4-2012

# Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected

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CONNECTICUT
LAW REVIEW

VOLUME 44 APRIL 2012 NUMBER 4

## Article

# Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected

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*One feature of the ACA that appealed to observers across the political spectrum was the creation of health insurance "exchanges." Among other things, exchanges are intended to aid consumers in making simple and transparent choices regarding the purchase of health insurance. This Article considers how exchanges might benefit from the use of "default" options—both online and off. Given the significant number of Americans that have limited or no Internet access, offline defaults may be an attractive way to promote coverage of the "unconnected."*

## ARTICLE CONTENTS



# Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected

BRENDAN S. MAHER*

## I. INTRODUCTION

Virtually everyone has heard of the Patient Protection and Affordable Care Act ("ACA"), although some may know it only by other names.[1] It has been the most discussed legislation in decades.

Befitting the immensity of the debates it occasioned, the ACA is literally and figuratively colossal. The legislation utterly reconfigures the American healthcare landscape in myriad ways.[2] This short Article focuses on one of the ACA's many reforms: the creation of health care exchanges, administered by either the federal or state governments, through which individuals may purchase the insurance the ACA requires them to have (or pay a fee for not having). In particular, this Article considers how policymakers could construct the exchanges to best effectuate one of their purposes—to make the purchase of insurance simple and transparent—vis-à-vis the considerable number of Americans who lack

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[1] *See* Robert Barnes, *Supreme Court to Hear Challenge to Obama's Health-Care Overhaul*, WASH. POST, Nov. 14, 2011, at A1 (noting that some have taken to "derisively call [the legislation] Obamacare"). The landmark legislation is actually two acts. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, 30 and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified in scattered sections of 20, 26, and 42 U.S.C.). This Article refers to both collectively as the "ACA."

[2] The constitutional questions posed by the ACA, and the resulting debates, are well known. Scholarly discussion of other dimensions of the ACA has also been extensive. *See, e.g.*, Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577 (2011); Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534 (2011); Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811 (2011); Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873 (2011); Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111 (2010); Brendan S. Maher, *The Benefits of Opt-In Federalism*, 52 B.C. L. REV. 1733 (2011); Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care by Dumping Sick Employees?*, 97 VA. L. REV. 125 (2011); Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 KAN. J.L. & PUB. POL'Y 266 (2011).

Internet access amenable to making a health insurance choice online ("the unconnected").

Part II describes the ACA and its reliance on private insurance to finance health care. Part III describes the creation of health care exchanges and the evident congressional intent that such exchanges promote consumer choice regarding the purchase of health insurance. Part IV considers how policymakers might create exchanges that aid "the unconnected" in exercising insurance choice.

## II. THE ACA AND PRIVATE INSURANCE

People have always gotten sick and needed treatment. For much of human history, treatment was (1) affirmatively harmful, (2) useless, or (3) palliative. Curative treatment was rare. In the late nineteenth and twentieth centuries, as medicine transformed from lightly-disguised shamanism to science, doctors began to have the capability, drugs, and technology to cure, or at least stabilize, conditions that would have been untreatable in the past—aside from the provision of drugs to numb or mask the pain.

People, it turns out, do not enjoy being sick and wish to get well. And they are willing to pay for it. As the science of medicine became more advanced, it offered more cures, for which more people were willing to pay (and pay more), than the number of people who were willing to pay (and the amounts they were willing to pay) for the more primitive "medicine" of times past. Harmful, useful, and palliative treatments were not particularly costly. Curative treatments, on the other hand, can be.[3] Soon enough, treatment costs for certain medical conditions reached a level where significant numbers of the populace could not afford to purchase the needed medical care for unlikely, but not astronomically unlikely, conditions.[4]

An individual presented with the possibility that he may face a cost he cannot bear, such as the cost of medical treatment for Condition A, has multiple options.[5] One of those options is to purchase private insurance.[6]

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[3] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 259 (1982) (noting increase in medical costs attributable in part to scientific and educational advances that improved quality of care).

[4] *See* STARR, *supra* note 3, at 236, 259–60 (discussing emerging demand for health insurance and the risk of individuals facing infrequent but "exceptionally large" medical costs).

[5] Other options include (1) to do nothing, and, in the event the condition occurs, simply not obtain treatment and live with or die from the condition; (2) to do nothing, and in the event the condition occurs, seek the charity of others to pay for the treatment; (3) to save enough money so as to be able to pay out of pocket for the medical care needed should Condition A occur; (4) to purchase insurance sold by the government; (5) to elect a government that agrees to provide for the necessary care out of public funds to those who need it; or (6) some combination of the foregoing.

[6] Insurance can be private or public. Like the ACA, this Article focuses on the former.

