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Realizing Health Reform's Potential

Implementing the Affordable Care Act: State Action on the 2014 Market Reforms

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Abstract: The Affordable Care Act includes numerous consumer protections designed to improve the accessibility, adequacy, and affordability of private health insurance. Because states are the primary regulators of health insurance, this issue brief examines new state action on a subset of protections—such as guaranteed access to coverage and a ban on pre-existing condition exclusions—that go into effect in 2014. The analysis finds that, to date, only one state passed new legislation on all of these protections, and an additional 10 states and the District of Columbia passed new legislation or issued a new regulation on at least one protection. The analysis also finds that—without new legislation—some states face limitations in fully enforcing these reforms. These findings suggest an acute need for states to take action in 2013 to help ensure that consumers are fully protected by and benefit from the Affordable Care Act's most significant reforms.

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OVERVIEW

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, ushers in significant reforms designed to improve the accessibility, affordability, and adequacy of private health insurance. These reforms will phase in over time, with the most dramatic changes scheduled to take effect for health insurance plans or policy years beginning on or after January 1, 2014. These changes—known as the "2014 market reforms"—include guaranteed access to coverage, a ban on preexisting condition exclusions, restrictions on the use of health status and other factors when setting premium rates, and the coverage of a minimum set of essential health benefits, among other critical consumer protections.[1]

The Affordable Care Act significantly strengthens standards for private health insurance under federal law and protects consumers across the nation.

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States continue to be the primary regulators of health insurance and thus are key players in enforcing federal laws and ensuring that consumers receive the benefits of federal protections. Although states have the primary responsibility to enforce federal health insurance law, federal regulators will enforce the Affordable Care Act if a state fails to "substantially enforce" it. Federal enforcement could subject insurers to significant fines for failure to comply with the law's requirements.[2]

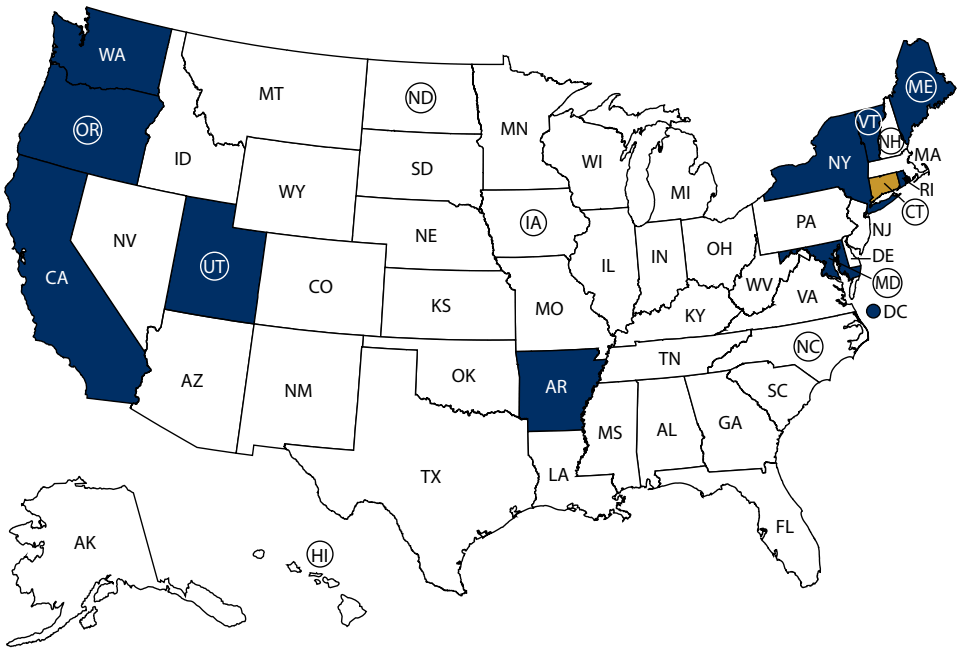
To understand states' progress in implementing the Affordable Care Act, this issue brief examines new actions states took from January 1, 2010, to October 1, 2012, on seven of the most critical 2014 market reforms. Our analysis shows that only one state took new legislative or regulatory action on all of these protections while an additional 10 states and the District of Columbia passed new legislation or issued a new regulation on at least one protection (Exhibit 1). The binding nature of new legislation and new regulations means a state has full authority to enforce and write new rules on these consumer protections. With this enforcement and rulemaking authority, states have the flexibility to provide additional guidance on how reform should be implemented and use a broad array of regulatory tools to ensure compliance with the Affordable Care Act.

