

During debate leading to passage of the [Patient Protection and Affordable Care Act](#) (“Affordable Care Act” - ACA), President Obama [stated](#): “we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you will be able to keep your health care plan, period.” However, recently, many people have received cancellation notices from their health plan or insurer, and some have found that available alternatives do not allow them to keep their physician. The Associated Press estimated on November 2 that at least [3.5 million Americans](#) had received cancellation notices.

Given the incentives embedded in the ACA, it was actually quite predictable that many Americans would lose their health insurance. The ACA requires health plans and insurers in the group and individual markets to provide an “[essential health benefits](#)” package, prohibits them from excluding persons based on [preexisting conditions](#), and prohibits them from basing premiums on [health status](#). While the ACA allows health insurance that was in effect when the ACA was enacted (March 23, 2010) to be “[grandfathered](#),” both the statute and implementing regulations impose criteria for grandfathered status that are difficult to meet.

First, the statute itself requires both health plans and group insurers, including those that are grandfathered, to abide by many of the new ACA requirements. For example, the ACA [prohibits](#) grandfathered health plans and grandfathered group insurance from excluding applicants based on preexisting conditions, from basing premiums on health status, from having lifetime or annual limits, and from rescinding coverage except for fraud or misrepresentation. Also, the ACA [requires](#) grandfathered health plans and grandfathered insurers (both group and individual) that offer dependent coverage to offer it to dependents up to 26 years of age. Many health plans and insurance policies that were in existence on March 23, 2010 do not meet these criteria.

Second, in its June 2010 [rule](#), the Department of Health and Human Services (HHS) set relatively stringent criteria for maintaining grandfathered status over time. For example, if a health plan or insurance coverage eliminates coverage for the diagnosis or treatment of a particular condition, increases cost-sharing by a relatively small amount, or decreases the annual or lifetime limits for individual policies, it no longer qualifies for grandfathered status. Finally, if an employer decreases its contribution to an employee’s plan by more than 5 percentage points, the plan is no longer considered to be a grandfathered plan.

Prior to the ACA, health insurers and employers often made adjustments to their plans at the time of annual renewal. Strict criteria for maintaining grandfathered status limits their flexibility to adapt to changing market conditions. In its June 2010 regulatory impact analysis, HHS itself estimated that by 2013, 45 percent of large employer plans and 66 percent of small employer plans would [relinquish their grandfathered status](#). In that same analysis, HHS estimated that the percentage of individual insurance policies losing grandfathered status would [exceed the 40 to 67 percent pre-ACA annual turnover](#) of individual policies.



The primary purpose of the ACA's health insurance regulations was to increase the prevalence of comprehensive health insurance, including among persons with pre-existing conditions. To accomplish this goal, the ACA required health plans and insurers to offer a comprehensive set of benefits, accept all persons regardless of health risk, and refrain from basing prices on health status. In an attempt to prevent low-risk individuals from discontinuing insurance,¹ and to increase the number of low-risk persons paying into insurance pools, the ACA required most Americans to purchase health insurance or pay a penalty (tax).² Even under the best of circumstances, this approach will cause many people to lose their existing insurance, increase insurance prices for most people, and increase health care expenditures.³

In a [recent article](#), I recommended a very different approach to health insurance reform. Instead of requiring all persons to purchase a comprehensive set of benefits with limited price variation, I proposed that Congress and state legislatures repeal those laws that prohibit insurers from offering a wide variety of insurance products at varying prices. This would allow both individuals and families to purchase less expensive health insurance that meets their particular needs. Targeted subsidies and private philanthropy are likely to be more effective than comprehensive insurance at assuring quality medical care for low-income persons and for persons who cannot obtain affordable insurance because of a pre-existing condition.

¹ Data suggest that similar health insurance regulations at the state level have resulted in many low and average-risk people discontinuing their insurance. *See, e.g.*, Bradley Herring and Mark V. Pauly, The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market, NBER Working Paper 12504 (Aug., 2006).

² The Supreme Court recently ruled that the individual mandate was unconstitutional as a regulation under the Commerce Clause and the Necessary and Proper Clause, but that the penalty for not purchasing health insurance was constitutional as a tax. *See National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2590-2591, 2593, 2599-2560 (2012).

³ This approach will lead to greater expenditures for both positive and negative reasons. On the positive side, more people will have a source of payment for needed medical care. On the negative side, greater third-party coverage for even minor expenses leads to excess administrative expenses, costs resulting from disputes about coverage and sometimes fraud, and costs from the tendency to use excess resources when a third party is paying (sometimes referred to as "moral hazard"). For a discussion concerning excess expenditures associated with third-party payment, *see* Don W. King, U.S. Health Care Reform: Comprehensive Insurance or Affordable Care? 7(3) J. L. Econ., & Pol. 439, 441-450, 457-460 (Spring, 2011).

