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# AMERICAN HEALTH BENEFIT EXCHANGES: STATE REGULATORS MUST ENCOURAGE PRIVATE MARKET PARTICIPATION

ELIZABETH BAYLY\*

On March 23, 2010, President Obama signed into law the most sweeping federal health care reform since the enactment of Medicare in 1965.<sup>1</sup> As its name implies, the Patient Protection and Affordable Care Act<sup>2</sup> (“PPACA”) seeks to ensure enhanced access and affordable health insurance for all United States citizens.<sup>3</sup> In order to reach this goal, the PPACA’s approach is to preserve the country’s primarily private insurance based health coverage system, and to increase participation through the implementation of various reforms.<sup>4</sup> Two key provisions of the PPACA, the requirement that states develop and maintain health benefit exchanges (the “exchange”)<sup>5</sup> and the requirement that health insurers use at least

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1. Press Release, Sebelius Remarks: Health Reform and You: How the New Law Will Increase Your Health Security, Department of Health & Human Services (April 6, 2010), <http://www.hhs.gov/news/press/2010pres/04/20100406b.html>; see also *Medicare: A Timeline of Key Developments*, HENRY J. KAISER FAMILY FOUND., <http://www.kff.org/medicare/medicaretimeline.cfm> (last visited Feb. 27, 2012) (explaining that between 1965 and 2006, the program covered over forty-two million people).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.). The PPACA, as used in this article, also includes amendments made to it by the Health Care and Education Reform Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010).

3. Amy Goldstein, *Priority One: Expanding Coverage*, in LANDMARK: THE INSIDE STORY OF AMERICA’S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR US ALL 73 (2010).

4. See, e.g., Patient Protection and Affordable Care Act § 1312, 42 U.S.C.S. § 18032 (LexisNexis Supp. 2011) (requiring “consumer choice” and defining a qualified individual, establishing risk pools, and emphasizing the “voluntary nature of the exchanges”).

5. *Id.* § 18031(b)(1). The Patient Protection and Affordable Care Act requires each state, by 2014, to “establish an American Health Benefit Exchange . . . that facilitates the purchase of qualified health plans.” *Id.* § 18031(b)(1)(A).

eighty percent of the premiums collected to pay for claims,<sup>6</sup> are designed to provide consumers with insurer transparency, more choices and to ensure fair insurance pricing.<sup>7</sup> The PPACA, through the Secretary of Health and Human Services (“HHS”) and the National Association of Insurance Commissioners (“NAIC”), lays the groundwork for the exchanges<sup>8</sup> but leaves the details to states and states’ current insurance regulation systems.<sup>9</sup> It is critical that these reforms be implemented in a fashion that takes into consideration the economic realities of our current health care system and the private health insurance market. Failure to do so is likely to result in increased insurer insolvencies and potentially, the failure of the PPACA’s approach to health care reform.

This paper argues that to accomplish the PPACA’s goals, federal and state regulators must work together with the private insurance industry to develop regulations and state legislation that will implement the mandates of the PPACA, encourage participation, and promote the efficient operation of the private insurance market. Part I outlines the basic economics of any insurance market and explains how insurers profit. Part II explores the history of health insurance and how the United States has become one of the few countries that operates health insurance through a largely market based system.<sup>10</sup> Part III goes on to explain the current health care market system and explains the creation and function of the exchanges as they are outlined in the PPACA. Part IV evaluates the business implications that the exchanges will have on the current health care industry through risk selection, premium rating, and premium adjustment and the medical loss ratio.

## I. THE ECONOMICS OF INSURANCE

In general, insurance attempts to quantify the abstract concept of risk by weighing an individual’s probability of experiencing future loss and the extent of that loss with the individual’s ability to absorb that loss.<sup>11</sup> Individuals exchange constant small payments equal to the insured’s expected loss, called the insurance

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6. *Id.* § 300gg-18(b)(1)(A)(ii). The threshold for employer based plans is eighty percent, but individual and small employer plans must pay eighty-five percent of premiums towards medical claims. *Id.* § 300gg-18(b)(1)(A)(i).

7. AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT, § 2 (Nat’l Ass’n of Ins. Comm’rs, Draft 2010).

8. 42 U.S.C.S. § 18041(a) (requiring the Secretary to consult with the NAIC and other interested parties in developing exchange regulations).

9. *Id.* § 18041(b).

10. See T. R. Reid, *Myths About Health Care Around the World*, WASH. POST, Aug. 23, 2009, at B03 (outlining basic health insurance models, including, Great Britain’s National Healthcare Service, a national system financed by the federal government through taxes; Germany’s system that is much like the United States’; and Canada’s national health insurance system, run by the government but implemented by the private sector).

11. ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW § 10(c)(1) (LexisNexis 4<sup>th</sup> ed. 2007).

premium, for the insurer's promise to cover the risk of larger losses resulting from future events.<sup>12</sup> Insurers, however, are not inclined to cover all possible risk of an individual's future loss because of the possibility of moral hazard.<sup>13</sup> Moral hazard is an unintended consequence of insurance that occurs when an individual is more inclined to participate in riskier activities or take fewer precautionary measures because he knows he has insurance coverage.<sup>14</sup> This phenomenon actually increases the probability of loss to the insurer.<sup>15</sup> To avoid moral hazard, an insurer will leave some responsibility on the individual by either adjusting premiums based on individual activities or by charging a deductible,<sup>16</sup> coinsurance,<sup>17</sup> or copayments.<sup>18</sup> Though these tactics do not completely prevent moral hazard, they do help counter the insurer's loss.<sup>19</sup>

An insurer's probability of loss decreases as the insurer increases the number of individuals in the group it insures.<sup>20</sup> It would be impossible and very inefficient for an insurer to calculate each individual's expected loss.<sup>21</sup> Instead, an insurer attempts to pool similarly situated individuals into risk pools in order to spread risk of loss evenly.<sup>22</sup> Insurers use underwriting to place individuals in the appropriate risk pool.<sup>23</sup> Underwriting uses various factors affecting an individual's health status, such as health history, to determine whether the insurer will accept an

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12. *Id.* § 10(c)(1)-(c)(2).

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.* § 10(c)(2). A plan's deductible determines how much an individual must pay before any insurance benefits kick in. *Id.* Typically, a higher deductible will mean a lower premium because an individual will be paying more out of pocket before insurance coverage begins. *Id.*

17. *Id.* Coinsurance is the ratio at which the individual and the insurer split costs beyond the deductible. *Id.*

18. See NAT'L ALLIANCE ON MENTAL ILLNESS ET AL., JOINT STATEMENT ON MEDICATION COST SHARING IN STATE MEDICAID PROGRAMS I (2008), available at [http://www.nami.org/Template.cfm?Section=Access\\_to\\_Medications&Template=/ContentManagement/ContentDisplay.cfm&ContentID=62472](http://www.nami.org/Template.cfm?Section=Access_to_Medications&Template=/ContentManagement/ContentDisplay.cfm&ContentID=62472) (defining copayments as cost sharing devices that shift financial burden to the patient).

19. JERRY & RICHMOND, *supra* note 11, § 10(c)(2).

20. *Id.* § 10(c)(1). The following hypothetical is modeled after a similar example provided by Jerry and Richmond: X has a one-in-100 chance of suffering a loss of \$1000 and is willing to pay insurer Y \$15 (his premium) to assume that loss. If Y groups 99 other people like X and charges each of them \$15, Y will collect \$1500. If each of the insured has a one in 100 chance of loss, one of them will probably suffer a loss and Y anticipates paying \$1000. Y earns a profit of \$500 and each X is covered in case he is the one who suffers. *Id.*

21. *Id.* § 10(c)(2).

22. *Id.*

23. HENRY J. KAISER FAMILY FOUND., HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 2008 UPDATE 5-6 (2008) [hereinafter A PRIMER 2008 UPDATE] ("Underwriting is the process of determining whether or not to accept an applicant for coverage and determining what the terms of coverage will be, including the premium.").

individual for coverage.<sup>24</sup> Forming these pools, however, can result in the negative economic effect of adverse selection.<sup>25</sup> When a group of similarly situated people are in a group insured at the same premium, some people will always be better risks for the insurance provider than others.<sup>26</sup> When less risky individuals realize that they are paying too high a premium due to the more risky individuals within their pool, the less risky will leave the pool altogether.<sup>27</sup> Insurers will adjust factors such as premiums and scope of coverage<sup>28</sup> in an attempt to avoid insuring too many high risk, high cost people.<sup>29</sup>

Economically, both parties that enter into an insurance contract should be better off than before.<sup>30</sup> Individuals are able to transfer risk of loss to someone else and avoid facing large future payments, and the insurer makes a reasonable return by assuming risk from statistically profitable groups of individuals.<sup>31</sup>

## II. A HISTORY AND OVERVIEW OF THE PRIVATE HEALTH INSURANCE MARKET IN THE UNITED STATES

Health insurance is a relatively recent phenomenon that began much differently than it exists today.<sup>32</sup> The earliest forms of insurance coverage focused on lost income resulting from accidents or sickness instead of covering particular health services.<sup>33</sup> Traditional insurers were reluctant to offer more comprehensive

24. *Id.* For instance, medical underwriting considers “age, family history, lifestyle, and current health.” U.S. BUREAU OF LABOR STATISTICS, U.S. DEP’T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK 106 (2010). Applications for coverage typically include questions about these factors. *Id.*

25. JERRY & RICHMOND, *supra* note 11, § 10(c)(2).

26. *Id.* For a simplistic example: A and B are insured drivers grouped in a pool as females, under thirty, living in the suburbs. A tends to drive much faster than B and has accrued five speeding tickets in the past year. This particular insurer does not consider speeding tickets for placing A and B in their risk pool, and charges both A and B the same average premium. A, however, is a much higher risk than B.

27. GARY CLAXTON, HENRY J. KAISER FAMILY FOUND., HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 4 (2002). In the example above, when B realizes that her risk of loss is only about \$500 and she is paying \$1,000 in annual premium to cover A’s risk for the insurer, B will likely drop the insurance and take her chances.

28. JERRY & RICHMOND, *supra* note 11, § 10(c)(2).

29. *See* CLAXTON, *supra* note 27, at 5 (defining underwriting as a preemptive process that insurers use to evaluate individuals for acceptance, coverage, terms, and premium based on the individuals’ varied risk within a risk pool).

30. JERRY & RICHMOND, *supra* note 11, § 10(c)(2).

31. *See id.* (outlining a hypothetical situation where X transfers risk to Y in exchange for payments so that Y ultimately makes a profit).

32. Eleanor D. Kinney, *For Profit Enterprise in Health Care: Can it Contribute to Health Reform?*, 36 AM. J.L. & MED. 405, 407 (2010).

33. Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, MONTHLY LAB. REV., Mar. 1994, at 3, 3. In 1798, Congress established the earliest coverage for health services in the United States. *Id.* The U.S. Marine Hospital services made deductions for hospital services from seamen’s salaries. *Id.* Franklin Health Assurance Company of Massachusetts wrote the first accident policy in 1850 that paid the insured \$200 in case of bodily injury resulting from a railway or steamboat accident, for a 15-cent premium. *Id.* In the late 1800s, Aetna Life Insurance Company and

health insurance because the losses associated with medical insurance were extremely hard to predict.<sup>34</sup> Additionally, prior to 1920, the general public did not believe actual health insurance was necessary.<sup>35</sup> Shortly after World War I, demand for medical care and medical costs began to rise.<sup>36</sup> During this time the general population began to concentrate in urban areas,<sup>37</sup> the public began to accept medicine as a science,<sup>38</sup> and there was hospital growth and increased wealth.<sup>39</sup> As demand quickly grew, so did the cost of health services.<sup>40</sup> At this time, the American Medical Association (“AMA”) developed stringent standards for doctor licensing and education making it more difficult and expensive for doctors to enter the field, essentially limiting the supply of doctors.<sup>41</sup> With fewer doctors to provide service coupled with stable demand for those services, the price of medical services increased.<sup>42</sup> Simultaneously, the financial strains of the Great Depression meant that few people were able to afford the rising cost of hospital care and hospitals were steadily losing income.<sup>43</sup> In 1929 consequently, a group of Dallas teachers contracted with a hospital to provide certain services for a fixed annual payment.<sup>44</sup> This was the beginning of prepaid hospital services that were popular throughout the 1930s.<sup>45</sup> These single hospital plans, however, increased competition among hospitals and threatened individual hospital solvency.<sup>46</sup> In response, community

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Travelers Insurance Company began offering insurance coverage to protect against “loss due to temporary total disability occasioned by all diseases except tuberculosis, venereal disease, insanity, or disabilities due to alcohol or narcotics.” *Id.* at 4. In 1910 Montgomery Ward established the first group health insurance policy for its employees, contracting with the London Guarantee and Accident Co. in New York to provide one-half the employee’s salary if he was unable to work due to illness or injury. *Id.*

34. Melissa Thomasson, *Health Insurance in the United States*, ECON. HISTORY ASS’N. (Feb. 01, 2010 18:21), <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>.

35. *Id.*

36. *Id.*

37. *Id.*; John Preskitt, *Health Care Reimbursement: Clements to Clinton*, 21 BAYLOR U. MED. CENTER PROC. 40, 40 (2008). Families that once had room for sick family members in their rural homes, no longer had extra space in their new urban homes. *Id.*

38. Thomasson, *supra* note 34. The sick began visiting hospitals for treatment. *Id.*

39. *See id.* (describing health insurance as a “normal good” so that income and demand rise simultaneously).

40. *Id.*

41. *Id.*

42. Joseph Ross, *The Committee on the Costs of Medical Care and the History of Health Insurance in the United States*, 19 EINSTEIN Q. J. BIOLOGY MED. 129, 129–130 (2002).

43. Scofea, *supra* note 33, at 5.

44. *Id.*; Preskitt, *supra* note 37, at 41.

45. Thomasson, *supra* note 34. These prepaid contracts were advantageous to both the consumers and the hospitals. The consumers were able to cover their risk and affordably pay for hospital care. *Id.* The hospitals were earning steady income even if their beds were not full. *Id.*

46. *Id.*

hospitals organized together and this structure became known as Blue Cross.<sup>47</sup> Blue Cross operated as a not for profit organization and private insurers remained reluctant to enter the health insurance market.

By the 1940s, private insurers realized that they could avoid adverse selection by offering health plans to groups of employed workers.<sup>48</sup> This group's demographic was less risky because it was composed in large part of young, healthy, low-risk people who did not seek insurance on their own.<sup>49</sup> This tactic proved to be profitable and private insurers held a competitive pricing advantage over Blue Cross.<sup>50</sup> When wages froze during World War II, employers even began to pay portions of their employee's health insurance premiums to entice workers through benefits packages.<sup>51</sup> By 1958, private health insurers insured about seventy-five percent of the American population.<sup>52</sup>

Employer based health insurance continues to dominate the private health insurance market.<sup>53</sup> In 2009, about 170 million Americans were insured through their employers.<sup>54</sup> Through employer provided insurance, "employers subsidize the cost of insurance" as part of the employee's compensation benefits.<sup>55</sup> The employee bears a portion of the cost through premiums, out of pocket expenses, copayments, deductibles, and coverage scope.<sup>56</sup> Even though most companies do

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47. *Id.* While hospitals faced particular guidelines as part of the Blue Cross group, they also enjoyed benefits from being a member, including not-for-profit status, tax exemption, and freedom from the normal insurance regulation. *Id.*

48. *Id.*

49. *Id.*

50. *Id.* See Jon Kingsdale & John Bertko, *Insurance Exchanges Under Health Reform: Six Design Issues for the States*, 29 HEALTH AFF. 1158, 1159 (2010) (contrasting community rating and individual rating). Community rating uses a community's overall demographics to determine a group's risk and insurers use this rating to charge everyone the same premium. *Id.* A community rating system requires the insurer to charge the same premium to everyone. Thomasson, *supra* note 34. In contrast, the private insurers could offer experience ratings that gave healthy people lower premiums. *Id.* Experience rating allows an insurer to evaluate each individual's health risk based on factors such as his health history in order to determine individual premium pricing. Kingsdale & Bertko, *supra*, at 1159.

51. See Scofea, *supra* note 33, at 6 (describing a Congressional act that froze wages but allowed employers to offer insurance plans which resulted in a growth of insurance plans). Employers also received a tax break on the money spent for employee premiums. Thomasson, *supra* note 34.

52. Thomasson, *supra* note 34.

53. See *Health Insurance and State: NCSL Overview*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/?TabId=14509> (last updated Sept. 2011) (providing that 55.3% of people were covered by employment-based health insurance in 2010 and 31% of people were covered by government health insurance).

54. U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY: TABLE H101. HEALTH INSURANCE COVERAGE STATUS AND TYPE OF COVERAGE BY SELECTED CHARACTERISTICS (2009).

55. Andrew Villegas, *Employer-Based Insurance Explained*, KAISER HEALTH NEWS (Sept. 28, 2009), <http://www.kaiserhealthnews.org/Stories/2009/September/28/NPR-employer-explainer.aspx>.

56. *Id.*

not provide workers with individual insurance plan options,<sup>57</sup> employer sponsored group policies tend to be significantly cheaper than individual policies.<sup>58</sup>

For individuals not covered by employer insurance, and small businesses that do not provide employer sponsored healthcare coverage, the market is slightly different.<sup>59</sup> Prior to the PPACA's passage, insurers used underwriting to evaluate an individual's risk and then adjust policy costs accordingly.<sup>60</sup> Insurers would group an individual with other similarly situated individuals and put the group into a "pool" in order to spread risk and create expected costs for the pool that were relatively predictable and stable over time.<sup>61</sup> Insurers would adjust an individual's coverage, premium, deductibles, and copayments in order to balance the risk pool.<sup>62</sup> To avoid adverse selection, insurers had to anticipate differences in future costs among individuals in the risk pool.<sup>63</sup> In order to do so, health insurers used tactics such as underwriting, rescission or policy cancellation, and instituting lifetime maximums.<sup>64</sup> Insurers then priced premiums accordingly.

For the health insurance provider, premiums are liquid assets and these assets are balanced with reserves and a surplus on the balance sheet.<sup>65</sup> The reserves reflect anticipated claims payments and expenses, and insurers are required to maintain a surplus in case expense predictions are too low.<sup>66</sup> In a given year, the ratio of premiums spent on claim payments to total premiums collected is the medical loss ratio ("MLR").<sup>67</sup> Premium dollars spent on expenses other than claims payments

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57. *Id.*

58. Compare HENRY J. KAISER FAMILY FOUND., SURVEY OF PEOPLE WHO PURCHASE THEIR OWN INSURANCE 4 (June 2010), <http://www.kff.org/kaiserpolls/upload/8077-R.pdf> (finding that individuals in 2010 paid an average of \$3,606 for health insurance), with HENRY J. KAISER FAMILY FOUND. ET AL., EMPLOYER HEALTH BENEFITS 1 (2010), <http://ehbs.kff.org/pdf/2010/8085.pdf> (finding that the average individual contribution to an employer sponsored health plan in 2010 was \$899).

59. See PETER HARBAGE, CTR. FOR AM. PROGRESS ACTION FUND, THE INEFFICIENT INDIVIDUAL MARKET 1 (Mar. 23, 2009), [http://www.americanprogressaction.org/issues/2009/03/pdf/administrative\\_costs.pdf](http://www.americanprogressaction.org/issues/2009/03/pdf/administrative_costs.pdf) (determining that one of the main reasons that the individual insurance market is expensive is due to underwriting).

60. A PRIMER 2008 UPDATE, *supra* note 23, at 6.

61. *Id.* For an explanation of the underwriting, see *supra* notes 23–24 and accompanying text.

62. *Id.* at 5–7. See SARAH LUECK, CTR. ON BUDGET AND POLICY PRIORITIES, STATES SHOULD TAKE ADDITIONAL STEPS TO LIMIT ADVERSE SELECTION AMONG HEALTH PLANS IN AN EXCHANGE 2 (2011) (suggesting that plans must set deductible and copayment amounts in ways to avoid adverse selection).

63. *Id.* at 6.

64. Troyen A. Brennan & David M Studdert, *How Will Health Insurers Respond to New Rules Under Health Reform?*, 29 HEALTH AFF. 1147, 1148 (2010). Lifetime limits determine the maximum dollar value of benefits an insurer will pay during an insured's lifetime. See Patient Protection and Affordable Care Act § 2711, 42 U.S.C.S. § 300gg-11 (LexisNexis Supp. 2011).

65. MASS. DIV. OF HEALTH CARE FINANCE & POLICY, STUDY OF THE RESERVES AND SURPLUSES OF HEALTH INSURERS IN MASSACHUSETTS 1–2 (2010).

66. *Id.*

67. Len M. Nichols, *Implementing Insurance Market Reforms Under the Federal Health Reform Law*, 29 HEALTH AFF. 1152, 1153 (2010).



include operating costs, marketing, and profits that go to surplus and investors.<sup>68</sup> Some states regulate the MLR, setting limits on the amount of premium dollars spent on administrative costs.<sup>69</sup> Regulation discourages insurers from charging unfair premiums and garnering excess profits while ensuring insurers' solvency.<sup>70</sup> If the MLR is set too high, an insurer will not have the capital available to run administrative operations efficiently, if at all, and will choose to leave the market.<sup>71</sup> If the MLR is set too low, insurers will maintain excess premiums and keep additional capital for profits.<sup>72</sup> An appropriately regulated MLR strikes a balance between the two, encouraging market efficiency.<sup>73</sup> Effective MLR regulation also depends on the insurer's business model.<sup>74</sup>

Today's health insurers include both for-profit and not-for-profit companies.<sup>75</sup> In either model, the company must collect at least enough in premiums to remain solvent.<sup>76</sup> In a for-profit insurance model, the company must not only maintain operating levels, but also show investors a suitable return. As medical costs rise and

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68. *Id.*

69. *Id.* at 1154.

70. Compare John Carroll, *Plans Scramble to Defend Their Medical Loss Ratios*, MANAGED CARE (Jan. 2010), <http://www.managedcaremag.com/archives/1001/1001.regulation.html> (discussing Democrat complaints that publicly traded insurers tout profits and relatively low MLRs on Wall Street so regulation is necessary to prevent the "elaborate sham"), with Letter from the Nat'l Ass'n of Ins. Comm'rs to Kathleen Sebelius, Sec'y, U.S. Dep't. Health & Human Servs. (Oct. 27, 2010) (expressing concerns that an MLR that is too strictly regulated could result in destabilized markets and undermine insurer solvency).

