Bloomberg BNA

Tax Management Weekly Report™

Consumer Driven Health Care 2.0: Are Private Health Insurance Exchanges the New 'Killer App'?

By Alden J. Bianchi

In a September 27, 2012, front page article, the *Wall Street Journal* reported that Sears Holdings Corp. and Darden Restaurants, Inc., had adopted a consumer-driven health care arrangement under which each employer would provide its employees with a fixed sum of money with which to purchase medical coverage through an online marketplace—or ''private health insurance exchange.''[1] According to the report, the change ''isn't designed to make workers pay a higher share of health coverage costs.'' Instead, the companies claim that the change will put more control over health benefits in the hands of employees.

While the *Journal's* account may leave the reader with the impression that the approach that Sears Holdings and Darden Restaurants have adopted is something entirely new, this is not the case. Beginning in earnest with the technology boom in the 1990's, employers routinely offered to pay premiums on all or at least a good portion of a basic level of group health coverage, either individual or individual and family, and also made available more generous coverage options that employees could elect and pay for. Even then, it was not uncommon for various coverage options to be provided by different carriers. What is new is not employee choice, nor is it the ability of employees to buy-up to increasingly generous coverage. Rather, the innovation resides in the enhanced flexibility introduced by the availability of private insurance exchanges. The number of available choices will be much greater under a private exchange.

The *Wall Street Journal* article may describe an important development in employer-sponsored health insurance, but it gave no hint of the formidable regulatory environment with which the consumer-driven/private exchange model must contend. This article addresses that regulatory environment. Section I explains the difference between public insurance exchanges—or ''American Health Benefit Exchanges'' established under §1311(b)(1) of the Patient Protection and Affordable Care Act[2] (the ''Act'')—and private exchanges. Section II examines the regulatory background of consumer driven health care in the employer-sponsored plan setting. Section III describes the relationship of private exchanges to the Act's employer shared responsibility rules. Section IV speculates on the impact of yet-to-be-issued rules under the Act's insurance plan nondiscrimination rules. And Section V offers some closing remarks and observations.

I. Introduction—Public vs. Private Exchanges

A health insurance ''exchange'' is a mechanism for organizing the health insurance marketplace to help consumers and small businesses access coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. Section 1311 of the Act, which requires each state to establish an ''American Health Benefit Exchange'' no later than January 1, 2014,[3] provides as follows:

> (b) AMERICAN HEALTH BENEFIT EXCHANGES.—
>
> (1) IN GENERAL.—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an ''Ex-

[1] David Hall, ''The Morning Ledger: Corporate Health Benefits Get Radical Remake,'' *Wall St. J.* (9/27/12).

Alden J. Bianchi, Esq., is the practice group leader of Mintz Levin's Employee Benefits and Executive Compensation Practice. He will discuss the impact of the Affordable Care Act on employers at the Bloomberg BNA Tax Policy & Practice Summit, to be held November 13 and 14 at the Ritz Carlton Hotel in Washington, D.C.

[2] P.L. 111-148, as amended.

[3] P.L. 111-148, §1311(b).

 ISSN 0884-6057

change'') for the State that—(A) facilitates the purchase of qualified health plans; (B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a ''SHOP Exchange'') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and (C) meets the requirements of subsection (d).

The Act prescribes the following functions of American Health Benefit Exchanges[4] (or ''public exchanges'' to distinguish them from ''private exchanges'' described below):

- Creating an electronic calculator to allow consumers to assess the cost of coverage after application of any advance premium tax credits and cost-sharing reductions;
- Operating an internet website and toll-free telephone hotline offering comparative information on qualified health plans and allowing consumers to apply for and purchase coverage if eligible;
- Determining eligibility for the health insurance exchange, tax credits and cost-sharing reductions for private insurance, and other public health coverage programs, and facilitating enrollment of eligible individuals in those programs;
- Certifying individuals who qualify for an exemption from the requirement to carry health insurance; and
- Establishing a ''Navigator'' program to assist consumers in making choices about their health care options and accessing their new health care coverage, including access to premium tax credits for some consumers.

