

HEALTH CARE EXCHANGES: HOW THE GOVERNMENT CAN USE MARKET FORCES TO FIX THE HEALTH CARE SYSTEM

*Bracken H. Longhurst**

INTRODUCTION

Most Americans agree that the current health care system is broken,¹ since health care costs have dramatically increased over the past several decades, continue to climb, and show no sign of relenting in their ascent.² However, while health care costs have increased, the number of people who have adequate health insurance has decreased to record lows.³ These startling trends serve as a call to fix the health care system to save families and governments from financial peril.

Agreeing that the health care system is broken, however, does not translate into a broad consensus of how to fix it. On March 23, 2010, President Barack Obama culminated a contentious legislative battle by signing into law the Patient Protection and Affordable Care Act (“PPACA”).⁴ While the battle surrounding PPACA’s passage has ended, the contentious debate about PPACA’s substance rages on. Opponents are challenging the constitutionality of PPACA in federal courts.⁵ In Congress, some are attempting to defund portions of

* William S. Boyd School of Law, J.D. Candidate, May 2012. Special thanks to my wife, our parents, and our children for their continued love, support, and patience. I also appreciate Kammi Rencher for her strong editorial support and the other members of the *Nevada Law Journal* staff for their dedicated efforts relating to this Note.

¹ Lydia Saad, *Americans Rate National and Personal Healthcare Differently*, GALLUP (Dec. 4, 2008), <http://www.gallup.com/poll/112813/americans-rate-national-personal-healthcare-differently.aspx>.

² CONG. BUDGET OFFICE, *RIISING HEALTH CARE COSTS: CAUSES, IMPLICATIONS, AND STRATEGIES 1–5* (1991), available at <http://www.cbo.gov/ftpdocs/76xx/doc7665/91-CBO-001.pdf>; see also PRICE WATERHOUSE COOPERS, *THE FACTORS FUELING RISING HEALTHCARE COSTS 2* (2002), available at <http://www.ahipresearch.org/pdfs/PwCFinalReport.pdf>.

³ CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, *P60-238, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009*, at 22 (2010).

⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010).

⁵ See, e.g., *Florida ex rel Bondi v. U.S. Dep’t of Health & Human Servs.*, 780 F.Supp.2d 1256 (N.D. Fla.), *aff’d in part and rev’d in part* by *Florida ex rel Att’y Gen. v. U.S. Dep’t of Health & Human Servs.*, 648 F.3d 1235 (11th Cir. 2011). Certiorari to the Supreme Court of the United States was granted in this case on November 14, 2011. *U.S. Dep’t of Health & Human Servs. v. Florida*, 132 S. Ct. 604 (2011).

PPACA.⁶ Meanwhile, congressional opponents have vowed to repeal and replace PPACA.⁷ In the midst of this sharp debate, President Obama has publicly recognized that PPACA is not perfect, and has expressed his amenability to legislation that might further health care reform.⁸

This Note presents a viable and relatively simple solution to fixing the broken health care system, either by replacing or amending PPACA—an expansion of health insurance exchanges to more comprehensive health care exchanges. Health care exchanges (“HCE”) would combine a health insurance exchange with a health provider exchange,⁹ and would reward consumers that focus on value.¹⁰ HCEs would fix the health care system and deliver the major commitments and goals of both proponents and opponents of PPACA, which are: 1) lower overall health care costs, 2) lower health insurance premiums, 3) increase the number of people covered by adequate health insurance, 4) remove the pre-existing conditions barrier to adequate health insurance for nearly all individuals, and 5) allow individuals to keep the doctor and health insurance plan of their choice.¹¹ In addition to these lofty benefits, HCEs could also empower consumers; increase accountability of health insurance providers (“insurance providers”), health care providers (“doctors”), and patients or customers (“consumers”); reduce non-productive billing practices and negotiations between doctors and insurance providers; allow portability of health insurance plans; and reward good participation while punishing bad behavior.

HCEs would likely have broad bipartisan support because they would accomplish bipartisan goals instead of focusing on the contentious political debate of whether government or market control is more productive to fix the

⁶ N.C. Aizenman, *House GOP Begins Drive to Defund Health-Care Overhaul*, WASH. POST, Feb. 18, 2011, at A02.

⁷ Albert R. Hunt, *Vow to Repeal Health Care Holds Little Promise*, N.Y. TIMES, Nov. 21, 2010, <http://www.nytimes.com/2010/11/22/us/22iht-letter.html> (noting “House Republicans’ ‘Pledge to America’ vowed ‘to repeal and replace the government takeover of health care’”).

⁸ President Barack Obama, Remarks by the President in State of the Union Address (Jan. 5, 2011) (transcript available at <http://www.whitehouse.gov/the-press-office/2011/01/25/remarks-president-state-union-address>) (“Now, I have heard rumors that a few of you still have concerns about our new health care law. . . . So let me be the first to say that anything can be improved. . . . We can start right now by correcting a flaw in the legislation . . .”).

⁹ The idea of a health provider exchange is a new concept. Similar to a health insurance exchange, a health provider exchange would bring market participants together to assist consumers in selecting a doctor.

¹⁰ See John F. Cogan, R. Glenn Hubbard & Daniel P. Kessler, *Making Markets Work: Five Steps to a Better Health Care System*, 24 HEALTH AFF. 1447, 1453 (2005). See generally Thomas Bodenheimer, *The Political Divide in Health Care: A Liberal Perspective*, 24 HEALTH AFF. 1426, 1443 (2005). Insurance exchanges alone, while helpful, are unlikely to fix the health care system because they only address the cost of insurance premiums. To truly fix the health care system, policy makers need to address the cost of health care services as well and the cost of insurance premiums. Insurance exchanges put downward pressure on the cost of insurance premiums through increased competition; however, the rising cost of health care services put upward pressure on the cost of insurance premiums. Therefore, to truly fix the health care system, policy makers need to put downward pressure on both the costs of insurance premiums and the cost of health care services.

¹¹ See Sarah Nightingale, *Obama’s Health Care Reform Plan Targets Eight Goals*, LUBBOCK AVALANCHE-J., Aug. 23, 2009, available at http://lubbockonline.com/stories/082309/loc_485065725.shtml; *Statement of Purpose*, THE HERITAGE FOUND., <http://www.heritage.org/Initiatives/Health-Care> (last visited Mar. 16, 2012).

broken health care system.¹² Progressives generally argue that government control is more productive.¹³ They argue that increased regulation enables the government to force health care costs down to sustainable levels and fix the broken health care industry.¹⁴ On the other side, conservatives argue that markets are more productive,¹⁵ and that increased regulation only increases health care costs and further breaks the health care system.¹⁶ They argue that removing regulations would reduce health care costs and fix the health care system.¹⁷ Both sides are right, and both sides are wrong. Because the health care system is broken, and health care is an atypical product, government intervention is needed to organize health care into a properly functioning market. Yet, once the market incentives are properly aligned, government intervention decreases or destroys the market's ability to deliver effective results because decisions would be made based on politics instead of economics.

Instead, HCEs focus on who is at fault for increasing health care costs. Doctors blame insurance providers for not adequately reimbursing them for services provided.¹⁸ Insurance providers blame doctors for over-charging and performing unnecessary care.¹⁹ Doctors and insurance providers blame consumers for being uninsured.²⁰ Consumers blame insurance providers for reducing coverage and raising premiums.²¹

Who really is at fault: insurance providers, doctors, or consumers? In reality, they are all at fault—yet none are fully to blame. For the most part, each participant acts according to the incentives of the current health care system. Consumers want the best available care while paying the least amount, doctors want to improve consumers' health while making a sufficient profit to survive as a business, and insurance providers want to decrease health care costs to ensure solvency and profitability. This Note will explain why these incentives, while individually good and necessary, are misaligned.

