Later this year, new provisions of the Patient Protection and Affordable Care Act of 2010 will transform the health care industry. Consumers will be able to purchase insurance through health insurance marketplaces, but many people who already have insurance could see their premiums rise. Insurers will need to help consumers navigate the new system.

The Patient Protection and Affordable Care Act of 2010 (ACA) has 2 key goals: extending medical coverage to more people and guaranteeing certain basic benefits to all insured individuals. These goals, which have animated the health care debate for decades, are admirable, but they come at a cost. By 2014, as some of the most robust parts of the ACA go into effect, the impact of this legislation will begin to become apparent.

The law will provide additional coverage and new benefits for many people. The ACA attempts to extend coverage under private insurance in 3 ways: by guaranteeing the right to purchase health insurance [1], by limiting rating factors [2], and by making income-based premium subsidies available for some people with incomes up to 400% of the federal poverty level [3]. New health insurance marketplaces (also called health benefit exchanges) and the Small Business Health Options Program (SHOP) for small employers, which will go into effect in 2014, will offer additional ways to buy private insurance for both new and existing participants in the health insurance system.

The tradeoff is that premiums for many people may increase sharply. People who are already in the health insurance system will pay more for newly mandated benefits and higher levels of coverage, which in the past they might have opted not to buy. People who are outside of the system may continue to forgo insurance, despite federal penalties for doing so, which could result in a costlier risk pool. New taxes and fees will also increase the cost of insurance. While federal subsidies for premiums and cost sharing will help to soften the blow for some, not everyone will qualify for assistance, and many who do qualify will receive only partial support.

Meanwhile, the health care costs on which consumer premiums are based will likely continue to spiral upward. Because the federal subsidies only redistribute the burden of paying for insurance, the pressure from taxpayers to address health care costs will likely be greater than ever. This pressure should provide even more incentive for insurers and providers to collaborate on ways to improve the quality and efficiency of care.

Insurers will have a role to play in helping consumers navigate this new environment of more choices and, for many, increased costs. The first way we can help is through education. No one inside or outside the industry knows everything that will happen, but we can address misinformation, of which there is plenty, and we can help to alleviate uncertainty on the part of consumers. As health insurance marketplaces begin operating later this year, the people we all work to serve are going to want to know how the changes will affect them, how they can navigate the system, and why they may be paying more. We can help them to understand.

Operational Challenges

By the time key provisions of the ACA, such as the individual mandate and guaranteed issue, go into effect in January 2014, nearly 4 years will have passed since the president signed the ACA into law. That sounds like plenty of time, but the complexity of the work coupled with delays in receiving regulations and technical guidance make the October 2013 deadline for open enrollment and the January 2014 effective date for coverage extremely challenging. The ACA is bringing about a top-to-bottom overhaul of the way consumer health insurance works in the United States; just a few hundred pages of legislation have provided a replacement blueprint for an industry that spent decades developing into its current form. Of course, the ACA did not arrive fully formed. Tens of thousands of pages of regulations have been written, and some regulations are still being created with only months remaining until the newly formed health insurance marketplaces go into operation. In addition, a complex web of information technology systems will be needed to support the marketplaces, and insurers’ interactions with the marketplaces and their support of products sold on the market.

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places will involve another layer of technological and security considerations—all of which must align with the provisions of the ACA. The scope and complexity of reform and tight timeframes make it a tough target. The need to move forward on implementation based on best information, before all final requirements are known, makes it a moving target as well.

Change management is a challenge for any business, but health care reform magnifies that challenge for health insurers. New rules impose standards for an insurer’s medical loss ratio, which is the amount an insurer spends on administrative expenses compared to the amount it spends on health care. Under these new rules, at least 80% of the money the insurer receives in premiums must be spent covering the cost of care for policyholders (the exact ratio varies from market to market and from state to state; in large group markets, the amount is 85%). If more than 20% (in large group markets, 15%) of the money received in premiums is spent on administrative costs, the difference must be rebated to customers [4]. These new standards have gone into effect at precisely the time when insurers need more administrative resources, not fewer, to implement a host of changes.

**Business Challenges**

Once insurers, providers, and other participants in the health care system settle into a post-ACA world, we will all be in a different business than we were before. Previously, insurance of any kind, including health insurance, relied on fundamental concepts of risk management and used tools to strike a delicate balance between pooling and segmenting risks. This has been necessary for insurers to serve their customers and to maintain the financial stability necessary to continue serving them.

The ACA is upsetting the balance that has long been in place in the health insurance market, both in North Carolina and in all but a handful of other states. This is especially true for the individual insurance market, where people buy coverage on their own rather than as a member of a group. For example, consumers will now benefit from “guaranteed issue”—if they want coverage, an insurer must offer it to them, whether or not they have preexisting conditions or some other kind of heightened risk.

