Implementing Insurance Market Reforms Under The Federal Health Reform Law

By Len M. Nichols

ABSTRACT Lost in the rhetoric about the supposed government takeover of health care is an appreciation of the inherently federalist approach of the Patient Protection and Affordable Care Act. This federalist tradition, particularly with regard to health insurance, has a history that dates back at least to the 1940s. The new legislation broadens federal power and oversight considerably, but it also vests considerable new powers and responsibilities in the states. The precedents and examples it follows will guide federal and state policy makers, stakeholders, and ordinary citizens as they breathe life into the new law. The challenges ahead are formidable, and the greatest ones are likely to be political.

OVerheated rhetoric about a federal takeover and radical socialism notwithstanding, the insurance reform provisions of the Patient Protection and Affordable Care Act of 2010 actually represent a continuation of federalism, American health policy–style. The tradition of federalism goes back at least to the McCarran-Ferguson Act of 1945, when the federal government delegated regulation of health insurance to the states as long as state actions remained consistent with federal purpose.1 Delegation to the states was required at that time because of a recent Supreme Court ruling that health insurance is indeed interstate commerce and subject to federal jurisdiction.2 The more contentious issue, by far, was whether insurance was commerce, not whether it was interstate and thus subject to federal authority under the Constitution.

Clearly, with the passage of the new health reform law, federal purpose has once again been broadened, and on a larger scale than ever before. The law, however, follows precedents and examples that will guide federal and state policy makers, stakeholders, and ordinary Americans in its implementation.

This paper focuses on the law’s provisions affecting health insurance and the related structures for coordination between the states and the federal government. These include provisions that take effect soon, such as the national or federally supported state high-risk pools, as well as others that will go into effect in 2014. Challenges to implementing these provisions are daunting, but the largest hurdles are likely to be political rather than technical. I return to the political dimension of implementation challenges in the concluding section.

Immediate Reforms: New Activities

The main reason that the new health care reform law’s state-based health insurance exchanges, major insurance reforms, mandates, and subsidies were delayed until 2014 was to postpone the costs and ensure that the ten-year federal price tag was below $1 trillion. This figure represents the political ceiling on the cost of health reform. However, given the law’s intent to forge an invigorated federal-state partnership, rather than a federal takeover, the timeline now looks more ambitious than drawn out.

HIGH-RISK POOLS The new law requires that within ninety days of enactment (that is, by 23 June 2010), all Americans and legal immigrants who have been uninsured for at least six months and who have a serious preexisting
condition be eligible to buy an insurance product intended for a high-risk pool. This product is to be priced at a standard rate for a standard population. In terms of actuarial value, it is to cover at least 65 percent of expected expenses, without waiting periods caused by preexisting conditions. The law appropriates $5 billion to expand and support eligible individuals’ access to the new pools.

► STATES WITH EXISTING POOLS: According to the National Association of State Comprehensive Health Insurance Plans, thirty-five states already have high-risk pools in operation. But one state, Florida, has not allowed new enrollment in its pool since 1991. Two states, Alabama and South Dakota, have risk pools that are open to those made eligible by the Health Insurance Portability and Accountability Act (HIPAA) of 1996—in other words, to those who lost group coverage involuntarily and have exhausted all other options.

All other state risk pools have preexisting condition waiting periods of at least three months; most require waits of six to twelve months. No state risk pool charges premiums as low as standard rates for a standard population, although all limit premiums to some multiple (most often 1.5–2 times) of the standard amount. Even these higher premiums are still below the actual costs incurred. Thus, in effect, states do subsidize all enrollees, typically through assessments on individual-market insurers. Fifteen states have explicit income-based subsidies as well.

Some pools have benefit packages that are not as generous as the new law requires. All pools combined cover nearly 200,000 enrollees, whereas as many as four million Americans could qualify under the new law.

► NEED FOR COORDINATION: Furthermore, because some states do not even have a high-risk pool today, and no state is currently in compliance with all of the new national requirements for high-risk pools, coordination between the U. S. Department of Health and Human Services (HHS) and the states will be absolutely necessary for this provision to become operational nationwide by mid-June. It will also be judged as a trial of how the reform in general will be implemented.

► FEDERAL GUIDANCE: HHS Secretary Kathleen Sebelius sent a letter to all governors and independent insurance commissioners on 2 April 2010 clarifying her intent to build on existing state programs and make this a joint effort with the states, and asking states to indicate by 30 April whether they would cooperate with HHS to create risk pools. As of early May, eighteen states had said that they would not create pools, including Hawaii, which has an employer mandate to provide coverage.