71. MARK LABORDE, AETNA JACKSON/TAMPA MKTS., COMMENTS OF AETNA INC. BEFORE THE JOINT PUBLIC HEARING OF THE FLORIDA OFFICE OF INSURANCE REGULATION & THE FLORIDA HEALTH INSURANCE ADVISORY BOARD 7 (May 4, 2010).

72. See *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance*, HEALTHCARE.GOV, [http://www.healthcare.gov/news/factsheets/medical\\_loss\\_ratio.html](http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html) (last visited Aug. 22, 2011) (discussing how today's insurers spend a substantial part of premiums on costs such as profits and salaries) [hereinafter *Getting Your Money's Worth*]; see also James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, HEALTH AFF., July–Aug. 1997, at 176, 179 (explaining that traditionally, some state regulators only allowed insurers to raise premiums if medical costs forced the medical loss ratio higher than the target in an effort to prevent insurers from raising premiums at a higher rate than medical expenses).

73. See *Getting Your Money's Worth*, *supra* note 72 (describing NAIC's involvement in determining MLR regulation and the HHS Secretary's ability to adjust the medical loss ratio in order to keep the state market stabilized and provide an effective market transition).

74. See Jennifer Haberkorn, *Medical Loss Ratios. Health Insurers Will Soon be Required to Spend a Specific Share of the Premiums They Collect on Health Care for Policyholders*, HEALTH POL'Y BRIEF (Health Affairs, Bethesda, MD), Nov. 24, 2010, at 2 (comparing Medicare, a government run program that maintains a ninety-seven to ninety-eight percent MLR with large health insurers who in 2009 had medical loss ratios between sixty-eight to eighty-eight percent).

75. See, e.g., *About Kaiser Permanente*, KAISER PERMANENTE, <http://xnet.kp.org/newscenter/aboutkp/fastfacts.html> (last visited Aug. 23, 2011) ("Kaiser Permanente is one of the nation's largest not-for-profit health plans."); *Investor Information*, AETNA, <http://www.aetna.com/investors-aetna/index.html> (last visited Feb. 24, 2012) (providing information for the company's investors, including annual reports and proxy statements).

76. LABORDE, *supra* note 71, at 7.

insurance companies strive to remain profitable, premiums will dramatically increase.<sup>77</sup>

### III. THE EXCHANGES

One way that the PPACA seeks to reform the current health care industry is by requiring states to develop exchanges.<sup>78</sup> The exchanges will function as a state created insurance marketplace for qualified individuals and employers to compare and purchase affordable health insurance.<sup>79</sup> According to the U.S. Census Bureau, in 2009, of the approximate 304 million people in the United States, 16.65% had no form of health insurance.<sup>80</sup> One reason for this is because employer based insurance is the most common way Americans get health coverage.<sup>81</sup> The number of uninsured has risen significantly in the past two years due to the recession and weak job market that pushed more Americans from the large employer market to the individual health insurance market.<sup>82</sup>

The individual segment of the potential health insurance market is dominated by the “young invincibles”<sup>83</sup> with about one third of people age twenty to twenty-nine foregoing health insurance.<sup>84</sup> The uninsured population also includes those individuals that private providers reject because of pre-existing conditions or some other disproportionately large risk factor.<sup>85</sup> The rest of the individual insurance market, then is saturated with older, less healthy people that cost providers more to insure.<sup>86</sup> The Exchanges target this individual segment of the market.<sup>87</sup>

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77. See Tom Kiskan, *Medical Costs Driven by Unhealthy Lifestyles, Says Insurance Executive*, M.VCSTAR.COM, <http://www.vcstar.com/news/2011/apr/14/medical-costs-driven-by-unhealthy-lifestyles/> (last updated April 14, 2011) (noting that rising medical costs increases insurance premiums); HENRY J. KAISER FAMILY FOUND., *EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 10–11* (2011), <http://ehbs.kff.org/pdf/2011/8225.pdf> (outlining the large premium increases among insured groups between 2010 and 2011).

78. Patient Protection and Affordable Care Act § 1311, 42 U.S.C.S. § 18031(b) (LexisNexis Supp. 2011).

79. Goldstein, *supra* note 3, at 76.

80. U.S. CENSUS BUREAU, *supra* note 54.

81. Villegas, *supra* note 55.

82. Robert Wood Johnson Found., *Impact of the Economy on Health Care*, PPACADEMYHEALTH 1–2 (Aug. 2009), <http://www.PPACAdemyhealth.org/files/HCF0/findings0809.pdf>. From 2007–2009, the number of uninsured rose by about 5 million. HENRY J. KAISER FAMILY FOUND., *THE UNINSURED AND THE DIFFERENCE HEALTH INSURANCE MAKES 1* (Sept. 2010), <http://www.kff.org/uninsured/upload/1420-12.pdf>.

83. Term coined for the group of individuals younger than thirty who believe that they can do without broad insurance coverage. Alec MacGillis, *The Individual Mandate: How It Will Work*, in LANDMARK: THE INSIDE STORY OF AMERICA’S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR US ALL 86 (2010).

84. *Id.* at 87.

85. *Id.* at 93.

86. *Id.* at 87.

87. See Patient Protection and Affordable Care Act § 1311, 42 U.S.C.S. § 18031(b) (LexisNexis Supp. 2011) (limiting exchanges to qualified individuals and small employers).

The market within the exchanges will only include individuals and small employers. Additionally, most individuals will qualify for subsidies to purchase insurance in the exchange.<sup>88</sup> A small employer qualifies for participation in the exchanges if during the calendar year, the employer has an average of at least one but no more than one hundred employees.<sup>89</sup> The exchanges will create larger pools for individuals and small-employer groups in order to spread risk among the members of these groups, creating a residual market.<sup>90</sup> In theory, these exchanges will create the type of risk pools that large businesses inherently create.<sup>91</sup> The health plans offered in these exchanges must be “qualified health plans” as defined by the PPACA and the Secretary of HHS.<sup>92</sup> Qualified health plans are placed into one of four levels of coverage: platinum, gold, silver, or bronze.<sup>93</sup> For small employer groups, the employer chooses the level offered, and the employee may

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88. Goldstein, *supra* note 3, at 79.

89. 42 U.S.C.S. §18024(b)(2). Individual states may decide whether the employee limit should be 50 or 100. *Id.* §18024(b)(3).

90. Because there is such a large number of individuals that either choose not have health insurance or are rejected by the private market, the current state of the health insurance system provides an environment for creating a residual health insurance market. TOM BAKER, *INSURANCE LAW AND POLICY: CASES AND MATERIALS* 693 (2nd ed. 2008). Residual markets are legislatively created marketplaces designed to provide insurance for people who are unable to purchase insurance in the open market. *Id.* at 693. In other segments of insurance, states have created residual markets for those who can not be insured by the private market either because they can not afford it or because the private market rejects them. *Id.* at 694. For instance, all states have created residual markets for automobile insurance. *Id.* In most states it is a law that to be eligible to drive, one must carry auto insurance. *Id.* For those that cannot afford insurance, or have such a bad driving history that they can not be approved for insurance, most states have created a residual market, where these high risk individuals can obtain insurance. *Id.* In order to allow these individuals to still participate in the system, states require insurance providers to contribute to a pool that provides these risky individuals with the minimum coverage. *Id.* By doing so, the states are balancing the importance of the economic goals of insurers’ solvency with the social goal of providing access to the insurance to all individuals. *Id.* In essence, the state run exchanges will act as residual health insurance markets for those Americans currently uninsured. *Id.*

91. See AM. ACAD. OF ACTUARIES, *CRITICAL ISSUES IN HEALTH REFORM: RISK POOLING I* (2009) (describing the concept of risk pooling and contrasting employer based risk pooling and risk pooling in the individual market).

92. 42 U.S.C.S. § 18021.

93. *Id.* § 18022(d)(1). These levels of coverage must have actuarial values of ninety percent, eighty percent, seventy percent, and sixty percent respectively. *Id.* An actuarial value estimates the average percentage that the plan will pay in expenses based on the cost sharing provisions of the plan. CONSUMERS UNION, *WHAT WILL AN “ACTUARIAL VALUE” STANDARD MEAN FOR CONSUMERS?* 1 (2011), [http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/01/consumers\\_union-health\\_policy\\_brief-2011\\_01-what\\_will\\_an\\_actuarial\\_value\\_standard\\_mean\\_for\\_consumers.pdf](http://prescriptionforchange.org/wordpress/wp-content/uploads/2011/01/consumers_union-health_policy_brief-2011_01-what_will_an_actuarial_value_standard_mean_for_consumers.pdf). The value is based on a standard population, however, so each individual will not actually get that amount of coverage. *Id.* at 3. In fact, actuarial value systems are designed so that lower risk individuals will end up paying a larger share of expenses. *Id.*

choose a plan offered within that level.<sup>94</sup> Specific health plans will differ within different state exchanges.<sup>95</sup>

The Secretary of HHS will provide grant money to states to develop the exchanges.<sup>96</sup> On February 16, 2011, HHS named seven states, “Kansas, Maryland, New York, Oklahoma, Oregon, and a consortium of New England states,” that will share \$241 million in “early innovator” grants.<sup>97</sup> These grants are specifically tailored toward helping these states create the information technology infrastructure required for implementing the exchanges.<sup>98</sup> The states will also determine whether the exchanges operate as a government agency or a non profit entity established by the state.<sup>99</sup> Small states will have one exchange, large states may have more than one exchange (subsidiaries in geographically distinct areas), or separate states may agree to interstate exchanges.<sup>100</sup> The structure of the exchange must be in place by January 1, 2014.<sup>101</sup> If a state opts out of creating its own exchange, the Secretary may step in and establish an exchange in the state.<sup>102</sup> Some states, such as Maryland, immediately began drafting legislation for individual state exchanges,<sup>103</sup> while others, like Alaska and Minnesota, adamantly refused to participate or apply for federal grants.<sup>104</sup>

The exchanges have basic functions outlined in the PPACA to promote clarity, including: certify plans, provide toll free phone and website for consumers, create a plan rating system, and establish a standard presentation format.<sup>105</sup> In order to promote transparency within the exchanges themselves, the PPACA requires exchanges to keep accounting, publish their own costs, and allows the HHS to investigate exchanges and conduct annual audits.<sup>106</sup> Exchanges must work with interested parties including consumers, individuals experienced in facilitating

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94. 42 U.S.C.S. § 18032(a).

95. *See id.* § 18031(d)(3)(B)(i) (describing a qualified health plan as one that adheres to regulations adopted by the Secretary as well as those created by the state exchanges).

96. *Id.* § 18031(a).

97. Dena Bunis, ‘Exchange Innovator’ States Get \$241 Million in Grants, CQ HEALTHBEAT (Congressional Quarterly, D.C.) Feb. 16, 2011, at 1, <http://www.cq.com/doc/hbnews-3814328>.

98. *Id.*

99. 42 U.S.C.S. § 18031(d)(1).

100. *Id.* § 18031(f).

101. *Id.* § 18031(b)(1).

102. *Id.* § 18041(c).

