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Perspective

Health Insurance Reform and the Tensions of Federalism

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The enactment of the Patient Protection and Affordable Care Act (ACA) marks the beginning of a new chapter in the centuries-long debate about the appropriate balance between the states and the federal government in the development, administration, and enforcement of domestic policy in the United States. As health care reform is implemented, a new set of federalism-related tensions will arise regarding the best ways to ensure health care coverage for all Americans, secure access to care, promote prevention and wellness, and modernize delivery systems in an effort to achieve better outcomes at lower cost.

Today, government incentives for and oversight of health care coverage for nonelderly Americans are responsibilities divided between the federal and state levels — an approach that highlights the best and worst in our health care system. The flexibility that allows states and local governments to move quickly to address varying needs, to innovate, and to set geographically sensitive priorities locally also permits the creation of tremendous disparities in the availability of high-quality, affordable health care. Insurance coverage rates for the nonelderly, for instance, range from about 75% in Texas to about 94% in Massachusetts, and state approaches to ensuring and enforcing insurance-market protections for the sickest Americans vary widely.

Our ability to achieve a workable federal–state balance will be seriously tested as the Obama administration and the states define and apply their roles in implementing the myriad new policies for regulating and expanding access to private insurance. These new responsibilities include securing immediate access to high-risk pools for all eligible Americans, implementing an array of insurance-market reforms on an ongoing basis, and eventually establishing health insurance exchanges. The degree to which these challenges related to early-year implementation of insurance reforms are met will have major implications for future challenges regarding the division of responsibilities between the federal and state governments (see box).

To summarize briefly, the ACA establishes new minimum federal standards for insurance policies, in order to rein in discriminatory underwriting practices and excessive premium differentials and ensure widespread access to private insurance. The states license insurers and enforce both federal and state insurance laws, but the secretary of health and human services

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Insurance-Market Reforms and Market-Stabilization Initiatives in the Health Care Reform Law.

Creation of high-risk pools — effective June 21, 2010 (90 days after enactment)

Creation of state insurance exchanges or federal fallback exchange — effective January 1, 2014

Adoption of insurance-market reforms, with the application of standards to all new health insurance plans and to many grandfathered plans (i.e., those that were in force as of the date of enactment of the reform law). Reforms include those listed below:

Effective October 1, 2010:

Permits parents to keep children on their insurance plans up to the age of 26 years

Prohibits lifetime limits on benefits

Restricts annual limits on essential benefits

Prohibits the exclusion of preexisting conditions for children

Establishes medical loss ratios (limiting the percentage of premiums that can be used for administrative overhead and profit)*

Prohibits plans from rescinding coverage

Effective January 1, 2014, for plans offered through insurance exchanges:

Prohibits plans from denying coverage because of an individual's health status (guaranteed issue and guaranteed renewal)*

Prohibits plans from varying premiums for any reason except for family size, geographic location, and age (if varied according to age, the highest premium may be no more than three times the lowest premium)*

Prohibits exclusions for preexisting conditions

Establishes minimum "essential benefits" that must be offered*

Eliminates lifetime annual limits on essential benefits

Prohibits plans from rescinding policies, except in the case of nonpayment of premiums

* This rule does not apply to grandfathered plans.

(HHS) can enforce the federal law if a state fails to do so. The same model — the setting of a federal floor, an expectation of state innovation and implementation, and a federal fallback — applies to the establishment and operation of the new insurance exchanges, which will offer private insurance options.

Although the political far right may characterize the ACA as a one-size-fits-all government takeover of our health care system — and the far left may wish it were — the insurance reforms in fact embrace a hybrid federal–state approach. The new statute envisions and permits varied approaches to applying federal rules and regulations. We expect federalism-related tensions over reform to center around the ways in which the administration interprets and implements the law; the ways in which interpretations are received and applied by states, plans, providers, purchasers, and patients; the extent of state variation in the law's application and enforcement that the federal government sanctions; and the way in which the federal government uses its backup authority when states fail to meet basic standards.

The administration will need to work quickly, competently, and decisively to implement provisions such as high-risk pools, insurance-market reforms, and eventually state-based exchanges, or it will quite literally pay the cost. Under the new regulatory structure, states will continue to license plans, enforce federal and state rules, and run the exchanges through which private insurance will be offered. The value of federal tax credits to individuals and families will be based on the premiums offered through the exchanges. As a result, states that are effective in using the reform structure to drive down premium costs will save federal dollars, and states that fail to control premium costs will drive up federal costs.

The challenge of hybrid federal–state approaches is that the chain can only be as strong as each individual link. Some states have already implemented high-risk pools and state-level exchanges, and many have already implemented other insurance-market reforms. The secretary of HHS should draw on those states' experiences as they implement the federal guidelines, to avoid causing undue disruption of insurance markets. Early evidence suggests that Secretary of HHS Kathleen Sebelius (a former Kansas governor and insurance commissioner) and her staff plan to do just that.

Some states are willing to implement the reforms but have relatively little experience or expertise in doing so. For those states, the Department of Health and Human Services must provide timely and meaningful technical and financial assistance to ensure a smooth transition.

Finally, there are states that, for policy, political, or other reasons, have little or no interest in collaborating with the federal government in implementing the ACA. Already, a number of governors and attorneys general have filed lawsuits designed to block implementation of the individual mandate and, by extension, some elements of insurance reform, since near-universal coverage may not be achievable without an individual requirement to purchase insurance.

In a similar vein, at least 19 states have declined federal dollars available under the ACA for

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the creation of high-risk insurance pools. The high-risk pools are designed to provide coverage to people who have previously been denied insurance because of preexisting conditions. The secretary will need to move decisively to create a federal fallback program to ensure that all Americans, regardless of their state of residence, have access to the insurance protections passed by Congress.

In short, the secretary — working with the rest of the administration and Congress — has to prepare to ensure the best and avert the worst outcomes. For each insurance-reform provision, the secretary must be prepared to answer a wide array of questions from states and the public regarding policy interpretation, to give timely guidance, to provide technical and financial assistance, and to create federal fallbacks for cases in which states cannot or will not act.

In the case of high-risk pools, the secretary has proposed state allocations of $5 billion in federal funds, but many questions remain. What will happen if resources run out? How will the federal government define and enforce provisions to ensure that states that have such pools today do not substitute federal dollars for the state dollars they have been using to date? Should the pools be combined with existing state pools or operated separately and with the same or different premium-rating standards? How should the premiums for enrollees be set? What is the deadline for states to have a qualified high-risk pool established? If a state is not going to establish one, when will a federal backup pool be established? How will it be run and administered? Will its creation delay protections that are required to be in effect this year?

Long before the October 1, 2010, effective date of other insurance reforms, the administration will also need to provide thoughtful guidance for states regarding implementation and enforcement. There are inherent tensions between state and federal interests that must be resolved before insurance exchanges are established. And the implementation of the law's substantial Medicaid expansion will also create new tests for the balance of power and responsibility between states and the federal government.

Done right, the implementation of the ACA can achieve the advantages of a minimum national standard for coverage and greater equity among Americans without sacrificing the states' traditional roles, responsibilities, and flexibility. Done wrong, implementation will create excess layers of bureaucracy, and delay will ensure that this historic health care reform legislation falls far short of its goals. It remains to be seen whether leaders at all levels of government will be able to navigate the political and policy-related shoals, but clearly, federal–state tensions are about to be seriously tested.

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

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