The secretary’s letter lays out five options for states, ranging from complete state operation of a new pool to sole federal operation of the program. The letter also sets the tone for implementing the rest of the health reform law’s insurance-related provisions. It implies that reform could indeed turn into a purely federal affair, but only if states refuse to develop practical ways for working with federal authorities to expand access to coverage and care, in a manner that is affordable to families and governments alike.

► STATE RESPONSE: Georgia’s insurance commissioner, a Republican gubernatorial candidate, set the tone of opponents of the reform within a week by refusing to help set up a new risk pool, thus forcing the federal government to go it alone in Georgia. This is an example of political actions with administrative consequences that may beget political consequences down the road.

PREMIUMS AND TRANSPARENCY The other major new area for states is in assessing premiums and judging insurers’ performance. Starting with the 2010 plan year, HHS must create a joint mechanism with the states for annual assessment and public reporting of “unreasonable” premium increases.

Today, twenty-five states have the authority to review and deny or modify premium increases, so this provision will mostly entail teaching and equipping the other states to act. The health reform law authorizes HHS to make grants to allow states to build their capacity in this regard. The definition of “unreasonable” will come from HHS in a regulatory process involving the states, the insurance industry, and consumers. In addition, the Patient Protection and Affordable Care Act authorizes HHS to make grants to states to create consumer assistance or ombudsman programs, to help consumers navigate the insurance landscape in their state. HHS will lead a process in which all states and all insurers adopt uniform definitions of terms used in plan comparison documents, at which point information about insurers’ performance on a variety of cost, quality, and safety metrics will be readily available to all.

► MEDICAL LOSS RATIOS: Perhaps the most far-reaching change in this area is in the required reporting of medical loss ratios—the fraction of premium dollars collected that are actually spent on health services instead of on administrative, underwriting, marketing, and capital costs, including profits or surpluses, or both. Reporting is required in the 2010 plan year, using standard definitions yet to be created. In 2011, all commercial insurers will have to meet minimum loss-ratio requirements in all markets: 80 percent for...
nongroup and small-group markets, 85 percent for large-group markets. Starting in 2010, nonprofit Blue Cross and Blue Shield plans will also have to spend 85 percent on health services to preserve their federal tax exemption. These limits are likely to force changes among insurers that primarily sell nongroup policies today, for 80 percent is more stringent than market norms and current requirements in the fourteen states that regulate medical loss ratios today.

**UNDERWRITING CHANGES:** High medical loss ratios are one key transitional signal that the relative importance and profitability of aggressive medical underwriting will decline over time—a longtime goal of reformers. But the transition—and the endgame—will probably cause some insurers to leave the market altogether. The health care reform law authorizes discretion on the part of the HHS secretary if enforcement of the medical loss ratio provisions would overly destabilize a given marketplace, as opposed to simply affecting specific competitors. State policy makers will and should be involved in assessing the stability and performance potential of their own marketplaces.

**Immediate Reforms: Existing Activities**

Everything else related to insurance that precedes the start-up of state-based health insurance exchanges merely extends existing rules and conventions in specific areas. However, the cumulative effect will be to raise premiums somewhat, and there will be public and costly disputes about how much increase is justified by the law.

The unprecedented part of these regulations is that they apply to self-funded plans—typical for large employers such as Xerox—as well as those sold in the currently regulated small-group and individual markets. Therefore, the Department of Labor, which has overseen self-funded plans since the 1974 Employee Retirement Income Security Act (ERISA), will also need to cooperate with HHS and the states to ensure uniform application of the new health reform law.

Areas of coverage changes include an end to lifetime limits for everyone and to preexisting condition exclusions for children under age nineteen; restrictions on annual limits on benefit payouts; an end to insurers’ ability to rescind coverage except in cases involving intentionally fraudulent claims; an extension of family coverage to children without access to their own group coverage until they reach age twenty-six; and provision of certain specified preventive benefits with no copayment for enrollees.

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**Exchanges**

The bulk of transformational changes to the insurance market occur in 2014 as new markets, or exchanges, are created with new rules to governing competition within them.

**SETTING UP AN EXCHANGE** It is well known that individuals and small employers pay far more per dollar of insurance coverage than large employers pay. In many ways, the purpose of reform is to enable all Americans to have access to the same economies of scale, product choice, and risk pooling that workers in large firms have. The central innovation necessary to accomplish this is the exchange.

