2011).

<sup>42</sup> 42 U.S.C.A. § 18022(d) (West 2010).



exchanges may look different than one sold outside the exchanges. No two bronze plans need look alike, as long as actuarial equivalency requirements are met between the two.<sup>43</sup> Therefore, the insurer who only sells its bronze plan outside of the exchange could manipulate the design of its bronze plan, such as the co-pay and deductible structure, to attract less costly, low-risk beneficiaries.<sup>44</sup>

Some States may actually worsen the regulatory disparity between the exchange insurance market and non-exchange insurance market. States are primarily responsible for regulating the non-exchange insurance markets.<sup>45</sup> Accordingly, they could eliminate the disparities between the two markets by taking action to regulate the non-exchange market to mirror the regulation of exchange market.<sup>46</sup> However, many States will not do so because they are politically opposed to health care reform, including the exchanges. They view the exchanges as an overreach of federal regulation that sacks the States with the costs of operating the exchanges.<sup>47</sup> In fact, as of May 2013, twenty-seven States have deferred to the federal government to set up insurance exchanges in those States.<sup>48</sup> There is fear that such opposition States might sabotage the exchanges by failing to level the regulatory playing field, refusing to enforce the ACA insurance reforms, and/or refusing to set up the risk adjustment and reinsurance programs.<sup>49</sup>

*B. High Costs Associated with Uneven Regulation of Individual Plans Versus Large Group and Self-Insured Plans*

Adverse selection and high costs within the individual exchanges are also likely to occur because of differences in how the ACA regulates individual and small group insurers versus large group and self-insured plans, particularly the latter.<sup>50</sup> To

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<sup>43</sup> Greaney, *supra* note 41, at 250-51.

<sup>44</sup> *Id.*

<sup>45</sup> Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 28 (2011) (noting that States retain their traditional regulatory role over insurance, but that the federal regulatory power over insurance is expanded, particularly within the insurance exchanges).

<sup>46</sup> Timothy Stoltzfus Jost, *The Commonwealth Fund, Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, ST. LOUIS U. J. HEALTH L. & POL'Y 27 (2011) (arguing that States could keep costs down in the exchanges if they similarly regulate health plans outside of the exchanges and/or are careful not to impose extra costs on exchange plans).

<sup>47</sup> Abigail R. Moncrieff, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20-SPG KAN. J.L. & PUB. POL'Y 266, 291-92 (2011) [hereinafter Moncrieff, *Centralization*] (discussing the irony of State opposition to the exchanges despite the ACA's intent to provide States with flexibility in operating the exchanges).

<sup>48</sup> *State Decisions for Creating Health Insurance Marketplaces*, HENRY J. KAISER FAMILY FOUND. (May 28, 2013), <http://kff.org/health-reform/state-indicator/health-insurance-exchanges>.

<sup>49</sup> Jost, *supra* note 46, at 13 (noting that State regulatory opposition to the exchanges could lead to adverse selection and threaten the viability of the exchanges).

<sup>50</sup> *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732-33 (1985) (explaining the difference between insured and self-insured plans).

illustrate the differences between how the ACA regulates these different insurance markets, it is helpful to think of the ACA insurance reforms as applying to four different insurance markets: self-insured plans; individual plans and small group employment plans;<sup>51</sup> grandfathered health plans; and large group plans. The ACA most heavily regulates the individual and small group plans, especially those that are sold within the exchanges.<sup>52</sup> Large group employer plans are generally subject to fewer ACA regulations and are regulated jointly by ERISA and State insurance regulations.<sup>53</sup> Self-insured plans are subject to even fewer ACA regulations than large group employer plans, are exempt from State insurance regulation, and are almost completely regulated by ERISA.<sup>54</sup>

As a result of these differing levels of regulation, some scholars contend that large employers, especially self-insured employers, will engage in targeted dumping of high-risk employees onto the individual exchanges, thereby creating an adverse selection problem for the individual exchanges.<sup>55</sup> Targeted dumping is likely to occur because a number of consumer protection provisions that apply to individual and small group plans do not apply to large employer plans and/or self-insured plans.

First, the ACA imposes only limited new coverage requirements upon self-insured and large group plans, namely the requirements to cover clinical trials, to cover preventive services without cost sharing, to limit out-of-pocket spending, and to not impose annual or lifetime limits on coverage.<sup>56</sup> These same new benefit requirements also apply to individual and small group plans, but the individual and small group plans are subject to additional requirements that do not apply to large group fully-insured and self-insured plans, such as the EHB requirements,<sup>57</sup> single-risk pool requirement,<sup>58</sup> and the prohibition against engaging in discriminatory premium setting.<sup>59</sup> Accordingly, compared to large group plans and self-insured plans, small group and individual insurers, especially those within the exchanges, are required to provide more comprehensive and non-discriminatory coverage, which is more costly to provide and tends to attract high-risk enrollees.<sup>60</sup>

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<sup>51</sup> This market can technically be broken down into two sub-markets: individual and small group plans sold inside the exchange, and individual and small group plans sold outside the exchange.

<sup>52</sup> Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1585 (2011).

<sup>53</sup> *Id.* at 1592 (noting that after the ACA, the large group market will continue to be lightly regulated by ERISA and HIPAA with fewer new ACA regulations impacting that market).

<sup>54</sup> 29 U.S.C. § 1144(a), b(2)(B) (2006); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (interpreting ERISA to exempt self-insured plans from State regulation).

<sup>55</sup> Monahan & Schwarcz, *supra* note 12, at 128.

<sup>56</sup> *Id.* at 147-48 (outlining the few specific ACA coverage mandates that apply to both the individual market and the large group and self-insured plan markets).

<sup>57</sup> 42 U.S.C.A. § 300gg-6(a) (West 2013).

<sup>58</sup> *Id.* § 18032(c) (West 2010).

<sup>59</sup> *Id.* § 18032(c).

<sup>60</sup> JONATHAN GRUBER, COLORADO HEALTH BENEFIT EXCHANGE BACKGROUND RESEARCH 12-13 (2012), available at [http://dailycaller.com/wp-content/uploads/2012/02/Colorado\\_](http://dailycaller.com/wp-content/uploads/2012/02/Colorado_)

Second, two out of three of the ACA's risk adjustment programs do not apply to many large group plans and/or self-insured plans.<sup>61</sup> The third risk adjustment program, the permanent risk adjustment program, also excludes self-insured plans.<sup>62</sup> As these programs operate to take away the incentive for targeting only risk beneficiaries, self-insured plans and large group insurers have no incentive not to dump their high-risk beneficiaries onto the exchanges and keep their low-risk beneficiaries.<sup>63</sup>

Third, the ACA encourages large group and self-insured plans to dump high-risk beneficiaries onto the exchange through the ACA wellness program provisions. As long as certain strict requirements are met, the wellness provisions allow employers to reward employees with premium and cost-sharing reductions, when they achieve or maintain health goals, such as weight loss or a healthy BMI.<sup>64</sup> The premium reductions can be as high as thirty percent<sup>65</sup> and employers can use such programs to favor and reduce costs for low risk employees, while driving high-risk employees onto the individual exchanges.<sup>66</sup> While the ACA prohibits using these programs as a subterfuge for discriminating against high-risk employees based on health status, some scholars contend that it will be impossible to enforce this provision.<sup>67</sup>

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Gruber\_Jan\_2012\_NARRATIVE.pdf (predicting, within Colorado, that the EHB requirement will drive up individual market insurance premiums by 5.3%); JILL S. HERBOLD & PAUL R. HOUCHEMS, INDIVIDUAL AND SMALL GROUP PREMIUM CHANGES UNDER THE ACA, 2 (2011), available at [http://www.in.gov/aca/files/Individual\\_SmallPremium\\_Increases.pdf](http://www.in.gov/aca/files/Individual_SmallPremium_Increases.pdf) (predicting, within Indiana, that the EHB requirement will drive up premiums in the individual market by 20% to 30%); PEPPER ET AL., *supra* note 17, at 21 (predicting, within Oregon, that the EHB requirement will drive up premiums by 6% in the individual market); JENNIFER SMAGULA & JONATHAN GRUBER, THE IMPACT OF THE ACA ON WISCONSIN'S HEALTH INSURANCE MARKET, 22 (2011), available at <http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf> (predicting, within Wisconsin, that the EHB requirement will drive up individual market insurance premiums by 6% to 7%).

<sup>61</sup> 42 U.S.C.A. § 18061-62 (West 2010) (applying the ACA's temporary reinsurance and risk corridor programs solely to the individual and small group markets).

<sup>62</sup> *Id.* § 18063 (providing that "each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) . . . if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974)").

<sup>63</sup> Monahan & Schwarcz, *supra* note 12, at 151 (arguing that the "ACA largely excludes employers, especially those that are self-insured, from the risk-sharing arrangements described above that are designed to mute insurers' incentives to attract comparatively healthy risks").

<sup>64</sup> Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 *CONN. INS. L.J.* 199, 214-17 (2008) (providing a summary of the ACA's wellness program provisions).

<sup>65</sup> 42 U.S.C.A § 300gg-4(j)(3)(A) (West 2010).

<sup>66</sup> Monahan & Schwarcz, *supra* note 12, at 169.

<sup>67</sup> *Id.* (arguing that "the core problem [with enforcement] is that in order to incentivize healthy living, a wellness program must provide benefits only to those who are, in fact, healthier").

The contrast in ACA regulations applying to individual and small group plans versus employment-based plans plainly provides a foundation and open invitation for employers to engage in selective dumping of high-risk employees onto the individual exchanges. Self-insured plans, even more than large group plans, are likely to engage in selective dumping because of the complete absence of State regulation and limited federal regulation.<sup>68</sup> Unlike large group plans, self-insured plans may also exacerbate adverse selection problems for the exchanges by gaming the exchange system. More specifically, employers may choose to self-insure, design plans that are low cost with thin coverage and remain that way as long as their health care costs are low.<sup>69</sup> Then, if and when their health care costs spike, they can fully-insure and purchase through the exchange, if they are a small employer, or dump their employees on the exchange, thereby flooding the exchange with high-risk beneficiaries.<sup>70</sup>

While the world of self-insured plans may seem like a limited universe of large employers, it is a growing universe.<sup>71</sup> Small employers who self-insure no longer need to worry about directly absorbing the impact of catastrophic claims, as a series of court decisions have held that an employer can purchase stop-loss insurance with a low attachment point<sup>72</sup> and still remain self-insured for ERISA preemption purposes.<sup>73</sup> With the increasing trend towards small employers self-insuring, the problem of selective dumping and accompanying adverse selection for the individual exchanges may be larger than predicted.

### C. Low-Risk Individuals Choosing Grandfathered Health Plans

Regulatory differences similarly arise when comparing individual exchange plans to grandfathered health plans. Grandfathered plans are plans that existed as of the date of the ACA's enactment,<sup>74</sup> and such plans are exempt from many of the ACA's consumer protection regulations. For purposes of this article, some of the

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<sup>68</sup> *Id.* at 159.

<sup>69</sup> Jost, *supra* note 46, at 19-20.

<sup>70</sup> *Id.*

<sup>71</sup> Kathryn Linehan, Nat'l Health Pol'y Forum, *Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market* 1, 3 (2010), available at [http://www.nhpf.org/library/issue-briefs/IB840\\_PPACASmallGroup\\_12-21-10.pdf](http://www.nhpf.org/library/issue-briefs/IB840_PPACASmallGroup_12-21-10.pdf) (noting that in 2009, 82.1% of firms with 500 or more employees offered self-insured health plans, but only 13.5% of firms with fewer than 100 employees did so). Large employers choose to self-insure because they can afford to cover the risk of directly insuring their employees.

<sup>72</sup> CHRISTINE EIBNER ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., EMPLOYER SELF-INSURANCE DECISIONS & THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (ACA) 1, 93 (2011), available at <http://aspe.hhs.gov/health/reports/2011/LGHPstudy/EmployerSIDACA.pdf> (finding that 1/3 of small employers will self-insure if attachment points are as low as \$20,000). A low attachment point for triggering stop-loss insurance largely shifts the risk to the stop-loss insurer.

<sup>73</sup> *Bill Gray Enters. v. Gourley*, 248 F.3d 206, 209 (3d Cir. 2001); *Thompson v. Talquin Bldg. Prods.*, 928 F.2d 649, 653 (4th Cir. 1991); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986).

<sup>74</sup> 42 U.S.C.A. § 18011 (West 2010).

most relevant exclusions, include the requirement to provide EHBs, guaranteed issue and renewability, the prohibition against discrimination based on health status, the requirement to use modified community rating for premium setting, the requirement to provide internal and external grievance procedures, and the requirement to provide unimpeded access to emergency, pediatric, obstetric, and gynecological care.<sup>75</sup> Moreover, individual, but not group, grandfathered health plans can still use pre-existing condition exclusions, longer waiting periods, and annual limits on benefits.<sup>76</sup>

Significantly, grandfathered plans lose their grandfathered status if they make certain changes to their plan content and/or structure that disadvantage their enrollees.<sup>77</sup> Because grandfathered plans are so restricted in the types of changes that they can make and still keep their grandfathered status, it is believed that most, if not all grandfathered plans will lose their status within a few years.<sup>78</sup> Insurer efforts to change cost-sharing or premiums are severely hampered by the grandfathered health plan regulations, and therefore it will be hard for such plans to maintain their grandfathered status, given likely medical technology changes, changes to the plan's pool of beneficiaries, and changes to the claims history of beneficiaries.<sup>79</sup> Nonetheless, unless or until they disappear, grandfathered health plans will likely cause adverse selection problems for the individual exchanges.

To the extent that grandfathered plans continue to exist, they may promote adverse selection against the exchanges through lemon-dropping, or encouraging high-risk beneficiaries to seek coverage in the individual exchanges, while keeping low-risk beneficiaries within the grandfathered plan.<sup>80</sup> Keeping only the low-risk beneficiaries within the grandfathered plan also allows grandfathered plans to more effectively avoid dealing with increasing insurance costs and having to change the content or structure of their insurance plan with the possibility of losing their grandfathered plan status. Many high-risk beneficiaries will not want to stay with their grandfathered plans because such plans are likely to have thinner coverage than

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<sup>75</sup> Elizabeth Weeks Leonard, *Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act*, 36 J. CORP. L. 753, 766-67 (2011) (outlining the ACA exemptions for grandfathered plans).

<sup>76</sup> Richard A. Epstein & Paula M. Stannard, *Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability*, 38 AM. J.L. & MED. 243, 247 (2012).

<sup>77</sup> 45 C.F.R. § 147.140 (2011) (providing that grandfathered health plans lose their status if they change their scope of benefits, increase co-insurance percentages, increase fixed-amount cost-sharing (other than co-payments) above medical inflation plus fifteen percentage points, increase co-payments above five dollars plus medical inflation or medical inflation plus fifteen percentage points, decrease the 2010 employer contribution rate by more than five percent, add an annual limit on benefits where none existed in 2010, add an annual limit for a plan that imposed only a lifetime limit, unless the annual limit is not less than the lifetime limit, or lower annual limits for plans that had an annual limit in 2010).

<sup>78</sup> Leonard, *supra* note 75, at 756 (arguing that most grandfathered plans will lose their status because they can make changes only for the benefit of participants and only at the plan's expense).

<sup>79</sup> Jost, *supra* note 46, at 18.

<sup>80</sup> *Id.* at 13.

individual exchange plans, as a result of the fewer regulations imposed on grandfathered plans versus exchange-based plans.<sup>81</sup>

Alternatively, some plans with healthy risk pools will maintain grandfathered plan status as long as their risk pool remains healthy, while other plans, with high-risk pools, will abandon grandfathered plan status *ab initio*.<sup>82</sup> Beneficiaries in the latter risk pools may immediately seek the likely comprehensive coverage available within the individual exchanges. As a result, these healthy risk pools of individuals will not be seeking coverage access through the individual exchanges, which would otherwise help with risk spreading and avoiding adverse selection.