The majority—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms. To understand whether states did not take action because regulators have existing authority to enforce federal law (through, for example, a broad provision that allows the insurance department to enforce federal insurance protections), we also surveyed state regulators about their legal authority to enforce and write new rules regarding the 2014 market reforms. We found that 11 states passed new legislation that explicitly requires (or allows) state regulators to enforce or issue regulations regarding some or all of the 2014 market reforms (Exhibit 1). But, of the remaining states, only eight reported that they already have

Exhibit 1. State Action on 2014 Market Reforms Under the Affordable Care Act, as of October 2012

- Passed new law or issued new regulation on all seven 2014 market reforms
- Passed new law or issued new regulation on at least one 2014 market reform
- Took no action on 2014 market reforms

- Passed new law on enforcement or rulemaking authority regarding 2014 market reforms



Notes: Maine, Massachusetts, New Jersey, New York, and Vermont required insurers to provide coverage to individuals on a guaranteed basis prior to the Affordable Care Act. Utah has explicit authority to enforce some, but not all, of the 2014 market reforms. Hawaii has explicit authority to enforce the 2014 market reforms but does not have explicit authority to write new regulations regarding these requirements. In contrast, Iowa has the authority to issue new regulations regarding the 2014 market reforms but does not have explicit authority to enforce these requirements. New Hampshire has explicit authority to enforce and issue regulations on the 2014 market reforms, but this authority is conditioned upon approval by a legislative oversight committee.
Source: Authors' analysis.

full enforcement or rulemaking authority regarding the 2014 market reforms while 22 states reported that there could be some limits on their authority to do so, although state authority varied significantly. Ten states did not respond to the survey.

These findings suggest that many states may need to take action in 2013 to ensure that consumers receive the full benefits promised under the Affordable Care Act. Because states are expected to be the primary enforcers, most will need to implement the new protections so they are reflected in state law or—at a minimum—give the insurance department the authority to enforce and write new rules on the 2014 market reforms.

Even though states can use existing authority to promote compliance with many of the Affordable Care Act's requirements, questions remain about how effectively states can enforce the 2014 market reforms without new or expanded legal authority. These open questions suggest that states may need to take new state action to help ensure compliance with the law and to limit or preclude federal enforcement of these reforms. Because states can decide whether to take new action to ensure that state laws are consistent with the 2014 market reforms, much may depend on the enforcement standard set by the federal government and whether states can rely on their existing authority to meet this standard. For these reasons—and to ensure that state regulators have the requisite authority needed to fully protect consumers—state policymakers should consider taking action on the 2014 market reforms during their 2013 legislative sessions.

BACKGROUND

States have historically been the primary regulators of private health insurance.[3] Although states continue to play this role, the Affordable Care Act sets a minimum federal standard for consumer protections such as the 2014 market reforms, and allows—but does not require—states to enforce these protections.[4]

The Affordable Care Act largely uses the regulatory framework that Congress adopted in 1996 with the Health Insurance Portability and Accountability Act (HIPAA), which improved access to insurance as well as its renewability and portability.[5] Under HIPAA, federal regulators will step in to enforce federal law only after a state informs the federal government that it is not enforcing or if federal regulators determine that a state has failed to "substantially enforce" a provision following an investigation.[6] In response to HIPAA, nearly all states passed new laws or issued new regulations implementing the federal requirements.[7]

Because the Affordable Care Act uses the same enforcement standard as HIPAA, federal officials may step in to enforce some or all of the law's provisions if a state substantially fails to do so.[8] In states where federal regulators are directly enforcing the Affordable Care Act, federal regulators can impose significant fines on insurers that fail to comply with the law's requirements.[9]

The federal standard established by the Affordable Care Act includes significant reforms that—depending on the reform at issue—apply to insurers in the individual, small-group, or large-group markets in all 50 states and the District of Columbia (Exhibit 2). Under the law's regulatory framework, states have considerable discretion regarding whether to substantially enforce these and other requirements.

ABOUT THIS STUDY

This analysis is based on a review of new actions taken by all 50 states and the District of Columbia between January 1, 2010, and October 1, 2012, to implement or enforce seven of the Affordable Care Act's most critical consumer protections that go into effect for health insurance plan or policy years beginning on or after January 1, 2014. We refer to these provisions as the Affordable Care Act's 2014 market reforms. Our review included new state laws, regulations, and subregulatory guidance. The resulting assessments of state action were confirmed by state regulators.