After discussing the current health care system in Part II, this Note will explore the possible health care system under HCEs in Part III. Part IV will

¹² See generally Bodenheimer, *supra* note 10; Cogan, Hubbard & Kessler, *supra* note 10.

¹³ See Bodenheimer, *supra* note 10, at 1427 (“In the health care arena, many liberals feel that governments . . . are the only social institutions that can implement the balance between the needs of each individual and those of all individuals—that is, the community.”).

¹⁴ *Id.* at 1434.

¹⁵ See *id.* at 1428 (“[C]onservatives . . . promote a laissez-faire economy with minimal government intervention.”); Cogan, Hubbard & Kessler, *supra* note 10, at 1447.

¹⁶ See Cogan, Hubbard & Kessler, *supra* note 10, at 1448 (noting that government policy “has contributed to the spread of wasteful (inefficient) medical practice, rising health care costs, and rising rates of uninsurance”).

¹⁷ See Connie Marshner, *Health Insurance Reform: What Families Should Know*, THE HERITAGE FOUND. (December 13, 2007), <http://www.heritage.org/research/HealthCare/wm1739.cfm>.

¹⁸ See Cristina Olson, Note, *Desperate Doctors and Antitrust Laws: The Best Ways for Lawmakers to Simulate Physician Collective Bargaining*, 10 NEV. L.J. 811, 813–14 (2010).

¹⁹ Victoria Colliver, *Disagreement About Reasons for Rising Costs*, S.F. CHRON., Mar. 19, 2011, at A1.

²⁰ See generally Brief for the American Hosp. Ass'n et al. as Amici Curiae in Support of Petitioners with Respect to the Individual Mandate, Dep't of Health & Human Servs. v. Florida, No. 11-398, 2012 WL 16232 (Jan. 13, 2012).

²¹ Robert J. Blendon et al., *The Beliefs And Values Shaping Today's Health Reform Debate*, 13 HEALTH AFF. 274, 284 (1994).

discuss the roles of federal and state governments in establishing and maintaining HCEs, and Part V will briefly conclude.

II. THE CURRENT HEALTH CARE SYSTEM

A. Overview

According to a 1919 study, the biggest loss stemming from illness was lost wages.²² Today, in contrast, health care costs are so substantial that the inability to pay medical bills often forces Americans into bankruptcy.²³ Because health care costs have dramatically increased over the past several decades, medical bills have become a financial threat to Americans.²⁴

In addition to threatening the financial stability of Americans, the increasing costs of health care threaten the financial stability of federal and state governments. Acting as a safety net to society, federal and state governments provide funding for health insurance programs like Medicare and Medicaid.²⁵ As health care costs increase, governments are directly affected by the increased cost of providing insurance coverage.²⁶ The government is also indirectly affected by rising health care costs because more people enroll in government health insurance programs as private health insurance becomes more expensive.²⁷

With rising health care costs threatening the financial stability of families and governments, one important question must be answered: Why are health care costs rising so dramatically? While many individual factors contribute to rising health care costs, the most significant reason is because the current health care system lacks incentives to increase value by lowering costs and increasing quality.²⁸ To illustrate this lack of incentive, this section will discuss current trends regarding how consumers obtain health insurance, how consumers select doctors, and why consumers often ignore the economic value of health care services.

B. Obtaining Health Insurance

In 2009, just over half of Americans (55.8 percent) gained access to health insurance under employment-based health insurance.²⁹ Employers began offer-

²² REPORT OF THE HEALTH INSURANCE COMMISSION OF THE STATE OF ILLINOIS 15–17 (1919).

²³ David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009) (stating that “[i]llness or medical bills contributed to 62.1 [percent] of all bankruptcies in 2007”).

²⁴ See CONG. BUDGET OFFICE, *supra* note 2, at 1–5.

²⁵ *Id.*

²⁶ *Id.*

²⁷ See DENAVAS-WALT ET AL., *supra* note 3, at 22, 24.

²⁸ See generally Jason D. Fodeman & Robert A. Book, “*Bending the Curve*”: *What Really Drives Health Care Spending*, BACKGROUND, Feb. 17, 2010, available at www.heritage.org/Research/HealthCare/bg2369.cfm; Heidi Ellen Kluber, *Rising Healthcare Costs in the United States: Contributing Factors and Potential Solutions* (Dec. 1, 2008), available at <http://ecommons.txstate.edu/honorprog/88> (unpublished honors thesis, Texas State University).

²⁹ DENAVAS-WALT ET AL., *supra* note 3, at 24.

ing health insurance benefits during the wage freezes of the 1940s to incentivize and attract employees.³⁰ Offering health insurance benefits quickly became the norm for large businesses because of the tax incentives provided by the federal government.³¹

Employment-based health insurance provides consumers with significant benefits. In addition to receiving financial assistance to obtain coverage, consumers benefit from employment-based health insurance by pooling risk with a group.³² Pooling risk provides bargaining power, which results in lower overall costs and allows consumers with poor health histories to obtain health insurance where they might not otherwise be able to do so.³³ Finally, consumers benefit from employment-based health insurance because they receive health insurance as tax exempt compensation.³⁴

Employment-based health insurance also has disadvantages. First, the employer decides which health insurance provider will cover the group.³⁵ While the employer may offer consumers a few different health insurance plans to choose from, consumers are severely limited in choosing a plan that is best for their unique circumstances.³⁶ As a result, health insurance providers compete to provide plans that employers feel are best for the employer, rather than for the individual consumer.³⁷ Second, consumers who want to keep their health insurance plan cannot do so when changing employment.³⁸ This lack of portability often creates “job-lock,” where consumers avoid transferring employment to avoid losing health insurance benefits.³⁹ Finally, households with two employed members who have access to employment-based insurance benefits lose significant compensation value because households usually only participate in one employment-based insurance plan.⁴⁰

³⁰ Catherine Hoffman et al., *Holes in the Health Insurance System — Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390, 391 (2004).

³¹ *Id.*

³² William S. Custer et al., *Why We Should Keep the Employment-Based Health Insurance System*, 18 HEALTH AFF. 115, 116–18 (1999).

³³ *Id.*

³⁴ *Id.* at 116–17.

³⁵ Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*, 18 HEALTH AFF. 28, 29 (1999) (“[W]e consider a number of criticisms of the current system, focusing on one: the fact that employers choose one or a limited set of health insurance options to offer employees . . . so that employees do not have the same ability (or responsibility) to choose . . .”).

³⁶ *See id.*

³⁷ David Leonhardt, *How Insurers Do, and Don't, Compete*, N.Y. TIMES (Aug. 25, 2009, 9:00 PM), <http://economix.blogs.nytimes.com/2009/08/25/how-insurers-do-and-dont-compete/>.

³⁸ Alan C. Monheit & Philip F. Cooper, *Health Insurance and Job Mobility: Theory and Evidence*, 48 INDUS. & LAB. REL. REV. 68, 68 (1994) (“The nonportability of employment-related health insurance has been recognized as an important shortcoming of the prevailing system of private health insurance in the United States.”).

³⁹ *Id.*

⁴⁰ *See* U.S. GEN. ACCOUNTING OFFICE, EMPLOYER-BASED HEALTH INSURANCE: HIGH COSTS, WIDE VARIATION THREATEN SYSTEM 4 (1992) (“The growth in health care costs represents a substitution of employee health benefits for cash wages.”).