#### *D. Young, Healthy Adults Avoiding the Individual Exchanges*

The funneling of high-risk beneficiaries into the exchanges may also be exacerbated by the ACA's dependent coverage expansion, which allows parents to keep their children on the family health insurance policy until the child reaches the age of twenty-six.<sup>83</sup> For those under the age of twenty-six without employment-based insurance, the option may be more popular than purchasing insurance through the exchanges, since there is little if any additional cost to the family to add a dependent onto the family policy.<sup>84</sup> For the individual exchanges, a failure of young and healthy individuals to seek coverage through the individual exchanges poses a risk selection problem. The incentive to choose the dependent coverage expansion over exchange-based insurance will result in many young and healthy individuals being carved out of the individual exchange risk pools.<sup>85</sup> Accordingly, the individual exchange risk pools will be disproportionately high-risk and exchange costs and premiums will rise.<sup>86</sup>

#### *E. Higher Administrative Costs Associated with the Exchanges*

Not only will the exchanges potentially attract more high-risk beneficiaries than low-risk beneficiaries, but the exchanges face additional costs that the non-exchange markets do not face. The exchanges are required to be self-sustaining and there will be administrative costs associated with running the exchanges.<sup>87</sup> The exchanges are expressly responsible for establishing eligibility for Medicaid and for premium tax credits, contracting with navigators to educate and facilitate individual enrollment in plans, operating a consumer hot line, hosting a consumer website with comparative health plan information, rating exchange plans on quality and price and providing consumers with a calculator for determining insurance costs.<sup>88</sup> While these measures

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<sup>81</sup> *Id.*

<sup>82</sup> *Id.* at 8.

<sup>83</sup> 42 U.S.C.A. § 300gg-14(a) (West 2010).

<sup>84</sup> Joel C. Cantor et al., *Expanding Dependent Coverage for Young Adults: Lessons from State Initiatives*, 37 J. HEALTH POL. POL'Y & L. 99, 122 (2012) (noting that the dependent coverage expansion will be popular because "enrolling young adults in a parent's plan will be free, at the margin, for many families").

<sup>85</sup> *Id.* at 123.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.* at 49.

<sup>88</sup> 42 U.S.C.A. § 18031(d)(4) (West 2010).

are beneficial for beneficiaries, they also cost money and will likely drive up costs within the exchanges. In past insurance exchanges, the exchanges merely dumped their administrative costs on top of the exchange insurers' administrative costs, without attempting to reduce the latter.<sup>89</sup>

Someone has to pay for those costs and the States are unlikely to subsidize most of these exchange costs.<sup>90</sup> Accordingly, the exchanges may impose licensing, tax, or regulatory fees upon insurers wishing to participate in the exchanges.<sup>91</sup> However, this means that providing insurance inside the exchange will be more expensive for these insurers, or they will likely pass along those costs to consumers in the form of higher premiums.<sup>92</sup> The healthiest and least costly enrollees will likely avoid such exchange plans and opt for plans with lower premiums outside of the exchange.<sup>93</sup>

Administrative costs within the exchanges will also be higher because of the need to create new economies of scale. Insurers in the existing individual market for health insurance have existing economies of scale in place.<sup>94</sup> However, within the individual exchanges, insurers have to build entirely new economies of scale by building a whole new system of insurance, with additional administrative and marketing costs.<sup>95</sup> It seems likely that exchange insurers will also pass these costs down to their beneficiaries through higher premiums and costs.

#### F. Market Share and Risk Pool Size

Market share size and risk pool size are also major cost concerns for the individual exchanges. In the past, state-based insurance exchanges have had difficulty attracting a sufficient number of beneficiaries to create the market share necessary for exchange insurers to achieve economies of scale.<sup>96</sup> Economies of scale are necessary so that there is robust competition and the insurers can achieve administrative cost savings and exercise sufficient bargaining power to drive down

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<sup>89</sup> Elliot K. Wicks & Mark A. Hall, *Purchasing Cooperatives for Small Employers: Performance and Prospects*, 78 MILBANK QUARTERLY 4, 511-46 (2000).

<sup>90</sup> Jost, *supra* note 46, at 49 (arguing that States are unlikely to reimburse the exchanges for costs other than those associated with processing applications for State health care programs, like Medicaid).

<sup>91</sup> Jessica D. Allen, Note, *A Way Forward: Establishing Financially Self-Sustaining Health-Insurance Exchanges Under the Patient Protection and Affordable Care Act*, 98 IOWA L. REV. 773, 793 (2013) (exploring the use of fees on exchange insurers as a method for creating financially self-sustaining exchanges).

<sup>92</sup> Jost, *supra* note 46, at 49.

<sup>93</sup> Elliot K. Wicks, Cal. Healthcare Found., *Building a National Insurance Exchange: Lessons From California* 3 (2009), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BuildingANationalInsuranceExchange.pdf> (explaining that insurers do not like the head to head competition within exchanges for fear that if they need to raise their premiums, the healthiest enrollees will just leave for a competitor plan).

<sup>94</sup> Westfall, *supra* note 39, at 118 (discussing the economic problems with the ACA insurance exchanges).

<sup>95</sup> *Id.*

<sup>96</sup> Wicks, *supra* note 93, at 3 (explaining that "an exchange is often just one health plan loss away from failure").

prices.<sup>97</sup> Moreover, without a sufficient number of beneficiaries, insurers lose interest in joining the exchanges,<sup>98</sup> especially if the exchange risk pool is comprised mostly of premium subsidy beneficiaries.<sup>99</sup> Such an exchange lacks the bargaining power necessary to impose upon the participating insurers standards that will be favorable to the beneficiaries.<sup>100</sup> Insurers in such a situation can take more of a take it or leave it attitude towards the exchanges.

A similar problem occurs if the insurance market within a State and within an exchange in that State is dominated by a few large insurers, who act in a monopolistic manner to undercut the bargaining power of the exchange.<sup>101</sup> Whether insurers lose interest in the exchange or whether the insurer market is highly concentrated, an exchange without sufficient insurers for robust competition is an exchange without bargaining power, a situation that will likely lead to higher costs for exchange enrollees. Such an exchange will also likely have difficulty attracting new insurers, who would otherwise increase competition and drive down prices within the exchange.<sup>102</sup> Whether the lack of sufficient exchange plans is the result of few beneficiaries or market concentration, the effect is a vicious circle. If an insufficient number of plans—especially large plans—fail to join the exchanges, then not enough people will want to enroll through the exchanges.<sup>103</sup> Accordingly, the incentive to buy through the exchanges will be reduced due to the lack of plan choice, and as a result, insurer competition within the exchanges will be soft and premiums may increase.<sup>104</sup>

Beneficiary pool size also has an impact on administrative costs. In terms of cost spreading, a large pool of beneficiaries is necessary to keep per capita administrative costs down. There are a number of fixed costs associated with the exchanges and those costs will likely be passed onto enrollees.<sup>105</sup> If there are fewer beneficiaries within the exchanges, then the per capita costs will be higher.<sup>106</sup>

Small beneficiary pools can also lead to higher provider prices. Insurers contract with networks of providers and are able to extract price concessions from those

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<sup>97</sup> *Id.*

<sup>98</sup> Moncrieff, *Centralization*, *supra* note 47, at 293.

<sup>99</sup> Jost, *supra* note 46, at 28 (arguing that “if the exchange is limited to individuals who receive the premium tax credit, with few self-payers and small-employer participants, it will be unattractive to insurers and will lack bargaining power”).

<sup>100</sup> *Id.* (arguing that such an exchange will have an unattractive risk profile and will have difficulty imposing minimum standards on plans joining the exchange).

<sup>101</sup> *Id.* (arguing that exchanges will have difficulty imposing minimum standards in a market dominated by three or fewer insurers).

<sup>102</sup> *Id.*

<sup>103</sup> Wicks, *supra* note 93, at 3.

<sup>104</sup> Jost, *supra* note 46, at 16.

<sup>105</sup> *Id.* at 16 (explaining that administrative efficiencies are only achieved if the personnel, IT, publication, legal, rent and utility costs must be spread out over as many enrollees as possible).

<sup>106</sup> *Id.*



providers, if the insurers can bring a large pool of patients to those providers.<sup>107</sup> However, the insurer's bargaining power to reduce prices is greatly diminished where the pool of patients is small.<sup>108</sup> As with administrative costs, those higher provider prices are likely to be passed along to beneficiaries in the form of higher premiums or cost-sharing.

Finally, an insufficient number of beneficiaries also poses an adverse selection problem. To avoid adverse selection, a stable exchange needs at least one hundred thousand enrollees with seventy-five percent of the enrollees being non-Medicare and non-Medicaid.<sup>109</sup> Without a sufficiently diverse group of enrollees, risk spreading and cost spreading is difficult, which, of course, leads to adverse selection.<sup>110</sup> Many small states with smaller risk pools may have difficulty maintaining viable, diverse exchange risk pools and may need to join with other States to create a sustainable exchange.<sup>111</sup>

### *G. State Run High-Risk Pool Dumping on the Individual Exchanges*

Large employers and self-insured plans may not be the only ones engaging in selective dumping on the exchange, as state-run high-risk pools may seek to dump their beneficiaries on the exchange as quickly as possible. Prior to the ACA, a number of states created high-risk pools for high-risk beneficiaries,<sup>112</sup> but the incentive to maintain such pools may be disappearing because of the operation of the ACA temporary reinsurance program for the individual market.

The ACA's temporary reinsurance program encourages state high-risk pools to cease functioning for two reasons. First, HHS has promulgated a Rule that the state high-risk pools are not eligible to receive any of the reinsurance money.<sup>113</sup> Therefore, the state high-risk pools will want to dump their beneficiaries onto the exchange, where insurers can use those beneficiaries to improve their eligibility for reinsurance funds.<sup>114</sup>

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<sup>107</sup> *Id.* at 17.

<sup>108</sup> *Id.*

<sup>109</sup> ALAIN ENTHOVEN ET AL., COMM. FOR ECON. DEV., MAKING EXCHANGES WORK IN HEALTH-CARE REFORM 7-8 (2009), available at <http://www.allhealth.org/briefingmaterials/MakingExchangesWorkinHealth-CareReform-1701.pdf> (arguing that "an even larger size [pool] is preferable from the point of view of economies of scale in administration of multiple plans and overall market impact").

<sup>110</sup> Jost, *supra* note 46, at 17 (arguing that small risk pools are volatile and subject to destabilization by a few large claims).

<sup>111</sup> Moncrieff, *Centralization*, *supra* note 47, at 293-94 (citing West Virginia as an example of a State that would need to create a regional exchange in order to avoid adverse selection problems stemming from small risk pools).

<sup>112</sup> NAT'L CONFERENCE OF STATE LEGISLATURES, COVERAGE OF UNINSURABLE PRE-EXISTING CONDITIONS: STATE AND FEDERAL HIGH-RISK POOLS, available at <http://www.ncsl.org/issues-research/health/high-risk-pools-for-health-coverage.aspx> (updated Feb. 2013) (noting that from 1976 through 2009, 35 States set up high-risk pools enrolling over 200,000 people).

<sup>113</sup> 42 C.F.R. §153.400(a)(2)(iii) (2013).

<sup>114</sup> Brett Norman, *States Rethink High-Risk-Pool Plans*, POLITICO, (Jan. 29, 2013, 04:27 AM EST), <http://www.politico.com/story/2013/01/states-rethink-high-risk-pools-exchanges->

Second, if one state keeps many of its high-risk enrollees in a state-run high risk pool, then the reinsurance assessments against insurers and self-insured plans in that state are more likely to flow out of state to states that eliminated their high-risk pools and dumped those beneficiaries onto their respective exchanges.<sup>115</sup> The necessity for quickly eliminating these State-run high-risk pools is enhanced by the fact that the reinsurance payouts decrease over the three years of the temporary reinsurance program.<sup>116</sup>

This sudden dumping phenomenon by the states could drive up costs and insurance premiums within the individual exchanges.<sup>117</sup> The individuals in state high-risk pools are, by definition, the sickest of the sick and the costliest of the costly. Accordingly, quickly dumping them en masse onto the exchanges could cause exchange premiums to spike or make it difficult for exchange plans accepting those enrollees to remain financially viable.

#### *H. The Voluntary Medicaid Expansion and High Costs in the Individual Exchange*

State action on Medicaid may also contribute to high costs within the individual exchanges. First, a state's failure to accept the ACA Medicaid expansion will likely drive up individual exchange premiums within that state's exchange.<sup>118</sup> When initially enacted, the ACA was supposed to expand Medicaid to those earning up to 133% of the Federal Poverty Level ("FPL").<sup>119</sup> However, the Supreme Court, in *Nat'l Fed'n of Indep. Bus. v. Sebelius*, ruled that the expansion is optional, not mandatory for the States.<sup>120</sup> In response, twenty-one States have chosen not to expand Medicaid.<sup>121</sup> Accordingly, within these States, those who fall under 133% of

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86831.html (explaining that "the state high-risk pools may offload as many people as they can onto the exchanges as soon as they open in 2014 or risk losing a piece of that \$20 billion pie").

<sup>115</sup> *Id.* (noting that Wisconsin is concerned that if it does not eliminate its State high-risk pool quickly, then reinsurance assessments on Wisconsin insurers will flow to cover the cost of high-cost plans in other States).

<sup>116</sup> 42 U.S.C.A. § 18061(b)(3)(B)(iii) (West 2010) (providing for \$10 billion in reinsurance payments in 2014, \$6 billion in 2015, and \$4 billion in 2016).

<sup>117</sup> GRUBER, *supra* note 60, at 13 (predicting that folding the Colorado high-risk pool into the exchange will cause Colorado individual market premiums to increase by 5.5%); HERBOLD & HOUCHE, *supra* note 60, at 1 (predicting that merging the Indiana high-risk pool into the individual market will drive up Indiana individual market premiums by 35% to 45%); SMAGULA & GRUBER, *supra* note 60, at 22-23 (predicting that merging the Wisconsin high-risk pool into the individual market will drive up individual market premiums by 16%).

<sup>118</sup> AM. ACAD. OF ACTUARIES, IMPLICATIONS OF MEDICAID EXPANSION DECISIONS ON PRIVATE COVERAGE 2 (Sept. 2012), available at [http://www.actuary.org/files/Medicaid\\_Considerations\\_09\\_05\\_2012.pdf](http://www.actuary.org/files/Medicaid_Considerations_09_05_2012.pdf) (predicting that individual market premiums will go up by at least 2% for States that reject the Medicaid expansion).

<sup>119</sup> 42 U.S.C.A. § 1396a(a)(10)(A)(i)(VIII) (West 2013).

<sup>120</sup> *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, at 2607-08 (2012).

<sup>121</sup> *Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAMILY FOUND. (as of Dec. 11, 2013), <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

FPL will be forced to seek out insurance through the individual insurance exchanges.<sup>122</sup> While those under 100% of FPL will be unlikely to find any affordable insurance, those between 100% and 133% of FPL will be heavily incentivized to seek coverage through the individual exchanges because they are eligible for premium subsidies.<sup>123</sup>

Exchange costs will likely increase if the exchanges are forced to absorb this group, between 100% and 133% of FPL. First, this group is going to be a costly, high-risk group with more complex medical problems.<sup>124</sup> Second, because most of these beneficiaries have been previously uninsured, they will aggressively seek out health care now that they are insured and they will have higher initial claims costs.<sup>125</sup> Third, if the ACA temporary reinsurance program, described *infra*, applies to these beneficiaries, then the reinsurance amounts, which are fixed amounts per year, would decrease per capita with the addition of this group, resulting in higher premium rates for everyone else.<sup>126</sup> Fourth, the fact that individuals with monthly or yearly income variation will continuously churn between Medicaid eligibility and exchange-based coverage or no coverage will also add to insurer costs.<sup>127</sup> Exchange insurers will likely have long term, instead of short term, added “risk premiums” to account for both the early instability in the new market, as well as the persistent uncertainty of churning.<sup>128</sup> Churning also adds to insurer administrative costs as insurers must continuously reestablish relationships with beneficiaries who have churned in and out of exchange-based coverage.<sup>129</sup> Moreover, churning makes it more difficult to implement a permanent risk adjustment program, described *infra*, that fully compensates insurers with disproportionate high-risk beneficiaries.<sup>130</sup>

Even in some States that agree to expand Medicaid, there is an effort underway to shift the cost of covering these newly eligible individuals onto the individual exchanges. For example, Arkansas is seeking an HHS waiver to purchase insurance

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<sup>122</sup> Emily Whelan Parento & Lawrence O. Gostin, *Better Health, but Less Justice: Widening Health Disparities After National Federation of Independent Business v. Sebelius*, 27 NOTRE DAME J.L. ETHICS & PUB. POL’Y 481, 505-06 (2013).