We also surveyed state regulators about their authority to enforce or write new regulations regarding the 2014 market reforms. In presenting these results, we only identify the 11 states that took new action regarding the Affordable Care Act. We do

Exhibit 2. Seven 2014 Market Reforms Under the Affordable Care Act, Effective January 1, 2014

2014 market reform	Description
Accessibility	
Guaranteed issue	Requires insurers to accept every individual and employer that applies for coverage.[c]
Waiting periods	Prohibits insurers from imposing waiting periods (i.e., the period that must pass before an employee is eligible to be covered for benefits) that exceed 90 days.[a]
Affordability	
Rating requirements	Requires insurers to vary rates based solely on four factors: family composition, geographic area, age, and tobacco use; prohibits insurers from charging an older adult in the oldest age band more than three times the rate of a younger person in the youngest rate band; prohibits insurers from charging tobacco users more than 1.5 times the rate of a non–tobacco user's rate.[b,c]
Adequacy	
Preexisting condition exclusions	Prohibits insurers from imposing preexisting condition exclusions with respect to plans or coverage.
Essential health benefits	Requires coverage of specified benefits that include 10 categories of defined benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[b,c]
Out-of-pocket costs	Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles, to the level established for high-deductible health plans that qualify as health savings accounts; indexes this level to the change in the cost of health insurance after 2014.[c]
Actuarial value	Requires insurers to cover at least 60 percent of total costs under each plan; requires plans to meet one of four actuarial value tiers (bronze, silver, gold, or platinum) as a measure of how much costs are covered by the plan.[b,c]

Note: Unless otherwise noted, the provisions apply to new plans in the individual market as well as new and grandfathered plans (those in existence before the Affordable Care Act that have not made significant changes since March 23, 2010) in the small-group and large-group markets.

[a] Does not apply to plans in the individual market.

[b] Does not apply to plans in the large-group market.

[c] Does not apply to grandfathered plans. Note that guaranteed issue in the small-group market was already required under HIPAA and thus applies to grandfathered plans in the small-group market.

not identify the states that may rely on their existing enforcement and rulemaking authority to enforce the Affordable Care Act; these findings are presented only in aggregate.

This issue brief is limited to state action on the Affordable Care Act's private market reforms that apply both inside and outside of the law's new health insurance exchanges and does not include a review of state action on exchange development. We also do not address the considerable efforts that states undertook to select an essential health benefits benchmark plan. Preliminary analysis by the authors suggests that many states have taken new action in these areas. Although further research on these issues is forthcoming, it is separate from the analysis presented here on the 2014 market reforms.

A state may not have taken action on the 2014 market reforms if existing state law is consistent with the Affordable Care Act, or if the state already has authority to enforce federal law.[10] For example, several states—including Maine, Massachusetts, New Jersey, New York, and Vermont—required insurers to provide coverage to individuals on a guaranteed basis prior to the Affordable Care Act and may not need to take new state action on this 2014 market reform. Because our findings are limited to new state action since January 1, 2010, we did not analyze whether existing state laws are consistent with federal requirements.

FINDINGS

Only one state has taken new legislative or regulatory action on all seven 2014 market reforms examined in this brief, while an additional 10 states and the District of Columbia passed new legislation or issued a new regulation on at least one of these protections. The majority—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms. Because some states may be able to enforce the Affordable Care Act without new action, we also surveyed the states and found that state enforcement and rulemaking authority vary significantly. Eleven states passed new legislation that explicitly requires (or allows) state regulators to enforce or issue regulations regarding some or all of the 2014 market reforms. But, of the states that have not yet passed new legislation, a minority—only eight states—reported full enforcement and rulemaking authority regarding the 2014 market reforms. Below we discuss trends in state action and describe the variation in state enforcement and rulemaking authority regarding the 2014 market reforms.

Few States Took Action on the 2014 Market Reforms

Eleven states and the District of Columbia passed new legislation or issued a new regulation on at least one of the 2014 market reforms (Exhibit 3). Of these, only one state took new action on all seven of the reforms studied. Most—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms.

Only Connecticut Took New Legislative or Regulatory Action on All 2014 Market Reforms

Only Connecticut took action on all seven of the 2014 market reforms studied in this brief. In 2011, Connecticut passed legislation establishing a new section in its insurance code entitled "Compliance with the Patient Protection and Affordable Care Act—Regulations."[11] This section requires insurers to comply with specified sections of the Public Health Service Act, as amended by the Affordable Care Act, and authorized the insurance commissioner to adopt regulations to implement these provisions.