The Act directs the Secretary of the Department of Health and Human Services (''HHS'') to establish criteria for the certification of qualified health plans consisting of four ''metallic'' levels of coverage (bronze, silver, gold, and platinum), differentiated by their actuarial value.[5]'' These plans form the basis of the product offerings that low-income individuals may choose among and with respect to which premium tax credits and cost-sharing subsidies are available. Premium tax credits and cost-sharing subsidies are available only for health insurance coverage purchased through a public exchange.[6]

HHS is tasked with the job of developing standards for public exchanges relating to marketing; provider choice, network access (with a focus on low-income and medically-underserved individuals), accreditation, clinical quality measures, patient experience rating assessments, utilization management, provider credentialing, complaints and appeals processes, network adequacy, quality assurance and improvement measures, and standardized enrollment forms and formats for presenting health benefits plan options, among others.[7]

Private exchanges are additional mechanisms for organizing the health insurance marketplace; and they too aspire to create more efficient and competitive markets for individuals and small employers. But private exchanges differ in three important respects from their public counterparts.

- Public exchanges must be organized as non-profit or government agencies.[8] Private exchanges, in contrast, may (and in most if not all instances will) be organized by private sector entities—e.g., consulting firms, integrated health care delivery systems or insurance companies. (There is, however, nothing to prevent a state from establishing a private exchange.)
- Public exchanges have access to and are charged with administering a program of premium tax credits and cost-sharing reductions for low-income individuals to assist them to purchase health insurance coverage and access benefits. Low-income individuals can use their subsidies only on public exchanges. Private exchanges have no such access to public funds.
- Private exchanges are not subject to the federal rules governing marketing, provider choice, network access, accreditation, etc. that apply to public exchanges.

Precisely because private exchanges are freed from the many constraints imposed on their public counterparts, they are ideally suited to the role of insurance aggregator. As a consequence, they can be pressed into service as intermediaries in the manner described by the *Wall Street Journal*. According to their proponents, private exchanges will enable product choice well beyond what is available under current, carrier-centric models. Detractors demur, claiming that private exchanges will cause a fragmentation of the risk pool by siphoning off the better risks. They also worry that the ''defined contribution'' approach that is a key feature of the private exchange model will result in cost-shifting to employees in a manner similar to what 401(k) plans did to the retirement plan market.

II. The Regulatory Background

Employer-sponsored group health plans, and (in the case of fully-insured arrangements) health insurance issuers (i.e. state-licensed carriers) that issue health insurance coverage, are governed by a patchwork of overlapping federal laws, which include:

ERISA

Group health plans other than those of churches and state and local governments are generally subject to the group health plan requirements (Title I, Subtitle B, Part 7) of the Employee Retirement Income Security Act of 1974 (''ERISA'').[9] These rules are administered by the Department of Labor, which oversees group health coverage provided by employers in the private sector. ERISA applies to group health plans that are both insured and self-insured, as well as health insurance issuers providing group health coverage. But it does not generally apply to governmental plans or church plans.[10]

The Internal Revenue Code

Group health plans are also subject to parallel provisions set out in group health provisions in Chapter 100

[4] P.L. 111-148, §1311(d)(4).
[5] P.L. 111-148, §1302(d).
[6] *See* Code §36B(c)(2)(A)(i); P.L. 111-148, §1402(f)(2).
[7] P.L. 111-148, §1311(c).
[8] P.L. 111-148, §1311(d)(1).
[9] P.L. 93-406, as amended.
[10] ERISA §4(b).

  TMW ISSN 0884-6057

of the Internal Revenue Code (the ''Code''). The Code's provisions apply to all group health plans (including church plans) but not to governmental plans or health insurance issuers.[11] Under the Code, the Department of Treasury can enforce the group health plan requirements through the imposition of an excise tax.[12]

The Public Health Service Act

Title XXVII of the Public Health Service Act (''PHSA'')[13] imposes requirements on health insurance issuers in the individual and group markets and on self-funded nonfederal governmental group plans.[14] The Secretary of HHS is the primary enforcer of the PHSA as it applies to governmental plans. But with respect to health insurance issuers, the PHSA generally defers to the states.[15]

The Act amended the PHSA to add a series of insurance market reforms that include a bar on annual and lifetime limits, described below. These provisions are incorporated by reference into Part 7 of ERISA and Chapter 100 of the Code.[16] Accordingly, the Act's insurance market reforms apply to group health plans of private sector employers, churches, units of government, and health insurance issuers.

Section 1301(b)(3) of the Act defines the term ''group health plan'' with reference to PHSA §2791(a). PHSA §2791(a), in turn, provides in relevant part:

> (a) GROUP HEALTH PLAN.—
>
> (1) DEFINITION.—The term ''group health plan'' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
>
> (2) MEDICAL CARE.—The term ''medical care'' means amounts paid for—
>
> (A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
>
> (B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and
>
> (C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

ERISA §3(1) defines the term ''employee welfare benefit plan'' to mean and include:

> ''[A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) *medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death* or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services . . ..'' (Emphasis added).