<sup>123</sup> *Id.*

<sup>124</sup> AM. ACAD. OF ACTUARIES, *supra* note 118, at 2.

<sup>125</sup> CTR. ON BUDGET & POLICY PRIORITIES, WHY A STATE’S HEALTH INSURERS SHOULD SUPPORT EXPANDING MEDICAID 2 (SEPT. 2012), *available at* <http://www.cbpp.org/files/medicaid-and-insurers-memo.pdf> (arguing initial claims costs are higher for a group of previously uninsured people versus those who are continuously insured).

<sup>126</sup> AM. ACAD. OF ACTUARIES, *supra* note 118, at 2-3.

<sup>127</sup> An example of churning is when someone has sporadic jobs and their income varies greatly from month to month, meaning that some months they are eligible for Medicaid and other months they will be forced to obtain insurance through the exchanges or will have no insurance at all in a non-Medicaid expansion State.

<sup>128</sup> CTR. ON BUDGET & POLICY PRIORITIES, *supra* note 125, at 2-3.

<sup>129</sup> *Id.* at 3 (arguing that it will be difficult for insurers to manage chronic conditions as beneficiaries churn between coverage and no coverage).

<sup>130</sup> *Id.* (arguing that it will be difficult to implement an effective risk adjustment system where a significant portion of a State’s population remains uninsured).

from the individual exchanges for the newly eligible Medicaid population.<sup>131</sup> Instead of the state fully internalizing the cost of insuring these newly eligible beneficiaries, the state is putting the burden on insurers within the individual exchange to provide coverage and manage the cost of their care. Other states are considering following suit.<sup>132</sup>

For the individual exchanges, this alternative Medicaid expansion proposal drives up costs in a number of ways. First, this Medicaid group has a higher morbidity rate, thereby driving up premiums, the cost of which must be covered by either other exchange beneficiaries or by federal subsidies.<sup>133</sup> Second, this group increases the overall demand for care services, driving up provider reimbursement demands, thereby leading to higher premiums.<sup>134</sup> Third, as with the group of beneficiaries between 100% and 133% of FPL, if the ACA temporary reinsurance program applies to these Medicaid beneficiaries, then the per capita reinsurance amounts would decrease per capita, resulting in higher premium rates for everyone else.<sup>135</sup>

*I. The ACA's Attempt to Push Back Against Adverse Selection and High Costs within the Individual Exchanges*

To some extent the ACA implements measures designed to avoid adverse selection and high cost problems. For example, the individual mandate aims to eliminate adverse selection by requiring most individuals to either purchase insurance or pay a tax penalty, with certain exemptions.<sup>136</sup> The point of the individual mandate is to push healthy individuals into the individual insurance market, so that adverse selection is less likely to occur.<sup>137</sup> The individual mandate spreads the risk, as the healthy individuals pay more in premiums than they spend on health care, thereby cross-subsidizing high-risk beneficiaries and preventing adverse

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<sup>131</sup> Sara Rosenbaum, HealthReformGPS, *Using Medicaid Funds to Buy Qualified Health Plan Coverage for Medicaid Beneficiaries* (2013) available at <http://www.healthreformgps.org/wp-content/uploads/SR-Arkansas-premium-support-pdf.pdf>.

<sup>132</sup> Julie Piotrowski, *Health Affairs, Premium Assistance in Medicaid*, HEALTH POL'Y BRIEF 3 (2013), available at [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_94.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_94.pdf) (reporting that Tennessee, Pennsylvania, Ohio, and Florida are considering a similar plan).

<sup>133</sup> ROBERT M. DAMLER ET AL., MILLIMAN, CONSIDERATIONS FOR MEDICAID EXPANSION THROUGH HEALTH INSURANCE EXCHANGE COVERAGE 5 (2013), available at <http://publications.milliman.com/publications/healthreform/pdfs/considerations-for-medicaid-expansion.pdf> (noting that the "morbidity difference between those with incomes below 138% of FPL may be 15% to 25% greater than those with incomes in the range of 138% to 300% of FPL").

<sup>134</sup> *Id.* at 4.

<sup>135</sup> *Id.* at 5.

<sup>136</sup> See generally 26 U.S.C.A. § 5000A (Westlaw 2010).

<sup>137</sup> Oechsner & Schaler-Haynes, *supra* note 35, at 282-83 (explaining that the individual mandate prevents healthy individuals from gaming the system by waiting until they get sick to purchase insurance).

selection.<sup>138</sup> For several reasons, the individual mandate may not be as powerful in fighting adverse selection and tamping down costs as first appears. First, the mandate penalty is not that much of a “big stick” in terms of a penalty, at least not until 2016. In 2014, the mandate penalty is the greater of \$95 per person or 1% of your income above the income tax filing limit, and \$395 per person or 2% of your income above the income tax filing limit in 2015.<sup>139</sup> Even when fully implemented, in 2016, the mandate penalty is the greater of \$695 per person or 2.5% of your income above the income tax filing limit.<sup>140</sup> These penalties may not be strong enough to incentivize healthy people to purchase insurance.<sup>141</sup> Individuals value losses more than they value gains, so they are more willing to forego the penalty and pay for the value of insurance, only if the penalty is high enough.<sup>142</sup>

Moreover, for at least some people, the delta between the penalty amount and the cost of insurance is large, with the insurance plan costing much more than the penalty. The average premium cost for a bronze level exchange plan could be between \$4,500 and \$5,000 per year,<sup>143</sup> whereas someone earning a little over \$50,000 per year faces a 2.5% penalty or roughly \$1,000,<sup>144</sup> a delta of \$4,000 or more. If such a moderate income individual is healthy, they face a low incentive to pay an extra \$4,000 or more to buy insurance and avoid the penalty.<sup>145</sup> When the penalties are low compared to the cost of insurance, healthy non-risk-averse people will be willing to forgo insurance and pay the penalty.

For others, there is absolutely no penalty-based incentive to purchase insurance. These individuals will be exempt from the mandate because the annual cost of the lowest cost bronze level plan is more than 8% of their annual income, after taking

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<sup>138</sup> Amy B. Monahan, *On Subsidies and Mandates: A Regulatory Critique of ACA*, 36 J. CORP. L. 781, 787 (2011).

<sup>139</sup> 26 U.S.C.A. § 5000A(c) (Westlaw 2010).

<sup>140</sup> *Id.*

<sup>141</sup> Oechsner & Schaler-Haynes, *supra* note 35, at 284; PEPER ET AL., *supra* note 17, at 28 (predicting, in Oregon, that premium rates in the individual market will increase by an average of 15% because people with high morbidity are more likely to purchase insurance than those who are young and healthy). *But see* Baker, *supra* note 52, at 1615-21 (arguing that the individual mandate penalty is strong enough to encourage sufficient participation to avoid adverse selection problems, and even if there is adverse selection, the exchanges will remain sustainable).

<sup>142</sup> Monahan, *supra* note 138, at 796-97 (arguing that individuals value losses more highly than gains and are more likely to buy insurance and gain the value of insurance, than pay a high penalty).

<sup>143</sup> DAVID NEWMAN, CONG. RESEARCH SERV., INDIVIDUAL MANDATE AND RELATED INFORMATION REQUIREMENTS UNDER PPACA 1, 7 n.25 (2011), available at <http://healthreformgps.org/wpcontent/uploads/CRSreportonPPACAUG2011.pdf> (projecting the annual bronze level plan premium to be \$4,800 per year); Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Senator Olympia Snowe (Jan. 11, 2010), available at [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10884/01-11-premiums\\_for\\_bronze\\_plan.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10884/01-11-premiums_for_bronze_plan.pdf) (estimating the average annual bronze level premium to be between \$4,500 and \$5,000 per year).

<sup>144</sup> This accounts for a roughly \$10,000 income tax filing limit.

<sup>145</sup> Monahan, *supra* note 138, at 796-97.

into account any premium assistance tax credits.<sup>146</sup> Taking into account the projected costs of bronze level plans, this means that some individuals earning 250% of FPL to approximately 500% of FPL could be exempt from the mandate because insurance would be unaffordable to them.<sup>147</sup> Healthy individuals within that group, who have low expected health care costs may very well choose not to pay thousands of dollars a year for insurance.<sup>148</sup> There is no downside for them because they are exempt from the mandate penalty.

The ACA attempts to push this low-risk group into the individual exchanges by limiting enrollment to one annual exchange enrollment period, with an exception for changes in status, such as losing a job.<sup>149</sup> The limited enrollment period is supposed to incentivize low-risk individuals to not game the system and wait until they get sick to obtain exchange-based coverage because it will not be easy to enter market. Still, some with non-emergent and non-chronic illness, like a future need for knee replacement surgery, may still game the system. They may initially pay the penalty, purchase insurance when they are ready to have their surgery, and then drop the insurance and pay the penalty again after their health care crisis passes.<sup>150</sup> The choice of these otherwise healthy individuals to pay the penalty and then game the exchange system causes the exchanges to become heavily weighted with high-risk beneficiaries.<sup>151</sup>

The ACA also uses three risk adjustment programs to prevent some insurers from cherry picking good risks, while other insurers get stuck with all of the high-risk enrollees, creating adverse selection problems.<sup>152</sup> Two of the three risk adjustment programs are temporary. The first program applies in 2014, 2015, and 2016 and is a reinsurance program for insurers in the individual market.<sup>153</sup> The program imposes assessments on insurers and administrators for self-insured plans, and then uses those funds as reinsurance for insurers who insure high-risk enrollees.<sup>154</sup>

The second program also covers the years 2014 through 2016 in the form of a risk corridor program for exchange plans.<sup>155</sup> The program sets a target amount for annual insurer claims costs and if an insurer's claims costs come in under that amount by 3% or more, then the insurer must pay some of that money to the

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<sup>146</sup> 26 U.S.C.A. § 5000A(e)(1)(A) (Westlaw 2010).

<sup>147</sup> Monahan, *supra* note 138, at 788-91.

<sup>148</sup> *Id.* at 792.

<sup>149</sup> 42 U.S.C.A. § 18031(c)(6) (Westlaw 2010).

<sup>150</sup> Epstein & Stannard, *supra* note 76, at 254 (criticizing burdensome ACA regulations for allowing healthy individuals to strategically enter and leave the exchange market, thereby driving adverse selection).

<sup>151</sup> *Id.*

<sup>152</sup> Baker, *supra* note 52, at 1614 (explaining that these programs shift funds between insurers, such that the enrollee is really paying his or her fair share of premiums as part of a larger pool of many insurers, rather than paying premiums based on the limited risk pool of that enrollee's insurer).

<sup>153</sup> 42 U.S.C.A. § 18061 (West 2010).

<sup>154</sup> *Id.*

<sup>155</sup> *Id.* § 18062.

government.<sup>156</sup> In turn, if an insurer's claims costs are 103% of the target number or higher, then the government uses the money paid into the program to provide reinsurance to those insurers for those excess costs.<sup>157</sup>

The permanent risk adjustment program authorizes states to assess a charge against all individual and small group insurers, other than self-insured plans, who tend to have enrollees with a lower than average actuarial risk, and to shift those funds to individual and small group insurers, other than self-insured plans, who tend to have enrollees with higher than average actuarial risk.<sup>158</sup> The program provides financial assistance for insurers who end up with high-risk enrollees, while penalizing those who would try to cherry pick low-risk beneficiaries.

There are concerns that these three programs will not be effective. First, risk adjustment technology is new and tends to under-predict the costs of high-risk enrollees and over-predict the costs of low-risk enrollees.<sup>159</sup> At best, risk adjustment programs only assist in reducing the cost differences between multiple plans, and in the case of the ACA risk adjustment programs, the ability to do so is weak, given the lack of existing data to compare the risks of beneficiaries across plans.<sup>160</sup>

Second, assuming states cooperate in developing risk adjustment systems, they may have difficulty in collecting the data necessary to develop an effective risk adjustment system, especially the data needed from non-exchange insurers.<sup>161</sup> Moreover, insurers may have a hard time collecting data to assess risk for short-term beneficiaries, who are only on the exchange for a brief time period, as a result of job changes or Medicaid churning.<sup>162</sup>

Third, insurers have demonstrated a history of evading risk adjustment programs and continuing to cherry pick good risks, while trying to stick other insurers with poor risks. For example, similar to the ACA exchange provisions, Part D includes protections against adverse selection, such as risk adjustment, reinsurance and risk corridors.<sup>163</sup> Despite these preventive measures some Part D plans have been able to structure plan designs to lure in healthier, low-risk enrollees and drive away costlier, high-risk enrollees.<sup>164</sup> A similar situation occurred with Medicare Advantage.<sup>165</sup>

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<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.* § 18063(a).

<sup>159</sup> CONG. BUDGET OFFICE, DESIGNING A PREMIUM SUPPORT SYSTEM FOR MEDICARE 27 (2006), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7697/12-08-medicare.pdf> (explaining that overprediction and underprediction cost errors can cause premiums to rise in plans that attract high-risk enrollees); Baker, *supra* note 52, at 1614-15 (explaining that the risk adjustment programs' success depends on advancements in risk adjustment technology).

<sup>160</sup> LUECK, *supra* note 37, at 3-4.

<sup>161</sup> Jost, *supra* note 46, at 15.

<sup>162</sup> *Id.*

<sup>163</sup> LUECK, *supra* note 37, at 3 (drawing an analogy between adverse selection in the Medicare Part D program, Medicare Advantage program, and Federal Employees Health Benefits Program and the likely adverse selection to occur within the health insurance exchanges).

<sup>164</sup> *Id.*

There is no reason why the same thing would not occur with regard to the exchanges, except that adverse selection may occur not only among plans within the exchanges, but may also occur between insurers inside the exchange and insurers outside the exchange.<sup>166</sup>

Insurance brokers may even assist insurers in evading the risk adjustment programs. Brokers make money off of commissions, so they will direct consumers to wherever their commissions are going to be highest.<sup>167</sup> If a broker is not getting a commission or a sufficient commission from exchange business, then he or she will not direct business toward the exchange or will engage in “street underwriting” in which the broker moves high-cost business to the exchanges and low-cost business outside of the exchanges.<sup>168</sup> There is a history of insurance brokers undermining insurance exchanges because of the lack of exchange commissions or poorly structured exchange commissions.<sup>169</sup>

Finally, the fact that premium subsidies and cost-sharing reductions for low-income beneficiaries are only offered through the exchanges<sup>170</sup> also appears to fight adverse selection. To the extent that these lower income beneficiaries are healthy and low-risk, the ACA subsidies encourage this group of healthy consumers to buy insurance through the individual exchanges, thereby promoting risk spreading.<sup>171</sup> However, if those who tend to qualify for these subsidies tend to fall more into the high-risk category, then the use of exchange-based subsidies only further incentivizes these high-risk individuals to migrate toward the individual exchanges, thereby driving up exchange costs.

### III. MANAGED CARE IN THE EXCHANGES

#### *A. Why and How Insurers Might Fight Back Against High Exchange Costs*

Adverse selection and high costs are very real and serious threats to the viability of the exchanges. The question and part of the focus of this article is what will be the response to these adverse selection and high cost concerns. Many have focused on possible federal and state government responses to save the exchanges from adverse selection and high costs.<sup>172</sup> However, the focus of this article is on the insurer’s

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<sup>165</sup> *Id.* at 8 (explaining how Medicare Advantage plans upcoded enrollees’ health risk in order to qualify for high risk adjustment payments).

<sup>166</sup> Westfall, *supra* note 39, at 118 (arguing that exchange insurers may engage in “cream skimming,” or competing for the healthiest enrollees, instead of competing on the basis of quality and efficiency).

<sup>167</sup> *Id.* at 118.

<sup>168</sup> Jost, *supra* note 46, at 52.

<sup>169</sup> Wicks & Hall, *supra* note 89, at 538

<sup>170</sup> 26 U.S.C.A. § 36B (West 2010); 42 U.S.C.A. § 18071 (West 2010).

<sup>171</sup> Westfall, *supra* note 39, at 130-131 (arguing that subsidies encourage low-risk enrollees to participate in the exchange, encourage risk-sharing across types and can offset the price effects of adverse selection).