Insurance is simply a deal wherein the insured incurs a small, regular loss (the premium) to avoid an infrequent large loss (the cost of treating Condition A). The insurer collects the premium and bears the risk of the large loss. Insurance permits risk-averse individuals to have the necessary resources to pay for unusual events; its appeal in the health care context is straightforward.

In the United States, nascent health insurance arrangements arose in the early twentieth century.[7] Private health insurance rose in importance and popularity for both historical and legislative reasons, most notably the imposition of wage controls in World War II and the enactment of the Employee Retirement Income Security Act ("ERISA") in 1974.[8] By the time of the national and legislative debates that preceded the ACA's enactment, Americans possessed a robust familiarity with (if not a preference for) private insurance.[9]

Familiarity aside, private health insurance circa 2010 was far from perfect, and few contended otherwise. Its imperfections need not be canvassed here; only two broad observations are necessary. First, at the time of the ACA's enactment, insurance coverage was simply too costly for many Americans.[10] Second, many people were unable to get insurance because they posed too large a risk for an insurer to economically insure.[11]

Both long before and immediately prior to the ACA's passage, some argued that the problems of cost and availability were better addressed using a different approach to health care financing than by relying on private insurance.[12] For example, legislators advanced proposals to have the government pay for health care directly or have the government offer

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[7] *See* STARR, *supra* note 3, at 200–09, 241–42 (1982). Companies attempted to offer private health insurance as early as the 1850s, but failed. *Id.* at 241.

[8] David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 25–26, 29 (2001).

[9] *See, e.g.*, Elizabeth Weeks Leonard, *Can You Really Keep Your Health Plan? The Limits of Grandfathering Under the Affordable Care Act*, 36 J. CORP. L. 753, 759 (2011) (noting that President Obama's assurances that his vision of health care reform would allow people to keep their existing insurance "comport[ed] with the public's apparent preference for private, market-based solutions").

[10] Paul Steinhauser, *Poll: Health Care Costs Too Expensive, Americans Say*, CNN.COM (Mar. 19, 2009), http://articles.cnn.com/2009-03-19/politics/health.care.poll_1_health-care-americans-coverage?_s=PM:POLITICS.

[11] *See, e.g.*, Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 575 (2008) (noting difficulty of obtaining non-group insurance); Robert Pear, *Coverage Now for Sick Children? Check Fine Print*, N.Y. TIMES, Mar. 29, 2010, at A13 (discussing the problem of obtaining coverage for individuals with pre-existing conditions).

[12] The United States has a history of unconsummated flirtations with national approaches to paying for health care other than by extensive use of private insurance. *See, e.g.*, John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 314 (1997) ("On about a twenty-year cycle during this century, we have considered and rejected joining our industrialized neighbors in treating health care as a public good through national statutory health insurance."). The run-up to the ACA's enactment was no different.

revenue-neutral public health insurance.[13] Nonetheless—whether through a thoughtful consideration of the costs and benefits of those plans, cold political calculations, or cowardice in the face of demagoguery—those alternatives were rejected.

Instead, the ACA embraced a private insurance model, in which the primary payor for health care for the non-poor and non-elderly would be private insurers. To deal with the problems of cost, the ACA offered subsidies and some cost-control measures, available to those below a certain income level, to be used to purchase private insurance.[14] To deal with the problem of availability, the ACA barred insurance companies from engaging in risk underwriting—raising premiums based on the individual medical risk posed by a potential insured. Underwriting prohibitions were coupled with an insurance mandate, to prevent adverse selection from destroying the insurance market.[15]

The ACA, in other words, reflected a Congressional determination that private insurance is the mechanism through which health care is to be paid. A full examination of the reasons justifying that particular policy choice will no doubt occupy scholars and future historians for years. One of those reasons—an argument frequently advanced in favor of private health care financing—involves the appeal of choice.[16] Indeed, as explained below, choice promotion was directly written into the statute.

Before proceeding, it is necessary to offer some important qualifying remarks. However one wishes to style the ACA's "mandate"—as a tax, requirement, penalty, suggestion, et cetera—the statute contemplates that, for non-elderly and non-poor individuals, insurance will be acquired, whether an individual wishes to purchase it or not.[17] Accordingly, one may immediately wonder whether describing the statute as one that is concerned with "choice" makes any sense at all. This Article does not

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[13] *See* United States National Health Care Act, H.R. 676, 111th Cong. § 205 (2009) (proposing a single payer scheme); *see also* JACOB S. HACKER, U.C. BERKELEY SCH. OF LAW: CTR. FOR HEALTH, ECON. & FAM. SECURITY, THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM 1, 1–2 (2008), *available at* http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf?# (arguing for the creation of public health insurance to compete with private health insurance providers).