103. *See* H.D. 166, S. 182, 2011 Leg., 428th Sess. (Md. 2011) (proposing the Maryland Health Benefit Exchange Act). On April 12, 2011, Maryland Governor Martin O’Malley signed the Maryland Health Benefit Exchange Act, creating a foundation for Maryland exchanges. *The Maryland Health Benefit Exchange*, MD. DEP’T OF HEALTH & MENTAL HYGIENE, <http://www.dhmf.maryland.gov/healthreform/exchange/SitePages/Home.aspx> (last visited Feb. 28, 2012).

104. Katie Pickert, *Health Reform: Reluctant States Could Invite a Federal Takeover*, TIME (Nov. 12, 2010), <http://www.time.com/time/nation/article/0,8599,2030932,00.html>.

105. 42 U.S.C.S. § 18031(d)(4).

106. *Id.* §§ 18031(d)(7), 18033(a)(1)–(3).

health plans, representatives of small businesses and the self employed, state Medicaid, and advocates for enrolling those in hard to reach areas.<sup>107</sup>

Beyond the exchanges, the PPACA makes changes to the insurance market in general. The PPACA requires insurers to create a single risk pool composed of enrollees in all health plans offered to the individual and small group markets respectively, including those who do not enroll through the exchange.<sup>108</sup> Medical underwriting is eliminated, along with rescission, cancellation, lifetime limits, screening for pre-existing conditions, and other discriminatory tactics.<sup>109</sup> To avoid the adverse selection problem created by these restrictions, the PPACA requires individual mandates.<sup>110</sup> These mandates would entice lower-risk individuals to enter the pool and balance total risk, even though they are paying the same premium as individuals with higher risk profiles.<sup>111</sup>

Within the exchange, an insurer must defend and HHS must approve any premium increase.<sup>112</sup> In an effort to control premiums, the PPACA puts limits on the MLR.<sup>113</sup> Insurers must spend at least eighty percent of net premium dollars collected on claims from the individual and small business market and eighty-five percent from the large employer market.<sup>114</sup> Insurers must provide enrollees with rebates for any amount lower than the thresholds.<sup>115</sup> A state may have a higher threshold or rebate program as long as it does not undercut the federal program.<sup>116</sup> The Secretary will determine the MLR definition with advice from the NAIC.<sup>117</sup>

The PPACA provides a structural framework for the exchanges focused on access to care, fair pricing, and transparency.<sup>118</sup> The PPACA establishes the exchanges' fundamental economic base reliant on private market participation;

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107. *Id.* § 18031(d)(6).

108. *Id.* § 18032(c).

109. *See generally id.* § 300gg-1 to 12 (regulating a variety of coverage limitations).

110. *Id.* § 18091. The individual mandate is a penalty that an individual must pay if he chooses not to obtain insurance coverage. *See* I.R.C. § 5000A (outlining the details of the penalty).

111. AM. ACAD. OF ACTUARIES, *supra* note 91, at 2.

112. 42 U.S.C.S § 300gg-94.

113. *Id.* § 300gg-18(b).

114. *Id.*

115. *Id.* § 300gg-18(b)(1).

116. *Id.* § 300gg-18(b)(1)(A)(i)-(ii).

117. *Id.* § 300gg-18(c). In October 2010, the National Association of Insurance Commissioners (NAIC) submitted to the Secretary of U.S. Department of Health and Human Services (HHS) a definition for the medical loss ratio. Letter from the Nat'l Ass'n of Ins. Comm'rs to Kathleen Sebelius, *supra* note 70. The medical loss ratio is defined as: (Reimbursement for clinical services plus expenditures to improve health care quality) divided by (Total premium revenue minus Federal and State taxes and licensing or regulatory fees). 42 U.S.C.S § 300gg-18(b).

118. Sharon Silow-Carroll et al., *Health Insurance Exchanges: State Roles In Selecting Health Plans and Avoiding Adverse Selection*, STATES IN ACTION (The Commonwealth Fund, D.C.), Feb.-Mar. 2011, at 1, <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Feature/Feature.aspx> (explaining the purpose of an insurance exchange and the goals that federal reform seeks to attain).

however, it leaves many details to state regulators.<sup>119</sup> Individual state decisions will determine whether the private market finds it economically justified to participate, thus determining the success of the PPACA as a whole.

#### IV. BUSINESS IMPLICATIONS AND PRIVATE INSURERS' ROLES IN THE EXCHANGE

The overarching objectives in regulating the private insurance market are to ensure fairness and reasonableness, protect insurer solvency, avoid excessive insurer profits and provide fair, adequate and clear options for American citizens.<sup>120</sup> In order for the exchange marketplaces to be successful, each must offer consumer choice and private insurers must be willing to participate in the marketplace.<sup>121</sup> As such, federal regulations must be effectively comingled with state insurance legislation. As individual states begin to implement the general regulations of the the PPACA, legislators must ensure that new state statutes work in concert with the federal statutes.

Further, state insurance regulators and the exchange operators must view the transition with an economic and business perspective.<sup>122</sup> Though the PPACA provides the groundwork, it will ultimately be up to the states to make these marketplaces successful. Federal regulations and state legislation and policies must strike the appropriate balance between reform objectives and political policy, particularly through risk selection, premium rating and premium adjustment.

##### A. Risk Selection

As previously explained, in order to establish economically fair prices for taking on health risk in the private individual market, insurers use risk classification.<sup>123</sup> The PPACA seeks to increase access to care by creating mandated risk pools within the exchanges that will eliminate risk selection.<sup>124</sup> These pools, however, can fall subject to adverse selection.<sup>125</sup> The PPACA encourages insurer participation in the exchanges by addressing adverse selection through an individual mandate.<sup>126</sup> For the individual mandate to be successful, there must be public support or another alternative should be considered.

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119. *Id.*

120. Kingsdale & Bertko, *supra* note 50, at 1159 (explaining how an exchange should “be organized and governed”).

121. *Id.* at 1161.

122. *Id.* at 1162.

123. See *supra* notes 60–64 and accompanying text; COMM. ON RISK CLASSIFICATION, AM. ACAD. OF ACTUARIES, RISK CLASSIFICATION STATEMENT OF PRINCIPLES 5, available at <http://www.actuarialstandardsboard.org/pdf/riskclassificationSOP.pdf> (last visited March 13, 2012).

124. Silow-Carroll et al., *supra* note 118, at 1.

125. *Id.* at 2.

126. See Patient Protection and Affordable Care Act § 5000A, 42 U.S.C.S. § 18091 (LexisNexis Supp. 2011) (requiring individuals to purchase health insurance or pay a penalty). In order for private

When an insurer creates risk pools, it considers factors such as past experience and future trends for groups with similar risk characteristics.<sup>127</sup> These factors determine averages and averages are applied to individuals within the group to establish pricing and coverage availability to the public.<sup>128</sup> In the individual and small group markets, one of the biggest challenges insurers face during risk classification is to avoid adverse selection in their risk pools.<sup>129</sup> When healthy people notice this premium rising to a level they no longer feel is worth paying, they will exit the pool, leaving the insurer with a single pool of high risk, high cost individuals.<sup>130</sup> Insurers typically respond to this situation through medical underwriting, lifetime limits, cancellation, and rescission.<sup>131</sup>

By setting up the exchanges, the PPACA seeks to eliminate current risk classification and pooling by creating a small number of structured risk pools.<sup>132</sup> The PPACA addresses the adverse selection problem inherent within these pools with an individual mandate.<sup>133</sup> The mandate is a legal requirement that an individual purchase an approved healthcare policy or pay a fee.<sup>134</sup> In theory, the mandate should be enough incentive to keep individuals within the exchange market and avoid disrupting the balanced risk pool within the exchange.<sup>135</sup> Some critics fear that the penalty for not complying with the mandate is not large enough,<sup>136</sup> and others that enforcement is not strict enough.<sup>137</sup>

The largest controversy, however, is the mandate's constitutionality.<sup>138</sup> The main question concerning the individual mandate is whether the Constitution allows Congress to enact legislation that requires individuals to purchase a product

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insurers to participate in the exchanges, adverse selection must be controlled through the individual mandate. AM. ACAD. OF ACTUARIES, *supra* note 91, at 1.

127. A PRIMER 2008 UPDATE, *supra* note 23, at 5–6.

128. *Id.* at 5 (explaining that insurers create risk pools compiled of people from different segments of the population but vary premiums based on a variety of factors and their averages).

129. Brennan & Studdert, *supra* note 64, at 1147–48.

130. *Id.* at 1148.

131. *Id.*

132. See Patient Protection and Affordable Care Act § 1312, 42 U.S.C. § 18032(c) (Supp. 2011) (outlining the risk pools in the individual and small group markets).

133. *Id.* § 18091.

134. I.R.C. § 5000A.

135. See Brennan & Studdert, *supra* note 64, at 1148 (determining that risk pools are inevitably uneven without a mandate requiring individuals to remain in the pools, but that insurers fear that the mandate in the PPACA may not be adequate to ensure compliance).

136. *Id.*

137. Mark Merlis, *Individual Mandate*, HEALTH POL'Y BRIEF (Health Affairs, Bethesda, MD), Jan. 13, 2010, at 6.

138. See Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2011-2012*, NAT'L CONFERENCE OF STATE LEGISLATURES (Feb. 20, 2012), <http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-PPACA.aspx> (giving detailed accounts of current legislation and actions that challenge various aspects of health reforms, including the individual mandate).

from the private market.<sup>139</sup> Those who support the legislation use Congress's Taxing Power, the Commerce Clause, and the Necessary and Proper Clause as support for Congressional power to pass the PPACA and implement the individual mandate.<sup>140</sup> Opponents argue, however that the mandate is a penalty and not a tax,<sup>141</sup> Congress can not compel economic activities in order to regulate them,<sup>142</sup> and that the mandate is unnecessary because it addresses a problem created by the PPACA.<sup>143</sup> Lawsuits have been decided in five state lower courts, with three holding the PPACA constitutional and two holding the PPACA unconstitutional.<sup>144</sup> Appellate courts have also addressed challenges to PPACA in the summer of 2011. The Sixth Circuit Federal Court of Appeals upheld the law in its entirety in June<sup>145</sup> while, in August, the Eleventh Circuit Federal Court of Appeals was the first federal appellate court to rule the mandate unconstitutional.<sup>146</sup> In its action against the PPACA, the state of Virginia attempted to bypass the Fourth Circuit and made a motion to the Supreme Court for expedited review.<sup>147</sup> The Supreme Court denied the request.<sup>148</sup>

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139. ROBERT A. LEVY, CATO INST., THE CASE AGAINST PRESIDENT OBAMA'S HEALTH CARE REFORM: A PRIMER FOR NONLAWYERS 3 (2011).

140. *Id.*

141. *Id.* at 8.

142. *Id.* at 6–7.

143. *Id.* at 10.