According to Connecticut regulators, many of the Affordable Care Act's requirements are already reflected in state law and regulators would have had the authority to enforce the 2014 market reforms even without new legislation.[12] However—similar to the state's approach in implementing HIPAA—the legislature passed new legislation to make it explicit to insurers and the federal government that the insurance department (DOI) has the authority to enforce the Affordable Care Act. Consistent with reports from other states, Connecticut chose to enact broad enforcement authority—rather than amending specific provisions of existing state law—to retain flexibility ahead of federal guidance on the 2014 market reforms.[13]

California addressed all but one of the 2014 market reforms studied and, in contrast to Connecticut, did so by amending or enacting specific provisions in state law.[14] Although California addressed all of the 2014 market reforms except limits on out-of-pocket costs, the state did not impose these requirements in all markets or for all types of plans. For example, legislators enacted all reforms except limits on out-of-pocket costs in the small-group market but legislation that would have extended some of these requirements to the individual market was ultimately vetoed by the governor.[15] Future legislation is expected to be considered during the state's special legislative session to address the remaining requirements necessary to implement the 2014 market reforms.[16]

Ten States and D.C. Took Action on at Least One 2014 Market Reform

Ten states and the District of Columbia passed new legislation or issued a new regulation on at least one of the 2014 market reforms (Exhibit 3). In addition to the District of Columbia, these states are Arkansas, California, Maine, Maryland, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. With the exception of Arkansas, these states and the District of Columbia passed new legislation to address the 2014 market reforms. Following the passage of new legislation, Utah and Washington also issued a new regulation on some of the reforms. The binding nature of legislative and regulatory action means that a state has full authority to enforce those consumer protections.

Exhibit 3. State Action on the 2014 Market Reforms, Provision by Provision, as of October 1, 2012

State	Accessibility		Affordability	Adequacy			
	Guaranteed issue	Waiting periods	Rating requirements	Preexisting condition exclusions	Essential health benefits	Out-of-pocket costs	Actuarial value
State legislative or regulatory action on all seven 2014 market reforms							
Connecticut	L	L	L	L	L	L	L
State legislative or regulatory action on at least one 2014 market reform							
Arkansas	—	—	—	—	R	—	—
California	L[a]	L	L[a]	L	L	—	L
District of Columbia	—	—	—[c]	—	L[b]	L[b,d]	L[b]
Maine	—	—	L	L	L	L	L
Maryland	—	L	L	L	L	L[b,d]	L
New York	—	—	—	L	—	—	—
Oregon	—	—	—	—	L	—	L
Rhode Island	—	—	—	L	—	—	—
Utah	—	L	—	—	L, R	—	—
Vermont	—	—	—	—	L	L	L
Washington	—	—	—	—	L, R	L, R	L

Key	Definition
L	The state passed a new law on the 2014 market reform.
R	The state issued a new regulation on the 2014 market reform.
—	The state has taken no official action on the 2014 market reform.

Note: States may have decided not to address a particular reform because state law is already consistent with it or because the state has the authority to enforce federal law. For example, Maine, Massachusetts, New Jersey, New York, and Vermont already required insurers to provide coverage to individuals on a guaranteed basis. The exhibit does not take into account such existing laws or authority.

[a] State action only applies in the small-group market. In 2012, California passed new legislation that prohibits plans in the small-group market—both health care service plans and commercial carriers—from varying rates using any factors other than age, geographic area, and family composition.

[b] State action applies only to qualified health plans sold through the exchange.

[c] In 2010, the District of Columbia passed new legislation that prohibits rating based on gender and establishes age bands that cannot vary by more than a ratio of three-to-one.

[d] State action applies only to coverage in the individual and small-group markets and does not extend to the large-group market.