Although states can opt out of the process, as Georgia has already done, the new law gives states the clear responsibility of creating their own exchanges and offers them many choices about how to do so. Unless they opt out, states must comply with federal regulations to create an exchange by 23 March 2012. If they fail or are not making adequate progress by 1 January 2013, then HHS can step in and organize a federal version, or contract directly with a local nonprofit entity to run an exchange within a state or among several states.

States will be able to apply for federal start-up grants and technical assistance. States may choose to run an exchange as a quasi-governmental authority, as Massachusetts does, or to turn the operation of the exchange over to a nonprofit entity. States could agree with neighboring states to operate a multistate exchange or decide to create substate exchanges within their own borders.

Finally, states can decide whether to have separate exchanges for individuals and for employers with fewer than 100 workers, or one melded exchange for all, as Massachusetts does. If states refuse to set up an exchange, HHS will face the same set of choices for each state exchange that the federal government creates.
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**Enforcing Insurance Reforms** Similar to HIPAA, the reforms that come into effect with the exchanges will work via state enforcement of new federal law or conforming state laws. The new requirements include guaranteed issue, or selling to all comers regardless of health status; guaranteed renewability, or the offer of annual policy renewals to returning policy holders; no restrictions because of preexisting conditions; an end to all high-risk pools; and modified community rating, which means that all payers in a community will pay the same rates, with only a few allowable variation factors—family status, geography, age (a 3:1 pricing ratio is allowed), and tobacco use (a 1.5:1 pricing ratio is allowed).

**Role of State Insurance Departments:** Because they have the requisite expertise, experience, and knowledge of local marketplaces, state insurance departments are likely to play the lead role in insurance reform regulation, at least in states that have the capacity to perform this task and already provide considerable oversight. The exchanges will be responsible for ensuring that insurers are “qualified health plans” as defined by HHS in regulation, which will include insurers’ compliance with new insurance reforms. Thus, insurance departments, exchanges, and HHS will need to cooperate and coordinate information and interpretations with each other, to clarify jurisdictions for insurers and consumers.

**Shared Responsibility:** In a real sense, the new temporary high-risk pools, the new annual process of reviewing premium increases, and the new medical loss ratio requirements of 2010–11 all create opportunities for the requisite expertise and trust to be developed within and among HHS, the states, and the insurance industry. If implementation of the interim steps is done well, then by 2014, state governments, insurers, and consumers will have grown accustomed to far greater transparency about insurers’ performance and the policy choices pursuant to that transparency. If this interim period does not go well, the prospects for successful, long-term insurance market reform and improved performance will dim considerably.

**Insurance Industry:** Of all of the actors, the insurance industry has the most to gain from smooth implementation, because failure to make private insurance markets work demonstrably better risks more regulation and government control in the long run. This self-interest may be an unexpected force that brings potential state and federal regulators together to devise a workable system.

This coincidence of interests has happened before with McCarran-Ferguson and with the Health Maintenance Organization (HMO) Act of 1973, which required employers to offer local and willing HMOs to their workers as competitive insurance products, even though many states had previously prevented this. The insurance industry also responded with self-interest to the Omnibus Budget Reconciliation Act of 1990, which standardized Medicare supplemental insurance products but left regulation of that market up to states. HIPAA imposed new regulations in the small-group and nongroup markets but again left regulation up to the states, unless they refused to get involved. In the case of HIPAA’s implementation, three states did refuse initially, but only one, Missouri, remains primarily dependent on federal regulation today.

That narrow episode of federal regulation of one state’s insurance had the effect of developing some insurance regulation expertise inside the federal government, which is fortuitous, given current implementation challenges. Similarly, many states have acquired much insurance market reform expertise since the early 1990s, as a result of state reforms and HIPAA.

**Technical Assistance:** Technical assistance from HHS to some states will be required under the new reform bill, but this will largely consist of channeling and directing expertise already acquired and present in other states. The HHS secretary, herself the former Kansas state insurance commissioner, brings that expertise to every meeting she attends, but she also personifies the point that most of this expertise resides in the states.

For example, when Missouri’s legislature decided not to pass conforming legislation to implement HIPAA, Missouri’s insurance department taught HHS staffers how to interpret insurers’ data and behavior so that HHS could enforce HIPAA within Missouri’s borders. Insurance departments everywhere have an ongoing interest in making insurance markets work, regardless of the politics of the moment. And that expertise is now part of HHS.7 This kind of pragmatic collaboration is what makes federalism,
and health policy in America, work.