144. See *Florida v. U.S. Dep't of Health and Human Servs.*, 780 F.Supp. 2d 1307, 1316 (N.D. Fla. 2011) (holding the individual mandate unconstitutional and not severable from the rest of the Act); *Mead v. Holder*, 766 F.Supp. 2d 16, 33, 35 (D.D.C. 2011) (upholding the mandate because decisions to purchase or not to purchase insurance are economical ones within the purview of Congress' Commerce Clause), *aff'd sub nom.* *Seven-Sky v. Holder*, No. 11-5047, 2011 U.S. App. LEXIS 22566 (D.C. Cir. Nov. 8, 2011); *Virginia Commonwealth ex rel. Cuccinell v. Sebelius*, 728 F. Supp. 2d 768, 788 (E.D. Va. 2010) (striking down the individual mandate as exceeding Congress's power under the Commerce Clause), *vacated*, 656 F.3d 253, 272-273, 2011 U.S. App. LEXIS 18632, \*28 (4<sup>th</sup> Cir. Sept. 8, 2011) (holding that the Virginia Commonwealth lacked standing to bring suit challenging the mandate's constitutionality and refusing to analyze the merits of the Commerce Clause challenge); *Liberty Univ., Inc. v. Geither et al.*, 753 F. Supp. 2d 611, 635 (W.D. Va. 2010) (upholding the law based on the Commerce Clause), *vacated*, 2011 U.S. App. LEXIS 18618 (4<sup>th</sup> Cir. Sept. 8, 2011) (remanding the case back to District Court to dismiss for lack of subject matter jurisdiction); *Thomas More Law Ctr. v. Obama*, 720 F.Supp. 2d 882, 895 (E.D. Mich. 2010) (upholding the law as a valid exercise of the Commerce Clause), *aff'd*, 651 F.3d 529 (6<sup>th</sup> Cir. 2011), *petition for cert. filed*, (U.S. July 26, 2011) (No. 11-117).

145. *Thomas More Law Ctr. v. Obama*, 651 F.3d 529, 549 (6<sup>th</sup> Cir. 2011), *petition for cert. filed*, (U.S. July 26, 2011) (No. 11-117).

146. *Florida v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1328 (11<sup>th</sup> Cir. 2011), *cert granted*, 132 S. Ct. 604 (2011). For an analysis of the Eleventh Circuit opinion, see Timothy Jost, *Appellate Court: Individual Mandate Falls but Rest of Affordable Care Act Survives*, HEALTH AFF. BLOG (Aug. 15, 2011), <http://healthaffairs.org/blog/2011/08/15/appellate-court-individual-mandate-falls-but-rest-of-affordable-care-act-survives/>.

147. *Petition for Writ Of Certiorari at 36-37, Commonwealth ex rel. Cuccinelli v. Sebelius*, 702 F. Supp. 2d 598 (E.D. Va. 2011).

148. *Commonwealth ex rel. Cuccinelli v. Sebelius*, 702 F. Supp. 2d 598 (2011), *cert denied*, 131 S. Ct. 2152.



Because the individual mandate is the crucible to the PPACA's success, some members of Congress began considering alternatives.<sup>149</sup> Most alternatives focus on individual responsibility without imposing a direct financial requirement on an individual<sup>150</sup> Even the Government Accountability Office performed a study that interviewed forty-one experts from twenty-one organizations that are healthcare stakeholders or researchers.<sup>151</sup> The report came up with nine possible alternatives to the individual mandate should the Supreme Court overturn the requirement. These alternatives include to:

modify open enrollment periods and imposing penalties for late enrollment; expand employers' roles in autoenrolling and facilitating employees' health insurance enrollment; conduct a public education and outreach campaign; provide broad access to personalized assistance for health coverage enrollment; impose a tax to pay for uncompensated care; allow greater variation in premium rates based on enrollee age; condition the receipt of certain government services upon proof of health insurance coverage; use health insurance agents and brokers differently; require or encourage credit rating agencies to use health insurance status as a factor in determining credit ratings.<sup>152</sup>

None of these alternatives on their own, though, will effectively address adverse selection.

Ultimately, premium rates drive adverse selection so any alternative to the mandate must limit adverse selection.<sup>153</sup> As premium rates rise, those who feel it unnecessary to pay those rates will exit the market and take their chances.<sup>154</sup> Premium rates themselves are largely driven by medical expenses.<sup>155</sup> The impetus for an individual to remain in the market must be high enough that he will be willing to purchase insurance instead of face the consequences of non-

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149. *Experts, Legislators Mull Alternative Ideas on Individual Mandate*, CALIFORNIA HEALTHLINE (Feb. 7, 2011), <http://www.californiahealthline.org/articles/2011/2/7/experts-legislators-mull-alternative-ideas-on-individual-mandate.aspx>.

150. *See id.* (outlining various congressional proposals). Representative Peter DeFazio (D-Ore.) suggested individuals be able to "opt out of the mandate" and sign an "'affidavit of personal responsibility' for their own health care costs" and not allow health care debt forgiveness during bankruptcy. *Id.* Senators Claire McCaskill (D-Mo.) and Ben Nelson (D-Neb.) suggest providing "financial incentives to individuals who purchase insurance during the open-enrollment periods." *Id.*

151. Letter from John E. Dicken, Dir. Health Care, U.S. Gov't Accountability Office, to E. Benjamin Nelson, Chairman, Subcomm. on the Legislative Branch, Comm. on Appropriates, U.S. Senate (Feb. 25 2011).

152. *Id.*

153. AM. ACAD. OF ACTUARIES, *supra* note 91, at 2 (explaining that when regulations such as rating rules impact adverse selection, they also impact premiums and incentives for individuals to participate in health insurance plans, beyond just the mandate, limit adverse selection).

154. *Id.* at 1.

155. Kiskan, *supra* note 77.

participation.<sup>156</sup> Options such as public outreach and education, enrollment period monitoring, and more assistance with enrollment, will not be enough incentive for an individual to continue to buy insurance.<sup>157</sup> Allowing broader premium fluctuations with age may be enough incentive for young people to enter, but then the risk pools face being unbalanced and insurers arrive at the same high cost pools they had before the exchanges.<sup>158</sup> The only sustainable option would be a tax, which mirrors the mandate.<sup>159</sup> The “correct” individual mandate will be enough incentive for a young healthy person to pay for basic health plan rather than pay the penalty.<sup>160</sup>

States should work with private insurers to increase public awareness, apply strict enforcement, and encourage trust in the state exchanges so as to persuade young, healthy individuals to participate in the exchanges or risk insurers’ mass exit from the individual market. The individual mandate’s amount must be in line with the cost of the cheapest insurance plan.<sup>161</sup> If there is too much of a gap between the amounts, healthy, low-risk individuals may feel financially better off simply paying the mandate and opting out of insurance.<sup>162</sup> Though it would be unwise to enforce mandate payments through direct criminal statutes, it will be important that state governments enforce the individual mandate penalties strictly

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156. See Vanessa Fuhrmans, *Mandated Health Insurance Squeezes Those in the Middle*, WALL ST. J., Sept. 15, 2009, at A1 (reporting about individuals in Massachusetts that choose to forego buying insurance in the exchange because saving their expected out of pocket medical costs and paying the penalty for not being insured, saves the individuals money).

157. See AM. ACAD. OF ACTUARIES, *supra* note 91, at 2 (determining that voluntary incentives will likely not be as successful as a mandate). Economical incentives will likely drive more people than social and moral incentives.

158. See *Nine Alternatives to Individual Health Insurance Mandate; Will They Work?*, INS. J. (Mar. 29, 2011), <http://www.insurancejournal.com/news/national/2011/03/29/192080.htm>. If younger, healthier people are paying lower premiums, the insurer is not collecting enough premium to make up for the riskier individuals in the pool. *Id.*

159. See Robert Pear, *Changing Stance, Administration Now Defends Insurance Mandate as a Tax*, N.Y. TIMES, July 18, 2010, at A14 (reporting that the Justice Department has argued that the requirement for people to carry insurance or pay the penalty is a valid exercise of Congress’s power to impose taxes).

160. See AM. ACAD. OF ACTUARIES, *supra* note 91, at 2 (“Proposals to implement alternative risk pooling arrangements need to maximize the enrollment of healthy risks, while not pricing the unhealthy risks out of the market.”). As this paper argues, the individual mandate is economically the most effective solution to adverse selection in the PPACA Exchanges. What the constitutional controversy boils down to, then may not be driven by constitutional principles, but one political party disappointed in the outcomes of health care reform. The party now is attacking the mandate in order to nullify the entire legislation. Politically, this tactic may prove successful; however economically, the PPACA requires the mandate to be successful. See A PRIMER 2008 UPDATE., *supra* note 23, at 5 (describing the consequence of significant adverse selection within a risk pool as a “death spiral” where as healthy people leave a risk pool, the average costs within the pool go up, which causes more healthy people to leave the pool, until the insurer can not afford to cover anyone in the pool).

161. See Fuhrmans, *supra* note 156 (describing the consequences of people leaving the exchanges if the penalty costs less than self insuring).

162. *Id.*

and fairly to individuals who choose not to obtain insurance.<sup>163</sup> Incorporating the mandate into the state tax code could relieve some of the administrative burden of enforcement as well as encourage consistent application.<sup>164</sup> Though penalties may bring public backlash, as exhibited by the various lawsuits challenging the mandate's constitutionality,<sup>165</sup> the state governments can use public education to show that participation is in everyone's best interest.

In 2007, Utah established its own limited health exchange for small businesses.<sup>166</sup> Utilizing a "defined contribution plan", individual employees choose their own health plans instead of employers selecting the plan options.<sup>167</sup> This approach has potential risk segmentation, however because those in poor health or with health problems may be more inclined to choose particular plans instead of others.<sup>168</sup> This adverse selection will eventually drive private insurers out of the market.<sup>169</sup> To address this problem, the health insurers participating in the exchange agreed to use risk adjustment to apportion the risk of individuals who used the exchange to purchase a plan.<sup>170</sup> Insurance carriers, business owners, and government agency representatives sit on the exchange's risk adjustment board.<sup>171</sup> Any of the board's decisions must be approved by the insurance commissioner.<sup>172</sup> The board works cooperatively to monitor and manage risk within the exchange to ensure private insurer participation.<sup>173</sup>

Massachusetts has been a forerunner in state health care reform and its legislature independently established a quasi government agency called the

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163. See Timothy Noah, *Maybe the Individual Mandate is Enforceable*, SLATE (last updated Apr. 7, 2010, 6:14 PM), <http://www.slate.com/id/2250098/> (contemplating that compliance with the mandate seems voluntary but that the IRS will enforce the mandate uniformly through the tax return process and if not followed, the IRS could seize tax returns).

164. See Jonathan Strong, *IRS Looking to Hire Thousands of Tax Agents to Enforce Health Care Laws*, DAILY CALLER (Mar. 22, 2010, 5:35 PM), <http://dailycaller.com/2010/03/22/irs-looking-to-hiring-thousands-of-armed-tax-agents-to-enforce-health-care-laws/> (discussing the federal tax code and the plan to implement aspects of the PPACA).

165. *Id.* See *supra* note 144 and accompanying text (describing five different lawsuits questioning the mandate and PPACA as a whole).

166. John Buntin, *A Closer Look: Utah's Health Insurance Exchange*, GOVERNING (April 26, 2011), <http://www.governing.com/topics/health-human-services/closer-look-utah-health-insurance-exchange.html>.

167. *Utah Health Exchange*, THE COMMONWEALTH FUND (Feb.–March 2011), <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Snapshots/Utah.aspx>.

168. *Id.*

169. Austin Frakt, *Dispatch from Massachusetts: The Individual Mandate is Working*, KAISER HEALTH NEWS (July 22, 2010), <http://www.kaiserhealthnews.org/Columns/2010/July/072210Frakt.aspx>.

170. *Utah Health Exchange*, THE COMMONWEALTH FUND (Feb.–March 2011), <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Snapshots/Utah.aspx>.