For the increasing number of consumers who are not eligible for employment-based or government health insurance,⁴¹ the individual health insurance market is riddled with barriers to accessing adequate health insurance.⁴² Individual health insurance plans are expensive, and the cost must be borne wholly by the individual.⁴³ Consumers who purchase individual health insurance plans do not enjoy any tax exemptions.⁴⁴ To compensate for increased premiums, individuals often are forced into plans with fewer benefits, higher deductibles, and more restrictions.⁴⁵ Furthermore, in the past and until PPACA becomes effective in 2014, people with a poor history of health and pre-existing conditions also face significantly increased costs and may even be denied coverage.⁴⁶

For consumers who do not qualify for employment-based health insurance and cannot afford or access individual health insurance, the government provides insurance coverage through programs like Medicare and Medicaid.⁴⁷ Unfortunately, many do not qualify for government insurance for various reasons.⁴⁸ Those who do qualify face greater difficulty finding a doctor who will accept the insurance because of the government's history of reimbursing doctors at relatively lower rates.⁴⁹

As health care costs increase, health insurance providers adjust to maintain solvency and profitability. To offset increased costs, insurance providers seek to increase revenue by raising premiums.⁵⁰ Because premiums continue to grow faster than wages, insurance providers attempt to moderate the increase in premiums by increasing deductibles and reducing what is covered by health insurance plans.⁵¹ Insurance providers also attempt to control costs by decreas-

⁴¹ See DENAVAS-WALT ET AL., *supra* note 3, at 22 (“The percentage of people without health insurance increased to 16.7 percent . . . [and t]he number of uninsured people increased to 50.7 million in 2009 . . .”).

⁴² Hoffman et al., *supra* note 30, at 392 (“[F]amilies are hard-pressed to find and pay for a policy in the individual insurance market.”).

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.* While PPACA makes it illegal for insurance providers to deny coverage based on pre-existing conditions after 2014, the general cost of health insurance will increase as the increased risk is spread across the market. This increase in cost will make it harder for people to obtain adequate health insurance in the individual market.

⁴⁷ While the government provided health insurance for a record high number of people in 2009, the overall number of people with adequate health insurance has still decreased. DENAVAS-WALT ET AL., *supra* note 3, at 24 (“The percentage and number of people covered by Medicaid is the highest since 1987.”). 1987 was the “first year that comparable health insurance data were collected.” *Id.* at 23–24.

⁴⁸ See Hoffman et al., *supra* note 30, at 392–94.

⁴⁹ See Julie Connelly, *More Doctors Are Opting Out of Medicare*, N.Y. TIMES, Apr. 2, 2009, at F9.

⁵⁰ *Id.* See Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w298 (2008) (“As health care costs continue to rise . . . , efforts to moderate premium increases have led to a shift . . .” (emphasis added)).

⁵¹ Schoen et al., *supra* note 50. Employers, worried about their own solvency and profitability, react to increased premiums by shifting the increased cost of health insurance onto employees, reducing the number of employees who receive benefits, reducing salaries, or laying off employees. U.S. GEN. ACCOUNTING OFFICE, *supra* note 40, at 10–12. This shifting

ing the reimbursement amounts that doctors receive for performing health care services.⁵² Government insurance programs reduce reimbursement rates simply by setting reimbursement amounts at the level it is willing to pay for services.⁵³ Doctors can accept or reject consumers covered under government programs, but doctors have no power to change the amount received for health care services performed.⁵⁴ The government sets reimbursement rates low based on the theory that doctors will increase efficiency to maintain profitability.⁵⁵ In reality, however, instead of increasing efficiency, doctors simply pass any lost margin onto consumers with private health insurance, or worse, those with no health insurance at all.⁵⁶

Private health insurance companies reduce reimbursement amounts by negotiating with doctors. Health insurance companies negotiate from a position of strength because most consumers are covered under private health insurance, and therefore doctors' revenue largely comes from health insurance companies.⁵⁷ Health insurance companies negotiate with doctors and establish a specific discounted rate for health care services before doctors provide treatment.⁵⁸ Doctors who agree to this discounted rate are considered "in-network," and insurance companies punish consumers who receive services from "out-of-network" doctors by requiring them to share more of the costs.⁵⁹ Furthermore, after a doctor bills a health insurance company for services performed, the insurance company works relentlessly to lower the amount it must reimburse the doctor.⁶⁰

Ironically, an indirect factor that determines the cost of health insurance is the number of people who lack adequate health insurance.⁶¹ When a consumer

of costs led to 25 million people between the ages of 19–24 being underinsured by 2007. Schoen et al., *supra* note 50.

⁵² See Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 648 (2008) ("Insurers (public and private) negotiate prices for much of the care many patients receive.").

⁵³ See Ira Burney et al., *Medicare Physician Payment, Participation, and Reform*, 3 HEALTH AFF. 5, 9–11 (1984).

⁵⁴ Jack Hadley, *How Should Medicare Pay Physicians?*, 62 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 279, 279 (1984).

⁵⁵ See Karen Davis & Stuart Guterman, *Rewarding Excellence and Efficiency in Medicare Payments*, 85 MILBANK Q. 449, 451 (2007) ("Such a system of payment rewards those hospitals and physicians that efficiently produce those units of care . . . because they can pocket any difference between the fixed price they are paid for each unit and the amount it costs them to produce it.").

⁵⁶ Beverly Cohen, *The Controversy Over Hospital Charges to the Uninsured — No Villains, No Heroes*, 51 VILL. L. REV. 95, 110–11 (2006). See generally Allen Dobson et al., *The Cost-Shift Payment "Hydraulic": Foundation, History, and Implications*, 25 HEALTH AFF. 22 (2006); Jean M. Mitchell et al., *Physicians' Responses to Medicare Fee Schedule Reductions*, 38 MED. CARE 1029 (2000).

⁵⁷ Cortney Kuntze, Comment, *Insured Versus Uninsured: The Fight for Equal Pricing in Health Care*, 29 J. LEGAL MED. 537, 538 (2008).

⁵⁸ Hall & Schneider, *supra* note 52, at 648.

⁵⁹ Kuntze, *supra* note 57, at 539.

⁶⁰ See James W. Marks, *Prompt Pay Statutes for Physicians' Billing Claims: An Imperfect Remedy for a Systemic Problem*, 20 J. MED. PRAC. MGMT. 135, 135 (2004).

⁶¹ FAMILIES USA, *PAYING A PREMIUM: THE ADDED COST OF CARE FOR THE UNINSURED* 15 (2005), available at http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.

fails to pay medical bills, medical providers are forced to recuperate that loss to remain solvent.⁶² Medical providers recuperate this loss by charging more for services to consumers who have adequate health insurance.⁶³ To cover the increased costs of coverage, health insurance providers pass this cost on to consumers by increasing the cost of health insurance.⁶⁴ Unfortunately, the increase in health insurance causes more consumers to lack adequate health insurance, and this creates an inflationary cycle for the cost of health care and health insurance.⁶⁵

In summary, most consumers gain access to adequate health insurance through employment-based insurance. For those not eligible for employment-based health insurance, the individual market is riddled with barriers to accessing affordable insurance. Although some are eligible for a government insurance program, the overall number of consumers who are uninsured or underinsured has reached a record high. As this number rises, the cost of health care also increases, thereby increasing insurance premiums. This perpetuates an inflationary cycle for health care and insurance costs.