The majority of these 10 states and the District of Columbia took action on two or more 2014 market reforms, while Arkansas, New York, and Rhode Island addressed only one reform. States were most likely to take action on the requirements designed to improve adequacy: all states either prohibited preexisting condition exclusions or required insurers to cover essential health benefits, limit out-of-pocket costs, or meet actuarial value requirements (Exhibit 4). With the exception of the ban on preexisting condition exclusions, these "adequacy" requirements are part of the Affordable Care Act's "essential health benefits package" that must be covered by all insurers in the individual and small-group markets, both inside and outside the exchange.[17]

States may have taken action on the adequacy reforms because most do not have an existing similar standard or because states addressed these reforms in exchange legislation or in selecting an essential health benefits benchmark plan. For example, the District of Columbia adopted this requirement in new legislation, but the new rules are limited to qualified health plans sold within the exchange and do not apply to plans offered outside the exchange. Thus policymakers may need to take additional legislative or regulatory action to apply these requirements to plans offered outside the exchange.[18]

Exhibit 4. State Action on the 2014 Market Reforms, by Type of Provision, as of October 1, 2012

Type of provision	2014 market reform	State
Accessibility	Guaranteed issue Waiting periods	California, Connecticut, Maryland, Utah
Affordability	Rating requirements	California, Connecticut, Maine, Maryland
Adequacy	Preexisting condition exclusions Essential health benefits Out-of-pocket costs Actuarial value	Arkansas, California, Connecticut, District of Columbia, Maine, Maryland, New York, Oregon, Rhode Island, Utah, Vermont, Washington

Note: States may have decided not to address a particular reform because state law is already consistent with it or because the state has the authority to enforce federal law. For example, Maine, Massachusetts, New Jersey, New York, and Vermont already required insurers to provide coverage to individuals on a guaranteed basis. The exhibit does not take into account such existing laws or authority.

States chose to take action on only some reforms for a number of reasons. Some states reported that existing state law is consistent with the Affordable Care Act and, thus, no new state action is required. For example, a handful of states have long required insurers to make coverage available on a guaranteed basis while other states pointed to existing requirements that insurers make coverage available to small employers on a guaranteed basis, as required under HIPAA. Because of these existing laws, states may not have taken action in response to the requirements of the Affordable Care Act.

Other states reported that they acted only where existing state law conflicted with federal law, either directly or where clarification of state law was needed. Still other states may have taken action on only certain reforms to promote a level playing field between plans sold inside and outside the exchange. Oregon, for example, passed new legislation on essential health benefits and actuarial value requirements, motivated by the need to limit adverse selection against standardized health plans sold through the exchange.[19] Some states noted they did not need to take action on all the 2014 market reforms because they already have the authority to enforce federal law. Although the reasons vary for why states acted on only some 2014 market reforms, such variation raises the question of potential regulatory or enforcement gaps.

In addition, some states implemented only certain components of the 2014 market reforms. The District of Columbia, for example, passed legislation in 2010 that prohibits the use of gender in rating and establishes age bands that cannot vary by more than a ratio of three-to-one.[20] Two other states—Delaware and New Mexico—did not take new action on the 2014 market reforms but, like the District of Columbia, amended their rating requirements to phase out or prohibit gender rating, among other requirements.[21] These provisions are consistent with some—but not all—of the Affordable Care Act's new rating requirements, which require insurers to vary rates based solely on family composition, geographic area, age, and tobacco use.[22] While the new legislation moved these states' rating rules closer to the federal standard, state policymakers may decide to take additional action on the remaining requirements by, for example, prohibiting rating based on health status.

Thirty-Nine States Took No Action on the 2014 Market Reforms

The vast majority of states—39 states—have yet to take action on the 2014 market reforms. States may not have acted because of political opposition to the Affordable Care Act, the need for additional guidance from federal regulators, or uncertainty in light of legal challenges to the law and the outcome of the 2012 presidential and congressional elections.

Despite this inaction, states continue to consider issues related to implementation of the Affordable Care Act. For example, four states—Maine, Massachusetts, Maryland, and Washington—passed new legislation (and, in Washington, issued new regulations) regarding the state's desire to administer a reinsurance program, a risk-adjustment program, or both.

Other states are making decisions in the context of exchange planning that affect their markets both inside and outside the exchange. Arizona, for example, has identified how it will divide up the state into different geographic rating areas in which insurers can vary premiums.[23] These actions suggest that state policymakers continue to consider critical issues ahead of 2014, even if states have not taken official legislative or regulatory action.

States that pass new legislation or issue new regulations have the authority to enforce and write rules regarding the new requirements. However, states that do not take such action may be limited in their ability to do so unless regulators have existing authority to enforce federal law. If a state already has this authority, state policymakers may not have taken action on the 2014 market reforms. In the next section, we explore the extent of states' existing authority to enforce federal law and what it could mean for state implementation of the 2014 market reforms.