[14] *See* CHRIS L. PETERSON & THOMAS GABE, CONG. RESEARCH SERV., RL 41137, HEALTH INSURANCE PREMIUM CREDITS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) (2010) (providing examples of subsidies and benefits that would be available to a family of three, both above and below the federal poverty line).

[15] Maher, *supra* note 2, at 1773 ("Specifically, the ACA limits the permissible scope of underwriting, abolishes the preexisting condition exclusion, and imposes an individual mandate requiring all individuals to have health insurance or pay a penalty.").

[16] *See infra* note 21. I do not suggest that government involvement in health care financing cannot involve choice; in fact, I believe it can. I assert merely that those who favor private insurance solutions often do so in part because of the belief that some desirable level of choice inheres in private arrangements.

[17] 42 U.S.C.A. § 18091 (West 2003 & Supp. 2011) (setting forth the requirement to maintain minimum essential coverage).

consider or evaluate the many careful arguments that have been made regarding the degree to which a mandate is a constitutionally impermissible act or, alternatively, a permissible but politically or substantively unwise interference with liberty.

The simple fact is that the ACA, permissibly or not, wisely or not, intends that all people will acquire insurance. Having made that decision, the statute thereafter explicitly endeavors to help people more ably choose *which* insurance to buy.[18] Thus, in discussing the ACA's concern with choice, it is not the predicate choice to buy or not to buy insurance that is referred to; rather, it is the choice of which insurance to buy. Indeed, regardless of what one thinks of the mandate, the fact is that most Americans desire to have health insurance.[19] In other words, most people would—even if not compelled—prefer to have insurance. That set of people would no doubt prefer a world in which they can credibly choose between policies. The ACA openly acknowledges that reality, and expects those charged with designing and operating the exchanges to navigate its practical challenges. Offered here is a modest examination of one dimension of that challenge. It is not a profound meditation on liberty, government power, or their intersection.

## III. THE ACA AND EXCHANGES

One of the attractive features of relying on private insurance to pay for health care is that it involves choice. A normal feature of private markets is that one can deal with providers who offer terms that are preferred; one can, in other words, shop around for bargains.[20] Insurance is simply a private bargain between an insured and the insurer,[21] and choice among insurance bargains is appealing.

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[18] *Id.* § 18003 (discussing the mandate that information be made available to all consumers regarding affordable coverage); *id.* § 18032 (discussing consumer choice).

[19] *See* Susan Page, *Poll: Americans Want Health Care Bill, but Not the Cost*, USA TODAY, July 14, 2009, *available at* http://www.usatoday.com/news/washington/2009-07-13-poll-health-care_N.htm ("Most Americans say it's important to overhaul health care this year . . . [according to a national poll], but they are less enthusiastic about some of the proposals to pay for it.").

[20] The government provision of goods, rightly or wrongly, is frequently criticized for providing less choice than the private provision of goods. Indeed, even when a plan involving the government is specifically labeled as optional—as was the case with Jacob Hacker's proposal to offer revenue-neutral public health insurance as an option—concern that such government insurance would drive private insurance from the market contributed to the political defeat of the proposal. *See* HACKER, *supra* note 13, at 5 ("[A] range of studies demonstrate that public insurance is able to provide a given level of benefits for less than they would cost through private insurance. Lower administrative costs and the ability to bargain for lower service and drug prices chiefly explain this advantage, as does the obvious lack of a profit margin in public programs.").

[21] *See* William T. Barker, *Insurance Defense Ethics and the Liability Insurance Bargain*, 4 CONN. INS. L.J. 75, 76 (1997) ("[M]arket forces . . . produce[] a fair bargain which serves the legitimate interests of both insurers and insureds.").

The problem with choice is that sometimes making choices is quite difficult. Humans are not rational calculators with unlimited time and attention; they are, instead, imperfect decision-makers with limited time and attention.[22] Some conditions, no doubt, promote behavior that closely resembles strict rationality, while other conditions promote departures from strictly rational behavior. Insurance purchasing is widely believed to be an area in which humans are extremely susceptible to cognitive biases and flawed decision-making.[23]

A system, like the ACA, in which individuals are required to make an insurance choice or pay a penalty, gains considerably in effectiveness and political acceptance if the choices it requires people to make are simple and transparent. "Simple" in this context means something that can be done in an amount of time and with an amount of effort that is not so large that it is particularly disruptive to a person's day-to-day activities. An insurance purchase is not "simple" if it takes as much time as buying a house. "Transparent" means something that can be done in such a way that the chooser has significant confidence that his choice reflects his actual preferences. Blindly picking something the purchaser does not understand is not a transparent purchase.