C. *Selecting a Doctor*

To effectively select a doctor, consumers need readily available information to compare the price and quality of services among doctors. Today, thanks to technological advances in communications, consumers can search for and compare the value of nearly every product or service they wish to purchase.⁶⁶ However, health care services are a glaring exception to this general rule.⁶⁷ One commentator succinctly stated, "Medicine is the one capitalist enterprise to reveal its price tag only after the purchase or transaction is completed."⁶⁸ Furthermore, consumers struggle to determine and compare the potential quality of a doctor's services.⁶⁹ Because this information is not readily available, the health care industry lacks competition based on value; therefore, health care costs dramatically increase.⁷⁰

Consumers struggle to compare doctors based on price because doctors do not disclose specific prices for potential health care services.⁷¹ There are three basic reasons that doctors do not disclose specific prices. First, doctors often charge different prices to different consumers depending on the consumer's

⁶² *See id.*

⁶³ *Id.*

⁶⁴ *Id.* at 13–14.

⁶⁵ *Id.* at 15.

⁶⁶ A variety of organizations offer resources for consumers to research products and services. *See, e.g.,* CONSUMERS UNION, <http://www.consumerreports.org/cro/aboutus/history/printable/index.htm>.

⁶⁷ *See* Howard F. Stein, *The Money Taboo in American Medicine*, MED. ANTHROPOLOGY, Fall 1983, at 1, 11.

⁶⁸ *Id.* (emphasis omitted).

⁶⁹ For a classic study of the difficulties associated with consumer comparisons of physician quality, see Jay L. Lebow, *Consumer Assessments of the Quality of Medical Care*, 12 MED. CARE 328 (1974).

⁷⁰ *See generally* CONG. BUDGET OFFICE, *supra* note 2, at 7–10, 21, 26–27.

⁷¹ Hall & Schneider, *supra* note 52, at 653–54.

insurance coverage.⁷² Second, every consumer is unique and may require different services, which makes it difficult for doctors to formulate specific prices for health care services.⁷³ Finally, doctors do not regularly compete for consumers based on price, so there is little need to establish and advertise specific prices for health care services.⁷⁴

Consumers struggle to compare doctors based on quality because information about quality is difficult to find and synthesize. Consumers can investigate doctors on the internet, but will likely only find general office information.⁷⁵ Beyond this, consumers often rely on the advice of other doctors, family, or friends.⁷⁶ While consumers' reliance on the opinions of those close to them helps ascertain quality, it also greatly restricts consumers to a relatively low number of potential doctors the consumer can compare. Depending on which doctors accept the consumers' particular insurance plan, consumers are left with even fewer options.

In summary, consumers need adequate information to effectively select and compare doctors based on economic value. Unfortunately, under the current health care system consumers do not have access to information regarding the cost or quality of services provided by doctors.

D. Consumers Often Ignore Value

The majority of consumers⁷⁷ ignore value because they have no direct incentive to lower health care costs. Health care costs barely affect most insured consumers because they do not pay the bulk of the expense for health care services.⁷⁸ Without an incentive to lower health care costs, consumers often disregard price altogether.⁷⁹ This disregard for price is dangerous because it removes the consumer as an important check on rising costs. Because consumers normally care about price, producers compete by increasing value.

⁷² *Id.* at 657.

⁷³ *Id.* at 658.

⁷⁴ *Id.* at 653–54; *see also* PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS 253–54 (5th ed. 1999).

⁷⁵ *Blue Cross of Blue-ray: Nearly Half of Adults Spend More Time Researching Latest Gadget Than Their Doctor*, PR NEWSWIRE, Jan. 13, 2011, available at <http://www.prnewswire.com/news-releases/blue-cross-or-blu-ray-nearly-half-of-adults-spend-more-time-researching-latest-gadget-than-their-doctor-113448289.html>.

⁷⁶ *See* FELDSTEIN, *supra* note 74, at 251, 253–54 (discussing factors that may influence a patient's choice and how patients have information about physicians).

⁷⁷ This would include those covered by employment-based health insurance and government insurance programs because consumers often pay little to be covered. 55.8 percent of people were covered by employment-based health insurance in 2009, whereas 30.6 percent were covered under a government program. DENAVAS-WALT ET AL., *supra* note 3, at 22, 24.

⁷⁸ Consumers arguably have an indirect incentive to lower health care costs. As health care costs increase, insurance premiums and the number of uninsured and underinsured consumers follow. However, this inflationary cycle is so subtle and far removed from the individual consumer that they respond only after they become powerless to do so.

⁷⁹ In addition to having no direct incentive to lower costs, consumers may also disregard costs because they feel powerless to do so. Consumers may feel powerless because they often have few choices regarding the insurance plan they have or the doctors they can see. Feeling powerless to affect prices, consumers may simply ignore it altogether.

Therefore, when consumers disregard health care costs, doctors and insurance providers will not compete by increasing value.

Consumers who are uninsured, underinsured, or have high cost sharing plans focus on value because they often have incentives, although limited, to lower health care costs.⁸⁰ Unfortunately, these consumers often lack the power to greatly affect health care costs. First, these consumers do not have the necessary information to compare doctors.⁸¹ Second, doctors are often hesitant to accept these consumers because collecting payment for services performed may be a greater challenge.⁸² Finally, these consumers⁸³ realize that by postponing medical care until the situation becomes serious, they can go to an emergency room and get free health care because emergency rooms must admit and treat every person who is critically ill, regardless of ability to pay.⁸⁴

In summary, most consumers do not focus on value because they have no direct incentive to lower health care costs. Additionally, those who do have limited incentives to lower costs ultimately lack the power to greatly affect health care costs.

E. John and Jane: A Hypothetical Illustration of the Current Health Care System

After John graduated from law school, he and his wife, Jane, moved across the country to begin work at Best, Brightest & Associates, a mid-sized law firm. The firm offered John full health benefits through Insurance Co. and John and Jane enrolled.

Jane, an accountant, found a job at American Accounting, and her company also offered generous health benefits. Because John and Jane already had full coverage from Best, Brightest & Associates, they did not join American Accounting's group plan and lost the benefits' value.

After a few months, John and Jane were excited to find out that Jane was pregnant. John and Jane wanted the pregnancy to go perfectly, and quickly sought to find an Obstetrician/Gynecologist (OB/GYN). They first searched the internet, but only found general office information. They then asked co-workers, friends, and acquaintances to suggest a good OB/GYN. After receiving a few names, John and Jane again searched the internet to compare those doctors. Of the doctors who accepted Insurance Co., John and Jane decided to go with Dr. Baby because her office was conveniently located.

Jane called Dr. Baby's office and scheduled an appointment, but although Jane was an accountant and known for pinching pennies, she never asked about cost. Out of curiosity, Jane had once before asked about a doctor's price, but

⁸⁰ See generally Fodeman & Book, *supra* note 28.

⁸¹ See *infra* Part II.A.ii.

⁸² See Manoj Jain, *Equal Treatment for the Uninsured? Don't Count on It.*, WASH. POST, Oct. 14, 2008, at HE05, available at <http://www.washingtonpost.com/wp-dyn/content/article/2008/10/10/AR2008101002679.html>.

⁸³ However, these consumers only make up a minority of the marketplace. See DENAVAS-WALT ET AL., *supra* note 3, at 22 ("The percentage of people without health insurance increased to 16.7 percent . . . [and t]he number of uninsured people increased to 50.7 million in 2009 . . .").