<sup>172</sup> Letter from John E. Dicken, Dir. Health Care, U.S. Gov’t Accountability Office, to E. Benjamin Nelson, Chairman, Subcomm. on the Legislative Branch, Comm. on Appropriations, U.S. Senate (Feb. 25, 2011), *available at* <http://www.worldcat.org/title/private-health-insurance-coverage-expert-views-on-approaches-to-encourage-voluntary->



response, especially efforts to promote managed care and related cost cutting measures.

The potential for adverse selection and high costs within the exchanges begs for insurers to take action to restrain such costs, assuming insurers see a potential profitable market in the individual exchanges and seek to tap into that market. While managed care may be unpopular with consumers and providers<sup>173</sup> and may not be the panacea to resolve any and all cost problems in the individual exchanges, insurers will likely attempt to use managed care-type tools to address these cost problems. After all, managed care has a proven track record of controlling costs and decreasing spending, without having a negative impact on quality health care.<sup>174</sup> As long as the individual exchange insurers adopt managed care tools, as a whole group, they avoid creating an adverse selection problem among themselves and may be able to repeat past managed care cost control successes.<sup>175</sup>

While some maintain that managed care is dead as a result of State Patients Bill of Rights laws,<sup>176</sup> such is not the case.<sup>177</sup> Instead, managed care merely changed its form, such that it “broadened provider networks, reduced physician risk-sharing, introduced new incentives under the rubric of pay-for-performance, relaxed gatekeeping, and focused utilization review on high cost items.”<sup>178</sup> Perhaps in

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enrollment-letter-to-e-benjamin-nelson-chairman-subcommittee-on-the-legislative-branch-committee-on-appropriations-united-states-senate/oclc/716123472?referer=di&ht=edition (GAO study outlining alternatives to the individual mandate that could have been used to encourage healthy individuals to purchase insurance had the mandate been struck down); Greaney, *supra* note 41, at 237 (arguing for the exchanges to be open to larger employers to diversify the risk pool); Monahan & Schwarcz, *supra* note 12, at 125 (outlining statutory and regulatory solutions to level the playing field between exchange-based coverage and large group and self-insured coverage); Oechsner & Schaler-Haynes, *supra* note 35, at 241 (arguing for equal regulation of insurance plans both inside and outside of the exchanges to battle adverse selection).

<sup>173</sup> Barbara J. Zabawa et al., *Adopting Accountable Care Through the Medicare Framework*, 42 SETON HALL L. REV. 1471, 1486 (2012) (explaining that providers oppose managed care because they lose control over patient care and suffer from lower reimbursement and patients oppose managed care because they believe that managed care cost cutting is tantamount to denial of access to necessary care).

<sup>174</sup> Robert F. Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation and Policy Making*, 16 STAN. L. & POL’Y REV. 233, 237-39 (2005) (finding that the literary consensus is that managed care reduced the rate of health care cost growth without evidence of a clear negative impact on health care quality).

<sup>175</sup> Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341, 375-76 (2001) (noting that it is important that insurers collectively promote managed care or otherwise they create their own adverse selection problems, as only low-risk enrollees seek out coverage through a managed care insurer, while high-risk enrollees enroll in more traditional insurance plans).

<sup>176</sup> Zabawa et al., *supra* note 173, at 1486-87 (detailing how State Patients Bill of Rights laws watered down managed care).

<sup>177</sup> Marc A. Rodwin, *The Metamorphosis of Managed Care: Implications for Health Reform Internationally*, 38 J.L. MED. & ETHICS 352, 359 (2010) (citing scholarly claims that managed care is dead, but declaring that the obituary is premature).

<sup>178</sup> *Id.*

response to the provider and patient backlash against utilization management and review, capitation and gatekeeping, MCOs became more sophisticated, subtle, and less blunt in their efforts to control costs, but they still engaged in such efforts.<sup>179</sup> These revised MCOs still successfully found ways to reduce costs and improve the quality of care, despite obstacles from the managed care backlash of the 1990s.<sup>180</sup>

Moreover, managed care is alive and well today in many different contexts. Of those receiving employment based insurance, 16% are still enrolled in HMOs, with another 65% enrolled in revised forms of managed care, either preferred provider organizations (“PPOs”) or point of service (“POS”) plans.<sup>181</sup> Managed care is thriving and growing even more in the Medicaid world, where, as of 2011, over 74% of Medicaid enrollees were enrolled in managed care plans in the United States.<sup>182</sup> Likewise, in Medicare, in 2012, 27% of all Medicare enrollees were enrolled in Medicare Part C, the managed care version of Medicare.<sup>183</sup>

#### *B. Managed Care’s Perseverance and New Tools for Controlling Costs in the Exchanges*

Insurer managed care efforts will certainly face obstacles within the exchanges. For example, the exchange-based network adequacy requirement<sup>184</sup> will interfere with insurers’ ability to develop restricted networks. Likewise, the ACA requirement that group health plans and insurers offer extensive internal and external grievance reviews<sup>185</sup> also hinders the ability of insurers to engage in strict utilization management and review.

Nonetheless, managed care has demonstrated a history of perseverance and survival despite obstacles. In the past, managed care revamped its tools to achieve cost cutting goals in new ways. As discussed *supra*, managed care found ways to avoid risk adjustment measures in Medicare Parts C and D. Managed care also extorted loopholes in statutes and regulations, such as State laws that restrict capitation, but fail to precisely define what capitation is prohibited.<sup>186</sup>

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<sup>179</sup> Linda Peeno, *The Second Coming of Managed Care*, 40-MAY TRIAL 18 (2004) (providing examples of the new ways that managed care controls costs, such as disease management programs, pseudo-scientific clinical practice guidelines, use of tiered benefits, and providers and physician profiling).

<sup>180</sup> Zabawa et al., *supra* note 173, at 1489.

<sup>181</sup> GARY CLAXTON ET AL., HENRY J. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY 68 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf>.

<sup>182</sup> *Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees*, HENRY J. KAISER FAMILY FOUND. (as of July 1, 2011), <http://www.statehealthfacts.org/comparemactable.jsp?ind=217&cat=4>.

<sup>183</sup> *Medicare Advantage Fact Sheet*, HENRY J. KAISER FAMILY FOUND. (2012), <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

<sup>184</sup> 42 U.S.C.A. § 18031(c)(1)(B) (West 2010).

<sup>185</sup> *Id.* § 300gg-19(b).

<sup>186</sup> Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL’Y & L. 427, 434 (2005) (finding that few states implemented guidelines regarding what sort of capitation agreements are prohibited and only one state took any enforcement actions against managed care insurers).

Moreover, some of the ACA's anti-managed care provisions are not as strong as they may seem. For example, the ACA's external review requirement may not have much teeth. Under ERISA, courts grant insurers a highly deferential standard of review when the ERISA plan design grants the plan great discretion in its coverage decisions.<sup>187</sup> The same thing could happen with the ACA internal and external grievance requirements.

At this early stage in the development of exchanges, it is difficult to predict how insurers will attempt to control costs within the health insurance exchanges, but one possibility is to promote or facilitate the growth of ACA endorsed delivery reform measures that mirror managed care.<sup>188</sup> For example, the Medicare Accountable Care Organization ("ACO") demonstration project calls for the creation of ACO entities comprised of providers and hospitals that are held jointly accountable for delivering low cost and high quality care to their Medicare patients.<sup>189</sup> The ACO providers still get paid on a fee-for-service basis, but, depending on the ACO model chosen, Medicare will pay the ACO bonuses and levy penalties against them based on their ability to reduce Medicare spending while maintaining or improving care quality.<sup>190</sup> Unlike traditional managed care, the cost accountability and risk falls upon the providers instead of the insurers, but, the payer, through setting cost and quality standards, is still indirectly managing spending, managing care, and eliminating wasteful and unnecessary care.<sup>191</sup> The similarity between ACOs and managed care is even closer where the ACO operates under a fully capitated system.<sup>192</sup> ACOs are already growing like gangbusters, especially in the private sector.<sup>193</sup>

Somewhat similar to the ACOs, the Bundled Payments for Care Improvement Initiative uses a quasi-capitated payment system to incentivize providers to cut costs and deliver high quality care.<sup>194</sup> Though there are different bundled payment models, the general approach is for Medicare and a group of providers to set a target bundled cost for all of the care associated with an episode of care surrounding a given

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<sup>187</sup> *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 375 (2002) (holding that courts will be highly deferential to ERISA plan coverage decisions where the plan design provides the plan with unfettered discretion in benefit determinations).

<sup>188</sup> Lawton Burns & Mark Pauly, *Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s*, HEALTH AFFAIRS 31, no. 11, at 2407, 2407 (Nov. 2012), available at [http://d1c25a6gwz7q5e.cloudfront.net/papers/download/12042012\\_BurnsPaulyACOsAppendix3.pdf](http://d1c25a6gwz7q5e.cloudfront.net/papers/download/12042012_BurnsPaulyACOsAppendix3.pdf) (explaining that ACOs are growing in the private sector).

<sup>189</sup> 42 U.S.C.A. § 1395jjj(b)(1)-(2) (West 2010).

<sup>190</sup> 42 C.F.R. § 425.600-08 (2011).

<sup>191</sup> Jessica Mantel, *Accountable Care Organizations: Can We Have Our Cake & Eat It Too?*, 42 SETON HALL L. REV. 1393, 1410-11 (2012).

<sup>192</sup> *Id.* at 1411.

<sup>193</sup> David Muhlestein, *Continued Growth of Public & Private Accountable Care Organizations*, HEALTH AFFAIRS BLOG (Feb. 19, 2013), <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/> (finding, as of 2012, over 150 private sector ACOs).

<sup>194</sup> 42 U.S.C.A. § 1395cc-4 (West 2010).

hospitalization.<sup>195</sup> The providers involved in that episode of care will continue to be paid by Medicare on a fee-for-service basis, but their total reimbursement will be measured against the target costs.<sup>196</sup> If they generate savings against the targeted costs, they share in those savings, but if they generate losses, then they must repay some of their reimbursement to Medicare.<sup>197</sup> The system is very much like a managed care capitated payment system<sup>198</sup> with one of the bundled payment models being fully capitated.<sup>199</sup>

The Patient-Centered Medical Home takes on a different aspect of managed care, the gatekeeper-like role of primary care providers.<sup>200</sup> Under the PCMH or Advanced Primary Care Practice (“APCP”) demo, Medicare will pay primary care providers an additional fee to coordinate a patient’s care with other providers, manage the patient’s overall health, monitor the patient’s health, and provide general oversight over the patient over the continuum of care.<sup>201</sup> Although patients in the APCP program are not required to obtain the primary care provider’s permission to see specialists, the primary care provider is still financially incentivized to regulate, monitor, control, and oversee the patient’s complete care. Many large private insurers are already testing medical home models outside of Medicare.<sup>202</sup>

Initially, insurers may be forced to use incentives to promote the spread of these reforms until these delivery reforms fully expand beyond Medicare and Medicaid demo programs and reach a tipping point of acceptance. However, eventually, assuming network adequacy requirements are met, exchange insurers may require that contracting providers agree to operate as ACOs, PCMHs, or be willing to accept bundled payments in order to be providers within the insurer’s network. The question is whether insurers can use these new models and other managed care-type tools to cut costs effectively or whether they will be stymied in their efforts.

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<sup>195</sup> *Id.* § 1395cc-4(c).

<sup>196</sup> *Fact Sheet: Bundled Payments for Care Improvement Initiative*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 30, 2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-30-2.html>.

<sup>197</sup> *Id.*

<sup>198</sup> Jeffrey Hammond, *Cash Only Doctors: Challenges & Prospects of Autonomy and Access*, 80 UMKC L. REV. 307, 311 n.23 (2011) (explaining that placing the provider at risk for providing treatment for a set amount of money is akin to managed care capitation).

<sup>199</sup> *Fact Sheet*, *supra* note 196.

<sup>200</sup> Peter Kalis & Judy Hlafcsak, *Healthcare Reform: Let’s Act Locally*, 50 DUQ. L. REV. 253, 265-66 (2012) (comparing the medical home model to HMOs).

<sup>201</sup> CTRS. FOR MEDICARE & MEDICAID SERVICES, MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE (MAPCP) DEMONSTRATION FACT SHEET (Apr. 5, 2012), *available at* <http://innovation.cms.gov/Files/fact-sheet/mapcpdemo-Fact-Sheet.pdf>.

<sup>202</sup> Alexandria Ottens, *There’s No Place Like Home: Moving Towards Patient-Centered Medical Homes for Healthcare Reform*, 20 ANNALS HEALTH L. ADVANCE DIRECTIVE 1, 4 (2011) (noting that United Health Care, Aetna, and Blue Cross/Blue Shield are all testing medical homes).

## IV. ERISA PREEMPTION AND THE EXCHANGES

A. *Managed Care Tort Liability*

Beyond the consumer protection obstacles embodied within state-based Patients Bill of Rights laws and certain ACA provisions, such as the network adequacy requirements and internal/external grievance process requirements, the lack of ERISA preemption for individual exchange insurers poses another difficult obstacle for managed care and cost cutting efforts within the individual exchanges. Historically, when insurers adopt aggressive cost cutting measures that result in patient injury, patients have tried to sue their insurer under State tort law principles.<sup>203</sup> More specifically, patients have sued their insurers successfully under a variety of liability theories, including apparent agency,<sup>204</sup> actual agency,<sup>205</sup> and corporate negligence.<sup>206</sup>

A well-known example of the application of apparent and actual agency liability to a managed care organization (“MCO”) is *Petrovich v. Share Health Plan of Illinois, Inc.*<sup>207</sup> In *Petrovich*, the plaintiff sued various treating doctors and her HMO for medical malpractice after her doctors negligently failed to diagnose her oral cancer.<sup>208</sup> Although the doctors were independent contractors of the HMO, the Illinois Supreme Court held that the HMO could be held liable for the doctors’ medical malpractice, provided the HMO held itself out as the provider of care without informing the patient that she was receiving care from an independent contractor doctor and provided the patient was seeking care from the HMO and not a specific doctor.<sup>209</sup> The Court further held that there was a genuine issue of material fact as to whether the HMO exerted sufficient control over the doctors involved to

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<sup>203</sup> Christopher Smith, *Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals Within Accountable Care Organizations*, 20 ANNALS HEALTH L. 165, 174-75 (2011).

<sup>204</sup> E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort & Contract*, 59 VAND. L. REV. 1207, 1208 (2006) (noting that as managed care exerted more control over financial and medical decisions for patients, they were more subject to liability through corporate negligence and ostensible authority theories).

<sup>205</sup> Gail B. Agrawal & Mark A. Hall, *What if You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS U. L.J. 235, 244 (2003) (noting that States expanded the reach of implied authority liability to MCOs where there was sufficient control of affiliated independent contractor doctors).

<sup>206</sup> Emmanuel O. Iheukwumere, *Application of the Corporate Negligence Doctrine to Managed Care Organizations: Sound Public Policy or Judicial Overkill?*, 17 J. CONTEMP. HEALTH L. & POL’Y 585, 613 (2001) (noting that staff model MCOs, like hospitals, have the same duty to select and retain competent healthcare providers, to maintain safe and adequate facilities and equipment for enrollees when the MCOs provide direct medical care, to oversee all who practice under their influence and control and to ensure that enrolled providers formulate, adopt and enforce adequate rules to ensure quality care).

<sup>207</sup> *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756 (Ill.1999).

<sup>208</sup> *Id.* at 760.

