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How Will Health Insurers Respond To New Rules Under Health Reform?

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ABSTRACT The Patient Protection and Affordable Care Act creates a host of new rules for all entities in health care, but especially for health insurers. The statute itself, and the regulations to which it gives rise, will change the nature of the insurance business, particularly in the small-group and individual markets. Regulatory proceedings and some litigation are likely to determine the final shape of the new rules. At the same time, collaborative efforts among insurers, providers, and regulators could lead to innovations that increase access to coverage while also reducing costs.

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History shows that in liberal democracies like the United States, new regulatory regimes present both obstacles and commercial opportunities for the relevant regulated industry.¹ Businesses that adjust rapidly and well to the new rules stand to gain a significant competitive advantage. This is exactly where health insurers are today, following the passage of the Patient Protection and Affordable Care Act of 2010. The act creates an impressive array of obstacles for health insurers to negotiate, and also opportunities that they can seize.

The perceived need of the government to rein in insurers was a major part of the political debate about health reform. More important, because the federal health reform law is essentially an effort to provide access for the uninsured partly through insurance regulation, insurers will be central actors in the reform's implementation. Unfortunately, the act arguably does not do enough to change the fundamental cost drivers in health care, and a growing inability to afford the current system will influence all the efforts to implement the reforms.²

Massachusetts Goes Federal

SIMILARITIES Despite some notable protestations to the contrary,³ the basic form of the

recently enacted health reform law has many similarities to the 2006 health reform in Massachusetts. First, there is a broad expansion of Medicaid. Given that much of Medicaid is “managed,” often by for-profit insurers, this is a commercial opportunity that many insurers will not miss. However, fiscal pressures and constraints on government payments to insurers will require strong medical management techniques to make the ventures commercially viable.

Second, the federal reform law requires wide-ranging changes to the individual and small-group markets. Insurers have typically viewed their customers as divided up into two segments: the self-insured market, consisting mainly of large, employer-based plans; and the small-group and individual markets. In the self-insured market, the financial risk for an employee's illness resides with the employer, and the insurance company's role is limited to that of third-party administrator. What's more, the major regulatory force in this part of the market is federal law, in the form of the Employee Retirement Income Security Act (ERISA).⁴ In the small-group and individual markets, on the other hand, health insurers exercise a more traditional insurance function, bearing financial risk for the illnesses of people they insure, under the oversight of state insurance regulation.

RISK SELECTION The challenge for insurers in

the small-group and individual markets has long been to avoid adverse selection into risk pools—that is, to avoid insuring many high-risk, high-cost people. They have used a range of techniques that universal-access proponents have opposed, including rescission or cancellation of policies after they have been issued, lifetime limits on payments, and medical underwriting.

STATE APPROACHES TO REGULATION States' regulation of these strategies has been uneven. Some states have required insurers to offer coverage and have permitted them to conduct only a minimal level of "experience rating"—the practice of pricing coverage according to the health histories of the insured—in their underwriting activities. In the absence of individual or employer mandates to obtain or provide coverage, such as those in the national health reform law, these states would almost inevitably end up with uneven risk pools as the healthy "gamed" the system in their insurance decisions. For example, a healthy person with knee pain might remain uninsured while having noninvasive examination and treatment, but when the doctor recommends expensive meniscus repair, he would then seek insurance. This creates a burst of spending for the new enrollee that the insurance actuary cannot predict.

Other states have taken a different approach. Some, such as California and Pennsylvania, have allowed insurers to apply harder-edged medical underwriting in a more systematic effort to price coverage according to consumers' health histories and profiles. This approach secured more moderate and predictable prices for average premiums but also drove up the costs of health insurance for the sick.

WHAT THE REFORMS CHANGED Massachusetts created a new order, as the federal health reform law will do nationwide in 2014. Both employer and individual mandates will be in place, and most medical underwriting will be eliminated. Under strong, tightly enforced mandates, insurers should be able to construct reasonable risk pools. However, many insurers fear that the mandates will fall short—in particular, that the penalties aren't adequate to force compliance with the individual mandate.