⁸⁴ See Jain, *supra* note 82.

the receptionist responded in vague terms that every patient was different and did not disclose a price. Since Jane's insurance would pay nearly the entire bill, Jane figured the price was unimportant.

Over the next several months, Jane visited Dr. Baby regularly. Dr. Baby worked with Jane and provided adequate health care. Since Insurance Co. was paying the bill, Jane was not concerned with the overall costs, and since Jane was not concerned with costs, Dr. Baby focused almost exclusively on delivering the best available care. Jane liked Dr. Baby; Jane would refer anyone in need of an OB/GYN to Dr. Baby.

While Dr. Baby was not concerned about the cost to Jane, Dr. Baby was concerned about being adequately reimbursed. Dr. Baby had previously agreed with Insurance Co. to discount the cost of her services by a specific amount. However, after applying that discount, Dr. Baby also knew that she would receive only a fraction of the amount she billed to Insurance Co. Furthermore, Dr. Baby had recently lost money on another patient who did not have adequate health insurance. Therefore, to obtain a profit and recuperate losses, Dr. Baby billed Insurance Co. more for Jane's costs than she expected to receive.

Insurance Co. was also concerned with operating a viable and profitable business and sought to reduce the amount paid to Dr. Baby. Insurance Co. recognized that Dr. Baby's bill was higher than average for the services provided. Insurance Co. worked relentlessly to lower the amount it was required to reimburse Dr. Baby. While Insurance Co. successfully reduced the amount owed, the amount Insurance Co. paid was still higher than average. Insurance Co. responded to the increased cost by increasing premiums.

The climbing cost of providing insurance benefits in a struggling economy caused John's firm to decide to lay off employees. Unfortunately, John was among those laid off. John found another job at a different firm, Capable Attorneys, which also provided John with health benefits, but through a different insurance provider. However, John and Jane's coverage was much less than before, and Dr. Baby did not accept their new plan. Jane was forced to switch doctors and again struggled to find a doctor.⁸⁵

In summation, John and Jane received the best available care and were fully satisfied with Dr. Baby, but were forced to accept a different insurance plan and select a different doctor. Dr. Baby satisfied a customer enough to receive future referrals and received enough revenue from Insurance Co. to

⁸⁵ This hypothetical could be continued to illustrate the inflationary cycle associated with underinsured consumers:

As health care costs increased generally, Health Insurance Co. increased the premium charged to customers, including Best, Brightest & Associates, to maintain solvency and profitability. The firm, also concerned with maintaining a viable and profitable business, decided it needed to reduce operating costs. It was committed to providing health benefits as a competitive advantage over other firms, so to reduce costs the firm decided to lay off one percent of its attorneys. Having been with the firm only a year, John was among the one percent laid off. Luckily, Jane continued to work, and John and Jane joined AA's group plan and enrolled in Insurance For All, Inc. While John and Jane were still covered, they were underinsured. Their new plan had a \$15,000 family deductible and their income had been greatly reduced. After an unrelated accident, John and Jane were faced with \$20,000 in medical bills. This cost, added to lost wages and mounting debt, forced John and Jane into bankruptcy. The doctors would recover the \$20,000 they lost by increasing costs.

maintain a profitable business, but ultimately lost a consumer who was happy with her services. Insurance Co. maintained solvency and profitability, but had to work relentlessly with Dr. Baby to lower the amount owed, and had to increase premiums to cover its costs, which ultimately reduced the number of its consumers. Overall, health care costs continued to increase and the number of people adequately covered by health insurance continued to decrease.

III. BETTER SYSTEM: HEALTH CARE EXCHANGES

A. Overview

A health care exchange (“HCE”) is an entity that organizes the health care market by combining a health insurance exchange (“insurance exchange”) with a similar health provider exchange (“doctor exchange”) into an online marketplace. HCEs would allow consumers to easily search for and compare insurance plans based on price, quality, consumer reviews, coverage, and participating doctors. Consumers could also search for and compare doctors based on price, quality, consumer reviews, accepted insurance plans, geographic area, and specialty. Furthermore, HCEs would reward consumers for selecting price-effective doctors and conversely punish the opposite behavior by imposing discounts or surcharges to consumers’ individual insurance premiums. Ultimately, through market forces, HCEs would drive down health care costs and insurance premiums while increasing the number of consumers covered by adequate health insurance.

B. Obtaining Insurance Through an HCE

To succeed, HCEs must incorporate a successful insurance exchange.⁸⁶ An insurance exchange is an online marketplace that connects consumers, insurance providers, and other financial contributors (employers, family members, government programs, etc.).⁸⁷ Consumers participating in insurance

⁸⁶ Currently, Massachusetts and Utah have insurance exchanges, known as Commonwealth Connector and Utah Health Exchange, respectively. *See* MASS. GEN. LAWS ANN. ch. 176Q, § 1 (West 2010); UTAH CODE ANN. § 63M-1-2504 (West 2010). While both insurance exchanges have similarities, they can also be seen as the two extremes of potential insurance exchanges. Trip Jennings, *NM Considers Models for Health Insurance Exchange*, N.M. INDEP. (June 4, 2010, 9:37 AM), <http://newmexicoindependent.com/56303/group-considers-models-for-nms-health-insurance-exchange>. Massachusetts has regulatory powers, whereas Utah is more market-oriented; Massachusetts relies on an individual mandate, whereas Utah attempts to grow by attracting consumers with benefits; Massachusetts limits participation of insurance companies and attempts to control plan benefits, whereas Utah wants all insurance companies to participate and only sets minimum standards for plan benefits. *See* MASS. GEN. LAWS ch. 176Q, § 1; UTAH CODE ANN. § 63M-1-2504. While either insurance exchange would work as part of HCEs and each state should adopt an insurance exchange appropriate for that state, this Note will follow many elements of Utah’s exchange because it is more market-oriented, and more likely to drive down costs through market forces.

⁸⁷ Timothy Stoltzfus Jost, *Health Insurance Exchanges: Legal Issues*, 37 J.L. MED. & ETHICS 51, 53 (2009) (“Health insurance exchanges are entities that organize the market for health insurance, much like stock exchanges do for securities or farmers’ markets for produce.”); Jennings, *supra* note 86 (“[T]he Utah plan . . . allows workers to pool contributions from several sources—an employer, government assistance or perhaps money from a spouse’s contribution from their employer—to have enough to buy a basic plan . . .”).

exchanges would receive all the benefits enjoyed by consumers receiving employment-based health insurance. In addition to receiving financial assistance to obtain coverage, consumers would pool their risk together to lower overall costs through increased bargaining power.⁸⁸ Pooling risk could also eliminate the pre-existing condition barrier for consumers, thereby allowing consumers with poor histories of health to obtain adequate health insurance.⁸⁹ Furthermore, consumers would receive health insurance benefits as tax exempt compensation.⁹⁰

However, consumers participating in insurance exchanges would not suffer the disadvantages of employment-based health insurance. First, employers would not choose the insurance plan in which consumers enroll. Rather, consumers would compare numerous plans and choose the one that best fits their unique circumstances. As a result, insurance providers would begin competing for business based on what consumers demand, and not what employers want. Second, consumers could keep their insurance plan when changing employment.⁹¹ This increased portability would largely eliminate the risk of “job-lock” and consumers would not worry about losing insurance coverage when changing jobs. Finally, consumer households with two employers who contribute toward health benefits would not lose compensation value, because the household could combine contributions from multiple sources to obtain better coverage or withdraw surplus funds from the insurance exchange as tax-free income.⁹²

Employers would continue to assist employees in obtaining adequate health insurance. However, instead of having the burden of shopping for and selecting one group plan for the entire company, employers would simply contribute an established amount, chosen at their discretion, into the insurance exchange, where employees can choose the plan that is best for them.⁹³ Employers would continue to receive the same tax benefits for, and continue to attract employees through, contributions toward employees’ health benefits.⁹⁴ Employers would further benefit from increased predictability in costs. The tax

⁸⁸ TIMOTHY STOLTZFUS JOST, *THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 2* (2010).