States May Face Enforcement Gaps Without New Legislation

State enforcement and rulemaking authority vary significantly across states, particularly in regard to the 2014 market reforms. Since January 1, 2010, 11 states passed new legislation that explicitly requires (or allows) state regulators to enforce or issue regulations regarding some or all of the 2014 market reforms. In the absence of new legislation, only eight of the remaining states reported full authority to enforce or issue new regulations on the 2014 market reforms (Exhibit 5).

Eleven States Amended Their Authority on the 2014 Market Reforms

Eleven states—Connecticut, Hawaii, Iowa, Maine, Maryland, New Hampshire, North Carolina, North Dakota, Oregon, Utah, and Vermont—passed new legislation to enforce or issue new regulations on the Affordable Care Act, including the 2014 market reforms. Although state action varied considerably among these states, regulators with enforcement and rulemaking authority are able to use a broad array of regulatory tools—such as market conduct exams, sanctions, and license revocation—to ensure compliance with the Affordable Care Act (Exhibit 6).

Of these 11 states, most passed new legislation to both enforce and issue new regulations regarding the 2014 market reforms. Some states combined this authority in a single provision while others amended separate parts of their code to adopt both enforcement and rulemaking authority. For example, North Dakota passed new legislation containing a single provision that directs its insurance commissioner to "administer and enforce" the Affordable Care Act while Oregon adopted separate provisions for enforcement and rulemaking authority.[24]

Some of these states addressed only one type of authority. Hawaii, for example, passed legislation that gives the DOI enforcement authority, but not rulemaking authority.[25] In contrast, Iowa passed legislation allowing its insurance commissioner to issue new regulations pursuant to the Affordable Care Act but it neither requires the commissioner to enforce the Affordable Care Act's requirements nor requires insurers to comply with the reforms.[26]

Exhibit 5. State Authority to Enforce and Issue New Regulations on the 2014 Market Reforms

Authority	Number of states
State passed new legislation that includes the explicit authority to enforce or issue new regulations on the 2014 market reforms.	11 states
State has full authority to enforce or issue new regulations on the 2014 market reforms without new legislation.	8 states
State has limited authority to enforce or issue new regulations on the 2014 market reforms without new legislation.	22 states
State did not respond to the survey.	10 states

Source: Survey responses from state regulators in all 50 states and the District of Columbia (referred to as a "state" for purposes of Exhibit 5). Assessments of state authority were confirmed by state regulators.

Exhibit 6. Select Regulatory Tools Used by State Health Insurance Regulators

Regulatory tool	Definition
Form review	Review, approval, or disapproval of insurer policy forms to ensure that insurers offer policies that comply with state requirements, including mandatory benefits and appropriate appeals procedures.
Rate review	Review, approval, or disapproval of insurer rates to ensure that insurers set premiums in accordance with state requirements.
Market conduct examinations	Periodic or targeted audits of insurers in response to specific practices or suspected issues designed to identify noncompliance with state requirements.
Sanctions	Fines levied against insurers for violating state requirements.
License revocation	Revocation of a license to engage in the insurance business in the state.

Source: M. Kofman and K. Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change* (Washington, D.C.: Georgetown University Health Policy Institute, 2006).

Of the 11 states that amended their authority, most states passed new legislation that included broad authority to cover all provisions of the Affordable Care Act, including the 2014 market reforms. But two states—New Hampshire and Utah—face some limitations on the extent of their authority. Utah, for example, passed a provision to allow enforcement of only select provisions of the Affordable Care Act, such as essential health benefits and waiting periods.[27] New Hampshire passed legislation that allows its DOI to both enforce and write new rules regarding the Affordable Care Act but only after prior approval from a legislative oversight committee.[28] New Hampshire regulators are currently reviewing their ability to enforce the Affordable Care Act, including the 2014 market reforms, to help ensure that consumers receive the benefits of the law.[29]

State regulators reported that explicit authority regarding the Affordable Care Act was motivated by the desire to ensure that the states would continue their role as the primary regulator of health insurance and to limit or preclude the need for enforcement by the federal government. Regulators pointed to the benefit of broad enforcement and rulemaking authority as a way to meet the Affordable Care Act's requirements while retaining the flexibility a state needs to monitor and regulate a unique marketplace. Another state noted that broad authority met the state's needs to preserve statutory requirements for grandfathered plans, especially in light of uncertainty about how to develop parallel requirements for grandfathered and non-grandfathered coverage. For the reasons above, states that have not yet done so might consider passing similar legislation giving regulators the broad authority to enforce and issue new regulations regarding the Affordable Care Act, including the 2014 market reforms.