If the choice process is not simple, or not perceived to be simple, people may avoid making the choice altogether and risk the penalty. They may also make the choice and end up unhappy because their lives were made more complicated than before. The former possibility undermines the overall aim of the statute, while the latter threatens its continued vitality. If the choice process is not transparent, or not perceived to be transparent, people may avoid making the choice altogether, feel unhappy that they have to make a choice which they do not understand, or, perhaps most importantly, be more likely to pick an option that does not actually match their preferences.

The ACA's drafters were aware of the foregoing. Accordingly, the statute provides for the creation of "exchanges" that promote simple and transparent insurance choices for consumers who participate in the exchanges.[24] To wit, the legislation requires that each state "not later than

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[22] *See* Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1477–78 (1998) (discussing some of the reasons and theories for why humans are often irrational decision-makers).

[23] *See, e.g.*, Derek E. Bambauer, *Shopping Badly: Cognitive Biases, Communications, and the Fallacy of the Marketplace of Ideas*, 77 U. COLO. L. REV. 649, 695–96 (2006) (stating that, in the insurance context, consumers have a cognitive bias that leads them to prefer insurance plans that may fail to minimize their total risk exposure).

[24] There are other reasons why—beyond promoting simple and transparent choice—exchanges (whether in the form the ACA contemplates or configured differently) are useful. *See* TIMOTHY STOLTZFUS JOST, COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 8, 10, 16, 20 (2010), *available at* http://www.commonwealthfund.org/

January 1, 2014, establish an American Health Benefit Exchange . . . for the State that . . . facilitates the purchase of qualified health plans."[25] Although the exchanges are administered by the individual states, the federal government, through the Secretary of Health and Human Services, has enormous influence in exchange design and operation.[26]

Part of that role involves gathering information and ensuring participating insurers meet the appropriate requirements. For example, to participate in an exchange, insurers may not use marketing strategies that discourage enrollment by "individuals with significant health needs;"[27] insurers need to demonstrate that they provide sufficient choice of covered providers;[28] they must meet certain performance targets;[29] and they must utilize uniform enrollment forms.[30] In addition, the Secretary and the exchanges are charged with providing specific information to consumers in an accessible form; and the government is to serve as a collator, digester, and creator of information readily usable by insurance consumers. For example, the Secretary is charged with developing a rating system that rates plans offered on an exchange "on the basis of the relative quality and price,"[31] as well as with developing an "enrollee satisfaction" system that "allows individuals to easily compare enrollee satisfaction levels between comparable plans."[32] Exchanges are required to "utilize a standardized format for presenting health benefits plan options in the Exchange."[33]

Whatever the insurer-participant requirements, whatever the substance of the information an exchange must make available, and in whatever form it must be made available (e.g., rating system, survey results, uniform format), the question remains: Through what channel(s) will the information contained in the exchange be communicated to consumers?

The primary channel for distribution of exchange information to consumers is the Internet. Immediately in the wake of the ACA, the

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~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf (discussing the many purposes exchanges serve).

[25] 42 U.S.C.A. § 18031(b)(1)(A) (West 2003 & Supp. 2011). States are also required to establish "SHOP" exchanges, through which small business owners can purchase insurance for their employees. *Id.* § 18031(b)(1)(B). A state can combine the two exchanges into one exchange if there exist "adequate resources to assist [both] individuals and employers." *Id.* § 18031(b)(2). Multi-state and sub-state exchanges are also permissible in certain circumstances. *Id.* § 18031(f).

[26] *See* Gillian E. Metzger, *Federalism Under Obama*, 53 WM. & MARY L. REV. 567, 577–78 (2011) (discussing the different roles that the States and the federal government have in designing and operating the exchanges under the ACA). Should a state not set up an exchange, the federal government will do so. 42 U.S.C. § 18041(c).

[27] 42 U.S.C.A. § 18031(c)(1)(A).

[28] *Id.* § 18031(c)(1)(B).

[29] *Id.* § 18031(c)(1)(D).

[30] *Id.* § 18031(c)(1)(F).

[31] *Id.* § 18031(c)(3).

[32] *Id.* § 18031(c)(4).

[33] *Id.* § 18031(d)(4)(E).