Act §1301(b)(2) (cross referencing PHSA §2791(b)) defines the term ''health insurance coverage'' to mean ''benefits consisting of medical care (provided directly, through insurance or reimbursement or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer.'' The term ''health insurance issuer'' is limited to an insurance company, insurance service or insurance organization (including a health maintenance organization) licensed to engage in the business of insurance in a state and subject to state law that regulates insurance.[17] But health insurance does not include a group health plan. The Act therefore distinguishes between an employer that offers a ''group health plan'' and an individual who has ''health insurance coverage.''

Health insurance coverage may be purchased in the group market or the individual market. PHSA §2791(b)(5) defines the term ''individual health insurance coverage'' to mean ''health insurance coverage offered to individuals in the individual market, ...'' And PHSA §2791(b)(4) defines ''group health insurance coverage'' to mean, ''*in connection with a group health plan*, health insurance coverage offered in connection with such plan.'' (Emphasis added). Thus, health insurance coverage purchased in the group market coexists with group health plans that are subject to ERISA, the Code and the PHSA.

In addition to the Act's insurance market reforms, which apply for the most part to both individual and group market products, group health plans are subject to a myriad of prior federal laws, including (1) Title I of the Health Insurance Portability and Accountability Act (HIPAA)[18] (imposing certain portability requirements), (2) the Newborns' and Mothers' Health Protection Act of 1996[19] (setting standards for benefits provided to mothers and newborns following childbirth), (3) the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008[20] (providing for parity between medical/surgical benefits and mental health benefits), (4) the Women's Health and Cancer Rights Act of 1998 [21] (requiring group health plans providing mastectomy coverage to cover prosthetic devices and reconstructive surgery), and (5) Michelle's Law[22] (extending the ability of dependents to remain on their parents' plan for a limited period of time during a medical leave from full-time student status). For the most part, these requirements apply to health insurance coverage issued

[11] Code §9831(a)(1) and (c).
[12] Code §4980D.
[13] The PHSA is codified in 42 USC §§300gg *et seq*.
[14] PHSA §2722(a)(1).
[15] PHSA §2723(a)(1).
[16] ERISA §715(a)(1) and Code §9815(a)(1), as added by P.L. 111-148, §1563(e) and (f), and redesignated by P.L. 111-148, §10107(b)(1).
[17] PHSA §2791(b)(1) and (2).
[18] P.L. 104-191.
[19] P.L. 104-204.
[20] P.L. 110-343.
[21] P.L. 105-277.
[22] P.L. 110-381.

in the group market, but not to individual market products.

A close and careful reading of the definitions of ''group health plan,'' ''group market'' and ''individual market'' is essential to understanding the differences in the regulatory treatment and status of arrangements that include access to a private exchange and those that do not. To understand why, consider a plan design that is the ''holy grail'' of some consumer-driven health care advocates: The employer provides a sum of money, which employees may apply to the purchase of health insurance coverage in the individual market without restriction and without any further employer involvement. In some iterations of this design, employees would be allowed to purchase coverage across state lines, and the employee contribution would be eligible for a tax deduction or perhaps even a tax subsidy in appropriate instances.

Under this fully-discretionary approach, the employer contribution that enables the purchase of individual market coverage is, from the perspective of the regulators, a Health Reimbursement Account (or HRA).[23] Because HRAs provide for welfare benefits consisting of and limited to ''medical care,'' they are group health plans. But what of the individual policy, which the employee selects and purchases with HRA funds? If that policy is part of the group health plan, then all of the requirements of the laws cited above should apply. This is not the result (i.e., that policies issued in the individual market are suddenly made subject to the federal laws that govern group health insurance products[24]) that the carriers would be likely to embrace.