⁸⁹ *See id.*

⁹⁰ Robert E. Moffit, *The Rationale for a Statewide Health Insurance Exchange*, WEB MEMO, Oct. 5, 2006, at 2, available at www.heritage.org/research/healthcare/wm1230.cfm.

⁹¹ Employees could keep their plan as long as both employers participated in the insurance exchange.

⁹² To ensure that employers and employees do not attempt to circumvent income tax requirements, insurance exchanges should have a maximum contribution allowed.

⁹³ Moffit, *supra* note 90, at 2.

⁹⁴ *See* Lois M. Collins, *Utah Health Exchange Growing as More Small Businesses Sign On*, DESERET NEWS (May 30, 2011), <http://www.deseretnews.com/article/700140212/Utah-Health-Exchange-growing-as-more-small-businesses-sign-on.html>; *Defined Contribution Frequently Asked Questions*, UTAH HEALTH EXCHANGE, <http://www.exchange.utah.gov/learn-more/defined-contribution-faqs> (last visited Mar. 16, 2012); *see also* *Why Use the Utah Health Exchange?*, TAX FREE PREMIUMS COMPLIANCE BLOG (March 15, 2011), <http://www.taxfreepremiums.com/blog/?p=230>.

benefits and increased predictability of cost would likely drive smaller employers to contribute toward employees' health benefits, even if only a little.⁹⁵

Empowered to choose, consumers could search for and compare insurance plans that are best for their unique circumstances. Consumers could select insurance plans based on price, consumer reviews, coverage, and participating doctors.⁹⁶ Consumers would also be aided in their search by a value rating attached to each participating insurance plan.⁹⁷ A good value rating would attract consumers, therefore increasing an insurance provider's sustainability. Insurance providers, eager to operate a sustainable and profitable business, would compete to increase their value rating by decreasing price, increasing coverage, or otherwise improving the value of insurance plans they offer.

In addition to using value ratings to compare insurance plans, consumers could contribute to value ratings and provide detailed reviews. Each consumer could give insurance plans an overall rating that would factor into an insurance plan's value rating. Because purchasing an item is akin to voting in the marketplace,⁹⁸ an insurance plan's value rating would also increase based on the total number of consumers electing that particular insurance plan. Additionally, consumers could also write detailed reviews about their experiences with insurance plans, both good and bad, that other consumers could use to gain information.

Doctors would also affect an insurance plan's value rating. First, an insurance plan's value rating would increase as more doctors accept that plan. This would incentivize insurance providers to attract doctors to a plan by treating doctors fairly. Second, an insurance plan's value rating would include the average value rating of doctors⁹⁹ who accept that plan. This incentivizes insurance providers to treat doctors with high value ratings better than those with low value ratings. Thus, insurance providers will avoid non-productive negotiations with doctors who have high value ratings, and welcome productive negotiations to lower claims submitted by doctors with low value ratings. If a doctor with a low value rating drops the insurance plan, the plan is rewarded with a higher rating; if the same doctor improves her own value rating, the plan is rewarded and the insurer is incentivized to reward the doctor.

⁹⁵ Employers' contributions would remain tax exempt. Furthermore, if an employer contributes nothing toward an employee's health benefits, but elects the insurance exchange as the company's group plan, the employer can receive tax benefits for any income employees apply toward their premium.

⁹⁶ Employers would choose a default plan on the HCE for those consumers unwilling or without desire to select a plan.

⁹⁷ The insurance value rating would factor in the following: consumer reviews, number of consumers in the plan, number of participating doctors, average doctor rating of participating doctors, number of successful bad faith claims, and any other numeric factor that could represent quality.

⁹⁸ This is often called "dollar-voting," where individuals determine the most desirable products by selecting those products to purchase. See Peter Lindsay, *Exposing the Invisible Hand: The Roots of Laissez-Faire's Hidden Influence*, 37 *POLITY* 295, 297 (2005).

⁹⁹ See *infra* Part III.A.ii. Similar to an insurance plan's value rating, a doctor's value rating reflects the overall quality of a doctor, including price charged and value delivered for health care services.

Along with the potential advantages, insurance exchanges also face potential challenges. One potential challenge is adverse selection.¹⁰⁰ Adverse selection is an economic term often associated with insurance that describes a market condition, also known as “death spirals,”¹⁰¹ that occurs when consumers choose a product “on a basis that increases the cost of providing that product.”¹⁰² All health insurance markets potentially face the risk of adverse selection, but because insurance exchanges pool consumers’ risk together, often guarantee coverage regardless of health, and may be subject to increased regulations, insurance exchanges are at a heightened risk of adverse selection since higher risk consumers are more likely to participate in the insurance exchange rather than the outside market.¹⁰³ Ultimately, if the insurance exchange provides coverage for more high-risk consumers than the outside market, the health insurance premiums within the insurance exchange would increase to cover the added costs associated with these consumers. If premiums in the outside market are less expensive for healthy consumers, healthy consumers would leave the insurance exchange, resulting in the insurance exchange becoming more saturated with higher risk consumers, leading to further increases in premiums. Further increases in premiums would lead to more consumers leaving the insurance exchange, and the spiral could continue causing the insurance exchange to fail.

Previous efforts to provide health insurance in a similar manner show that in order to avoid adverse selection, insurance exchanges must attract and maintain the necessary level of participation by health insurance providers, employers, and consumers, known as “critical mass.”¹⁰⁴ While states are just beginning to create insurance exchanges, in the past states have tried similar programs such as small group purchasing cooperatives and purchasing alliances.

In 1992, California created a small-business purchasing cooperative known as PacAdvantage.¹⁰⁵ Because PacAdvantage attracted 150,000 consumers at its peak,¹⁰⁶ many considered PacAdvantage successful.¹⁰⁷ However, in 2006, health insurance provider Blue Shield of California decided against offering insurance through PacAdvantage because the product was unprofitable; this

¹⁰⁰ TIMOTHY STOLTZFUS JOST, *THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES: EIGHT DIFFICULT ISSUES* 8 (2010) (“[T]he greatest threat facing exchanges is adverse selection.”); SARAH LUECK, *CTR ON BUDGET AND POLICY PRIORITIES, STATES SHOULD STRUCTURE INSURANCE EXCHANGES TO MINIMIZE ADVERSE SELECTION* 1 (Adverse selection “could prevent the [insurance] exchanges from operating effectively.”).

¹⁰¹ *Id.* at 3.

¹⁰² RICHARD A. IPPOLITO, *ECONOMICS FOR LAWYERS* 299 (2005). When consumers purchase health insurance based on prior health problems or increased risk of future health problems, the cost of providing health insurance increases. *See id.* Health insurance providers created exceptions to coverage for pre-existing conditions so consumers could not simply wait until they were sick to purchase health insurance to protect against adverse selection. *See id.*

¹⁰³ *See generally* JOST, *supra* note 100; LUECK, *supra* note 100.

¹⁰⁴ *See generally* LUECK, *supra* note 100.