Secretary was charged with creating an "Internet portal" that would present information regarding health insurance options in a "standardized format" that would include information pertaining to certain purchasing characteristics, such as premiums, cost-sharing, and nonclinical cost expenditures of the insurer.[34] Thereafter, the Secretary was charged with updating the portal and creating a template portal for use by the exchanges. The template portal was to be designed to include, for consumer review, a "uniform outline of coverage the plan is required to provide," "a copy of the plan's written policy," and to otherwise "present standardized information (including quality ratings) . . . to assist consumers in making easy health insurance choices."[35]

The ACA imposes upon the exchanges the duty to "maintain an Internet website though which [consumers] may obtain standardized comparative information on such plans,"[36] assign "relative quality and price" ratings to each plan, in accordance with the rating system developed by the Secretary,[37] employ a "standardized format for presenting" the various coverage options in the exchange,[38] provide an electronic calculator to determine coverage cost after applicable credits and reductions,[39] and inform parties as to whether or not the individual mandate is applicable to that individual.[40] However, it is not clear from the statute which of these required actions need be performed on the Internet website that the exchange is charged with creating. Clearly an exchange website must make available "standardized comparative information" and an electronic cost calculator, but the other requirements could conceivably be made available in hard copy alone. Nonetheless, the dominant presumption is that an exchange will seek to make as many of its required services available as possible through the exchange website.[41]

Beyond the Internet, the ACA contemplates two additional channels by which consumers may secure the information benefits of an exchange: a toll-free hotline[42] and the use of something the ACA calls "Navigators."[43]

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[34] *Id.* § 18003(a).

[35] *Id.* § 18031(c)(5)(B).

[36] *Id.* § 18031(d)(4)(C).

[37] *Id.* § 18031(d)(4)(D) (incorporating by reference the rating system to be developed by the Secretary per § 18031(c)(3)).

[38] *Id.* § 18031(d)(4)(E).

[39] *Id.* § 18031(d)(4)(G).

[40] *Id.* § 18031(d)(4)(H).

[41] For example, Oregon's Health Insurance Exchange Business Plan envisions that "[i]ndividuals eligible for commercial plans on the Exchange can chose [sic] a plan and enroll using the Exchange website." OREGON HEALTH INS. EXCH. CORP., OREGON HEALTH INSURANCE EXCHANGE CORPORATION BUSINESS PLAN 10 (2012), *available at* https://orhix.org/uploads/orhix_approved_business_plan.pdf.

[42] 42 U.S.C.A. § 18031(d)(4)(B).

[43] *Id.* § 18031(i).

Navigators are actors charged with educating the public regarding the availability of health insurance, providing "culturally and linguistically appropriate" information regarding available health insurance, and facilitating the obtaining of insurance coverage.[44] Furthermore, an exchange is required to establish a program to fund navigator efforts.[45] To be eligible to receive such funds, a potential navigator must have "existing relationships" with "consumers (including uninsured and underinsured consumers)" or demonstrate that it could "readily establish" such relationships.[46] The ACA envisions a variety of actors that could serve as navigators, including professional associations, community and non-profit groups, unions, chambers of commerce, and licensed insurance agents.[47]

Navigators, in short, are intended to be impartial intermediaries to facilitate informed consumer choice.[48] Their inclusion in the legislation reflects a congressional belief that obtaining private health insurance is not an inherently simple matter, and that citizens should have access to qualified and impartial intermediaries to aid them in their insurance decision-making. In addition, the ACA specifically recognizes that different segments of the populations—the uninsured, the underinsured, and those with linguistic and cultural differences—require specialized informational outreach.[49]

## IV. THE ACA AND THE UNCONNECTED

There is little question that exchanges are intended to, in practice, promote simple and transparent consumer choice. As discussed above, the Secretary and the state exchange administrators are charged with ensuring that (1) those who wish to offer policies on the exchange provide to the exchange administrators a certain type of information in a certain form and do not otherwise engage in efforts to confuse or mislead consumers based on health status; (2) certain categories of information—including synthesized data compiled by the exchange—be made available to consumers in standardized and comparable formats; (3) such information be accessible on an Internet exchange website; and (4) assistance is available both via phone and in-person through navigators.

The general scheme is sensible. It seems fairly obvious that the exchanges have largely been conceived as being Internet-centric. That is,

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[44] *Id.* § 18031(i)(3)(E).

[45] *Id.* §§ 18031(i)(1), 18031(i)(6).

[46] *Id.* § 18031(i)(2).

[47] *Id.* § 18031(i)(2)(B). Health insurance issuers cannot be navigators, nor can a navigator "receive any consideration directly or indirectly from any health insurance issuer in connection with" enrollment in an exchange policy. *Id.* § 18031(i)(4)(A)(ii).

[48] *Id.* § 18031(i)(4)–(5).

