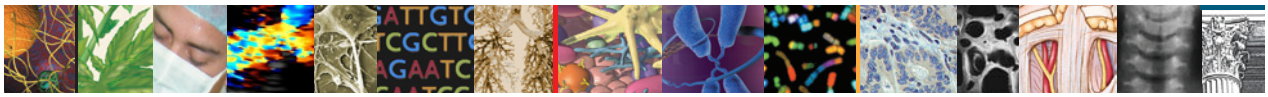

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Perspective

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A "Broader Regulatory Scheme" — The Constitutionality of Health Care Reform

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Although a federal court in Florida has allowed a state challenge to the constitutionality of health care reform to proceed to the next stage of litigation,[1] a second federal court in Michigan has already swiftly dispatched identical claims on the merits. In rejecting the plaintiffs' claim, in *Thomas More Law Center et al. v. Barack Hussein Obama et al.*, that the 2010 health care reform is unconstitutional, Judge George Steeh wrote on October 7 that according to a wealth of U.S. Supreme Court precedent, Congress's power to regulate individual activity under the Commerce Clause (in this case, through a mandate that individuals obtain health insurance) rests on whether the activity amounts to an "integral part of a broader regulatory statutory scheme that permissibly regulates interstate commerce."[2] In this regard, Steeh's opinion contains two central and intertwined conclusions. First, "economic decisions as to how to pay for health care services have direct and substantial impact on the interstate health care market." Second, the "minimum coverage provision is essential to the Act's larger regulation of the interstate business of health insurance."[2]

Both of these elements are essential to the holding. If there is no individual activity that directly and substantially affects interstate commerce, Congress cannot act. And if there is no broader statutory scheme regulating interstate commerce, then the federal law will fail the constitutional test, as other laws have done.[3,4]

For reasons that the U.S. District Court in Michigan found relatively obvious, the Patient Protection and Affordable Care Act (ACA) satisfies the first of these two requirements. As Judge Steeh noted, the health care market is unlike any other market, because there is no way that "living breathing beings" can opt out of it. Everyone needs health care at some point, and thus all of us are market purchasers, however reluctantly. How individuals buy health care is fundamentally a matter that affects the health care system nationwide.

But in order to be constitutional, a federal law must satisfy the second test: Congress must intervene in a manner that rises to the level of a broader regulatory scheme. Health care reform represents just such an intervention, offering a comprehensive redesign of the U.S. health insurance market. The law fundamentally transforms health insurance from a product designed to preserve profitability in the face of rampant adverse selection to a regulated industry whose long-

term strength and stability are essential to the public interest and that, in its restructured form, will therefore take on certain characteristics of a public utility.[4,5]

The redesign of U.S. health insurance to advance the national public interest addresses two profound threats to the survival of a functional health care system that is capable of serving Americans' needs. The first problem is that tens of millions of people are uninsured, either as a matter of a deliberate choice or as the result of financial or health-related exclusionary barriers. The second problem, triggered by the first, is rampant shifting of costs onto millions of other Americans who have chosen to be insured and are fortunate enough to be able to obtain coverage.

Of course, the individual mandate is central to the legislative scheme, since without a large pool of healthy adults and children, it is simply impossible to create the market conditions for stable health insurance — a fact that is universally recognized by economics experts. But if the ACA stopped at mandating coverage — leaving Americans to fend for themselves in finding products that would adequately finance health care for them and their families — it might not achieve the stature essential to a broad regulatory scheme.

The ACA represents a constitutional intervention into the health insurance market because of a combination of five results that it achieves. First, and perhaps most fundamentally, in a remarkable shift whose precedent lies in the watershed Civil Rights Act of 1964, the ACA transforms health insurance into a public accommodation. The Civil Rights Act barred private businesses such as hotels, bus companies, and restaurants from refusing to sell their products or services to customers on the basis of race. The ACA bars state-licensed health insurers from refusing to sell products to individuals on the basis of health status. This prohibition, which bars rescissions — the canceling of policies of people who become ill — and which applies at both the point of initial sale and the point of renewal, is binding on health insurers nationwide, regardless of whether they sell their products in the open market or through state health insurance exchanges. This basic reconceptualization of health insurance as a good whose availability is a matter of national public interest essentially frames health insurance the way the Civil Rights Act framed other business interests.