Insurers will also have to learn to operate within the health insurance exchanges, which—like the Health Connector in Massachusetts—are intended to act as customer-friendly "health insurance stores" and to demystify the purchase of coverage. Exchanges will package—some might say dictate—which products will be available and negotiate rates that can be charged.

Although this overview may suggest a straightforward road ahead for insurers, there is much in the law that is uncertain. Lawyers and legal schol-

ars will be busy interpreting the provisions and the regulations to follow. The national scale of the reforms will introduce complicated questions of federalism and will also add many political variables. In Massachusetts, virtually everyone from business through government wanted the reforms to work—but the same goodwill cannot be counted on in many other states.

Constitutional Challenges

IS THE MANDATE CONSTITUTIONAL? Although many surprises no doubt lie ahead, a few key questions are already evident. The most prominent question is whether the federal health care reform law itself is constitutional. Florida's attorney general, Bill McCollum, now joined by nineteen other state attorneys general, argues that it is not and has sued to overturn the law.⁵ The argument is based on several constitutional grounds but centers on the claim that the individual mandate to purchase insurance is not part of the regulation of commerce under the commerce clause of the Constitution and should therefore be a matter left to the states. The lawsuit also characterizes the penalties imposed on individuals who elect not to purchase insurance as a direct tax in violation of Article I, sections 2 and 9, of the Constitution.

POSSIBLE OUTCOMES Legal pundits are prognosticating about how the federal courts will decide these claims.⁶ The weight of legal opinion to date suggests that it is doubtful that the litigation will be successful in blocking the law, and also doubtful that states will be able to legislate themselves out from under requirements to set up exchanges.⁷ But as the legal scholar Randy Barnett has said, "the smart money is correct, right up until the time the Supreme Court does something different."⁸ Nonetheless, prudent insurers will be planning for the opening of the exchanges in 2014, rather than waiting for the Supreme Court to rule.

Defining Regulatory Roles

The thrust of federal regulation into individual and small-group markets under the Patient Protection and Affordable Care Act will not deal the state insurance commissioners out of oversight functions. Indeed, if the Massachusetts model is emulated by other states, the exchanges will operate independent of, but in tandem with, state insurance commissioners.

In Massachusetts this has worked well. Interviews with Nonnie Burns, state insurance commissioner from 2007 to 2009, and Jon Kingsdale, until recently the head of the Health Connector (the state "marketplace" for insurance purchase),

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demonstrate that each person sees his or her role as quite distinct. The insurance commissioner enforces the insurance law and has a critical oversight role defined by the economic frictions inherent in market reforms. The Connector's executive runs the insurance store.

To keep insurance affordable for those under a mandate to purchase it, health insurers will face severe pressure from exchanges to moderate any premium rate increases. This will be especially difficult for insurers if the mandates prove to be too weak to prohibit gaming, and adverse selection results, leading to deteriorating risk pools. Insurers would then have no choice but to cross-subsidize their individual and small-group products with their large-group business lines. But profit margins there may also narrow if hospitals and doctors seek to establish their own cross-subsidies as growth in Medicare and Medicaid payments slows. Such payment cuts are outlined by the health reform law's mandated savings in Medicare, and they will come on top of the financial reality of the 2010s and 2020s that governments must cut back to absorb the baby boom into already underfunded health care and retirement programs.