171. *Id.*

172. *Id.*

173. *Id.*

Commonwealth Health Insurance Connector Authority (“The Connector”).<sup>174</sup> When Massachusetts created its state exchange in 2006, state officials put significant effort into public education.<sup>175</sup> Massachusetts focused on making purchasing health insurance more of a social norm.<sup>176</sup> They encouraged enrollment at clinics and through easy online forums and used media and advertising to increase public awareness.<sup>177</sup> Massachusetts also incorporated the mandate into its state tax system.<sup>178</sup> The Connector developed an annual affordability schedule that determines the maximum monthly premium for individuals and uses this schedule to determine which plan options are considered affordable.<sup>179</sup> Individuals who are considered able to afford coverage under this schedule, but choose not to attain it are assessed a tax penalty.<sup>180</sup> The 2011 tax penalties for adults deemed able to afford coverage, are “based on half the cost of the lowest priced Commonwealth Care plan available.”<sup>181</sup> Today, Massachusetts has about ninety-seven percent of its population insured.<sup>182</sup>

The federal government’s heated defense of the individual mandate and the many alternatives proposed in case it is stricken, reflect the necessity of private insurer participation in the individual state exchanges. These insurers will only participate if they are assured that they can avoid adverse selection within the exchanges without their current strategies. For the PPACA to be successful in increasing access to care, the states must support the only effective way of controlling adverse selection, which is the individual mandate.

### B. Premium Rating

Premiums are insurers’ main source of revenue and actuaries determine premiums by incorporating a number of factors into risk and setting premiums accordingly.<sup>183</sup> Because insurers can easily adjust premiums with little regulation, unbridled rises in premiums can lead to unaffordable care and excessive profits.<sup>184</sup>

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174. AMY M. LISCHKO ET AL., THE MASSACHUSETTS COMMONWEALTH HEALTH INSURANCE CONNECTOR: STRUCTURE AND FUNCTIONS 1 (2009), available at <http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Issue%20Brief.pdf>.

175. MacGillis, *supra* note 83, at 90.

176. *Id.*

177. *Id.*

178. LISCHKO ET AL., *supra* note 174, at 8.

179. *Id.*

180. *Id.*

181. *Find Insurance: Individuals and Families Frequently Asked Questions*, HEALTH CONNECTOR, <https://www.mahealthconnector.org/portal/site/connector/menuitem.afc6a36a62cc1a50dbef6f47d7468a0c/?fiShown=default> (last visited Jan. 16, 2011).

182. MacGillis, *supra* note 83, at 90.

183. AM. ACAD. OF ACTUARIES, *supra* note 91, at 2.

184. See Reed Abelson, *Senate Pressing Insurers on the Amount of Premiums They Spend on Care*, N.Y. TIMES, Nov. 3, 2009, at B1 (explaining that in 2009 for-profit insurance companies spent as little

The PPACA attempts to ensure greater access to affordable care through community ratings and by requiring states to regulate premium changes.<sup>185</sup> Too much regulatory pressure to reduce premium pricing, however threatens insurer solvency.<sup>186</sup> In order to promote private insurer participation in state exchanges, state regulators must acknowledge the financial impact premiums have on business operations and create political balance in exchange leadership.

Instead of evaluating the risk of an individual buyer, the PPACA requires insurers to base premiums on community ratings.<sup>187</sup> Proponents argue that utilizing community ratings will provide greater access to care because high risk individuals will pay the same premiums as lower risk individuals.<sup>188</sup> These ratings are set in advance based on community attributes.<sup>189</sup> There are a few factors that allow very small adjustments to the premiums, including age, family composition, tobacco use, and location.<sup>190</sup> Additionally, premium rates will be compressed, in that premiums for adults can only be up to three times as large as those for the young.<sup>191</sup> Proponents also argue that the PPACA brings transparency to premium rate increases, requiring states to base any increase on “reasonable cost assumptions” and “solid evidence” and experts will evaluate the increases to ensure the assumptions are fair.<sup>192</sup> The hope is to provide consumers with access to information about rate increases and hold insurers accountable for their pricing.<sup>193</sup>

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as sixty-six cents of each dollar of premiums on doctor and hospital bills and the rest on administrative expenses, marketing, and profits); HEALTHCARE.GOV, HEALTH INSURANCE PREMIUMS: PAST HIGH COSTS WILL BECOME THE PRESENT AND FUTURE WITHOUT HEALTH REFORM I (2011), available at <http://www.healthcare.gov/law/resources/reports/premiums01282011a.pdf> (describing the growth of health insurance premiums and costs from 1999 to 2009 and how these growths severely outpaced wage growth).

185. See Patient Protection and Affordable Care Act § 2701, 42 U.S.C.S. 300gg(a) (LexisNexis Supp. 2011) (establishing community ratings); *Fact Sheet: Fighting Unreasonable Health Insurance Premium Increases*, HEALTHCARE.GOV, <http://www.healthcare.gov/news/factsheets/ratereview05192011a.html> (last visited Nov. 12, 2011) (reporting that on May 19, 2011, HHS issued a final regulation to implement the PPACA requirement that states evaluate large proposed premium increases and make sure they “are based on reasonable cost assumptions and solid evidence”) [hereinafter *Fact Sheet*].

186. See *supra* notes 71–73 and accompanying text; see also Letter from the Nat’l Ass’n of Ins. Comm’rs to Kathleen Sebelius, *supra* note 70 (expressing concern that destabilized insurance markets may undermine insurer solvency).

187. 42 U.S.C.S. § 300gg(a).

188. See Kingsdale & Bertko, *supra* note 50, at 1159 (discussing community rating and premium payments).

189. See 42 U.S.C.S. § 300gg(a)(2) (defining a rating area).

190. *Id.* § 300gg(a)(1)(A).

191. *Id.* § 300gg(a)(1)(A)(iii).

192. *Fact Sheet*, *supra* note 185.

193. *Id.*

Standardized premiums can pose a problem to the insurer's business model, however.<sup>194</sup> Strict premium regulation threatens not only private insurers' ability to remain profitable,<sup>195</sup> but more critically, the insurers' ability to remain solvent.<sup>196</sup> If premiums are regulated too low than what is optimal for an insurer's business operations, the insurer will not have enough capital to keep operations running efficiently, which causes insurers to leave the market or even face solvency problems.<sup>197</sup> An insolvent insurer is unable to pay operation costs and, more importantly, it can not pay claims.<sup>198</sup> One company's insolvency threatens the public trust in other companies.<sup>199</sup>

If the insurer faces higher costs in the highly regulated individual market inside the exchange, it will look to make more money in the less regulated employer-based market outside the exchange.<sup>200</sup> Insurers will raise premium prices for employer and small business plans outside the exchanges to subsidize the losses from the individual market within the exchange.<sup>201</sup> Costs are then passed on to employers.<sup>202</sup> Employers will lower the premium amount they are willing to cover and pass the cost onto employees, or choose to not provide coverage and pay the fine imposed by the PPACA for doing so.<sup>203</sup> Thus, consumers in the employer-

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194. See BAKER, *supra* note 90, at 638 (describing the consequences of premiums that are set too low).

195. LABORDE, *supra* note 71, at 7. For profit companies must also maintain adequate profits to please investors and stockholders. THOMAS WHEELEN & J. DAVID HUNGER, STRATEGIC MANAGEMENT AND BUSINESS POLICY: TOWARD GLOBAL SUSTAINABILITY 45 (13th ed. 2012).

196. See BLUECROSS BLUESHIELD OF N. C., IN THE SPOTLIGHT: HEALTH CARE REFORM AND PRE EXISTING CONDITIONS INSURANCE PLANS 1 (2010) (explaining that "pre-existing condition insurance plans do not charge 'actuarially justified' premium[s]" so they require additional funding).

197. James C. Capretta & Tom Miller, *How to Cover Pre-existing Conditions*, NAT'L AFF., Summer 2010, at 110, 115.

198. *Policyholder Information*, NAT'L ORG. OF LIFE & HEALTH, INS. GUARANTY ASS'NS, <http://www.nolhga.com/policyholderinfo/main.cfm/location/insolvencyprocess> (last visited Aug. 24, 2011). Though by state law, health insurers are members of the state's guaranty association that steps in to cover policies of an insolvent insurer, there are also maximum limits on how much each individual can receive no matter what his policy contract was. *Id.*

199. BAKER, *supra* note 90, at 638.

200. See Larry Levitt & Gary Claxton, *Remember the People Outside of the Exchanges*, HENRY J. KAISER FAMILY FOUND. HEALTH REFORM SOURCE (July 22, 2011), <http://healthreform.kff.org/notes-on-health-insurance-and-reform/2011/july/remember-the-people-outside-of-exchanges.aspx> (outlining that if plans outside exchanges have greater flexibility than those inside the exchanges, plans outside the exchanges will have pricing advantages and potentially attract healthier enrollees).

201. Troyen Brennan & Thomas Lee, *Risk-Shifting in Health Care and Its Implications: Part Two*, HEALTHAFFAIRS BLOG (Aug. 25, 2011, 1:02 PM), <http://healthaffairs.org/blog/2011/08/25/risk-shifting-in-health-care-and-its-implications-part-two/> (explaining the same phenomenon occurring in Medicare when health care providers face losses on Medicare, they cross subsidize those losses with patients in other segments of the market that pay more for care).

202. *Id.*

203. See *id.* (discussing employer decision making and cross subsidization).

based market effectively bear the cost of adverse selection.<sup>204</sup> Because exchanges need private insurers to remain solvent, there will be significant pressure on the exchanges to be fair to insurers and consumers. This will require significant communication and cooperation among the insurance commissioner, the exchange and insurers as well as public education.<sup>205</sup>

In 2011, Maryland's governor signed into law the Maryland Health Benefit Exchange Act that set up the Maryland Health Benefit Exchange.<sup>206</sup> The Act creates a Board of Trustees to oversee the exchange.<sup>207</sup> This board consists of the Secretary of Mental Health and Hygiene, the Commissioner, the Executive Director of The Maryland Health Care Commission and six members appointed by the governor.<sup>208</sup> These six people will include three who represent the interest of employers and individual consumers of the products offered by the exchange, and three members who demonstrate knowledge and expertise in a particularly relevant area such as health care finance.<sup>209</sup> Additionally, governor appointments must represent a diversity of expertise, race, gender, and ethnicity and the state's geographical areas.<sup>210</sup> The Board will appoint an Executive Director of the Exchange who will, among other things, manage the exchange.<sup>211</sup> Maryland's legislation reflects the legislature's attempt to keep the exchange from overly political influences. The bill balances interests by including both private insurer and community representatives to the Board of Trustees. Maryland's legislature attempts to limit the political influence over the exchange, and to ensure that the six appointed members of the board remain diversified in order to keep the system running efficiently.

In contrast to Maryland, Utah is an example of a compromise model for politically conservative states that want to limit government involvement in the exchanges.<sup>212</sup> Utah's health insurance exchange is part of the governor's Office of Economic Development.<sup>213</sup> Utah's governor sought input from the private sector and in December 2010, appointed a former insurance executive as the director of

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204. *See id.* (explaining that if insurers begin to drop coverage because it is unaffordable, those in the individual segment "will bear the brunt" of insurer cross subsidization).

205. *Id.* (addressing the risk shifting that exchanges will cause to the health care system and the implications the shifting will have on and among the different parties within the system).