**MANAGING COMPETITION** For exchanges to function like the large-group market does, they must expand the range of choices to individuals and small groups. They also must reduce the market power of some insurers while improving transparency and value per dollar spent for the ultimate consumer: individuals and families. In addition to fairer competition within the reformed framework described above, the new health reform law introduces three additional options that might spur innovation and more competition than would otherwise be the case.

▸ **MULTISTATE INSURERS:** First, the bill requires the federal Office of Personnel Management, which operates the Federal Employees’ Health Benefits (FEHB) program, to contract with two multistate insurers that would enter all or most exchanges. The idea is to encourage national plans to challenge locally dominant insurers.

▸ **BASIC HEALTH PLAN:** Second, the bill has an option for states to create a basic health plan, patterned after Washington State’s successful Basic Health Plan, to essentially function as a lower-cost, competitive option for lower-income exchange enrollees.8

▸ **CO-OP PLAN:** Third, the bill also enables local nonprofits to form a co-op plan that could function much like the original Blue Cross Blue Shield plans were expected to, reflecting local community values of inclusiveness and efficiency.9

▸ **BALANCED BEHAVIOR:** In a world in which guaranteed issue, modified community rating, and low-income subsidies are the law, that balanced behavior may be much easier to maintain than it proved for most Blue Cross Blue Shield plans in the increasingly competitive and voluntary insurance markets of the past thirty years. The exchanges’ task is to enable these new players to add competitive value for consumers.

This will be easier because each exchange is also required to perform risk-adjustment calculations so that no insurer should be penalized for attracting less-healthy enrollees than other insurers attract. Adjusting risk across grandfathered plans outside the exchange will pose some operational challenges, since benefits will not be directly comparable with those inside the exchange. However, this is technically feasible given an agreed-upon actuarial model, and it will minimize the risk of adverse selection against the exchange. Ensuring that stability in the insurance marketplace is an extremely important prerequisite of the long-term success of health reform.

**CLEARINGHOUSE AND TRACKING FUNCTIONS** Each exchange must coordinate enrollment with families whose eligibility for Medicaid or the Children’s Health Insurance Program (CHIP) will vary. This will be simplified by the reform law’s imposition of a common income definition on all programs, including adjusted gross income, the one used for income tax purposes, along with a requirement for HHS to develop a common enrollment form. HHS can also accept individual states’ versions of a common enrollment form if the form meets agreed-upon criteria by 2014.

This will also facilitate the other major clearinghouse function of the exchanges: tracking and reporting the flows of money, and commingling local private employer and individual premiums with federal tax credits that must be given to private insurers selling to specific people within the exchange. HHS and the exchanges will work together to verify that each exchange enrollee is a U.S. citizen and eligible for the tax credit.

This joint effort will be necessary to reassure Americans that federal and state funds are being allocated according to the letter and intent of the law. This is particularly important for restrictions on abortion and coverage of undocumented or illegal immigrants.

**The Politics Of Nullification**

So what am I really worried about? The twenty-one states that have joined lawsuits challenging the constitutionality of reform because it includes an individual purchase requirement are not likely to be prevail in court.10,11 However, that is not the point. The point, I fear, is to prolong the political and rhetorical war against this “unprecedented federal government overreach,” as some conservative pundits and politicians describe the national health reform law, to prolong their campaign to demonize reform and the politicians who support it.
This poisoned environment makes it difficult, if not impossible, for many state officials to cooperate and engage with HHS in the ways this paper outlines. Cooperation is absolutely necessary for the implementation of the law to be consistent with its intent as a joint federal-state enterprise, and not as a federal takeover. This is a palpable risk. Many states, in responding to the worst fiscal crisis for them since the Great Depression, have already laid off staff instead of hiring new key personnel who are needed to plan for health reform implementation—including the largest Medicaid expansion since the program’s inception. Foundations and federal technical assistance can help, but the pragmatic cooperation of at least some state officials is essential.

The irony is that by calling for outright repeal or rejection of key provisions, reform opponents would make the application of the law far less responsive to local or state concerns than it could be. Perhaps that is the intent, to make it easier to make the political case for eventual repeal. Intent is hard to discern. But I do know that it is indeed sad that we have come to this cul-de-sac on what could have been a bipartisan road to market-based reforms. As is often the case, Mark Pauly has said it best: The individual mandate with tax credits for low-income people “could have been the basis for a bipartisan compromise, but it wasn’t. Because the Democrats were in favor, the Republicans more or less had to be against it.”

We can do better than this, and we must, to make insurance reforms work as well as we need them to for all Americans, regardless of how they vote most often.

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NOTES

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