Thus, faced with limited ability to cross-subsidize, insurers will press the exchanges for fair payment. This will place state insurance commissioners, who must worry about both consumers and the solvency of insurance carriers, in an unenviable position. We can expect the interplay among exchanges, insurers, and insurance commissioners to be a key pressure point as politicians, regulators, and markets confront the reality of a health care system that costs more than anyone wants to pay. We can already see this occurring in Massachusetts today.⁹

Strategic Issues

The Patient Protection and Affordable Care Act does not appear to have a great deal of impact on the large-group, ERISA-governed segment of the

insurance market, but some aspects of the act do appear to apply to ERISA plans. What's more, there are dozens of places where the two federal statutes will coincide. As Timothy S. Jost of the Washington and Lee University School of Law has pointed out, there are some critical areas of confusion that will require clarifying regulation.¹⁰ The Department of Labor, which oversees ERISA, is likely to make some effort to harmonize its regulations and oversight with the national health reform law. The interaction of federal tax law, benefit law (ERISA), and health care law in some critical areas will take time to sort out.¹¹

INSURERS' PARTICIPATION One key issue for rules related to ERISA plans is whether, and in what circumstances, it will be permissible for a national insurance company to elect not to participate in the small-group and individual markets, and simply concentrate its business on administering the benefits of self-insured clients. There appears to be nothing in the health reform law itself to stop such a move, although companies that opted out would still be subject to the law's reporting requirements¹² and would have to pay what is essentially an insurer tax into the reinsurance risk pool for three years.

MARKET SEGMENTATION The more general point is that the law could stimulate a variety of forms of strategic market segmentation among insurers. This is certainly true with Medicare Advantage, which may be a much more challenging place to earn a margin in the future, given the mix of payment cuts and quality bonuses the law introduces.

Historically, insurers have jumped into Medicare managed care when the payments were generous and left that market when payments were less appealing. This may also be the case with respect to insurers' participation in state exchanges. Indeed, it appears that an insurer could even sell in the small-group and individual markets while opting out of the exchanges—the only price being that it would still have to pay into the exchange-administered risk-adjustment pool.

SELLING INSURANCE ACROSS STATE LINES Beyond these larger strategic questions, insurers must grapple with a host of smaller ones presented by specific provisions in the Patient Protection and Affordable Care Act. The law allows states to agree to enter into health insurance compacts that would permit products regulated by one state to be sold in another. Health insurers will want more details about how these potential interstate exchanges will work before deciding if they should push their state to join one.¹³

TRANSPARENCY AND COMPETITION Another question is what sort of new information will have to be disclosed as part of the transparency requirements of the exchange.¹³ Insurers will

also want to see whether any new nonprofit Consumer Operated and Oriented Plans that can be created under the new law will ever materialize and offer real competition.¹⁴ Given the law's requirement that there be at least two new nationwide health plans offered through exchanges—one of them nonprofit—insurers will also have to decide whether they want to offer such a product, which would be modeled loosely on the Federal Employees Health Benefit (FEHB) program.¹⁵

PREVENTION AND MEDICAL LOSS RATIOS Other questions include how much more the newly required preventive health services will cost, since the law proscribes any cost sharing by consumers for the preventive services rated most effective by the U.S. Preventive Services Task Force.¹⁶ And perhaps most important, how will the new requirements be structured to reduce the medical loss ratio—the portion of the insurance dollar that is actually used to pay for health care services—to 85 percent in large-group plans and 80 percent in small-group plans? A pivotal question for insurers in this area is what services will count as health services as opposed to administrative expenses. For example, does disease management count as a health service?¹⁷

PREPARING FOR CHANGES Insurers will need to stake out positions in relation to these issues in preparation for 2014, when most of the changes will go into effect and the regulatory shoe drops. At that point, the mandates should theoretically augment the risk pools so that preexisting condition exclusions can be eliminated¹⁸ and coverage guaranteed.¹⁹ Interestingly, though, the new law explicitly requires the states to risk-adjust plans based on their ultimate enrollment.²⁰ This will be a brave new world in the individual and small-group insurance markets. Plans that succeed will be those that have prepared accordingly.

A Platform For Better Insurance Products?

The Patient Protection and Affordable Care Act has some provisions that are likely to create new opportunities for plans trying to reduce health care costs while maintaining quality.