**The effects of rating changes.** Because everyone will have access to health insurance, new high-risk members will enter the pool. And pooling requirements will cause the cost of their care to be spread evenly across an insurer’s entire individual insurance population or across an insurer’s entire small-group insurance population. The ACA attempts to mitigate the negative impact that these high-risk members will have on rates by attempting to add healthier individuals to the insurance pool through an individual mandate that penalizes people who do not buy insurance [5]. There are also limited incentives for certain small employers to offer coverage [6] and penalties for large employers that do not offer coverage [7].

However, if a person is inclined to do without coverage—for example, a young, healthy individual with no dependents who is ineligible for substantial federal subsidies—he or she will likely find that paying the federal penalty is less expensive than buying insurance. If many of these low-risk people stay away, the cost to serve the insured population will increase, and premiums will rise accordingly.

The ACA will greatly limit insurers’ ability to charge their customers different amounts based on their risk level. It has always been common for insurers—whether they sell health, automobile, or home insurance—to engage in “rating” practices in which they adjust a member’s premiums based on his or her risk factors. In the health insurance industry, those risk factors have included such things as health condition, age, and sex.

Under the new law, rating based on a member’s age will be restricted. Insurers will not be allowed to charge their oldest members more than 3 times the amount that the youngest adult members pay.

A more significant change is that rating based on a person’s health condition will no longer be allowed. The population of individuals who are currently uninsured but who will soon be eligible to purchase coverage will include more persons who are sick than the population that is insured already. Because insurers will not be able to deny coverage based on preexisting conditions, people with more health problems and greater medical needs will be participating in the system, and these individuals will require more care than the other members. Aside from permitted differences in rating due to age, geographic location, and tobacco use, these less healthy individuals will pay the same as everyone else. The need to cover these sicker individuals will thus drive up the average cost of insurance plans.

The third major change in rating rules is that the ACA prohibits insurers from charging men and women different premiums. However, the effect of sex on a person’s actual medical costs changes over time. Young women use more health care services than do young men; however, Blue Cross and Blue Shield of North Carolina’s historic claims experience shows that the reverse is true for older individuals—men use more health care services than women. The cost effects of these differences are greater than the cost effects of age differences. Traditionally, insurers have adjusted people’s premiums accordingly, but they will no longer be allowed to do so. In addition, the inclusion of maternity care as an essential health benefit that all plans will be required to provide will increase premiums for men because of new pooling requirements. In a similar vein, required pediatric benefits, including newly required pediatric dental and vision care, will increase premiums for all adults, including those who have no children.

**The effect of the individual mandate.** The framers of the ACA understood that childless adults do not need pediatric care and that men do not need maternity care. The intent of the law was to even out the burden of costly conditions by sharing them among the entire population. But for that to
work, everyone must be part of the system.

In North Carolina, approximately 1.56 million nonelderly people lack any kind of health insurance [8]. Proposed regulations state that beginning on January 1, 2014, an individual who has no health coverage will pay a penalty of $95 per year or 1% of his or her taxable income, whichever is greater; by 2016, the penalty will grow to $695 per year or 2.5% of taxable income, whichever is greater [9]. For many people, a health insurance policy will cost more than that. This does not mean that the majority of people will choose the penalty over the mandate; after all, many people who do not have health insurance coverage would very much like to have it. It remains to be seen whether individuals who are not inclined to buy insurance will do so if the cost of insurance exceeds the penalty.

The Information Challenge

Although most insurers and providers have tried to steer clear of the political rancor that has permeated discussion of the ACA, people who buy insurance and use health care have heard a great deal of debate over the past 4 years. For many people, this has left them divided, confused, and fatigued. Given this environment, the health insurance industry faces a sizable challenge in its efforts to forge new relationships and win trust.

The more that people understand and appreciate the core value of buying insurance and using health care intelligently, the greater the likelihood that they will choose to participate in the system. Therefore, helping people become more informed about their health insurance options will increase the participation of those who are "good risks" and will help lower the cost of care over time. We who work in the industry can help people address these new questions, find the best value, and navigate their new choices. We will need to help them understand what they are getting, why they may be paying more, and how various parts of the law will affect them. Under the new system, health insurers will also need to assist people with new processes, such as applying for subsidies and demonstrating coverage.

Thus in a post-ACA world we all have 3 jobs: We have to do the jobs we had before, we have to be change agents, and we have to be educators.

The Underlying Costs

Ultimately, changes to risk pools and to rating requirements will change only the way that cost is divided among people. They will not change the costs themselves. Nor will subsidies, even for those who receive them in full measure. Medical costs are the primary driver of health insurance premiums, and this fact will remain the same.

Addressing the problem of high medical costs is an area in which insurers and providers can accomplish most through collaboration. It is now more important than ever to coordinate care, to deliver high quality care, and to demonstrate tangible value for everything that costs members money.

As we at Blue Cross and Blue Shield of North Carolina have been saying for several years, this is a shared responsibility that starts with a shared dialogue. These changes are law. Whether or not we asked for the changes, insurers are the front line charged with helping people to understand and accept them.

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