



Walking the Tightrope of Health Insurance Reform between 2010 and 2014

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Both political parties wax poetic about the need for popular insurance reforms, but legislating what is necessary and implementing it properly has always been the trick. In the aftermath of the

enactment of the Affordable Care Act, President Barack Obama and his administration are walking a policy tightrope: they must implement meaningful reforms in the transition to a stable insurance market without unduly disrupting existing insurance arrangements by means of excessive increases in premiums or declines in coverage.

Philosophically, the political extremes could not differ more in their views of the correct approach. Americans on the far left believe in aggressive regulation of private insurance to guarantee access and limit profit. In their view, if regulation drove insurers with high profits or skimpy benefits out of the marketplace,

consumers would be better served — even if it meant fewer plan choices and some disruption early in the process. Those on the far right believe that regulation of private insurance should be limited and consumers should face financial incentives and penalties to encourage healthy lifestyle choices and cost-effective health care decisions. In their view, if less regulation promotes innovation and choice at the cost of some discrimination, so be it.

Neither of these camps will be satisfied with the implementation of the insurance reforms. Many reform opponents seem to be eagerly awaiting implementation decisions justifying their claim that the president broke

his promise to permit Americans to keep their current coverage. Never mind that before reform passed, many small-business employers had changed or dropped their employee coverage, causing considerable disruption. Conversely, many reform supporters will accuse the administration of being too timid because of an overly close relationship with insurers. Never mind that excessively disruptive early implementation would threaten the ultimate goal of coverage for all Americans.

Implementing insurance reform is challenging from a policy and a political perspective, particularly given the fragmentation of U.S. insurance markets. Which rules apply to a particular plan will depend on whether it's an individual or a group plan, whether a group plan is large or small and insured or self-funded, and whether it existed when the law was enacted.

A clear policy goal when phasing in insurance reforms will be to avoid excessive market disruption until 2014, when the act's three core stabilizing provisions become effective: the availability of health insurance exchanges that offer consumers and small businesses plan choices selected on the basis of price and quality, tax credits and other direct financial assistance to ensure affordability, and the individual requirement to purchase insurance to reduce risk selection and cost shifting from the uninsured. The administration has tremendous discretion in implementing the early-year provisions for insurance reform, and the necessary balancing act has begun in two key areas: the issuance of interim final regulations to clarify which plans must meet new requirements and which, as "grandfathered" plans, will be subject to fewer rules and remain largely unchanged; and the defining of new rules governing medical loss ratios (MLRs, or the percentage of premium dollars that are spent on medical benefits, as opposed to administrative costs and profit) and the enforcement mechanisms for those rules.

To avoid disruption as insurance reforms are phased in, the law exempts plans that existed before March 23, 2010, from many of the relevant reforms. Qualifying plans will not have to offer newly designated "essential benefits" and may continue to use underwriting tools that will be unavailable to new plans, such as excluding preexisting conditions from coverage. Some plans, particularly those in the small and nongroup markets, may wish to stay "grandfathered" for as long as possible. This raises the question of how much these plans

should be allowed to change without losing this designation and being required to comply with the new rules.

The interim final regulations establish guidelines for new and grandfathered plans and define changes that would cause plans to lose grandfathered status. Generally, the rules permit changes that do not result in benefit reductions or substantial cost shifting to beneficiaries. For example, certain increases in beneficiaries' costs would be permitted, such as premium increases limited to medical inflation plus 15%, and grandfathered plans would not lose their status simply by enrolling new employees or their newly eligible dependents. If, however, a plan makes coverage changes, such as new exclusions of cancer treatment, or increases beneficiaries' coinsurance fee from 20% to 25% of the cost of the services, it would lose its grandfathered status and be required to meet the new rules at the start of the next plan year.

These regulations may not have been the simplest way to achieve the balance between reforming the system and minimizing disruption, but targeted policy implementation frequently produces more complex governing rules. Even with the policy as implemented, the administration estimates that 39 to 66% of existing plans will lose their grandfathered status by 2014, the year the core reforms of exchanges, tax credits, and the individual mandate go into effect. In any case, most experts project that consumers in the nongroup market and employers in the small-group market will eventually opt to purchase insurance through the exchanges, with their accompanying protections, because the larger

pools will result in insurance products that are more stable and affordable.