<sup>209</sup> *Id.* at 768.

create an actual agency relationship, given the HMO's capitation method for paying the doctors and its quality assurance review over the doctors.<sup>210</sup>

An example of corporate negligence in the MCO context is *Jones v. Chicago HMO*, in which an overburdened HMO staff doctor was unavailable to personally examine a sick child and negligently failed to diagnose and treat the child's meningitis.<sup>211</sup> The Illinois Supreme Court held that the HMO could be held liable for the child's resulting brain damage through corporate negligence.<sup>212</sup> The Court ruled that the plaintiff could prevail on a corporate negligence theory by proving that the HMO assigned an excessive number of patients to the HMO staff doctor, thereby overburdening the provider and indirectly resulting in the patient's injury.<sup>213</sup>

#### B. ERISA Preemption of State Tort Suits Against Managed Care

Despite plaintiffs' general success in suing HMOs under various tort doctrines, when a plaintiff sues his employment-based MCO for cost cutting that leads to patient harm, ERISA preemption of state tort law prohibits such plaintiffs from recovering from their insurer.<sup>214</sup> The Supreme Court's interpretation of ERISA, as applied to employment-based health plans, has rendered almost all such plans immune from state tort suits.<sup>215</sup> Accordingly, ERISA preemption has an impact on a large number of potential plaintiffs, as presently, almost sixty percent of non-elderly Americans receive their health insurance through their employers.<sup>216</sup>

ERISA was passed in 1974 with the goal of providing uniform federal regulation of employee welfare and benefits plans, so that large employers were not subject to the vagaries of fifty different state welfare and benefits laws.<sup>217</sup> Hence the strong federal preemption measures within ERISA, which are twofold in nature. First,

<sup>210</sup> *Id.* at 774-75.

<sup>211</sup> *Jones v. Chi. HMO Ltd. of Ill.*, 730 N.E.2d 1119, 1123 (Ill. 2000).

<sup>212</sup> *Id.* at 1128.

<sup>213</sup> *Id.* at 1132; *see also* *Shannon v. McNulty*, 718 A.2d 828 (Pa. Super. 1998) (holding that corporate negligence principles apply to HMOs where an HMO influences the delivery of health care and attempts to limit patient access to treatment).

<sup>214</sup> Peter Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 381 (2003) (noting the generally unsuccessful patient State law challenges against ERISA plans for injury due to delayed or denied care or MCO financial incentives to providers to limit care).

<sup>215</sup> Schapiro, *supra* note 2, at 46-47 (noting that the Supreme Court has interpreted ERISA to preempt State law claims against HMOs without providing a federal substitute remedy).

<sup>216</sup> JULIE SONIER ET AL., STATE HEALTH ACCESS DATA ASSISTANCE CTR., STATE LEVEL TRENDS IN EMPLOYER-SPONSORED HEALTH INSURANCE: A STATE-BY-STATE ANALYSIS 3 (Apr. 2013), *available at* <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405434> (finding that 59.5% of non-elderly Americans had employer-sponsored coverage in 2010 and 2011).

<sup>217</sup> 29 U.S.C. §§ 1001-1461 (2006); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (holding that the purpose of ERISA was "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government").

Section 514 of ERISA supersedes any state law that relates to employee benefit plans.<sup>218</sup> However, Section 514 preemption is not complete as the “savings” clause of Section 514 saves from federal preemption any state law that regulates insurance.<sup>219</sup> In other words, if a state law relates to employee benefit plans, but is also a regulation of insurance, then the state law is saved from preemption. Nonetheless, even a “saved” state law, as applied to self-insured plans, is further preempted by ERISA through the “deemer clause” of Section 514.<sup>220</sup> The “deemer clause” deems self-insured plans to be preempted from any and all state laws regulating employee benefits, even if the applicable law also regulates insurance.<sup>221</sup>

Second, even if Section 514 does not preempt a given state law, Section 502 of ERISA may still preempt the state law at issue. With regard to a wrongful denial of benefits, Section 502 provides for exclusive ERISA federal causes of action against an ERISA plan fiduciary for breaches of fiduciary duties owed to the plan and for other appropriate equitable relief.<sup>222</sup> The Supreme Court has interpreted this provision to fall under the complete preemption exception to the well-pleaded complaint rule, meaning that Section 502 completely preempts any well-pleaded state law cause of action that duplicates, supplements or supplants the Section 502 ERISA remedial scheme.<sup>223</sup>

The Supreme Court decision in *Aetna Health, Inc. v. Davila* provides the definitive interpretation of Section 514 complete preemption in relation to employment-based health insurance plans. In *Davila*, two plaintiffs, in separate, but consolidated cases, sued their insurers for rejecting their respective doctors’ recommendations related to coverage for an arthritis drug and an extended hospital stay following surgery, respectively.<sup>224</sup> The plaintiffs sought recovery under a Texas statute that provided for a state law cause of action against a health insurer who violates its duty to exercise ordinary care when making health care treatment decisions.<sup>225</sup>

The Supreme Court held that the state law claims were completely preempted by ERISA Section 502 because the state law claims were really claims for wrongfully denied benefits and were not claims alleging violation of a legal duty independent of ERISA.<sup>226</sup> The Court further held that ERISA preempted the state law claims because the state law claims supplemented the ERISA remedies with additional tort-like remedies.<sup>227</sup> Accordingly, the nature of the state law claims were for a denial of

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<sup>218</sup> 29 U.S.C. § 1144(a) (2006).

<sup>219</sup> *Id.* § 1144(b)(2)(A).

<sup>220</sup> *Id.* § 1144(b)(2)(B).

<sup>221</sup> *Id.*

<sup>222</sup> *Id.* at § 1132(a).

<sup>223</sup> *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207-09 (2004).

<sup>224</sup> *Id.* at 204-05.

<sup>225</sup> *Id.* at 205.

<sup>226</sup> *Id.* at 214.

<sup>227</sup> *Id.* at 214-16.

benefits, fell within the scope of ERISA and were completely preempted by ERISA Section 502.<sup>228</sup>

Given the ERISA statute and *Davila*, it appears that injured patients have few, if any, state law tort claims against their employment-based insurers when the insurer's actions proximately cause the patient's injury.<sup>229</sup> Justice Ginsburg's concurring opinion, in *Davila*, referenced a regulatory vacuum created by ERISA as to claims against ERISA plans, whereby "[v]irtually all state law remedies are preempted but very few federal substitutes are provided."<sup>230</sup> Available remedies are limited to the value of wrongfully denied benefits,<sup>231</sup> breach of fiduciary duty damages, where the fiduciary's actions result in a loss to the plan or a gain to the fiduciary<sup>232</sup> and other equitable relief.<sup>233</sup> However, the breach of fiduciary duty damages are only available to the plan itself, not the plan beneficiary.<sup>234</sup> Moreover, the Supreme Court has interpreted the equitable relief provision to narrowly include only the value of wrongfully denied benefits.<sup>235</sup> In the end, the beneficiary, in an ERISA action against his or her insurer, is limited to recovery for the value of wrongfully denied benefits and there are no ERISA consequential or punitive damages available.<sup>236</sup>

ERISA plan insurers obviously benefit from the veritable immunity that they receive from state tort law.<sup>237</sup> Providers and patients, on the other hand, are not so

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<sup>228</sup> *Id.* at 221.

<sup>229</sup> *But see id.* at 218-21 (interpreting *Pegram v. Herdrich*, 530 U.S. 211 (2000), as holding that ERISA does not preempt State law claims against physician owned HMOs, where the conduct at issue involves a mixed treatment and eligibility decision and not just a plan fiduciary eligibility decision); *Badal v. Hinsdale Mem'l Hosp.*, 2007 WL 1424205 (N.D. Ill. 2007) (holding that ERISA did not preempt claim against employment-based insurer where plaintiff was not complaining of wrongfully denied benefits, but was seeking to hold the insurer vicariously liable for his physician's negligence in misdiagnosing an ankle injury); *Smelik v. Mann*, No. 2003-CI-06936 (Tex. 224th Dist. Ct., Bexar Cnty. June 28, 2005), available at <http://www.crowell.com/pdf/managedcare/Smelik.pdf> (jury verdict against employment-based HMO for mismanaged care instead of denial of benefits).

<sup>230</sup> *Davila*, 542 U.S. at 222.

<sup>231</sup> 29 U.S.C.A. § 1132(a)(1)(B) (West 2013); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (holding that ERISA does not allow for extracontractual damages).

<sup>232</sup> 29 U.S.C.A. § 1132(a)(2) (West 2013).

<sup>233</sup> *Id.* § 1132(a)(3).

<sup>234</sup> *LaRue v. DeWolff, Boberg & Assocs.*, 552 U.S. 248, 254 (2008) (holding that only the ERISA plan, not the beneficiary, can recover damages for breach of an ERISA fiduciary duty).

<sup>235</sup> *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209-18 (2001) (narrowly interpreting ERISA's equitable relief provision).

<sup>236</sup> Peter K. Stris, *ERISA Remedies, Welfare Benefits, & Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA LAB. & EMP. L.J. 387, 394-95 (2009).

<sup>237</sup> Duncan MacCourt & Joseph Bernstein, *Medical Error Reduction & Tort Reform Through Private, Contractually-Based Quality Medicine Societies*, 35 AM. J.L. & MED. 505, 519 (2009) (explaining that ERISA plans highly value the benefits of ERISA preemption while placing the entire liability for medical malpractice squarely on the shoulders of providers).



welcoming of the Supreme Court's interpretation of ERISA preemption. The patient can still sue his or her provider for medical malpractice, but he or she is effectively denied access to the deep pockets of the insurer.<sup>238</sup>

ERISA preemption places providers in an even more uncompromising position. ERISA plans can impose cost cutting measures on or incentivize providers to adopt cost cutting measures without concern for any negative outcomes to the plan itself because the ERISA plan is unlikely to be held liable for any resulting patient injury.<sup>239</sup> Providers, however, are stuck between a rock and a hard place. On the one hand, providers must implement such cost cutting measures or face termination from the MCO provider network and loss of their patient base.<sup>240</sup> On the other hand, providers also have an ethical duty to provide all necessary care to their patients, regardless of cost,<sup>241</sup> and face potential malpractice liability if they cut beneficial care.<sup>242</sup> Because of ERISA preemption of ERISA plan state tort liability, providers must implement the MCO cost cutting measures, while at the same time shouldering all of the liability burden.<sup>243</sup> Accordingly, ERISA preemption removes the specter of medical malpractice liability as an obstacle to ERISA plan cost cutting measures, albeit at the expense of patients and providers. Plaintiffs' lawyers are much less willing to sue ERISA plans when their actions are connected to patient injury, especially given that the health care provider is still an available pocket for compensation.<sup>244</sup> Without question, ERISA plans can much more easily control costs with ERISA preemption than without it. Given the significance of ERISA preemption to insurers' ability to engage in cost control, the question is how this ERISA preemption dynamic will play out in the health insurance exchanges, if and when insurers attempt to use managed care-type tools control the anticipated high exchange costs and avoid adverse selection.

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<sup>238</sup> *Sanson v. Gen. Motors Corp.*, 966 F.2d 618, 625 (11th Cir. 1992) (Birch, J., dissenting) (“The combination [of an employee’s] state cause of action [being] preempted by ERISA even while ERISA denies him any alternative remedy . . . is disappointingly pernicious to the very goals . . . that motivated Congress to enact pension laws.”).

<sup>239</sup> See Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians & Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1932 (2003) (arguing that ERISA preemption allows employment-based MCOs to focus on cost cutting without regard for any negative quality impacts); MacCourt & Bernstein, *supra* note 237, at 519 (explaining that ERISA preemption allows ERISA plans to focus on profit from limiting medical care and avoid implementing quality measures, such as best practices standards).

<sup>240</sup> Dionne Koller Fine, *Physician Liability & Managed Care: A Philosophical Perspective*, 19 GA. ST. U. L. REV. 641, 673-76 (2003) (explaining that providers who fail to ration care or cut costs in line with ERISA plan policies face termination from the MCO’s provider network).

<sup>241</sup> MARK HALL, *MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS* 131 (Oxford Univ. Press 1997).

<sup>242</sup> Smith, *supra* note 203, at 174-75 (explaining that providers engage in defensive medicine because of fear of medical malpractice liability, which actually raises costs and undermines MCO cost cutting efforts).

<sup>243</sup> MacCourt & Bernstein, *supra* note 237, at 519.

<sup>244</sup> Agrawal & Hall, *supra* note 205, at 251 (explaining that both plaintiff and defense lawyers believe that ERISA preemption has deterred the number of plaintiff lawsuits against ERISA plans).

*C. The Lack of ERISA Preemption in the Individual Insurance Exchanges*

Although ERISA preemption will still apply to employment-based insurers within the SHOP exchanges, it will not protect individual exchange plans from state tort suits, where their cost-cutting measures proximately cause patient injury. Because ERISA only governs employee benefit plans and because individual exchange plans are not connected to employment, there is no ERISA protection for such plans. The result is a “tale of two” insurer markets, in which self-insured and fully-insured employment plans, inside or outside of the exchanges, will be protected by ERISA from potential state tort claims, but not so with regard to individual exchange plans.

The lack of ERISA preemption for individual exchange plans poses serious concerns for those insurers who wish to engage in cost-cutting and use managed care-type tools to combat the likely high costs within the exchanges. The threat of tort liability against individual exchange insurers may overly deter them from engaging in beneficial managed care cost cutting.<sup>245</sup> Not all managed care cost cutting is bad; historically, there is support for the argument that managed care can cut wasteful spending without harming patient quality.<sup>246</sup> However, the threat of liability does not discriminate and will deter all cost cutting, both good and bad.<sup>247</sup> As a consequence, individual insurers, without ERISA protection, may entirely abandon managed care and cost-cutting efforts within the individual exchanges.<sup>248</sup> Without those cost-cutting measures, insurers are unable to target wasteful spending and the adverse selection and high cost problems likely to impact the individual exchanges will remain unabated and will grow.

The threat of insurer liability could lead to a phenomenon akin to doctors who practice defensive medicine.<sup>249</sup> Physicians who engage in defensive medicine provide excessive or unnecessary care or tests, or avoid risky patients or treatments because they fear that skimping on care or caring for risky patients might expose

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<sup>245</sup> Katherine L. Record, Note, *Wielding the Wand Without Facing the Music: Allowing Utilization Review Physicians to Trump Doctors’ Orders, but Protecting them from the Legal Risk Ordinarily Attached to the Medical Degree*, 59 DUKE L.J. 955, 996 (2010) (arguing that tort liability must be strictly limited because “imposing unlimited liability, or creating liability risk even when coverage is properly denied, could deter managed care entities from implementing any cost-containment policies at all”).

<sup>246</sup> Max Huffman, *Competition Policy in Health Care in an Era of Reform*, 7 IND. HEALTH L. REV. 225, 248 (2010) (noting that HMOs in the 1990s successfully cut costs without damaging patient quality).

<sup>247</sup> Agrawal & Hall, *supra* note 205, at 261 (explaining that some scholars argue that the threat of medical liability is excessive because the tort system is imperfect and poses the threat of liability for harm unrelated to bad acts, as much as it poses the threat of liability for harm that can be tied to bad acts).

<sup>248</sup> *Id.* at 262 (arguing that “the specter of tort liability could chill innovation in techniques to manage care and cost or could lead the managed care industry to abandon the cost-control function entirely without another mechanism in place to fulfill that function”).

<sup>249</sup> Carl Giesler, *Managers of Medicine: The Interplay Between MCOs, Quality of Care & Tort Reform*, 6 TEX. WESLEYAN L. REV. 31, 62-63 (1999) (arguing that HMO tort liability could lead to the authorization of medically unnecessary care).

them to unpredictable tort liability.<sup>250</sup> Similarly, within the context of the individual exchanges, shifting or expanding the risk of liability away from the health care provider and onto the insurer raises concerns that individual exchange insurers will engage in an analogous form of defensive medicine-type behavior. Fearing liability, such insurers may remove beneficial cost constraints aimed at cutting waste, remove provider incentives that reduce wasteful spending, and approve wasteful and unnecessary medical claims. However, the failure to eliminate wasteful care only raises the overall cost of care, which will likely be passed along to exchange beneficiaries in the form of higher premiums. If the threat of insurer tort liability within the individual exchanges is too great and the costs to provide individual insurance are too high, then insurers may go further than engaging in defensive medicine-type behavior and might entirely abandon the individual exchanges.<sup>251</sup> Given that fully-insured or self-insured employment plans are shielded from state tort liability by ERISA and given that those markets are large insurance markets,<sup>252</sup> individual insurers have even less reason to work hard to make the individual exchanges function effectively. If costs get out of hand within the individual exchanges, insurers can just leave the individual exchanges and focus their efforts on employment-based insurance. Unfortunately, an exodus of insurers from the individual exchanges could ultimately lead to the collapse of the exchanges.