[49] *Id.* §§ 18031(i)(2)(A), (3)(i)(3)(E).

the "place" in which the vast majority of the information to be provided—as well as the place in which to make the final purchasing decision—is online. In summoning a mental picture of how the exchanges will look, one envisions a website where one comparison shops; a phone number to call and ask an exchange representative questions that arise, in large part, from the information presented on the Internet; and a collection of navigators armed with some hard-copy materials but likely significantly reliant on online sources to assist those who approach them. That all makes sense. The Internet is invaluable for reducing the time and effort it takes to make decisions. Less vividly conceptualized is how exchanges will deal with the non-trivial percentage of the population that either lacks Internet access entirely or lacks the type of Internet access amenable to making an online health insurance decision.[50] Fortunately, the ACA is designed so as to be flexible with respect to the needs of this group; the statute itself is not an obstacle. Sections IV.A and IV.B briefly consider how default options might be useful tools by which one of the asserted advantages of having exchanges—making choice simple and transparent—can be enjoyed by those who lack meaningful Internet access.

### A. *The Unconnected*

In November 2011, the U.S. Department of Commerce conducted a study regarding Internet access and use in the United States.[51] Several findings are of interest to those designing and administering exchanges.

Twenty percent of American households *never* use the Internet at all, and an additional nine percent only use the Internet outside the home (mostly at work, school, or someone else's home).[52] Among these subsets of the population, the following percentages do not have Internet access at home: thirty-eight percent of rural households;[53] forty percent of Hispanic households;[54] forty-two percent of African-American households;[55] and fifty-four percent of disabled households.[56] Internet access also varies across states. Broadband access—which is a reasonable proxy for home Internet access—ranges from eighty percent in Utah (the highest in the country), to only fifty-two percent in Mississippi (the lowest in the

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[50] The statute does not ignore the unconnected. *See supra* notes 44–45 and accompanying text. However, the details by which their choices are to be, in practice, aided by the exchanges are largely unspecified.

[51] UNITED STATES DEP'T OF COMMERCE, EXPLORING THE DIGITAL NATION—COMPUTER AND INTERNET USE AT HOME (2011), *available at* http://www.esa.doc.gov/sites/default/files/reports/documents/exploringthedigitalnation-computerandinternetuseathome.pdf.

[52] *Id.* at 38–39 fig.22–23.

[53] *Id.* at 17 fig.11.

[54] *Id.* at 15 fig.9.

[55] *Id.*

[56] *Id.* at 16 fig.10.

country).[57]

For the non-trivial percentage of the population that either does not use the Internet at all (the "never-Internets") or only uses it outside the home (the "Internet-restricted"), the prospect of purchasing health insurance through an exchange becomes more of a challenge (and less simple and transparent). Certainly, it is still possible: a never-Internet could visit a navigator or a state office and make a "hard-copy" insurance decision. But such a person—who may very well never have purchased health insurance before and might be intimidated by the prospect—might never purchase insurance at all, and simply hope to avoid or bear the penalty. Alternatively, the person might make an uninformed choice, overwhelmed by a flurry of papers and options that are more difficult to compare than if they were being considered in a more convenient way—such as on a computer at home, over the course of several days.

## B. *Default Solutions*

There are, no doubt, multiple potential means to address the difficulties facing the unconnected regarding insurance choice, by, for example, the deployment of additional government or navigator personnel. Yet one approach (which could be combined with others) seems comparatively inexpensive, and thus suggests an attractive marginal return: choice architecture.[58] As numerous scholars have argued, in circumstances in which choice is time-consuming, challenging, or runs up against cognitive biases, careful choice architecture can have great utility.[59] More specifically, the ACA may benefit from the wise use of default options.[60]

There are varied justifications for, and an extensive literature considering, default options.[61] Prominent among those justifications is the

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[57] *Id.* at 17–19 fig.12.

[58] *See* Charles F. Sabel & William H. Simon, *Minimalism and Experimentalism in the Administrative State*, 100 GEO. L.J. 53, 59 (2011) (noting the minimalist appeal of using "choice architecture" to promote desired outcomes).

[59] *See, e.g.*, RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS 10–11 (2008) (arguing that choice architecture improves decision-making in contexts where people are inexperienced or poorly informed); Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 ALB. L. REV. 241, 290 (2010) (arguing that health care exchanges effectively use choice architecture to better inform consumers about health insurance plans).

[60] Default options are but one aspect of choice architecture. THALER & SUNSTEIN, *supra* note 59, at 8.

[61] *See, e.g.*, *id.* at 33–35 (arguing that people are unlikely to make changes from a default option due to loss aversion and status quo bias); Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for "Asymmetric Paternalism,"* 151 U. PA. L. REV. 1211, 1224–26 (2003) (arguing that selecting the default option that is best for most people "would leave most individuals in an advantageous position"); Russell Korobkin, *Libertarian Welfarism*, 97 CALIF. L. REV. 1651, 1651 (2009) (arguing for default options because "most people routinely fail to make optimal decisions"); Gregory Mitchell, Review Essay, *Libertarian Paternalism Is an Oxymoron*, 99 NW. U. L.