The majority of Americans will not be noticeably affected by these reforms. Among workers with private insurance coverage, 57% are enrolled in generally large self-funded insurance plans,¹ and the percentage may be even higher when these workers' dependents are included. Because these plans were functioning well, unlike plans in the small and nongroup markets, Congress exempted them from many of the new requirements, including those related to the coverage of essential benefits. As a result, these plans, which will continue to be governed by relevant rules under the Employee Retirement Income Security Act, may be less concerned about retaining grandfathered status. This is because retaining the flexibility to further limit benefits and increase cost-sharing is an acceptable trade-off for having to come into compliance with, for example, the new preventive benefits that most large businesses are already providing.

Meanwhile, on the MLR front, insurers will be required, beginning this year, to report the MLRs of their plans. Large group plans that do not spend at least 85% of premiums on medical services, and small group and individual plans that do not spend at least 80%, will be required to provide rebates to enrollees beginning on January 1, 2011.

Because plans either have not had to report MLRs or have had the benefit of vague and frequently useless reporting requirements, the definition of "medical costs" has become a topic of heated debate. Although it is clear that costs associated with marketing, enrollment, and claims

processing are nonmedical and that payments to providers for services are medical, plans, providers, and consumers disagree on the status of expenditures for antifraud and antiabuse activities and quality-improvement activities. One question receiving particular scrutiny is whether care-management tasks performed by insurer-employed nurses are designed to reduce costs and utilization (in which case they would be nonmedical) or to improve patient care and ensure delivery of services (which would make them medical).

Further complicating matters are reports from the American Academy of Actuaries that administrative expenses such as those for agents, brokers, and underwriting could make it difficult for some small-group and non-group insurers to meet the MLR standards.² However, marketing through exchanges and the end of medical underwriting would probably result in lower administrative expenses and higher MLRs.² The Affordable Care Act gives the secretary of health and

human services the power to adjust MLR requirements to avoid market disruption, so the administration could phase in these requirements to stabilize markets. We expect the secretary, on the basis of recommendations from the National Association of Insurance Commissioners, to use this flexibility and to err on the side of ensuring that disruption and the accompanying political fallout are minimal until exchanges are in place in January 2014.

Myriad other reforms — such as high-risk pools, a new reinsurance program, coverage of children through their parents' policies until they reach 26 years of age, and the elimination of pre-existing-condition exclusions for children — also challenge the effort to avoid short-term disruption as the availability of health insurance coverage is expanded. Although the administration has generally embraced an implementation and communications strategy that prioritizes the minimization of disruption, consumers and businesses will ultimately care more about whether mean-

ingful, affordable coverage is offered than whether they keep the exact same policy they now have. The administration seems to understand that, until the states and the system have all the policy levers at their disposal in 2014 to achieve this objective, an implementation approach minimizing disruption is the order of the day.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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1. Employer health benefits: 2009 annual survey. Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, 2009.

2. Critical issues in health reform: minimum loss ratios. Washington, DC: American Academy of Actuaries, February 2010. (Accessed July 19, 2010, at http://www.actuary.org/pdf/health/loss_feb10.pdf.)

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Truth and Consequences — Insurance-Premium Rate Regulation and the ACA

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Over the past decade, the largest health insurance companies have seen a disproportionate increase in profits of 250%, or 10 times the rate of inflation. During the past year alone, there has been a double-digit increase in health insurance premiums.¹

In response to such increases, the new health care reform law, the Patient Protection and Affordable Care Act (“Affordable Care

Act,” or ACA), requires the secretary of health and human services, along with individual states, to establish a process for the annual review of unreasonable increases in health insurance premiums. As a result of the new statutory language, the Department of Health and Human Services (DHHS) and all relevant states will now review proposed premium increases, and health in-

surers will be required to justify any increases that these authorities consider unreasonable.

In recognition of the new burden this requirement places on states, the ACA will appropriate \$250 million in grant support over the next 5 years to provide states with additional resources to review proposed premium increases. In return for grants of \$1 million to \$5 million per year,