Even if insurers do not drop out of the insurance exchanges, their potential tort liability may cause insurance premiums within the exchange to rise. There are significant costs for insurers in defending against beneficiary tort suits and insurers tend to settle such suits early on, even if the insurer is probably not at fault.<sup>253</sup> Accordingly, at least some of these costs are not even attributable to valid tort claims. Yet, insurers are likely to pass these litigation and settlement costs along to enrollees in the form of higher premiums. By contrast, with ERISA preemption, there are fewer state tort claims against insurers, which means lower litigation and settlement costs.<sup>254</sup> Hence, ERISA plan insurers need not be concerned with passing along litigation and settlement costs to their beneficiaries.

Beyond the practical negative impacts of subjecting insurers to potential tort liability, imposing medical malpractice liability on insurers may be bad policy. Arguably, injured patients already have a source of recovery for medical malpractice injuries via their doctors and their doctors' medical malpractice insurer.<sup>255</sup> Imposing

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<sup>250</sup> David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609-10 (2005) (defining defensive medicine as a "deviation from sound medical practice that is induced primarily by a threat of liability").

<sup>251</sup> Monahan & Schwarcz, *supra* note 12, at 131-32 (arguing that adverse selection and the high costs associated with adverse selection could render the exchanges unsustainable).

<sup>252</sup> *Health Insurance Coverage of the Total Population*, HENRY J. KAISER FAMILY FOUND. (2011), <http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3> (noting that 48% of the country's population receives insurance through their employer).

<sup>253</sup> Agrawal & Hall, *supra* note 205, at 263.

<sup>254</sup> *Id.* at 251.

<sup>255</sup> Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491 (1997); Richard A. Epstein, *Vicarious Liability of Health Plans for Medical Injuries*, 34 VAL. U. L. REV. 581 (2000).

liability upon the insurer is duplicative and merely adds unnecessary costs onto the health care system.<sup>256</sup>

Individual exchange beneficiaries and health care providers would probably disagree with these arguments. On the surface, under the status quo, individual exchange beneficiaries who are injured by insurer cost cutting would welcome the ability to hold their insurers accountable. Some argue that “there is some reason to believe that managed care organizations are better positioned to process liability signals than are individual clinicians...[since] managed care organizations are in the business of spreading risk, and, with time and experience, should be more able to gauge their response to the increased risk of liability.”<sup>257</sup> Moreover, injured beneficiaries would view the insurer as the true locus of responsibility, at least where the health care provider correctly claims that the patient harm was the direct or indirect result of managed care cost cutting and not the provider’s independent medical judgment or skill. For the injured beneficiary, the insurer serves as another deep pocket for recovery and a deeper pocket than the health care provider.<sup>258</sup> The insurer may be seen as an easier target than the provider in the vein of the “big bad insurance company” in contrast to the kind doctor who is devoted to his community.

While on the surface the lack of ERISA preemption may seem like a good thing for exchange beneficiaries, a deeper dive reveals that beneficiaries will see negative impacts in the long run. As discussed *supra*, increased insurer liability can lead to increased costs. Insurers will not eat these costs; they will pass them along to individual exchange beneficiaries in the form of higher premiums.<sup>259</sup> In fact, the trickle down costs may be quite high, as compared to physicians, insurers are more likely to be subject to larger awards and/or punitive damages awards.<sup>260</sup> Exchange beneficiaries will suffer the consequences of increased insurer liability as much as they enjoy the benefits thereof. In fact, if individual exchange insurers are also providing insurance in other ERISA regulated markets, they may pass along the increased exchange-based litigation costs to all of their beneficiaries, and not just the ones in the individual exchanges.

Unlike beneficiaries, providers probably have less to lose from increased insurer liability in the individual exchanges. With the potential for insurer liability for medical malpractice, providers no longer have to bear the liability burden alone.<sup>261</sup> They will no longer be stuck in the middle between insurer cost cutting pressures, on one side, and the threat of medical malpractice liability if they cut beneficial care;

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<sup>256</sup> Agrawal & Hall, *supra* note 205, at 268.

<sup>257</sup> *Id.* at 270-71.

<sup>258</sup> Kristin Madison, *ERISA & Liability for Provision of Medical Information*, 84 N.C. L. REV. 471, 539 n.276 (2006) (discussing that MCOs have greater liability exposure than health care providers).

<sup>259</sup> *Id.* at 539 (arguing that insurer “informational liability may increase operational costs for MCOs, ultimately increasing premiums for consumers”).

<sup>260</sup> *Id.* at 539 n.276 (noting that “while punitive damages are rarely awarded in physician malpractice cases . . . courts have awarded substantial damages in cases involving MCOs”).

<sup>261</sup> Fine, *supra* note 240, at 679 (noting that “the current policy of encouraging control of health care costs through the use of MCOs, which achieves (or attempts to achieve) health care cost reductions through the use of bedside rationing, is unfair because physicians and MCOs do not share the liability burdens for such rationing”).

the insurer will have to share the burden, as well. In fact, if the insurer is found to be more at fault for the patient's injury, the provider may be able to shift a greater portion of the liability costs to the insurer through contribution and joint and several liability.<sup>262</sup>

Nonetheless, even providers could face a couple of potential downsides to increased individual exchange insurer liability. First, if individual exchange insurers face higher costs due to litigation, they could put pressure on providers to accept reimbursement cuts, as a way to offset the higher costs. Second, if insurer liability ultimately leads to insurers abandoning the exchanges, then many individual exchange beneficiaries will lose coverage and providers' covered patient population will shrink. While insured patients provide a steady stream of income for providers, there is less stability with regard to patients who cannot obtain insurance and must pay out-of-pocket.<sup>263</sup> An increase in uninsured patients would force providers to absorb some of the costs of caring for the uninsured population and pass those costs along to health care insurers and their beneficiaries.<sup>264</sup>

#### V. SOLUTIONS TO THE INDIVIDUAL EXCHANGE ERISA PROBLEM

##### *A. Altering the Scope of ERISA Preemption*

The lack of ERISA preemption within the individual exchanges plainly poses problems in terms of the ability of individual exchange insurers to engage in beneficial cost cutting and the potential for insurer tort liability to lead to high prices within the exchanges. There are various solutions to addressing the ERISA problem, but this article focuses on the creation of a no-fault insurer liability system. Such a proposal both protects insurers against catastrophic tort damages for harmful cost cutting and provides injured beneficiaries with some form of remedy when they are injured by insurer cost cutting. An alternative to the no-fault solution is to legislatively eliminate ERISA preemption for all insurers, thereby leveling the ERISA preemption playing field between individual exchange insurers and employment-based insurers. Some would argue that ERISA preemption relies too much on the competitive market to regulate insurers' abusive cost cutting tactics.<sup>265</sup> In the employment context, employers' information costs are too great in isolating and avoiding the abusive insurers and it is far from clear whether employers can pass these costs along to their employees, so that employees will choose their employer

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<sup>262</sup> *Dunn v. Praiss*, 656 A.2d 413, 416 (N.J. 1995) (holding that "a physician-provider who has been found guilty of medical malpractice [may] seek[] contribution from his HMO on the basis of its independent breach of contractual duty to a patient-subscriber of the HMO").

<sup>263</sup> Arthur Birmingham LaFrance, *Healthcare Reform in the United States: The Role of the States*, 6 SEATTLE J. SOC. JUST. 199, 222 (2007) (noting that the advent of health insurance in the 1930s provided doctors with a stable income).

<sup>264</sup> Jay, *supra* note 7, at 1151-52.

<sup>265</sup> Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) it Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2354 (2010) [hereinafter Moncrieff, *Assault on Litigation*] (arguing that employers do not monitor MCOs sufficiently to weed out MCOs with abusive practices).

based on the quality of that employer's insurers or the strength of that employer's efforts to combat insurer abuses.<sup>266</sup>

Elimination of ERISA preemption, across-the-board, and the specter of tort liability would certainly discourage insurers from engaging in cost cutting measures that negatively impact quality. It would also equitably ensure that insurers, and not just providers, are held accountable for cost cutting that harms patients. Moreover, all patients—not just those purchasing insurance from the individual exchanges—would have an additional deep pocket remedy source for their injury or harm. Finally, treating all insurers the same avoids a scenario under which insurers would avoid providing insurance through the exchanges and seek to provide insurance solely in the employment context in order to maximize their ERISA-based immunity from tort suits.

Despite the benefits of this solution, there are a number of problems. First, as discussed *supra*, the specter of potential tort liability could over deter insurer cost cutting, such that all insurers would refuse to engage in beneficial cost cutting, or cost cutting that eliminates waste from the health care system without causing harm to beneficiaries.<sup>267</sup> Second, open ended tort liability could drive up insurance costs throughout the industry.<sup>268</sup> All insurers might raise premiums to account for potential catastrophic tort damages, passing along the costs to beneficiaries and their employers. Third, the elimination of ERISA preemption is not politically feasible. ERISA preemption has withstood the test of time for forty years and history demonstrates that the insurance industry will not allow its repeal.<sup>269</sup>

Some argue that the Department of Labor (“DOL”) should give teeth to the ERISA “equitable relief” remedy, such that ERISA plans would face real liability for cost cutting that results in patient injury. The DOL could use its regulatory authority to define the “equitable relief” provision of ERISA to include damages for patient injuries, in addition to any wrongfully denied benefits.<sup>270</sup> Alternatively, the DOL could monitor employment-based insurers and impose penalties on those who abusively engage in cost cutting that leads to patient harm.<sup>271</sup> However, these solutions are not much different than eliminating ERISA preemption across-the-board and carry with them the same problems.

An alternative solution is the opposite extreme. Instead of eliminating ERISA preemption, Congress could expand ERISA preemption to include individual

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<sup>266</sup> *Id.* at 2352-55 (arguing that employers are incentivized to do what is cheapest, not best in terms of picking health insurers for their employees).

<sup>267</sup> Robert F. Rich, *The Two Faces of Managed Care Regulation & Policymaking*, 16 STAN. L. & POL'Y REV. 233, 272-73 (2005) (noting that insurers argue that MCO liability hinders the ability of MCOs to improve patient quality).

<sup>268</sup> *Id.* (noting that insurers argue that MCO liability increases the costs of managed care).

<sup>269</sup> Roderick M. Hills Jr., *Against Preemption: How Federalism Can Improve the National Legislative Process*, 82 N.Y.U. L. REV. 1, 42-43 (2007) (outlining repeated failures to repeal ERISA preemption throughout the 1990s due to massive public relations efforts by MCOs). Technically, ERISA preemption, as it is recognized today, is rooted in Supreme Court jurisprudence, but the Supreme Court is unlikely to reverse course, so a legislative reversal would likely be necessary.

<sup>270</sup> Moncrieff, *Assault on Litigation*, *supra* note 265, at 2341-42.

<sup>271</sup> *Id.* at 2342-43.

exchange insurers. Such a move would eliminate any disincentive for insurers to avoid the individual exchanges for fear of tort liability. Moreover, such tort immunity would allow individual exchange insurers to engage more freely in cost cutting measures and more effectively fight high costs within the exchanges.<sup>272</sup> As a consequence, premiums would be less likely to skyrocket due to the threat of insurer liability and insurers feeling hamstrung from engaging in cost cutting.

In the end, complete ERISA preemption across-the-board is no better than complete elimination of ERISA preemption. With universal ERISA preemption in place, individual exchange insurers, as is currently the case with non-exchange insurers, would not be held accountable when they engage in cost cutting that results in patient injury. Although the individual insurance exchanges impose quality regulations on the individual exchange insurers,<sup>273</sup> the fear remains that the lack of a tort deterrent would allow individual exchange insurers to engage in cost cutting that has a negative impact on patient quality.

Politically, patients and providers would strongly oppose such a policy solution. Under the status quo individual exchange beneficiaries will be able to sue their insurers for harmful cost cutting. Expanding ERISA preemption asks them to forego this tort remedy. If ERISA preemption is expanded, injured beneficiaries are left with a sole remedy against their physician, who may not be at fault for the injury. Likewise, providers would also oppose changing the status quo. Providers do not want to shoulder the entire burden of liability, as they do in the ERISA context. Accordingly, as much as the repeal of ERISA preemption across-the-board is dead on arrival, so is the policy solution of ERISA preemption expansion.<sup>274</sup>

### *B. A No-Fault Compensation System Solution*

#### 1. Why a No-Fault Compensation System is a Good Solution

The best solution to the ERISA problem in the individual exchanges may be a middle ground solution. Such a solution needs to balance the interests at issue. Insurers need to have some level of accountability for harmful cost cutting, while not being subjected to open-ended and possibly catastrophic tort liability. At the same time, physicians should not bear the burden of tort liability, when insurers are partially or fully at fault for the resulting harm. Moreover, patients should have access to sufficient remedies when they are injured by insurer cost cutting measures.

Accordingly, a better solution than the all or nothing solutions, outlined *supra*, is to create a no-fault compensation fund as a limited tort remedy against individual exchange insurers, when they engage in cost cutting measures that lead to patient harm. For many years, scholars have floated this idea as an entire replacement for the medical malpractice tort system.<sup>275</sup> Within the health law world, the no-fault

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<sup>272</sup> Theodore W. Ruger, *The United States Supreme Court & Health Law: The Year in Review*, 32 J.L. MED. & ETHICS 528, 531 (2004) (describing the *Davila* ERISA preemption of state tort law as allowing employers to more effectively cut health care costs).

<sup>273</sup> See 42 U.S.C.A. § 18031(c)(1) (West 2012).

<sup>274</sup> See Hills, *supra* note 269, at 53 (arguing that the ERISA preemption immunity created through Supreme Court decisions would never win a majority vote in Congress).

<sup>275</sup> See Paul J. Barringer et al., *Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again*, 33 J. HEALTH POL. POL'Y & L. 725, 728 (2008); Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointment, Future Success?*, 20 J. HEALTH POL.

concept has even been implemented in several limited situations. Congress enacted a no-fault system for childhood vaccination injuries through the National Childhood Vaccine Injury Act (“NVIC”).<sup>276</sup> Virginia and Florida also implemented a no-fault system for medical malpractice connected to birth injuries.<sup>277</sup>

The general overview of any no-fault compensation system is an administrative system versus a court-based litigation system, which provides predictable compensation in a less expensive and more expedient manner than litigation.<sup>278</sup> The victim need not show fault,<sup>279</sup> but need only show that his or her injury falls within the confines of the no-fault system, or that a triggering no-fault event occurred.<sup>280</sup> The plaintiff is often limited to recovering only compensatory damages, usually as a percentage of his or her actual economic loss, and usually excluding pain and suffering.<sup>281</sup>

No-fault compensation schemes generally have three goals. First, such schemes socialize the risk, compensating as many injured individuals as possible, spreading the burden of the damages across many actors and over time.<sup>282</sup> Accordingly, a larger percentage of payouts go to deserving victims, in contrast to the tort system, which absorbs some of the funds in the form of transactional costs.<sup>283</sup> Second, no-fault systems aim to limit the liability of the tortfeasor and provide the tortfeasor

POL’Y & L. 99, 106 (1995); Jeffrey O’Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 34-42 (1975).

<sup>276</sup> See 42 U.S.C.A. § 300aa-10-25 (West 2012).

<sup>277</sup> See Florida Birth-Related Neurological Injury Compensation Plan, FLA. STAT. §§ 766.301-316 (2010); Virginia Birth-Related Neurological Injury Compensation Act, VA. CODE ANN. §§ 38.2-5000 to -5021 (2007).

<sup>278</sup> See Sagir Mor & Orna Rabinovich-Einy, *Relational Malpractice*, 42 SETON HALL L. REV. 601, 625 (2012) (proposing a no-fault system for medical malpractice claims with a focus on improving the doctor-patient relationship).

<sup>279</sup> See Richard A. Epstein, *The Historical Origins & Economic Structure of Workers’ Compensation Law*, 16 GA. L. REV. 775, 800 (1982).

<sup>280</sup> See Joseph H. King Jr., *The Exclusiveness of an Employee’s Workers’ Compensation Remedy Against His Employer*, 55 TENN. L. REV. 405, 406 (1998); Mor & Rabinovich-Einy, *supra* note 278, at 625.

<sup>281</sup> See King, *supra* note 280, at 407.