Beginning in 2014, PHSA §2711 generally bars group health plans and individual and group market policies from imposing annual limits on the dollar value of health benefits. Interim final regulations issued under PHSA §2711 exempt health flexible spending accounts from these requirements,[25] but not so with all HRAs. The regulations instead distinguish between HRAs that are ''integrated with other coverage *aspart of a group health plan*,''[26] and those that are not. The former are deemed to pass muster under PHSA §2711 provided that the accompanying group health plan does so as well. The latter, which are referred to as ''stand-alone HRAs,'' presumably would violate the prohibition on annual limits. The regulatory status of stand-alone HRAs is unclear, and the regulators have invited comments.[27] Under guidance issued by HHS, stand-alone HRAs have been provided with a blanket waiver that will expire at the end of 2013.[28]

The current regulatory status of HRAs in respect to PHSA §2711 raises an important—perhaps even seminal—question: is an HRA that provides funds solely for the purpose of enabling or assisting participants to purchase health insurance of their choice in the individual market a stand-alone HRA? Or is it an HRA that is integrated with other coverage as part of a group health plan? While not perfectly clear under current law, it is at least sufficiently clear to conclude that such an HRA would be treated as a stand-alone HRA that would violate PHSA §2711 commencing in 2014. For the plan to be integrated, the ''health insurance coverage'' must be under a group plan, not an individual plan. The fully-discretionary approach, which combines an HRA and an individual market policy, appears to fall short of this standard. The HRA is, therefore, a stand-alone HRA. This conclusion is in accord with the private views of the regulators as expressed from time to time at industry and bar association conferences and meetings. The regulators are, of course, free to change this result, and they have been urged to do so in comments to the interim final rule implementing PHSA §2711.[29]

The private exchange described in the *Wall Street Journal* article appears to ensure compliance with the bar on annual and lifetime limits requirements under PHSA §2711 by combining the HRA with a group market health insurance product, presumably under a single ERISA plan. The HRA under this approach is, as a result, an integrated, rather than a stand-alone, HRA. The combined arrangement therefore satisfies PHSA §2711, assuming, of course, that the rules governing HRAs set out in the preamble to the interim final rule are not changed. And because the underlying insurance products are group products, the carriers will fully expect to be subject to COBRA and the other requirements identified above.

There is another important difference between the ''holy grail'' approach and that described by the *Wall Street Journal*: Products sold in the individual market are separately rated under a modified community rating approach based on rating area, age and tobacco use. In the case of age, premium rates are subject to a 3:1 limit, under which the cost of coverage for the oldest enrollees may not exceed three times the cost of coverage for the youngest.[30] In contrast, group products are usually ''composite'' rated. This means that a level premium is charged to the entire group irrespective of age. There is nothing in the account of the Sears/Darden arrangement to indicate what rating arrangement will apply,

---

[23] HRAs are account-based health plans that typically consist of a promise by an employer to reimburse medical expenses for the year up to a certain amount, with unused amounts available to reimburse medical expenses in future years. *See generally* Notice 2002-45, 2002-28 I.R.B. 93; Rev. Rul. 2002-41, 2002-28 I.R.B. 75 (explaining the statutory and regulatory foundations of HRAs and the rules under which they operate).

[24] *See* Preamble to the Final Regulations for Health Coverage Portability, T.D. 9166, 69 Fed. Reg. 78720, 78733 (12/30/04) (stating the view of the regulators that ''[i]f an employer provides coverage to its employees through two or more individual policies, the coverage may be considered coverage offered in connection with a group health plan and, therefore, subject to the group market provisions under HIPAA.'').

[25] Treas. Regs. §54.9815-2711T(a)(2)(ii), T.D. 9491, 75 Fed. Reg. 37188 (6/28/10); DOL Regs. §2590.715-2711(a)(2)(ii); 45 CFR §147.126(a)(2)(ii).

[26] 75 Fed. Reg. at 37190 (preamble) (emphasis added).

[27] 75 Fed. Reg. at 37191 (preamble).

[28] Memorandum dated Aug. 19, 2011, from Gary Cohen, Acting Director, Office of Oversight, CCIIO entitled, ''CCIIO Supplemental Guidance (CCIIO 2011–1E): Exemption for Health Reimbursement Arrangements that are Subject to PHS Act Section 2711,'' available at: http://cciio.cms.gov/resources/files/final_hra_guidance_20110819.pdf.

[29] *See, e.g.*, letter dated Aug. 25, 2010, from Hewitt Associates, LLC to Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration (''Hewitt requests that the final regulations provide that rules related to annual limits do not apply to stand-alone HRAs that are linked to the purchase of health insurance coverage in the individual market. . . .'').

[30] P.L. 111-148, §1201(4), adding PHSA §2701(a)(1).

  TMW ISSN 0884-6057

but since the arrangement has all of the earmarks of an employer plan, it is likely rated on a composite basis.