¹⁰⁵ DAVID DRANOVE, *CODE RED: AN ECONOMIST EXPLAINS HOW TO REVIVE THE HEALTH-CARE SYSTEM WITHOUT DESTROYING IT* 182 (2008).

¹⁰⁶ LUECK, *supra* note 100, at 2.

¹⁰⁷ *See* ELLIOT K. WICKS, *THE COMMONWEALTH FUND, HEALTH INSURANCE PURCHASING COOPERATIVES* 3 (2002).

left only two health insurance providers in the pool.¹⁰⁸ Offering coverage through PacAdvantage became unprofitable because employers with lower-risk employees left the pool to obtain less expensive coverage in the less regulated outside market.¹⁰⁹ As employers with the lowest-risk employees left, PacAdvantage raised premiums as high as the law allowed, which drove more employers to leave the pool.¹¹⁰ Because PacAdvantage failed to maintain the necessary level of insurance providers, employers, and consumers, PacAdvantage suffered from adverse selection and ultimately failed.¹¹¹

In 1994, Texas also attempted to pool small employers into purchasing groups by forming the Texas Insurance Purchasing Alliance.¹¹² Initially, the alliance fulfilled its purpose to provide health insurance coverage for small business at reduced costs.¹¹³ However, the alliance struggled to attract employers, and mostly attracted employers with higher-risk employees who faced increased costs in the outside market.¹¹⁴ Because the alliance was saturated with higher-risk groups, health insurance providers increasingly withdrew until ultimately the alliance failed.¹¹⁵

Insurance exchanges within the HCEs can avoid adverse selection by reaching critical mass. Insurance exchanges can attract insurance providers by offering a large number of consumers within the insurance exchange. Insurance exchanges can attract consumers by offering benefits that are not enjoyed in the outside market. States can ensure that insurance exchanges avoid adverse selection only if the federal government does not burden states with onerous and unnecessary restrictions placed on insurance exchanges. While adverse selection is a threat that must be addressed, states can overcome adverse selection in insurance exchanges the same way that other insurance plans have consistently overcome adverse selection: by attracting consumers to participate.

In summary, insurance exchanges would expand the number of people covered by adequate health insurance; would empower consumers to choose a health insurance plan tailored to their needs, keep that plan when changing employment, and capture lost compensation value; and would reward insurance plans and providers for increasing value delivered to consumers. Based on these and other benefits, insurance exchanges can overcome adverse selection and succeed.

¹⁰⁸ DRANOVE, *supra* note 105, at 182–83.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*; LUECK, *supra* note 100, at 2.

¹¹² WICKS, *supra* note 107, at 3.

¹¹³ Cappy McGarr, Op-ed., *A Texas-Sized Health Care Failure*, N.Y. TIMES, Oct. 6, 2009, at A31.

¹¹⁴ *Id.*

¹¹⁵ *Id.* (The Texas Insurance Purchasing Alliance “never attained a large enough market share to exert significant clout in the Texas insurance market.”); WICKS, *supra* note 107, at 3 (“The Texas Insurance Purchasing Alliance . . . cover[ed] only about 1,000 firms and 13,000 people at its height.”). Nearly identical stories can be told about efforts in Florida, North Carolina, and Colorado. *Id.*

C. *Selecting a Doctor Through a Doctor Exchange*

While insurance exchanges contribute to the HCEs' success, HCEs must also incorporate doctor exchanges.¹¹⁶ A doctor exchange is a website that empowers consumers to effectively search for and compare doctors by providing consumers with information to make an informed decision. To assist consumers with this information, doctor exchanges, like insurance exchanges, would distill this information into value ratings.

The first factor of a doctor's value rating would be price. The price used in the value rating would be the average amount billed per patient.¹¹⁷ Using the average amount billed per patient would give consumers a general reference point to compare doctors even though the cost of each patient varies depending on medical condition. Also, using the average amount billed versus amount collected would incentivize doctors to bill insurance companies an amount that is closer to the doctors' actual expected revenue. As a doctor lowers the amount billed for health care services, that doctor's value rating would increase.

However, value does not equate to "cheap," and it is not in consumers' or society's interest to incentivize doctors to reduce costs without restraint. Therefore, a doctor's value rating would also include factors to determine quality, such as consumer reviews, number of patients, number of malpractice suits, and the standard deviation of amount billed to patients.¹¹⁸ As the quality of a doctor's services lowers, that doctor's value rating would decrease.

Doctors' value ratings would incentivize doctors to increase value by decreasing costs and increasing quality. To decrease costs without reducing quality, doctors would perform a cost-benefit analysis of the services they provide. Doctors are in the best position to perform a cost-benefit analysis because they hold the most information and are largely emotionally detached from health care decisions.¹¹⁹ Many times, the decision may not concern whether or not to provide a procedure, but rather the most cost-effective way to provide that procedure.¹²⁰

A good value rating would reward doctors with increased consumers and increased sustainability as a business. Doctors, eager to operate a sustainable and profitable business, would compete to increase their value rating by

¹¹⁶ Doctor exchanges would only involve non-emergency doctors. Emergency doctors would be excluded because a consumer's choice is drastically altered in emergency situations; e.g., society should not expect a father to coldly perform a cost-benefit analysis when faced with the potential loss of his child.

¹¹⁷ Doctors would also include the cost of any services performed by a third party that the doctor referred the patient to receive (e.g., labs, x-rays, diagnostic tests, etc.).

¹¹⁸ The standard deviation would ensure that doctors treat patients with varying degrees of need; patients with low costs, high costs, and those in between. The greater the standard deviation, then the higher the doctor's value rating would be.

¹¹⁹ See Hall & Schneider, *supra* note 52, at 650–53 (explaining why patients feel powerless to shop for health care services).

¹²⁰ A great example would be a surgery. If the surgery requires a surgical device, the doctor could reduce the surgery's cost by comparing devices and using the least costly alternative. If, on the other hand, a surgical device was "nice" but ultimately too expensive and unnecessary, some doctors would forego using the device to increase their value rating and competitive advantage. This would lead other doctors to follow suit as their value rating would be adversely affected.

decreasing price, increasing quality, or otherwise improving the value of health care services they provide. As noted earlier, a good value rating would also reward doctors with an improved relationship with insurance providers.

In summary, doctor exchanges would empower consumers to effectively search for and compare doctors. The increased transparency and competition would incentivize doctors to increase the value of the health care services they provide by reducing costs and increasing quality. As a reward for increased value, doctors' practices would gain increased sustainability and profitability and doctors would enjoy an improved relationship with health insurance providers.

D. Consumers' Incentive to Focus on Value

While insurance and doctor exchanges provide the tools for consumers to effectively select insurance plans and doctors, the HCEs would provide consumers with a motivating purpose. Without a motivating purpose, consumers would continue to disregard value altogether; if consumers do not focus on value, the incentives for insurance providers and doctors would disappear. Therefore, the HCEs must incentivize consumers to focus on value.

HCEs would incentivize consumers to focus on value directly and indirectly. Directly, consumers would get a discount on their individual insurance premium for selecting a doctor with a high value rating.¹²¹ Conversely, consumers who select a doctor with a low value rating would be assessed a surcharge.¹²² While each member of a group policy would pay the insurance provider the same premium amount for insurance coverage, the HCE would combine the total surcharges and distribute the combined amount proportionately as discounts to those who qualify within each group.

Indirectly, HCEs would reward consumers for focusing on value by lowering a group's overall health care costs. If the consumers in a group consistently selected doctors with high value ratings in greater proportion than doctors with low value ratings, the group's health care costs would go down. The decrease in health care costs associated with the group would result in decreased premiums.