206. H.D. 166, S. 182, 2011 Leg., 428th Sess. (Md. 2011) (codified at MD. CODE ANN. INS. § 31-104(a) (LexisNexis 2011)).

207. MD. CODE ANN. INS. § 31-104(a) (LexisNexis 2011).

208. *Id.* § 31-104(b).

209. *Id.* § 31-104(b)(4).

210. *Id.* § 31-104(c).

211. *Id.* § 31-105(a)(1).

212. *See* Buntin, *supra* note 166 (describing an interview with the communications director of the Utah Office of Economic Development that suggests that Utah's Exchange had limited government requirements and restrictions, but rather government partnership gave small businesses an opportunity to develop a new model of insurance coverage).

213. *Id.*

Utah's health exchange.<sup>214</sup> The health exchange runs on a budget of only \$600,000 and a two person staff.<sup>215</sup> Utilizing the "contribution market"<sup>216</sup> approach, Utah seeks to provide the information platform for individual consumers to make informed decisions on health care purchases.<sup>217</sup> Initially, Utah allowed premiums for plans outside the exchanges to be different from premiums for plans inside the exchanges.<sup>218</sup> In March 2010, however the Utah legislature passed a statute requiring health carriers to charge the same rates for the same products, whether inside or outside the exchanges, in order to standardize rating practices in the small-group market.<sup>219</sup> Premiums may be adjusted for limiting factors such age, family composition and geographic area.<sup>220</sup> Utah combines a conservative market approach with limited government intervention and premium regulation to expand healthcare access for its citizens.<sup>221</sup>

Because premiums not only drive insurers' profitability, but their ability to adjust risk in order to remain solvent and operable,<sup>222</sup> it is imperative that as states set premium values, states consider the business implications such values will have and balance political influence over premium regulation. Today, only twenty-five states have a structure in place that regulates health insurance premiums spending.<sup>223</sup> The PPACA prohibits "unreasonable" premium increases but leaves defining "unreasonable" to the states.<sup>224</sup> Much like Massachusetts, individual states must balance regulatory roles between the state's insurance commissioner and the

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214. *Id.*

215. *Id.*

216. *Id.* Through the Utah Health Exchange, "small businesses can make a defined contribution—a fixed dollar amount per employee—toward health insurance, and their employees can compare and select health plans . . ." *Utah Health Exchange, supra* note 170, at 1. Employees pay the portion of the premium that the employer's fixed amount does not cover. *Id.* This system gives consumers more choices, employers more control over costs, and keeps the private industry actively involved in the health insurance market. *Id.*

217. *Utah Health Exchange, supra* note 170, at 1 (describing consumers' ability to view "side-by-side comparisons of health plans" and filter and sort the results).

218. *Id.*

219. *Id.*

220. Sabrina Corlette, *Debunking the Mythology: The Utah and Massachusetts Health Exchanges*, KAISER HEALTH NEWS (Apr. 6, 2011), <http://www.kaiserhealthnews.org/Columns/2011/April/040611corlette.aspx>.

221. Gregg Girvan, *Consumer Power: Five Lessons from Utah's Health Care Reform*, BACKGROUNDERS, Aug. 19, 2010, at 1, 2 (describing Utah's reforms that allow small business employees to purchase insurance through the exchange with little cost to the state and concluding that Utah's reforms will decrease health care costs while mandates and restrictions will increase insurance costs for citizens).

222. *See supra* notes 200–04 and accompanying text (discussing premium effect on profitability and operability).

223. Nichols, *supra* note 67, at 1153.

224. Patient Protection and Affordable Care Act § 2794, 42 U.S.C.S. § 300gg-94(a)(2) (LexisNexis Supp. 2011).



executive in charge of running the exchanges.<sup>225</sup> By maintaining this balance, premium regulation can be structured with input from the commissioner, the consumers, and insurers. Regulators must also consider that if premium rates are set too low or if mandates prove unable to control the structured risk pool and result in adverse selection, insurers will face higher costs.<sup>226</sup> This will drive insurers to cross-subsidize their costs in order to remain profitable, or even solvent.<sup>227</sup>

### C. Premium Adjustment/Medical Loss Ratio

When insurers collect premiums from consumers, a portion is spent on medical claims and related expenses and the rest of the funds are spent on administrative expenses such as marketing costs and profits.<sup>228</sup> The MLR is an important financial tool because it can reflect how efficiently an insurer spends its premium dollars; or how much value the consumer receives per premium dollar paid.<sup>229</sup> The PPACA regulates insurers' MLRs to provide more "value" per consumer premium dollar spent.<sup>230</sup> Overly strict regulation, however will actually promote inefficiency and drive private insurers out of the exchanges.<sup>231</sup> HHS must consider market stabilization and allow states leniency in establishing and maintaining their MLRs.

The PPACA tasks the Secretary of HHS and NAIC with creating a uniform definition and standardized methodology for calculating the medical loss ratio.<sup>232</sup> The PPACA requires that beginning in 2011, insurers must maintain medical loss ratios at eighty percent for small business and individual insurers and eighty-five

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225. See LISCHKO ET AL., *supra* note 174, at 2 (describing the various type of people involved in the Connector and their backgrounds).

226. See Capretta & Miller, *supra* note 197, at 115 (discussing unbalanced risk pools and adverse selection).

227. Brennan & Studdert, *supra* note 64, at 1149. Through cross subsidization, insurers will raise premiums on employer based plans and plans outside the exchanges in order to pass the cost on to the consumer. *Id.*

228. Haberkorn, *supra* note 74, at 1.

229. Robinson, *supra* note 72, at 176–77. A 2010 study performed by HealthScape Advisors, LLC determined that the average MLR for small group plans was 83.08 percent and the average MLR for individual plans was 80.24 percent. Sara Hansard, *Insurance Regulation: 2010 Data Show Small Group, Individual Health Plans Would Have to Make Rebates*, BLOOMBERG BUREAU OF NAT'L AFF. (May 4, 2011), [http://news.bna.com/hpln/HPLNWB/split\\_display.adp?fedfid=20840354&vname=macnotallissues&wsn=498259000&searchid=16769407&doctypeid=1&type=date&mode=doc&split=0&scm=HPLNWB&pg=0](http://news.bna.com/hpln/HPLNWB/split_display.adp?fedfid=20840354&vname=macnotallissues&wsn=498259000&searchid=16769407&doctypeid=1&type=date&mode=doc&split=0&scm=HPLNWB&pg=0).

230. See *Getting Your Money's Worth*, *supra* note 72 (describing the ways in which the law will help ensure "Americans receive value for their premium dollar").

231. Press Release, Indep. Ins. Agents & Brokers of Am., Big "I" Disappointed with HHS Regulations on MLRS (Nov. 22, 2010), (describing the Independent Insurance Agents & Brokers of America's concern that the PPACA's MLR regulation will have a "devastating effect on the private marketplace" and that "consumers will be negatively impacted").

232. Patient Protection and Affordable Care Act § 2718, 42 U.S.C.S. § 300gg-18(c) (LexisNexis Supp. 2011).

percent for large businesses.<sup>233</sup> Insurers must report their expenditures annually and if they do not meet the eighty percent or eighty-five percent standard, they must provide consumers a rebate for the difference.<sup>234</sup> The Secretary has authority to initially waive the MLR requirement if an individual state can prove that the eighty percent MLR will cause market destabilization.<sup>235</sup>

After considering input from current state regulators, insurance industry experts, and others experienced in insurance provisions, on October 21, 2010, NAIC submitted MLR recommendations to the Secretary.<sup>236</sup> A significant portion of the recommended regulations focus on defining what expenses may be included in health quality improvement (QI) because those expenses will not be included in the twenty percent limited administrative expenses.<sup>237</sup> The recommendation focuses on expenses that are “capable of being objectively measured and of producing verifiable results and achievements”; they must be “grounded in evidence-based medicine”; “widely accepted best clinical practice; or criteria issued by recognized professional medical societies, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.”<sup>238</sup> The QI activities must be “directed toward individual enrollees or may be incurred for the benefit of a special segment of enrollees.”<sup>239</sup> The focus of this definition is transparency, clear accountability, and creating the most “value” for consumers’ premium expense.<sup>240</sup>

While the PPACA’s definition of value, applied specifically though HHS, appears consistent on its face, it presents two major issues: it may not actually provide value to consumers and it may promote financial inefficiency.

Supporters of the regulation argue that the stringent requirement will force insurers to be economically more efficient.<sup>241</sup> For those insurers that choose to participate in the exchanges, many functions have potential to be streamlined,

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233. *Id.* § 300gg-18(b)(1)(A)(i)–(ii).

234. *Id.* § 300gg-18(b)(1)(A)–(B). For example, if an individual/small business insurer collects \$1,000,000 in annual premiums, it must spend \$800,000 on medical claims and \$200,000 on administrative expenses. If the insurer spends only \$700,000 on medical claims, it must rebate the \$100,000 to all qualified consumers.

235. *Id.* § 300gg-18(b)(1)(A)(ii).

236. Letter from the Nat’l Ass’n of Ins. Comm’rs to Kathleen Sebelius, *supra* note 70.

237. See NAT’L ASS’N OF INS COMM’RS, REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF THE MEDICAL LOSS RATIO FOR PLAN YEARS 2011, 2012 AND 2013 PER SECTION 2718(b) OF THE PUBLIC HEALTH SERVICE ACT 190-34 TO 39 (2010), available at [http://www.naic.org/documents/committees\\_ex\\_mlr\\_reg\\_asadopted.pdf](http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf); Patient Protection and Affordable Care Act § 2718, 42 U.S.C.S. § 300gg-18(b).

238. NAT’L ASS’N OF INS COMM’RS, *supra* note 237 at 190-34.

239. *Id.*

240. See Patient Protection and Affordable Care Act § 2718, 42 U.S.C.S. § 300gg-18(a)–(b). In December 2011, the Secretary issued a final interim rule effective January 3, 2012 defining the MLR requirements. 45 C.F.R. § 158.150 (2011) (defining “[a]ctivities that improve health care quality”).

241. See *Getting Your Money’s Worth*, *supra* note 72 (outlining various ways the new MLR rules will ensure value for consumers).

including “sales, enrollment, premium billing, collections.”<sup>242</sup> The exchanges are supposed to standardize and automate these processes with the ultimate goal of reducing administrative costs.<sup>243</sup> Opponents argue, however that the rebate requirement will increase insurer administrative costs, potentially driving up premiums.<sup>244</sup> Insurers generally do not keep the type of detailed information about premium payments that a rebate to individual consumers requires.<sup>245</sup> Additionally, employers also do not typically track the type of details insurers will require from employee sponsored plans.<sup>246</sup> These additional responsibilities will likely require businesses and insurers to add staff and IT systems to manage data requirements, driving up costs that will ultimately be borne by the consumer.<sup>247</sup> A 2010 study by the Health Insurance Report found that “twenty-seven percent of small group health insurance plans and forty-six percent of individual plans surveyed would have potential exposure to rebates” in 2012.<sup>248</sup>

Supporters of the PPACA also argue that the regulation provides transparency to premium spending.<sup>249</sup> Insurers will provide consumers with information about how their premiums are spent and how much goes towards medical care and health improvement care.<sup>250</sup> A stringent MLR definition and ratio will ensure that consumers receive the most value for their premium dollars.<sup>251</sup> There is potential, however for an impractical definition to create inefficiencies for the private insurer.<sup>252</sup> For instance, an insurer that collects \$1,000,000 in annual premiums, medical claims payments, and QI expenses must reach at least \$800,000. This leaves the insurer with \$200,000 to be dispersed among all administrative expenses. If the same insurer were to invest \$50,000 in a program that significantly reduced

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242. Kingsdale & Bertko, *supra* note 50, at 1161.