Second, the ACA establishes minimum national standards governing the design of health insurance sold in the individual and group-plan markets, as well as the design of self-insured employer-sponsored plans. In all insurance markets, these standards include bans against excessive waiting periods and against the imposition of annual and lifetime coverage limits, a requirement to cover preventive services with no cost sharing, and a requirement to cover routine medical costs associated with participation in clinical trials. In the individual and small-group markets, design regulation reaches further, specifying a minimum level of coverage for "essential health benefits" and limits on exposure to out-of-pocket costs for those essential benefits. Equally important are new rules that, according to a strategy of measuring the medical loss ratio (the proportion of money collected in premiums that is actually spent on medical care), position the industry for greater price regulation as a result of increased transparency of cost increases and their justifications.

Third, the ACA creates a nationwide system of health insurance exchanges serving the individual and small-group markets and gives states the option to expand their exchanges to reach larger groups. The law encourages states to establish and operate their own exchanges but guarantees access to a federally administered exchange in states that elect not to do so. Health insurance sold through exchanges will be subject to "qualified health plan" requirements, which are aimed at ensuring not only the integrity of coverage, but also, by stipulating that each plan's provider network must be adequate, the availability of affordable health care itself.

Fourth, the ACA establishes a uniform, national subsidy system that ensures Medicaid coverage for the poorest Americans and advance tax credits for insurance premiums for individuals and families who are not eligible for Medicaid but have low-to-moderate incomes. States, of course, participate in Medicaid on a voluntary basis, but all participating states will be required to extend coverage to newly eligible individuals, just as many previous Medicaid reforms have created new mandatory categories of beneficiaries. In this case, the new expectations are accompanied by considerable new funding.

Finally, the ACA uses the platform of uniform, stable financing to begin to change health care itself, on a nationwide basis. The law provides for a major investment in primary care through an

expansion of federally qualified health centers. This investment is coupled with a series of health care cost-cutting measures, as well as the establishment of national frameworks for quality improvement and public health and prevention, as well as pilot and demonstration projects that aim to improve the quality and efficiency of health care for the entire population over time.

The fundamental goal of the ACA is no less than the preservation of the U.S. health care system. In a country that depends on health insurance to finance care, preservation cannot happen without a comprehensive regulatory scheme that reaches from coast to coast and sets the minimum rules of market entry and operation for health insurers. The glide path to this new system is long and complex, but the law's end point is clear and visionary, and its constitutionality — at least in this first round — is incontrovertible.

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1. Florida et al. v. United States Department of Health and Human Services et al. Case No.: 3:10-cv-91-RV/EMT.
2. Case no. 10-CV-11156) E.D. Mich., Oct. 7, 2010.
3. United States v. Lopez, 514 U.S. 549 (1995).
4. United States v. Morrison 529 U.S. 598 (2000).
5. Priest AJG. Possible adaptation of public utility concepts in the health care field. Law Contemp Probl 1970;35:839-48.

Writing New Rules for Insurers — Progress on the Medical Loss Ratio

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Few undertakings in the short history of the implementation of health care reform have been as difficult or contentious as the drafting of regulations to define the statute's "medical loss ratio" requirement. Beginning in 2011, health insurers must report annually the percentage of their premium revenue (excluding expenditures for taxes and regulatory fees) that they spend on "reimbursement for clinical services" and on "activities that improve health care quality." This is their medical loss ratio. If the medical loss ratio of an insurer in the individual or small-group market falls below 80% (or, for large-group insurers, 85%), the insurer must rebate to its enrollees the difference between the reported ratio and the target percentage.

Traditionally, medical loss ratios were of interest only to investors. An insurer with a low or "favorable" ratio was spending less on health care and producing a greater profit, and thus represented a good investment. The Patient Protection and Affordable Care Act (ACA) reverses the incentives — too little spent on health care or quality improvement results in a rebate. The purpose of the statute, however, is not to produce rebates, but rather to give insurers an incentive to become more efficient. Some insurers currently spend as little as 60% of their premium revenues on health care.[1] The law should change that. It will also increase transparency — consumers will see how much of their premium dollars is actually spent on health care, which is, after all, why consumers buy insurance.

In an unusual move, Congress delegated to the National Association of Insurance Commissioners (NAIC) the task of establishing the definitions and methods to be used for calculating loss ratios. The NAIC, for which I serve as a consumer representative, has traditionally coordinated state regulatory efforts to make insurance regulation more uniform. Rarely, however, has it been called on to draft regulations for the federal government.

Given the special expertise of the state insurance commissioners in insurance regulation, as well as the spirit of cooperative federalism that underlies the health care reform law, asking the NAIC to draft the regulations made sense. But under the ACA, the Department of Health and Human Services (DHHS) reserves the responsibility for "certifying" the NAIC's proposal before it becomes federal law.

The NAIC began the task of drafting the loss-ratio regulation soon after the reform law was adopted, appointing two working groups of regulators. One drafted the form that insurers will use to report loss ratios. This group also defined the categories of expenses that will be reported.