argument that a default creator may be better, on average, at selecting options than the individual chooser.[62] An additional justification is that—if the default chooser is competent and impartial, and thus likely to choose a default within a given person's acceptable range of independent choices—people often legitimately wish to choose not to choose.[63] That is, in many settings people may prefer to simply accept a choice some other reasonable person has made.[64]

### C. *Online and Offline Defaults*

One can easily imagine the implementation of default options on an online health care exchange. Recall that the ACA requires plans be systematically rated for "quality and price."[65] A regulator can choose a default such that a person can "one-click" for default coverage of a specified quality and price, and make the default option a prominent option of the exchange website.[66] Whether the default should be lowest price, highest quality, or a "goldilocks" default (mid-level price and quality) would be up to the regulators running a given exchange. One suspects different exchanges would use different defaults, as the preferences of the subject populations would likely differ. Although default settings should be chosen with care,[67] it seems likely that regulators would be successful in

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REV. 1245, 1262–63 (2005) (discussing how default options could be used to maximize individual liberty and freedom to contract); Pierre Schlag, *Nudge, Choice Architecture, and Libertarian Paternalism*, 108 MICH. L. REV. 913, 915 (2010) (reviewing THALER & SUNSTEIN, *supra* note 59) (suggesting that smart default options can lead to more optimal outcomes); Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not An Oxymoron*, 70 U. CHI. L. REV. 1159, 1180–81 (2003) (suggesting that people choose the default option because they believe it "resulted from some conscious thought about what makes most sense for most people").

[62] *See* Sunstein & Thaler, *supra* note 61, at 1196 ("[T]he more complex the decision, the less attractive it will be to force people to choose for themselves, as opposed to having the option of . . . receiving the default option that has been selected with some care.").

[63] *See id.* at 1199 ("But much of the time, especially in technical areas, people do not particularly enjoy the process of choice, and a large number of options becomes a burden.").

[64] For example, it has long been held that one of the appeals of employer-provided health insurance is that the employer bears the burden of selecting the insurance, and employees enjoy some measure of utility in not having to do so. Most employees have no other choice and so are stuck with the "default," but there is still some reported appeal in having someone else choose.

[65] 42 U.S.C.A. § 18031(d)(4)(D) (West 2003 & Supp. 2011) (incorporating by reference the rating system to be developed by the Secretary pursuant to § 18031(c)(3)).

[66] The exchange would randomly assign an insurer who offered a policy that met the quality and price parameters, to avoid favoritism and cronyism.

[67] The more difficult a move away from a default becomes, the more the default threatens choice. *See, e.g.*, Mitchell, *supra* note 61, at 1246 (describing, but later criticizing the libertarian paternalistic argument that where "individuals can easily opt out of the default option, the paternalism of the plan does not overwhelm the liberty of [individuals]").

Moving away from a health insurance default would not be particularly painful. For example, if default options are used in an online context in the fashion described above, one simply does not click on the highlighted default option. Certainly stronger defaults could be employed, but that is an issue to

increasing the number of people purchasing insurance if they were to create and promote a "one-minute" option for doing so.

Default options for the unconnected are a little more challenging to envision, given the degree to which the Internet has so rapidly spoiled us. Nonetheless, default choices for the unconnected may make even more sense than they do for the connected. Because the temporal and cognitive cost associated with making a non-Internet health insurance choice is higher than the cost associated with making an Internet choice, a wisely-chosen and relatively soft default option would presumably appeal to even more of the unconnected population than the connected population.

There are a variety of ways to instantiate a non-Internet default option that could take nearly as little time as an online default option without sacrificing the ability to opt out of the default. A "one-shot" default option—available via Internet, phone, or mail—seems particularly appealing.

Consider a hypothetical one-shot Internet default. An exchange would inform consumers that, even if they have never used the Internet or do not have the Internet at home, they need to use the Internet only once for a very brief period (at a friend's house, a public library, or on a mobile device) to obtain insurance. A consumer need simply go the exchange website, click on the "mail default" button, enter his address, and he will be tentatively enrolled in a plan of the default quality and price that the regulator has chosen. The policy will be sent to the consumer's address, with explanatory literature, and the consumer will have thirty days to change the policy via mail or in person.[68] Alternatively, an exchange could set up a phone line where consumers could call in to choose the default option, or an exchange could make short mailing forms available at post offices that, if checked and sent to the exchange, would result in the consumer being enrolled in a default plan (with the thirty-day window to change). These one-shot defaults would permit a more thorough and convenient consideration of the health insurance choice by the consumer if the consumer so desired—one could chew on the default choice and its alternatives over thirty days, in one's armchair or at one's kitchen table, with the toll-free hotline handy—but would otherwise present a tidy means for obtaining the required insurance.