243. For example, the Massachusetts Health Connector operates with an administrative budget of three percent of total premiums. Martin Sipkoff, *Making Sense of the Reform Law's Insurance Pools & Exchanges*, MANAGED CARE (June 2010), <http://www.managedcaremag.com/archives/1006/1006.exchanges.html> (describing the Massachusetts Health Connector exchange operating with an administrative budget of only three percent of total premiums compared to private insurers with administrative budgets of five percent to twenty percent of premiums).

244. Letter from Steven B. Kelmar, Aetna Senior Vice President, Gov't Affairs & Public Policy to U.S. Dep't Health & Human Servs. I (Jan. 31, 2011).

245. *Id.* at 2.

246. *Id.* (describing the burden and expense that insurers will be required to bear from tracking information).

247. *Id.* at 3–4.

248. Hansard, *supra* note 229.

249. *Getting Your Money's Worth*, *supra* note 72.

250. *Id.*

251. *Id.*

252. See generally Letter from Steven B. Kelmar, to U.S. Dep't Health & Human Servs., *supra* note 244 (commenting on various issues regarding how HHS's Interim Final Rule implements MLR requirements and outlining eight general areas where the Interim Final Rule created inefficiencies and difficulties for the private insurer business model).

insurance fraud and abuse (currently not included in the QI definition), that reduced medical claims payments by \$200,000, the insurer would now have a MLR of only sixty percent which would require a rebate of \$200,000 to consumers for a total \$250,000 expense. In order for this to make financial sense to the insurer, premiums would have to rise to \$1,200,000, but the PPACA makes it very difficult for insurers to raise premiums.<sup>253</sup> Instead, the insurer would choose not to invest in such a fraud and abuse program because the insurer would lose money.<sup>254</sup> This scenario does not provide value to either the consumer, who would face higher premiums, or the insurer, who would bear losses for investing in fraud prevention. Further, if the MLR is set at too high a level compared to the economically “correct,” efficient operation that a private insurance company requires, then companies will choose to cut salaries and operation systems.<sup>255</sup> An insurer may choose to hire cheaper, less experienced staff, which may lead to mistakes, slower payments, or less customer service. As a result, an improperly set MLR would not encourage efficiency, but cause waste.

Another example of potential inefficiency caused by MLR regulation is found in Medicare. Proponents of a strict MLR point to Medicare which has not had an MLR lower than ninety-seven percent between 1993 to 2007.<sup>256</sup> Medicare however is not comparable to the private insurer.<sup>257</sup> Medicare has few administrative costs<sup>258</sup> and because it is funded by the federal government, it does not have to worry about profit margins and revenues.<sup>259</sup> Though Medicare purports to maximize efficiency by paying so much for medical claims and expenses, Medicare has historically been plagued by fraud and abuse.<sup>260</sup> Blindly paying properly coded claims may lead to a

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253. Patient Protection and Affordable Care Act § 2794, 42 U.S.C.S. § 300gg-94(a)(2) (LexisNexis Supp. 2011).

254. Letter from Steven B. Kelmar, to U.S. Dep’t Health & Human Servs., *supra* note 244, at 1 (noting Aetna’s concern that the final MLR formula penalizes insurers who invest in quality control programs such as fraud prevention).

255. *See id.* 3–4 (describing the tremendous administrative expenses that will be necessary if the MLR requires stringent reporting requirements and rebates).

256. Wendell Potter, *The Insurance Industry’s Lethal Bottom Line – and a Solution from Sens. Franken and Rockefeller*, CTR. FOR MEDIA & DEMOCRACY’S PR WATCH (Dec. 10, 2009, 8:36 AM), <http://www.prwatch.org/node/8747>.

257. Medicare is run by the federal government and financed by a payroll tax paid by workers and employers and also through premiums deducted from social security checks. SOC. SEC. ADMIN, MEDICARE 4 (2011), available at <http://ssa.gov/pubs/10043.pdf>. In contrast, private insurance companies are concerned with returning a profit to investors. *See supra* note 198 and accompanying text.

258. Robert A. Book, *Medicare Administrative Costs are Higher, Not Lower, Than for Private Insurance*, HERITAGE FOUND. (June 25, 2009), <http://www.heritage.org/research/reports/2009/06/medicare-administrative-costs-are-higher-not-lower-than-for-private-insurance>.

259. *See generally supra* note 257 and accompanying text (describing the basics of how Medicare operates).

260. *See, e.g.*, Bill Singer, *The Epidemic of Florida Medicare Fraud*, FORBES (Aug. 24, 2011, 9:40 AM), <http://www.forbes.com/sites/billsinger/2011/08/24/the-epidemic-of-florida-medicare-fraud/> (reporting that “[o]n February 10, 2011, federal prosecutors indicted 21 Miami-area residents . . . in

high MLR, but does not necessarily translate to an efficient system. Comprehensively monitoring for fraud is an additional expense that would require significant funding that would alter the MLR number.<sup>261</sup> There is a delicate balance in the definition of efficiency and how it is structurally defined through MLR regulation.

In its letter to the Secretary of HHS that accompanied its regulation suggestions, the NAIC reiterated its continued concerns about the potential consequences of the MLR.<sup>262</sup> The NAIC points out that consumers will not benefit from the MLR if the number destabilizes insurance markets where consumer choice is limited and insurer solvency is destabilized.<sup>263</sup> President and CEO of the Independent Insurance Agents & Brokers of America (the Big “I”), Robert Rusbuldt, responded to the proposed regulation with concerns that the rule will lead to, “severe market disruption, especially in the individual and small group markets.”<sup>264</sup> Charles E. Symington Jr., vice president for government affairs at the Big “I” voiced similar concerns in a press release, “the MLR provision of the new health care reform law will have a devastating effect on the private marketplace and consumers will be negatively impacted.”<sup>265</sup>

Though the legislation will allow individual state markets to make adjustments to the MLR if it threatens market destabilization,<sup>266</sup> the adjustments may not be enough incentive for insurers to continue participating in the individual market. States must also get the Secretary’s approval to have an adjusted MLR.<sup>267</sup> Currently, seventeen states have sought permission to adjust the MLR requirement and only seven have been granted permission.<sup>268</sup> Alternatively, in early 2011, California’s newly appointed Insurance Commissioner, Dave Jones proposed a plan

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connection with their alleged participation in a \$25 million home health care Medicare fraud scheme”). In 2010, Medicare paid fifty billion dollars in claims that did not meet program requirements. Jill Wechsler, *Insurers Want MLR Policies to Include Anti-Fraud Efforts*, MANAGED HEALTH CARE EXEC. (Apr. 1, 2011), <http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=714733&sk=&date=&pageID=2>.

261. While Medicare has a Health Care Fraud Prevention and Enforcement Team in place, the price tag for fraud prevention is huge. See Press Release, U.S. Dep’t of Health & Human Servs., Fed. Gov’t Expands Grassroots Fraud Prevention Efforts (Oct. 1, 2010) (announcing nine million dollars in grants awarded to consumer activist groups to help detect and prevent fraud) (emphasis added).

262. Letter from the Nat’l Ass’n of Ins. Comm’rs to Kathleen Sebelius, *supra* note 70.

263. *Id.*

264. Press Release, Indep. Ins. Agents & Brokers of Am., *supra* note 231.

265. *Id.*

266. See Patient Protection and Affordable Care Act § 2718, 42 U.S.C.S. § 300gg-18(b)(1)(A)(ii) (LexisNexis Supp. 2011) (allowing adjustments with approval).

267. See *id.* (allowing a state to lower the MLR percentage, but only if the Secretary determines that the twenty-five percent rate will be disruptive to the individual state’s market).

268. *Medical Loss Ratio Adjustments 2011*, HENRY J. KAISER FAMILY FOUND., <http://www.statehealthfacts.org/comparatable.jsp?ind=940&cat=17> (last visited Mar. 9, 2012).

to begin enforcing the federal MLR.<sup>269</sup> California's existing laws require individual insurers to maintain a seventy percent MLR.<sup>270</sup> Jones plans to raise this bar to the eighty percent federal level as soon as possible, so that the state is ready when the exchanges must be completed in 2014.<sup>271</sup> Immediate state implementation may run into a problem, though because states that currently regulate the MLR do not have a consistent definition, nor are their definitions the same as the federal definition. Changing the required state rate under the state definition, may not avoid the market disruption that insurers fear from federal regulation.

To avoid market disruption and maintain insurer participation, State commissioners must be extremely cognizant of individual insurer's financial state and be willing to be flexible with particular allowable expenses.<sup>272</sup> On the federal level, the Secretary must be willing to allow any state to alter the MLR requirement. States are using resources and insurance professionals to evaluate their markets.<sup>273</sup> It is imperative that the Secretary, HHS and the NAIC work with states when setting the MLR ratio and that states' definition to balance the overarching goals of value and transparency with the private insurers' business definition of value and goal of solvency and fairness.

## V. CONCLUSION

The PPACA's goal is to reform the health care delivery and insurance system so that as many Americans as possible have access to affordable health insurance and appropriate health care services. The PPACA contemplates that primarily, the private insurance market will provide enhanced access and mandates that the exchanges provide consumers with transparency, choice, and fair pricing. While the PPACA lays the groundwork for the exchanges, state regulators are tasked with the true challenge of building and operating them successfully.<sup>274</sup> In order to do this, it

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269. *Jones Proposes Plan to Enforce Medical-Loss Ratio Regulations*, CAL. HEALTH ONLINE (Jan. 4, 2011), <http://www.californiahealthline.org/articles/2011/1/4/jones-proposes-plan-to-enforce-medical-loss-ratio-regulations.aspx>.

270. *Id.*

271. *Id.*

272. See Patient Protection and Affordable Care Act § 2718, 42 U.S.C.S. § 300gg-18(b)(1)(A)(ii) (LexisNexis Supp. 2011) (addressing the possibility that regulation may cause state market disruption). For instance, another concern that the private industry has with the suggested regulation is that brokerage fees are included in administrative expenses. Letter from the Nat'l Ass'n of Ins. Comm'rs to Kathleen Sebelius, *supra* note 70. If disallowing these fees in the allowable expenses causes market disruption, regulators need to address the problem.

273. See, e.g., *State Roundup: Fla. Seeks MLR Waiver; Hospitals Struggle*, KAISER HEALTH NEWS (Mar. 15, 2011), <http://www.kaiserhealthnews.org/daily-reports/2011/march/15/states-health-care.aspx> (reporting that as of March 15, 2011, five states had filed petitions asking for an adjustment for federal medical loss rules for the individual insurance market); see *Medical Loss Ratio Adjustments*, *supra* note 268 (providing an up-to-date chart of individual state requests for MLR adjustments, the results, and other detailed information).

274. 42 U.S.C.S. § 18041.

is imperative that state regulators approach this task with a business perspective and develop a balanced structure that not only complies with the PPACA's mandates, but also encourages private market participation.