III. Employer Shared Responsibility

Beginning in 2014, ''applicable large employers'' (i.e., those with at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year) are subject to a non-deductible excise tax—or ''assessable payment''—if any full-time employee is certified as eligible to receive an applicable premium tax credit or cost-sharing reduction under either of the following circumstances:

No Coverage Prong

The employer fails to offer to all its full-time employees (and their dependents) the opportunity to enroll in ''minimum essential coverage'' under an ''eligible employer-sponsored plan.'' Under this prong, if an employer fails to make an offer of coverage to its full-time employees, an assessable payment is imposed monthly in an amount equal to $166.67 multiplied by the number of the employer's full-time employees, excluding the first 30.[31]

Coverage Prong

The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that, with respect to a full-time employee who qualifies for a premium tax credit or cost-sharing reduction, either is (a) ''unaffordable'' (i.e., the employee cost of coverage exceeds 9.5% of household income)[32] or (b) does not provide ''minimum value.''[33] If the employer makes the requisite offer of coverage, the assessable payment is equal to $250 per month multiplied by the number of full-time employees who qualify for and receive a premium tax credit or cost-sharing reduction from a health insurance exchange. The amount of the assessable payment under the coverage prong is capped at the amount that would be charged under the no-coverage prong. As a result, an employer that offers group health plan coverage can never be subject to a larger assessable payment than that imposed on a similarly situated employer that does not offer group health plan coverage.

''Minimum essential coverage'' includes coverage under an ''eligible employer-sponsored plan.'' An eligible employer-sponsored plan includes ''*group health plans* . . . offered in the small or large group market within a State''[34] but does not include ''excepted benefits'' as defined and described under the PHSA, e.g., stand-alone vision or dental benefits, hospital indemnity plans, etc. For the reasons described above in Section II, an HRA that is paired with an individual market product is not—at least under current law—an integrated arrangement. It is, rather a stand-alone HRA.

So is a stand-alone HRA that pays individual market premiums an ''eligible employer-sponsored plan?'' Since it is a welfare plan that provides medical benefits, it is. But that does not end the inquiry. While a stand-alone HRA might constitute an eligible employer-sponsored plan, that plan would not satisfy the minimum value requirement. Coverage is deemed to provide ''minimum value'' for purposes Code §36B(c)(2)(C)(ii) if it pays for at least 60% of all plan benefits, without regard to employee premium contributions. This is a measure of the plan's underlying actuarial value. The Act defines actuarial value relative to coverage of ''essential health benefits'' for a ''standard population.''[35] ''Essential health benefits'' means and refers to a comprehensive package of items and services that must be included in health insurance policies issued in the individual and small group markets.[36] A plan's actuarial value is based on the provision of benefits to a standard population without regard to the plan's actual experience.

Notice 2012-31 describes and requests comments on several possible approaches to determining whether health coverage under an eligible employer-sponsored plan provides minimum value, including the use of web-based calculators, design-based safe harbors, and actuarial certification. But the determination in each case assumes that the plan covers and pays for certain core benefits, i.e., physician and mid-level practitioner care, hospital and emergency room services, pharmacy benefits, and laboratory and imaging services—which an HRA does, but not at anything approaching 60% actuarial value. Using the fully-discretionary arrangement, the services provided under the insurance policy purchased in the individual market would not be aggregated with the monetary contribution provided under the HRA, and the monetary value of the HRA contribution, even if it covers 100% of participants' premiums, would not approach 60% of the actuarial value of plan benefits. Therefore, an employer relying entirely on a stand-alone HRA to purchase employee-selected individual market coverage would be subject to penalties under the no-coverage prong.

As is the case with the bar on annual limits under PHSA §2711, the opposite result accrues under the private exchange model. Health coverage furnished under the private exchange model described by the *Wall Street Journal* would likely constitute minimum essential coverage that provides minimum value, thereby allowing the plan sponsor to determine its liability under the (presumably) more favorable ''coverage prong.''

---

[31] Code §4980H(a).

[32] *See* Notice 2011-73, 2011-40 I.R.B. 474, and Notice 2012-58, 2012-41 I.R.B. 436 (establishing an ''affordability safe harbor,'' available at least through the end of 2014, under which employers are permitted to substitute Form W-2 income for household income for purposes of assessing affordability under Code §4980H(b)).