<sup>282</sup> See Donald G. Gifford et al., *A Case Study in the Superiority of the Purposive Approach to Statutory Interpretation: Brueswitz v. Wyeth*, 64 S.C. L. REV. 221, 247-248 (2012) (explaining that one of the purposes of no-fault compensation schemes is to ensure that more people are compensated than through the traditional tort system); Marc A. Rodwin, *French Medical Malpractice Law & Policy Through American Eyes: What It Reflects About Public and Private Aspects of American Law*, 4 DREXEL L. REV. 109, 135 (2011).

<sup>283</sup> See Elizabeth R. Pike, *Recovering From Research: A No-Fault Proposal to Compensate Injured Research Participants*, 38 AM. J.L. & MED. 7, 45-46 (2012) (touting the benefits of a no-fault system for injured research participants compared to the remedies available to them through the existing tort system); Rodwin, *supra* note 282, at 137 (noting that “studies show that malpractice litigation does not compensate most individuals injured due to negligence; furthermore, it holds parties liable for bad outcomes not caused by negligence”).



with predictable liability exposure.<sup>284</sup> This is important for tortfeasors who might otherwise abandon their product or industry due to the possibility of open-ended catastrophic tort damages. Third, no-fault systems seek to reduce the transactional costs spent to obtain a remedy and speed up the recovery process in contrast to the high transactional costs and slowness of the traditional tort system.<sup>285</sup> Generally, the overall compensation is lower, but it is seen as a tradeoff, providing more predictability and more compensation to more injured parties in exchange for avoiding the expensive, unpredictable and complex tort system.<sup>286</sup>

A no-fault system is fitting for insurer liability within the insurance exchanges because it splits the baby. Beneficiaries injured by insurer cost cutting can quickly and easily obtain some form of recovery through the fund, while insurers need not worry that catastrophic tort suits by injured beneficiaries could drive them into bankruptcy.<sup>287</sup> Predictability benefits both the injured beneficiary and the insurers. For beneficiaries, a no-fault system has advantages over the existing tort system, which is criticized for unpredictably overcompensating a few injured plaintiffs, while at the same time undercompensating or failing to compensate many plaintiffs with valid injuries.<sup>288</sup> Insurers, on the other hand, benefit from the predictability because the potential for catastrophic liability awards might otherwise drive insurers out of the individual exchange market, prevent them from entering the market or drive up costs and premiums within the individual exchange market. A no-fault system is also fitting for insurer liability within the individual exchanges, as such systems are very useful in situations where it is difficult to prove causation.<sup>289</sup> In the insurer liability context, it is not necessarily easy to demonstrate that an insurer cost cutting measure caused an individual's injury versus poor healthcare provider decision-making or judgment, or pure malpractice on the part of the healthcare provider.

Additionally, the timing for a no-fault system may be appropriate as a no-fault system is in alignment with the philosophy of the ACA.<sup>290</sup> The ACA is very much

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<sup>284</sup> See Gifford et al., *supra* note 282, at 249 (arguing that the existing tort system leads to unpredictable catastrophic awards that can cripple a business or drive up liability insurance rates).

<sup>285</sup> See Pike, *supra* note 283, at 45-46.

<sup>286</sup> See Mor & Rabinovich-Einy, *supra* note 278, at 842 (demonstrating that no-fault schemes are more efficient at compensating injured parties with a larger portion of no-fault funds going toward compensating the injured party as a result of attorneys' fees caps, limited discovery, and elimination of expensive trials).

<sup>287</sup> See Nadia W. Sawicki, *Patient Protection & Decision-Aid Quality: Regulatory & Tort Law Approaches*, 54 ARIZ. L. REV. 621, 653 (2012) (arguing the benefits of efficiency and uniformity for of no-fault compensation systems in the context of the protecting patients in the use of patient decision-making aids).

<sup>288</sup> See Amalea Smirniotopoulos, *Bad Medicine: Prescription Drugs, Preemption, & the Potential for a No-Fault Fix*, 35 N.Y.U. REV. L. & SOC. CHANGE 793, 842-43 (2011) (explaining that many medical malpractice plaintiffs within the existing tort system are unable to find or afford an attorney, and therefore bear the costs of their injuries alone).

<sup>289</sup> See Sawicki, *supra* note 287, at 653.

<sup>290</sup> See Nora Freeman Engstrom, *An Alternative Explanation for No-Fault's "Demise"*, 61 DEPAUL L. REV. 303, 354-55 (2012) (arguing that enactment of no-fault schemes have been

grounded on the concept of cost spreading.<sup>291</sup> The ACA seeks to spread the cost of health care across as much of the population as possible, through the individual mandate, insurance exchange subsidies, the Medicaid expansion, and the insurance exchanges. A no-fault system would track the ACA philosophy with an emphasis on spreading the cost of insurer-induced injuries.

A no-fault proposal in this limited context may also be timely because of the raging emotional debate over medical malpractice tort reform. When the excesses and limits of the tort system combine to reach a certain boiling point, historically, there has been greater success in enacting no-fault systems.<sup>292</sup> Such a tipping point may be at hand with regard to issues related to medical malpractice, and insurer cost cutting measures that lead to patient harm are part and parcel of medical malpractice. On one side, tort reformers passionately argue that defensive medicine is costing billions of dollars annually and that tort liability is causing some providers to leave certain specialties or limit services, producing severe access problems for patients.<sup>293</sup> At the same time, the opposition to tort reform tugs at the heart strings and rails against existing tort reform measures for their limitations and failure to provide compensation to legitimately injured patients, as illustrated in the movie *Hot Coffee*.<sup>294</sup>

## 2. Structuring the Insurer No-Fault Liability Fund and the Compensable Event

Having established the rationale and timing for a no-fault system, the next issue is how to construct one. This article envisions an administrative system modeled primarily after the NVIC system. Accordingly, what follows is a brief outline of the elements of the NVIC that are pertinent to the proposed insurer no-fault system.

Congress created the NVIC in 1986 as a federal no-fault compensation system for childhood vaccination injuries, after large damage awards against vaccine manufacturers raised concerns that they would stop manufacturing vaccines and would leave the market.<sup>295</sup> Under the NVIC system, an injured claimant files a claim with the United States Court of Federal Claims, which refers the claim to a Special

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most successful during time periods when there was a push to cost spread, such as with the creation of Medicare and Medicaid in the 1960s).

<sup>291</sup> See Kevin G. Volpp et al., *Redesigning Employee Health Incentives-Lessons from Behavioral Economics*, 365 NEW ENG. J. MED. 388, 389 (2011) (arguing that “[e]nabling employers to vary premiums on the basis of employees’ health-related behaviors or health outcomes could undermine some of the ACA’s intended benefits . . . [such as] spread[ing] the costs of addressing health risks across the population”)

<sup>292</sup> See Engstrom, *supra* note 290, at 359 (arguing that impatience with the limitations and excesses of the tort system led, in part, to the enactment of no-fault automobile accident legislation).

<sup>293</sup> See Amy T. Campbell, *Using Therapeutic Jurisprudence to Frame the Role of Emotion in Health Policymaking*, 5 PHOENIX L. REV. 675, 681-82 (2012) (discussing how emotion is driving policymaking in the context of medical malpractice reform).

<sup>294</sup> See *id.* at 682; *HOT COFFEE* (HBO Documentary Films 2011).

<sup>295</sup> See U.S. GEN. ACCOUNTING OFFICE, *VACCINE INJURY COMPENSATION: PROGRAM CHALLENGED TO SETTLE CLAIMS QUICKLY & EASILY* 1, 4 (Dec. 1999), available at <http://www.gao.gov/archive/2000/he00008.pdf>.

Master.<sup>296</sup> If the claimant's injury is identified on a vaccine injury table, which links specific vaccines to specific injuries, then the claimant is entitled to a presumption of causation.<sup>297</sup> The HHS Secretary serves as the Respondent and can rebut the presumption of causation by demonstrating that the injury was not caused by the vaccination.<sup>298</sup> If the HHS Secretary fails to rebut the presumption, then the presumption stands and the claimant wins.

Alternatively, if the claimant's claim does not appear on the vaccine injury table, then the claimant must prove causation and must do so under a preponderance of the evidence standard.<sup>299</sup> The claimant loses if he or she fails to meet the burden of proof, or if the HHS Secretary proves alternative causation.<sup>300</sup> Under either scenario, the HHS Secretary may also challenge the compensation amount,<sup>301</sup> and in the end, the Special Master makes the injury eligibility determination and the award compensation determination.<sup>302</sup>

Similarly, this article envisions an administrative system with a special master falling under the judicial branch, and a government agency—probably HHS—challenging the claim on eligibility and/or compensation level grounds. It is important to note the independence of the special master from HHS in the NVIC system, which eliminates concerns of improper influence from HHS on the special master.<sup>303</sup> The same must be done with regard to the insurer no-fault system in order to preserve independence and impartiality.

Beyond the general structural considerations, constructing a no-fault compensation scheme requires defining a compensable event and determining who should finance the no-fault system.<sup>304</sup> In defining the compensable event, no-fault systems do not focus on tortious conduct and fault for the injury at hand,<sup>305</sup> but rather, as with the NVIC, they focus on the issues of causation and the appropriate level of damages.<sup>306</sup> Oftentimes, there is also a monetary damages threshold to

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<sup>296</sup> See 42 U.S.C.A. § 300aa-12 (West 2012).

<sup>297</sup> See *Zatuchni v. Sec'y of Health & Human Servs.*, 69 Fed. Cl. 612, 620-21 (2006), *aff'd*, 516 F.3d 1312 (Fed. Cir. 2008)

<sup>298</sup> See *Nilson v. Sec'y of Health & Human Servs.*, 69 Fed. Cl. 678, 680-81 (2006).

<sup>299</sup> See *Zatuchni*, 69 Fed. Cl. at 621-22.

<sup>300</sup> See *Capizzano v. Sec'y of Health & Human Servs.*, 63 Fed. Cl. 227, 231 (2004).

<sup>301</sup> See Derry Ridgway, *No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Program*, 24 J. HEALTH POL. POL'Y & L. 59, 64 (1999) (the focus of NVIC disputes revolve around causation of the injury and the amount of compensation).

<sup>302</sup> See 42 U.S.C.A. § 300aa-12 (West 2012) (requiring a Special Master to make a recommendation within 240 days on whether or not to pay the NVIC claim and how much to pay).

<sup>303</sup> See Smirniotopoulos, *supra* note 288, at 848-49.

<sup>304</sup> See Gifford et al., *supra* note 282, at 251 (providing a structural overview of the National Vaccine Injury Compensation Program).

<sup>305</sup> See *id.* at 252 (noting that like other no-fault compensation schemes, those seeking compensation through NVIC need not prove tortious conduct on the part of the vaccine manufacturer).

<sup>306</sup> See 42 U.S.C.A. § 300aa-14(a) (West 2012).

trigger application of the no-fault system, which focuses the system on more serious claims and keeps down the costs of operating the system.<sup>307</sup>

Applying this sort of scheme to an insurer liability fund, the injured beneficiary should be required to demonstrate an injury, causation from insurer activity, such as negligent cost cutting, and the appropriate level of compensation. Both the eligibility of a claim and the award compensation level could be determined through hearings and written filings under a preponderance of the evidence standard.<sup>308</sup> The key issue, causation, could be established in one of two different ways, both with their advantages and disadvantages.

The first option is to design a no-fault system to very loosely mirror the NVIC system. Under the NVIC system, the injury table lists various injuries, categorized by vaccine, with a time period in which the injury must arise for the claim to be eligible.<sup>309</sup> With an insurer no-fault system, it is not possible to set up such a simple system. Unlike with vaccines, it cannot be said that a specific insurer action, such as a claim denial, leads to one of several specific injury types, such as death, stroke, or brain damage. Moreover, the list of possible injuries resulting from insurer actions is pretty much unlimited. Insurer actions can lead to any of a multitude of patient harms.

Accordingly, the closest analogy to the NVIC system would be to create a table of insurer cost-cutting activities, such as claim denials, coverage approval delays, specialist restrictions, utilization management, utilization review, that would presumptively trigger a claim. However, in addition to identifying an insurer practice on the table, the claimant would also need to present some sort of injury and something additional to demonstrate the causal link between the injury and the insurer practice. The best way to accomplish this, in a cost efficient manner, would be to require something akin to a Certificate of Merit (“COM”), as is used in many state medical malpractice cases. In the medical malpractice context, as a condition of filing a medical malpractice claim, the COM requirement requires plaintiffs to file a brief expert statement delineating the provider’s breach of the standard of care and causation of the plaintiff’s damages.<sup>310</sup> Similarly, the claimant to the insurer no-fault fund would have to present an expert statement identifying the claimant’s injury and delineating how the insurer’s practice caused the claimant’s injury. Combined with an insurer practice listed in the table, this would create a *prima facie* case or presumption of causation.

Following establishment of a presumption of causation, the HHS Secretary would then have the opportunity to rebut the presumption by demonstrating

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<sup>307</sup> See *id.* §§ 300aa-11, -12 (requiring NVIC claimants to have suffered injuries of \$1,000 or greater for the NVIC system to apply); Pike, *supra* note 283, at 58 (explaining that other countries use monetary thresholds to trigger application of no-fault compensation systems for those injured in research trials).

<sup>308</sup> See 42 U.S.C.A. § 300aa-13 (West 2012) (using a preponderance of the evidence standard to determine compensation eligibility within the NVIC system); Smirmiotopoulos, *supra* note 288, at 835 (discussing the general procedure used by most no-fault systems for determining eligibility and compensation levels).

<sup>309</sup> See 42 U.S.C.A. § 300aa-14 (West 2012).

<sup>310</sup> See Benjamin Grossberg, *Uniformity Federalism & Tort Reform: The Erie Implications of Medical Malpractice Certificate of Merit Statutes*, 159 U. PA. L. REV. 217, 222-25 (2010) (outlining the different State Certificate of Merit statutes).

alternative causation, such as no causation or provider malpractice as the sole cause of the injury. The HHS Secretary could be held to a preponderance of the evidence rebuttal standard in order to ensure that the HHS Secretary does not challenge every claim that arises, thereby maintaining lower transactional costs.

Though it seems unlikely, if the claimant identifies an insurer practice not listed on the table, then, as with the NVIC, the beneficiary would bear the burden of proof, under a preponderance of the evidence standard, to demonstrate that that insurer practice caused the claimant's injury. This alternative accounts for situations in which insurers come up with new cost cutting measures, not identified on the table, that potentially lead to patient harm.

Since the NVIC model hardly fits like a glove in the insurer liability context, this model illustrates an alternative that promotes the core no-fault concepts of cost-efficiency and expediency, while providing a check on frivolous claims. The claimant's costs—a bare bones expert statement—and proof burdens—the mere statement of a prima facie case—are substantially less than they would be in the tort system. At the same time, potentially frivolous claims are deterred by the requirement that the claimant must find an expert willing to state, on the record, that causation exists and the fact that the HHS Secretary always remains available to challenge causation. However, the preponderance of the evidence standard should incentivize the HHS Secretary to attack only those causation claims that are truly frivolous.

Recognizing the difficulties in creating an injury table in this context, an alternative causation approach is found in the Virginia Birth-Related Neurological Injury Compensation Act ("VBIA"), Virginia's no-fault compensation system for birth-related injuries. Under the VBIA, the Virginia Workers' Compensation Commission ("VWCC") reviews relevant records to determine if a baby's injury was due to birth-related medical malpractice and the appropriate level of compensation, using medical records, related documents, and sometimes interrogatories and depositions to make those determinations.<sup>311</sup> Applying the VBIA model to the insurer liability context, a special master would play the same role as the VWCC and would determine the existence of a claimant's injury, insurer causation, and the appropriate level of compensation using limited discovery from the claimant's insurance company and the patient's medical records.

Critics might claim that the similarities between a VBIA-type system and the tort system, as well as the difficulty of proving causation in the insurer liability context might result in an informal duplicate of the tort system, with all of its attendant costs, delays and failures to compensate deserving plaintiffs.<sup>312</sup> While the VBIA approach is fact intensive, it does avoid the injury table difficulties of the NVIC model. Moreover, there are several ways to limit the transactional costs and ensure an expedient and fair claims process in a VBIA model no-fault system.