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be resolved by state regulators; this Article offers no argument here for or against a default option of a particular strength. It simply suggests that a default option of some kind deserves consideration by exchange designers and administrators. Likewise this Article asserts that defaults can be flexible in the unconnected context.

[68] Coverage would not begin until thirty days had elapsed, to avoid the possibility of a consumer switching to a less generous policy after incurring costs the default policy would have covered.

## V. CONCLUSION

Default options have proven successful in the past regarding another "benefit" that, much like health care, is of interest to virtually everyone: retirement income.[69] As surely as people fall sick, they also age. With age comes retirement and the concomitant loss of employment income. Retirement planning, accordingly, interests everyone who dislikes the idea of working to death.

There are numerous models for how a society should best assure that retired individuals have the necessary resources to provide for themselves. One model favored in the United States has been the use of tax-favored savings accounts, the most popular version of which is the 401(k) arrangement.[70] Such savings accounts depend, of course, on the individual actually contributing money to the account. In addition to preferential tax treatment, such contributions are frequently, but not always, subject to employer "matching," in whole or in part.[71] Accordingly, 401(k) contributions are of significant value to workers; failing to contribute to one's 401(k) account, in many cases, amounts to throwing money away.

Nonetheless, far fewer workers were contributing to their 401(k) plans than economists and policy-makers expected.[72] One suggested reason for such a shortfall was that workers were falling victim to cognitive biases associated with long-term planning.[73] To address the smaller-than-desired rate and amount of contributions, the Pension Protection Act of 2006 encouraged employers to design retirement plans that, as the default, contributed a certain percentage of an employee's pay to tax-protected savings vehicles.[74] Employees could opt out, and thus retained final

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[69] *See* Sunstein & Thaler, *supra* note 61, at 1196–97 ("[W]hen 401(k) plans offer more choice, participants are slower to join, perhaps because they are overwhelmed by the number of choices and procrastinate.").

[70] *See* Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 445, 448–49 (2010) (noting the prevalence of 401(k) arrangements); Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451, 453–58 (2004) (discussing tax-favored savings accounts).

[71] *See* Emily Brandon, *7 Signs of a Good 401(k) Plan*, U.S. NEWS & WORLD REPORT (July 11, 2011), http://money.usnews.com/money/retirement/articles/2011/07/11/7-signs-of-a-good-401k-plan (noting that in 2010 eighty-five percent of 401(k) plans provided an employer contribution).

[72] John Beshears et al., *Public Policy and Saving for Retirement: The "Autosave" Features of the Pension Protection Act of 2006*, *in* BETTER LIVING THROUGH ECONOMICS x, x (John J. Siegfried ed., 2010) (discussing lower level of retirement savings than expected and using default "auto-saving" as a policy response).

[73] Henry J. Aaron, *Retirement, Retirement Research, and Retirement Policy*, *in* BEHAVIORAL DIMENSIONS OF RETIREMENT ECONOMICS 43, 53–56 (Henry J. Aaron ed., 1999); Sunstein & Thaler, *supra* note 61, at 1160.

[74] Pension Protection Act of 2006, Pub. L. No. 109-280, 120 Stat. 780 (codified as amended in scattered sections of 26 and 29 U.S.C.); *see* Brendan S. Maher, *Creating a Paternalistic Market for Legal Rules Affecting the Benefit Promise*, 2009 WIS. L. REV. 657, 659 n.7 ("The Act encourages employers to enroll employees automatically in defined-contribution plans absent an employee choosing to opt out.").

discretion over the allocation of their resources as between current and future expenditure.[75] Most observers believe the statute's encouragement of defaults has been successful in promoting retirement savings.[76]

Although the retirement comparison has obvious limitations, perhaps similar success could be achieved through the use of default options in connection with the ACA exchanges—particularly for the unconnected. The ACA "wants" everyone to have insurance and openly prefers a world in which people obtain insurance consistent with their preferences. Accordingly, default options that result in more people having insurance, and insurance they are happy with, serves the social goals the ACA aims to achieve. And while there might be differences across states as to the appeal of defaults or the appropriate default strength, such questions are easily accommodated through federalism. The ACA contemplates states having flexibility in running their exchanges. Some may embrace defaults, and others may reject them for practical or theoretical reasons beyond the scope of this Article, but there does not appear to be any reason why they should not be thoughtfully considered.

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[75] Pension Protection Act, *supra* note 74.

[76] Jack VanDerhei, *What Do You Call a Glass That is 60–85% Full?*, EMPLOYEE BENEFIT RESEARCH INSTITUTE (July 7, 2011), https://ebriorg.wordpress.com/2011/07/07/what-do-you-call-a-glass-that-is-60–85-full/ (summarizing research regarding the effect of the Pension Protection Act's auto-enrollment provisions).