[33] Code §4980H(b). *See* Notice 2012-31, 2012-20 I.R.B. 906 (proposing rules for determining minimum value). Coverage is generally deemed to provide ''minimum value'' if it pays for at least 60% of all plan benefits, without regard to employee premium contributions. *See* Code §36B(c)(2)(C)(ii); Notice 2012-31, §IV.

[34] Code §5000A(f)(2) (emphasis added).

[35] P.L. 111-148, §1302(d)(2).

[36] *See* P.L. 111-148, §1302(b) (prescribing the following 10 broad categories or essential health benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.)

IV. Insurance Nondiscrimination

The Act imposes nondiscrimination rules for fully-insured plans that are modeled on the nondiscrimination standards that have applied to self-funded plans since 1978.[37] Under Code §105(h), the exclusion from income is totally or partially denied to ''highly compensated individuals'' who are covered under a self-insured medical reimbursement plan that discriminates as to either eligibility or benefits. A ''highly compensated individual'' is defined to mean an individual who is (1) one of the five highest paid officers, (2) a shareholder who owns more than 10% in value of the stock of the employer, or (3) among the highest paid 25% of all employees. This determination is made on a controlled group basis.[38]

In PHSA §2716(b)(2), Congress directed that regulations include rules ''similar to'' the Code §105(h) provisions dealing with nondiscriminatory eligibility classification, nondiscriminatory benefits, and controlled groups. The regulations also must use the Code's definition of ''highly compensated individual.'' PHSA §2716 was slated to take effect for plan years commencing after September 23, 2010, but in Notice 2011-1[39] the IRS delayed enforcement of the rule pending the development of guidance. The contours of this guidance, once issued, will have important consequences for private exchanges that offer a broad range of coverage options.

''Eligibility'' is one of two basic testing criteria (the other being ''benefits'') under Code §105(h). There has been a good deal of debate over whether ''eligibility'' means that a participant is enrolled in a plan or merely could enroll if he or she chooses to do so. Put another way, should eligibility be tested based on plan design—i.e., on the basis of what options are available to participants—or on what benefits participants actually elect (the so-called ''take-up'' rate)? If the regulators adopt the former, design-based test, the private exchange model should comply easily with PHSA §2716. It would, after all, be difficult to make a claim of discriminatory eligibility when all participants have the same menu of choices and options. On the other hand, reading PHSA §2716 to require testing based on the take-up rate, vastly complicates the discrimination testing equation. Lower paid employees will in all likelihood choose lower cost options or opt-out altogether, while higher paid employees can be expected to select richer, more expensive coverage in greater numbers, thereby making compliance difficult if not impossible.

V. Conclusion

The emergence of private exchanges in the role of an aggregator and intermediary in the group health insurance market has important collateral consequences, including the following:

- Public exchanges and private exchanges serve very different functions and populations—the former primarily assisting low income individuals to access subsidized coverage and providing small groups with access to pre-packaged product offerings; the latter serving primarily large groups. Thus, these entities as much compete with as complement one another.
- The ''holy grail,'' fully-discretionary approach *could* be made to work with perhaps a modest regulatory fix. Whether it *should* be made to work is another question. It may be that the private exchange model is ultimately judged a superior adaptation of consumer-driven health care.
- Lastly, if the private exchange model takes hold, private exchanges will proliferate. The need to differentiate will likely drive product and service innovations. It will also lead to the offering of ancillary products (e.g., access to other group benefits) and services (technical advice) in an effort to diversify profit centers and capture competitive advantage. Ideally, these innovations will also include health care reform's loftiest goals—to contain costs, increase quality, and expand coverage.

Sears and Darden have deployed a private exchange to move in the direction of the ''holy grail'' of consumer driver health care while at the same time complying with key legal and regulatory requirements. And they have done so in a way that may—despite the inevitable objections of purists—ultimately prove more agreeable to plan sponsors, who retain control over plan design and the insurance products in which their money is being invested. That said, it is perhaps best to view the Sears/Darden approach as an opening move, and not an end product.

At least for the moment, the approach adopted by Sears and Darden manages to integrate evolving demands for, and ideas about, employment-based health care coverage with an existing regulatory regime that goes back more than 30 years. And it does so—at least in the author's view—elegantly. Whether it also satisfies the critics on either side of the consumer driven health care debate is another matter.

---

[37] P.L. 111-148, §1001(5), as replaced by P.L. 111-148, §10101(d).

[38] Code §105(h)(5) and (8).

[39] 2011-2 I.R.B. 259.

  TMW ISSN 0884-6057