Although broad authority can serve many needs, regulators in a number of states—even those with broad enforcement and rulemaking authority—anticipate the need to take additional legislative or regulatory action to reflect the 2014 market reforms in state law or amend existing state laws that conflict with these requirements. A number of these states indicated that they had or were preparing such legislation for the 2013 legislative session.

Some States Have Limited Existing Authority to Address the 2014 Market Reforms

Eight states reported full authority to enforce the 2014 market reforms without passing new legislation (Exhibit 5). We refer to "full authority" as the ability to require full compliance with and issue new regulations on the 2014 market reforms. While most states indicated that their authority is derived from provisions giving the DOI the ability to broadly enforce insurance laws, there was significant variation across states. In one state, for example, regulators have long been able to issue new rules to minimally meet federal standards. Other states have general authority to execute all laws that relate to insurance and the DOIs interpret these provisions to apply to both state and federal law. Another state has the authority to

coordinate regulatory activities with the federal government in regulating insurance, which the state relies on to enforce federal law.

Not all state DOIs, however, have such broad enforcement or rulemaking authority regarding federal law. In the absence of new legislation, 22 states reported that they had no enforcement and rulemaking authority regarding the 2014 market reforms or that this authority was limited. We refer to "limited authority" as 1) the ability to require compliance with and/or issue new regulations on some, but not all, of the 2014 market reforms, or 2) the ability to take some actions—such as review policy forms or rates—to ensure that insurers comply with the 2014 market reforms, but unable to issue guidance on these requirements or use the state's full suite of regulatory powers, like market conduct exams, sanctions, and license revocation, to enforce the 2014 market reforms.

Enforcement Authority. In response to our survey, regulators in a number of states cited general authority to regulate the sale of insurance or prevent unfair trade practices as their source of authority to enforce the 2014 market reforms. Although these provisions do not explicitly reference federal law, at least some regulators have adopted the position that a policy that fails to comply with federal law also fails to meet these standards, which allows regulators to take enforcement action if necessary.

Other states noted that they have inherent authority to enforce federal law based on their ability to regulate insurance and prevent illegal or unfair trade practices. However, regulators in some states raised concerns about past state court rulings that could undermine this authority. Regulators in another state indicated that they would use their authority to regulate insurer solvency to help enforce the 2014 market reforms. According to regulators, the state could use this authority to enforce the 2014 market reforms because of concerns that an insurer might face large federal fines for failure to comply with the Affordable Care Act. Some regulators noted that reliance on this type of general or inherent enforcement authority can be a powerful tool, but—without additional statutory authority to enforce the Affordable Care Act's most dramatic changes in 2014—may be valuable only to the extent that insurers do not challenge the state's interpretation of its authority.

Many states noted that they would rely heavily on their authority to review and approve policy forms and rate filings to enforce the 2014 market reforms in the absence of new legislation. In many states, regulators have the authority to approve or disapprove policy forms and can require insurers to amend their policy forms to ensure that they comply, or do not conflict, with the Affordable Care Act.[30] Regulators could, for example, disapprove any policy that includes preexisting condition exclusions or does not include the state's essential health benefits package. And, once a policy is approved for use, regulators can typically enforce the provisions of the policy should an insurer violate one of these requirements.

Regulators in one state, for example, noted their plans to require insurers to file an attestation of compliance with the Affordable Care Act and state law under the state's broad authority to review and approve policy forms. During this form review process, regulators would ensure that insurers filed the attestation and that the policy contained a provision incorporating the attestation, which would give regulators the ability to enforce the Affordable Care Act's requirements, including the 2014 market reforms.

Yet, regulators in some states reported that reliance on form review alone is likely to be an imperfect solution to enforcing the 2014 market reforms and thus ensuring that consumers receive the benefits promised under the Affordable Care Act. As one regulator put it, the use of form and rate review authority is a "reasonably good enforcement tool" but regulators could be limited if this is their sole source of authority to enforce the 2014 market reforms. For example, regulators questioned how a state would use form review to determine whether an insurer is complying with guaranteed issue requirements, which is related more to an insurer's marketing practices than the content of a policy. Another regulator asked how a state relying solely

on form and rate review would address noncompliance in previously approved products.

Even though regulators expect few problems with ensuring that forms comply with the 2014 market reforms, some raised concerns about whether they could enforce federal requirements that had no corresponding requirement reflected in state law. Indeed, some regulators raised concerns about their ability to respond to consumer complaints, require an insurer to change its practices, or impose sanctions without express authority to enforce federal law. Others noted that a major limitation of using form and rate review authority alone is that most states would be unable to issue interpretive guidance on what the Affordable Care Act means and how the DOI will interpret a particular provision.