NEW CARE MODELS First, the medical home concept gets a boost from new Medicaid provisions that pay qualified medical homes higher amounts. The program will be studied as if it were a demonstration project.²¹ Similarly, insurers will be able to learn from both pediatric and Medicare-based demonstration projects on accountable care organizations.²² Both approaches provide an opportunity to see if money can be saved by making providers at least partly responsible for the cost of care and weaning them from fee-for-service payments. The same is true of ex-

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periments with bundling of payments authorized by the new law.²³

PAYMENT REFORMS On the payment front, there is also the potential for some new concepts to be developed at the federal level that can then be emulated by private health insurance plans. The new Independent Payment Advisory Board is charged with developing comprehensive payment reform. The board's proposals are to be implemented automatically when Medicare costs become unsustainable, unless Congress passes an equivalent set of cost-cutting reforms.²⁴

If Medicare develops and leads relatively radical payment reform, private insurers will in some respects be freed to mimic it without facing the harrowing opposition from providers that they would experience were they to act alone. Insurers should also be able to readily accommodate any insights into comparative effectiveness that come out of the new Patient-Centered Outcomes Research Institute.²⁵ Although the law carefully restricts the use of the new evidence by the secretary of health and human services (HHS) in making coverage decisions and setting reimbursement rates, the findings themselves should help create new, cost-effective standards of care.

Conclusion

Insurers' efforts to adapt to the new rules of the health reform law must start with a clear look at the economic situation—specifically, the floundering financial state of the health care system. Although impressive in its scope, the law does not automatically alter the key forces that are bankrupting the U.S. health care system, principal among which is fee-for-service provider reimbursement.

REGULATING DURING THE COST CRUNCH Some would argue that the choice of tackling access to health coverage first was strategic, because it

adds to the imperative to contain costs. But no matter what the strategy, the need for cost reform is now even greater.²⁶ For insurers, this means finding new ways to eliminate unnecessary care; paying less for services from hospitals, doctors, and nurses; or both. All such efforts will occur in the context of the deepening inability of the federal and state governments to afford an increasing cost burden of health care and pensions in the coming decades.

In light of the cost crunch, the letter of the Patient Protection and Affordable Care Act's provisions may be less important than the actions states take to make the new system financially sustainable over time. Follow-on regulations focused on cost control may crystallize quickly as the economic situation deteriorates. Consider the automobile industry, which has fought emission regulations for thirty years. In the current state of that industry, stringent carbon emission regulations went into place in early 2010 with barely a whimper of protest.²⁷

As the national health reform law moves toward implementation, health insurers will have to walk a difficult line, caught between regulators' expectations and their own relative inability to control medical spending, which is largely in the hands of providers. Success for the health care system will probably depend on collaboration among regulators, insurers, and providers. It will also depend on a regulatory regime that is flexible enough—particularly on antitrust issues—to ensure that these three groups co-

operate to pursue the goal of providing access to high-quality health care at a cost that the public can accept.

A NEW REGULATORY MODEL Fifteen years ago, toward the end of the last big push for national health reform, one of us and Donald Berwick—who was recently nominated to lead the Centers for Medicare and Medicaid Services—sketched out the broad strokes of such a model of regulation for the health care arena.²⁸ Drawing on John Braithwaite's concept of responsive regulation,²⁹ we encouraged regulators and the regulated to find common aims, to create safe havens for major innovation, and to develop vehicles for sharing those innovations widely. We reviewed evidence demonstrating that regulatory duplication is almost always inefficient. We urged that a major regulatory focus be on integrated systems of care, emphasizing the importance of managing care over fee-for-service reimbursement.

All of these points are relevant today, as HHS starts to put the regulatory flesh on the bones of the Patient Protection and Affordable Care Act, and as states take up their responsibilities. The next step has to be ideas for cost control that can keep the system afloat. These will probably require collaboration, as well as a turn away from the finger-pointing that characterized debate on the health reform legislation. Wherever possible, regulators, insurers, and providers should approach reform with their eyes on shared goals, fortified by the realization that the cost structure of the current system is unsustainable. ■

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