First, imposing strict time limits on pre-hearing discovery and the hearing process, with few, if any, options for extensions, should promote expediency. Second, limiting discovery cuts down on both the delays and costs involved in the

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<sup>311</sup> See VA. CODE ANN. §§ 38.2-5003-04, -5006-08.1 (2007).

<sup>312</sup> See Smirniotopoulos, *supra* note 288, at 842-44 (discussing the difficulty of determining causation in a no-fault system applied to medical injuries, especially those involving injuries due to medical devices and drugs).

claims process.<sup>313</sup> Limited discovery also provides the added benefit of ensuring that the insurer has some skin in the game and is still properly incentivized to avoid cost cutting that leads to patient harm. In other words, if insurers know that they may have to perform some document production, respond to interrogatories and possibly participate in depositions, then they may take greater care to avoid harmful cost cutting. They will want to avoid the transactional costs involved in being a participant in the no-fault system process. This requirement addresses the criticism that removal of fault and participation of the alleged tortfeasor from the no-fault process hinders the ability of the process to improve quality of care.<sup>314</sup>

Third, a lenient preponderance of the evidence standard for proving causation should also reduce transactional costs in proving a valid claim.<sup>315</sup> Though such a standard may also result in overcompensation for some claimants who do not have valid claims of causation, the claimant is still required to meet a certain burden of proof. Moreover, the HHS Secretary provides a check on frivolous claims through the Secretary's right to present evidence of alternative causation and to challenge the beneficiary's claim.

While the VBIA model may raise concerns that it is too much like the existing tort system in terms of costs and inefficiency, it has certain advantages, as well. First, it avoids the NVIC model problems of developing an injury table and allows for more flexibility in assessing potential claims. Second, the fact-intensive nature of the VBIA model requires some participation by insurers in the process, a cost that insurers will have to take into consideration when determining how aggressively they want to engage in cost cutting. Third, the fact-intensive nature of the VBIA model, unlike the NVIC model, may allow for better accuracy in ensuring that the most deserving claimants receive compensation. Regardless of which compensable event model is chosen, there should be built in checks on the damage awards to ensure that excessive damage awards do not swallow the no-fault system. First, the government should be allowed to challenge the level of compensation. Second, the final damages award should be based on compensatory damages, such as medical expenses, life-care-type expenses, and lost wages, as well as pain and suffering capped at a certain level.<sup>316</sup> To allow for non-compensatory damages and/or potentially unlimited pain and suffering damages undermines the predictability and certainty that insurers need to buy into the concept of a compensation fund.<sup>317</sup> Restricting or capping the available damages also helps to limit the cost to administer the no-fault system.<sup>318</sup> Moreover, limiting compensation to compensatory

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<sup>313</sup> See *id.* at 852 (proposing limited discovery for a no-fault compensation system for medical drug and device injuries).

<sup>314</sup> See Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 102-05 (1998) (noting that it is unclear whether the VBIA has had any effect on quality of care in obstetrics).

<sup>315</sup> See Smirniotopoulos, *supra* note 288, at 842-44 (arguing that a lenient preponderance of the evidence standard is necessary in no-fault systems where causation is difficult to prove).

<sup>316</sup> See King, *supra* note 280, at 407.

<sup>317</sup> See Gifford et al., *supra* note 282, at 255 (arguing that capping the NVIC damages allows for compensation of more victims and keeps vaccine manufacturers' costs stable).

<sup>318</sup> See David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries*, 286 JAMA 217, 220 (2001) (finding a cap on damages and threshold damages

damages addresses a common critique of the tort system that there is excessive payment for noneconomic injuries compared to compensatory damages.<sup>319</sup>

On the surface damage limitations might appear to undercompensate beneficiaries compared to the tort system, but the reality is more nuanced. A cap on damages allows for more victims to be compensated, albeit at a lower level.<sup>320</sup> Injured beneficiaries are still assured some level of compensation, without much of their award being eaten up by litigation costs and attorneys' fees. It is a tradeoff; injured beneficiaries get faster and more certain, but lower financial recoveries, but must forego potentially larger, but very uncertain and time-consuming efforts to obtain tort damages through the court system.<sup>321</sup> While critics claim that this tradeoff undercompensates or fails to encompass the full range of injured individuals,<sup>322</sup> the argument is especially weak with regard to an insurer no-fault system, because even claimants that lose their claims may still have viable medical malpractice claims against their healthcare providers for their injuries.

### 3. Funding the Insurer No-Fault Liability Fund

The second major issue to be addressed in developing a no-fault compensation system is the funding of the fund. Usually, the funding comes from charges imposed on those who tend to cause the injuries that are being compensated through the fund, which in the case of the NVIC system is the vaccine manufacturers.<sup>323</sup> Applied to insurer liability, this would mean imposing a tax or fee on all individual exchange insurers. However, a better policy would be to spread the risk and costs further; the insurer liability fund should be funded through a tax or fee imposed upon all insurers, including employment-based plans and self-insured plans.

Such an approach accomplishes two goals. First, the liability burden is spread out among many plans, having a less severe impact on any individual plan or only on

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requirement triggering eligibility for a no-fault claim can control the cost of administering a no-fault system).

<sup>319</sup> See Engstrom, *supra* note 290, at 370 (explaining that one of the drivers behind no-fault automobile accident systems was the concern that there was overcompensation for noneconomic damages in the tort system, especially for minor automobile injuries).

<sup>320</sup> See Gifford et al., *supra* note 282, at 255 (arguing that capping the NVIC damages allows for compensation of more victims as lower damage awards allow for spreading the damage awards across a larger group of individual victims).

<sup>321</sup> See Jeffrey O'Connell & John Linehan, *Neo No-Fault Early Offers: A Workable Compromise Between First & Third-Party Insurance*, 41 GONZ. L. REV. 103, 134 (2005) (noting that in worker's compensation systems the injured party exchanges prompt, limited pay-outs to forego the uncertain opportunity of the tort system's riches).

<sup>322</sup> See Bovbjerg & Sloan, *supra* note 314, at 115 (arguing that the VBIA has failed to reach out to the "full, intended population of eligible claimants"); Lindsay J. Stamm, *The Current Medical Malpractice Crisis: The Need for Reform to Ensure a Tomorrow for Oregon's Obstetricians*, 84 OR. L. REV. 283, 306 (2005) (noting that plaintiffs' attorneys contend that no-fault systems shortchange some injured parties who might otherwise fare well under the existing tort regime).

<sup>323</sup> See 42 U.S.C.A. § 300aa-15(f) (West 2012) (funding the NVIC through an excise tax on each vaccine dose); Robert L. Rabin, *Some Thoughts on the Efficacy of a Mass Toxics Administrative Compensation Scheme*, 52 MD. L. REV. 951, 976 (1993).

those plans within the exchanges. The insurance industry, as a whole can better absorb the impact of the cost of the fund than a smaller group of individual exchange plans. Moreover, to the extent that insurers pass the fee along to their beneficiaries, the cost impact on beneficiaries should be lessened because the fund costs are spread out over so many insurers and their beneficiaries, not just the individual exchange beneficiaries.

Second, part of the idea behind creating an insurer liability compensation fund is to level the playing field between individual exchange insurers and employment-based plans. Under the status quo, employment-based plans have an unfair advantage over individual exchange plans because of ERISA preemption. The former can do more than the latter to cut costs without concern for potential liability consequences. Equity supports forcing ERISA plans to shoulder at least part of the liability burden. To fund the compensation fund through individual exchange insurers alone only moderately spreads the risks and costs and minimally alleviates the liability pressure faced by individual exchange insurers.

A common concern with the funding mechanism of no-fault systems is that funding such systems without tying the funding to individual fault fails to incentivize those causing injury to mitigate the risk.<sup>324</sup> Critics claim that where there is no individual blame or fault, there is no deterrent effect on negligent actors.<sup>325</sup> This criticism is questionable given that the tort system has not effectively deterred medical malpractice, and at least one study found that no-fault systems provide better deterrence than the traditional tort-based system.<sup>326</sup>

Even assuming that the criticism is valid, deterrence concerns may be reduced in several ways. First, if the VBIA compensatory event model is adopted, insurers against whom claims are made will still have to participate, to some extent, in the administrative process. The hassle and cost of participating in the claim process should encourage insurers to take care when engaging in cost cutting measures. Getting wrapped up in a myriad of no-fault claims every year certainly detracts from an insurer's bottom line and profitability. Second, the fee or tax on insurers could be subject to increase annually, depending on the number and value of claims made against the fund in the prior year. If, in a given year, the awards against the fund are high, then a fee increase would occur the following year. Such a scheme would incentivize individual exchange insurers to collectively avoid engaging in risky cost cutting measures that could increase the number of claims against the fund and result in an annual fund fee increase that impacts all insurers. Third, the fund fees could be experience rated with regard to the individual exchange insurers' contribution. In other words, an individual exchange insurer with a high number of no-fault claims in a given year would owe a greater fee the following year than an insurer with a better track record. This would likely cause an individual exchange insurer to carefully choose its cost-cutting measures, or risk an excess of claims connected to that insurer and a higher fund fee for the following year. Of course, if the no-fault system is

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<sup>324</sup> See Henry Huang & Farzad Soleimani, *What Happened to No-Fault? The Role of Error Reporting in Healthcare Reform*, 10 HOUS. J. HEALTH L. & POL'Y 1, 7-8 (2009) (arguing, in the context of medical errors, that the lack of the stigma of fault in a no-fault system fails to sufficiently encourage doctors to avoid mistakes).

<sup>325</sup> See Studdert & Brennan, *supra* note 318, at 220.

<sup>326</sup> See *id.* (finding that carefully designed no-fault systems are "far better placed to [deter] than negligence-based litigation"); Mor & Rabinovich-Einy, *supra* note 278, at 626-27.



poorly designed, there is a danger that some weak beneficiary claims will prevail, while some deserving beneficiary claims fail, resulting in some insurers overpaying and others underpaying based on experience rating.<sup>327</sup> Nonetheless, the use of experience rating may allow the fund administrators to better set the appropriate fees in order to ensure that the fund remains solvent.<sup>328</sup>

#### 4. Other Relevant Considerations

Beyond defining the compensable event and the funding mechanism, there are several other matters that should be considered in developing an insurer no-fault system, including a statute of limitations, joint and several liability, comparative or contributory negligence, attorneys' fees, and the exclusive nature of the fund remedy. First, there should be a timeliness requirement or statute of limitations for the insurer liability fund in order to promote predictability, efficiency, and to avoid stale claims. An appropriate statute of limitations could be borrowed from state medical malpractice statutes of limitation, since the injuries involved are similar to or the same as those in medical malpractice cases.

Second, joint and several liability should not apply within the context of the insurer no-fault fund. Joint liability between providers and insurers is likely to be a common occurrence in this environment as beneficiary injuries may arise jointly from provider malpractice and insurer practices. However, the fund should only be responsible for the percent of damages flowing from the insurer practice. To allow for joint and several liability, increases the unpredictability and size of the awards against the fund and potentially forces the fund to seek contribution from a fellow tortfeasor, such as a provider, a costly and time consuming endeavor. Rather, the HHS Secretary and the claimant should be allowed to submit evidence as to how to apportion the damages, and the Special Master should make a decision regarding apportionment of damages attributable to the insurer practice. The claimant would then be left to pursue the rest of his or her damages in court against the other tortfeasor(s). Third, contributory or comparative negligence should also apply within the insurer no-fault liability fund. If the HHS Secretary can demonstrate that the claimant contributed to his or her own injury, then the fund liability should be decreased. Without contributory or comparative negligence, the fund would be overpaying in some situations and some claimants would receive a windfall.

Fourth, attorneys' fees are an important consideration. In the NVIC, attorneys' fees are capped,<sup>329</sup> but this has led to criticism that good attorneys' are not incentivized to take these cases and that vigorous advocacy is discouraged because attorneys' fees are awarded regardless of the outcome of the claim.<sup>330</sup> Accordingly, attorneys' fees should be large enough to encourage attorneys to take these cases, but not so large as to jeopardize the cost efficiency of the system. Moreover, the special master could be given discretion as to how much to award in attorneys' fees, based

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<sup>327</sup> See Smirniotopoulos, *supra* note 288, at 842-43 (explaining that variation in claimant recovery and experience rating-based fund fees can lead some alleged tortfeasors to overpay into the system, while others underpay).

<sup>328</sup> See *id.* at 846-47 (explaining how the NVIC and VBIA used experience-rating to ensure solvent no-fault systems).

<sup>329</sup> See Ridgway, *supra* note 301, at 75 (NVIC attorneys' fees are capped at \$30,000).

<sup>330</sup> See Smirniotopoulos, *supra* note 288, at 847.

on the strength of the causation claim, thereby incentivizing attorneys to vigorously represent their clients within the insurer liability fund system.

Finally, unlike the NVIC system,<sup>331</sup> the remedy available through the compensation fund should be final and should completely replace any available judicial remedy that an injured beneficiary has against his or her insurer. To allow for a judicial opt-out provision only reintroduces the tort system into the equation again and undermines the no-fault system. It drives up the costs of the system thereby limiting the funds available to victims and destroying the cost efficiency of the program.<sup>332</sup> Injured beneficiaries would have two bites at the apple,<sup>333</sup> and if the court system remains a resource for potential plaintiffs, then liability fears could drive up insurer costs and cause some insurers to drop out of the individual exchange market.<sup>334</sup> Finally, despite the proposed finality of the remedy, it is important to remember that some claimants may also still have alternative remedies available through malpractice suits against their providers, even if they lose their insurer liability claim.

## VI. CONCLUSION

Given the lack of ERISA preemption for individual exchange insurers, the exchanges are full of potential perils for beneficiaries and insurers alike. Under the status quo, insurers are subject to potential costly liability if they engage in cost cutting that leads to patient harm. The status quo fails to recognize that not all cost cutting is bad and insurers should be encouraged to engage in beneficial cost cutting of wasteful care. Moreover, insurers should be encouraged to promote low costs within the exchanges in order to help the exchanges to thrive.

Beneficiaries, on the other hand, deserve a remedy when they are injured by harmful insurer cost cutting measures. Nonetheless, unlimited liability of exchange insurers will only lead to high premiums and costs for exchange beneficiaries. Costs associated with liability and the threat of liability will most certainly be passed onto the consumer in the form of higher premiums.

A balanced system should serve both the insurers' and beneficiaries' interests and there are a number of options available. Most options are not political feasible, practically feasible and/or are inequitable to either the insurers or the beneficiaries. However, a no-fault compensation is an attempt to find a middle ground. It seeks to benefit both the insurer, through limited liability and predictability, and the beneficiary, through limited, but more certain damage recovery. The no-fault

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<sup>331</sup> See 42 U.S.C.A. § 300aa-21(a) (West 2012) (allowing claimants to file suit against vaccine manufacturers if the claimant rejects the recommendation of the Special Master).

<sup>332</sup> See *Bruesewitz v. Wyeth, LLC*, 131 S. Ct. 1068, 1084 (2011) (Breyer, J., concurring) (holding that NVIC was created to provide compensation without time-consuming and expensive litigation and to stabilize the vaccine market, so that manufacturers would not abandon the market out of fear of liability); Gifford et al., *supra* note 282, at 255-57 (arguing that allowing for judicial appeals leads to victims with stronger claims filing suit in court, while those with weak claims file their claims through the no-fault system).

<sup>333</sup> See Gifford et al., *supra* note 282, at 261-62.

<sup>334</sup> See *Bruesewitz*, 131 S. Ct. at 1085 (Breyer, J., concurring) (holding that the purpose of the NVIC was to prevent vaccine manufacturers from leaving the market due to fears of tort liability).

solution is not the perfect solution. It has its drawbacks, but it effectively balances the interests at hand.

Still, it is important to recognize that the no-fault solution may not be possible at this early stage of the exchanges. Oftentimes, the move to a no-fault system requires a true and real crisis, as with the NVIC and the Virginia and Florida birth injury legislation.<sup>335</sup> Accordingly, it may require skyrocketing insurance costs within the exchanges, health insurers leaving the exchanges due to high costs and many tort suits against individual exchange insurers before a crisis level is reached and the impetus for legislative action arises.

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<sup>335</sup> See Mor & Rabinovich-Einy, *supra* note 278, at 629-30.