In summary, HCEs' reward system would incentivize consumers to focus on value by rewarding consumers for doing so. As consumers focus on value, insurance providers and doctors are incentivized through the HCE to increase the value of services. As the participants all focus on increased value, health care costs and insurance premiums decrease.

E. John and Jane: Hypothetical Illustration of HCEs

John and Jane moved across the country to begin work at Best, Brightest & Associates. The firm contributed \$1000 per month toward an insurance plan

¹²¹ Some might also argue that those in the group that made not choices, i.e., never incurred costs from doctors' services, should get a discount, others would argue that might increase the amount of people foregoing adequate care. That debate will be left for others to determine.

¹²² Both the discount and surcharge would be proportionate to the deviation from the average doctor rating. In other words, the higher the rating, the bigger the discount; the lower the rating, the bigger the surcharge.

on the state's HCE. John and Jane accessed the insurance exchange and chose a plan from Affordable Insurance (AI) that cost \$1000 and suited their circumstances well.

Jane also found a job at American Accounting. The company contributed \$500 per month toward an insurance plan on the state's HCE. John and Jane decided to stay with AI and received the \$500 per month surplus in their HCE account tax-free.

After finding out that Jane was pregnant, John and Jane logged into their HCE account and searched in the doctor exchange for OB/GYNs in the area who accepted their insurance plan. Jane, a penny-pincher, was eager to find a doctor with a high value rating so they could qualify for a discount off their insurance premium. John wanted a doctor with good customer service and low patient wait times. John searched through several customer reviews and found a few doctors that fit their needs. Together, John and Jane agreed to visit Dr. Baby because she had both a high doctor rating and good customer reviews.

Over the next several months, Dr. Baby worked with Jane and provided adequate health care. Jane visited Dr. Baby regularly, but because Jane's pregnancy was low risk, Dr. Baby saw Jane less than other patients. Dr. Baby performed ultrasounds and several tests, but, based on Jane's circumstances, reduced the number of tests she ordered. When the time for delivery came, Dr. Baby suggested a reputable and cost-effective hospital and delivered the baby. Jane liked Dr. Baby so she logged into the HCE, awarded Dr. Baby a high consumer rating, and wrote a detailed and positive review.

Dr. Baby was concerned about collecting a sufficient amount to operate a viable and successful business and increasing her value rating to attract more patients. Dr. Baby billed Jane's insurance company (AI) for the services she performed. Because Dr. Baby had a high value rating, she knew that it was beneficial to AI's value rating that she accepted its insurance plan. Dr. Baby also wanted to maintain her high value rating, so instead of inflating the amount she billed to AI, Dr. Baby billed AI the amount she expected to receive. The lower amount billed to AI, together with Jane's positive review, increased Dr. Baby's value rating.

AI was also concerned with operating a viable and profitable business. Because Dr. Baby billed a reasonable amount, AI did not need to reduce the amount to remain solvent or profitable. AI avoided working relentlessly to lower the amount owed to Dr. Baby because it would be unproductive and negatively affect its value rating to do so. Because the amount Dr. Baby billed AI was reasonable, AI was able to lower premiums to John and Jane's group plan.

While the costs of health care and insurance benefits decreased, the economy continued to struggle, and John was laid off. John quickly found another job at Capable Attorneys. In addition to John's salary, Capable Attorneys provided John with a defined contribution of \$500 toward his health benefits on the state's HCE. While it was less than the \$1000 he received before, when combined with the \$500 contribution from Jane's employer, it was enough to allow John and Jane to maintain insurance through AI (the insurance of their choice), and Jane continued to see Dr. Baby (the doctor of her choice).

In summation, John and Jane were empowered to select the health insurance that best fit their circumstances, were assisted in locating a quality doctor, were rewarded for selecting a quality doctor, and were enabled to keep the health insurance and doctor they wanted after changing employment. Dr. Baby was able to operate a viable and successful business, be rewarded for her quality and value (by keeping Jane as a client and attracting more consumers with an improved value rating), and obtain greater leverage over her ability to collect from the insurance company. The insurance company, AI, was able to lower premiums while maintaining solvency and profitability, and because it provided adequate coverage and treated Dr. Baby well it was rewarded with keeping John and Jane as clients, attracting more consumers, and improving its value rating.

Under the improved system created through HCEs, health care costs would decrease and the number of people adequately covered by health insurance would increase, which would lead to overall improved financial stability.

IV. THE ROLES OF FEDERAL AND STATE GOVERNMENTS

Because HCEs would be comprehensive and affect consumers, doctors, and insurance providers, both federal and state governments must participate in creating and maintaining HCEs. The federal government should require all states to establish and maintain an HCE. First, each state's HCE would include an insurance exchange. Congress should give states wide latitude to establish and maintain an insurance exchange according to the particular circumstances of each state. Second, each state's HCE would incorporate the federal doctor exchange into its HCE. Finally, each state would administer the finances of its HCE, including but not limited to: collecting contributions, distributing payments for insurance premiums, and applying discounts and surcharges based on selected doctors.

The federal government should ensure that each state acts to solve the problem of rising health care costs, ensure that each state has the freedom to act according to that state's particular circumstance, and establish a federal doctor exchange. The federal government should ensure that each state acts to solve the problem of rising health care costs by requiring each state to establish an HCE. To ensure that states have the freedom to act according to the particular circumstances of each state, the federal government should limit laws, rules, and regulations pertaining to HCEs to those that are essential to equity and ultimate success. Finally, the federal government should establish and maintain a doctor exchange, and require all doctors¹²³ to participate to ensure that all states are treated fairly.¹²⁴ In establishing the federal doctor exchange, the federal government should specify the factors, with the weight associated with each factor, involved in determining doctors' value ratings. The federal government should also establish rating areas based on the number of doctors within that area.

¹²³ Doctor exchanges would only involve non-emergency doctors.

¹²⁴ Without doing doctor exchange on the federal level, some states may be tempted to loosen requirements for doctors in doctor exchange, thereby enticing doctors to move from states with stricter requirements.

V. CONCLUSION

The current health care system is broken. There are many opinions on how to fix the health care system, but none can succeed without using market forces to lower health care costs. Market forces will only work, however, if the government fixes the market by realigning the incentives of each participant of the health care system to lowering health care costs. HCEs properly realign the participants' incentives to lower health care costs by combining insurance exchanges with doctor exchanges and incentivizing consumers to focus on value.

HCEs, through market forces, would drive down health care costs and insurance premiums while increasing the number of consumers covered by adequate health insurance. Insurance exchanges would provide consumers with all the benefits of employment-based insurance, including shared cost, pooled risk, and tax benefits. Unlike employment-based insurance, consumers in insurance exchanges would choose their own plans, have increased portability of their plans, and capture lost compensation value from health benefits. Insurance exchanges would reward insurance providers that increase value with increased consumers, and would incentivize insurance providers to treat doctors fairly.

Doctor exchanges would empower consumers with the tools and information needed to search for and select doctors based on value. Doctor exchanges recognize the unique position doctors have in performing a cost-benefit analysis on health care services, and would reward doctors who decrease costs and increase value. Doctors who effectively focus on value are rewarded with increased consumers and improved relationships with insurance providers.

Finally, the HCEs' reward system incentivizes consumers to focus on value by rewarding consumers who do so. Consumers who select doctors with high value ratings receive discounts on their individual insurance premiums, while those selecting doctors with low value ratings pay a surcharge. As consumers in a group select doctors who have high value ratings, the group's insurance premium will decrease.