Rulemaking Authority. Most states have broad authority to issue new regulations or guidance, but this authority typically only extends to requirements that are reflected in state law. Because the 2014 market reforms are likely not reflected in state law in the 39 states that have yet to take action on these requirements, these states may be unable to issue regulations on all the reforms.

Some states face additional hurdles in issuing new regulations, even if they have incorporated the 2014 market reforms. This is because a number of DOIs can only issue "legislative rules" where members of the legislature—either a committee or the full legislature—must approve (or can disapprove) new insurance regulations before they become effective. Some states with this requirement noted that it would not be problematic in implementing the Affordable Care Act because they expect to have a supportive legislature. However, in states where legislators are opposed to the Affordable Care Act, obtaining legislative approval may prove difficult.

These limitations notwithstanding, some states reported they would be able to use existing regulatory authority to address certain 2014 market reforms. For example, a number of states noted the possibility of enforcing the Affordable Care Act's rating requirements by incorporating this standard into the state's existing rate review process. Other states have passed exchange legislation that includes the authority to issue new regulations and noted the possibility of issuing regulations that extend federal exchange requirements—including at least some of the 2014 market reforms—to plans sold outside of the exchange.

POLICY IMPLICATIONS

Our findings reveal that few states have taken formal legislative or regulatory action on the 2014 market reforms, with only one state addressing all of the protections. States may have chosen not to act for a number of reasons. First, states may have waited until closer to 2014 when the reforms become effective. Indeed, our prior research shows that more states took action to implement the Affordable Care Act's early market reforms, which went into effect on September 23, 2010.[31] Second, states may not have acted on the 2014 market reforms because of uncertainty surrounding the law, including a challenge of the law's constitutionality before the Supreme Court of the United States, political opposition, and the results of the 2012 presidential and congressional elections. Third, states may have been waiting on key regulations from the federal government before taking new action.

Because so few states have taken formal action to address the 2014 market reforms, 2013 will be a critical time period for state policymakers who wish to limit direct federal enforcement of the reforms and for consumers expecting to benefit from these new protections. State legislators and regulators should consider whether new legislation or regulations—either to amend existing state law or give the DOI the authority to enforce or write new rules—may be appropriate to ensure that consumers in their state receive the full benefits promised under the Affordable Care Act. Indeed, a number of regulators reported that they had or were preparing legislation on the 2014 market reforms for the 2013 legislative session.

The need for state action is acute because some states may face enforcement gaps if relying solely on existing authority to enforce the 2014 market reforms. Indeed, regulators raised concerns about how a state

could respond to a consumer complaint regarding the 2014 market reforms without explicit authority to enforce federal law. Will state regulators merely monitor for violations of federal law and then refer complaints to the federal government? Or will states be expected to try to resolve complaints before referring consumers to federal regulators? How will the process compare to states' current lack of authority to enforce consumer protections in self-funded plans, which are regulated by the federal government?

Despite these gaps, most regulators have the authority to use at least some of the regulatory tools needed to successfully enforce the market reforms, even without new legislation. The benefits of using existing authority to enforce the 2014 market reforms include avoiding the need for new legislation and using regulatory mechanisms that regulators are already familiar with, such as form and rate review.

However, regulators also reported that—without additional authority—they cannot use all the regulatory tools they might need. For example, states may be limited in their ability to regulate insurers' marketing practices, which cannot be easily tracked by reviewing policy forms and rate filings and because some DOIs may not initiate market conduct exams until after regulators have received a sufficient number of consumer complaints. And, unlike new legislative or regulatory action, form and rate review are unable to address ambiguities when the 2014 market reforms do not exist in state law or conflict with existing state standards. In light of these limitations, state policymakers may decide to take new action to ensure that state laws are consistent with federal laws, to avoid confusion and the need for coordination between the state and federal governments, and to address regulatory gaps.

The extent of state action on the 2014 market reforms—and thus expanded state authority—may ultimately be influenced by the enforcement standard that federal regulators adopt. Federal regulators can define what it means for a state to "substantially enforce" the 2014 market reforms and whether explicit legal authority will be required to meet this standard. If existing authority—such as form and rate review authority—is considered sufficient (without requiring new legislative or regulatory authority), states may decide not to enhance their existing authority. As a result, some states reported that they could be limited in their ability to fully enforce the Affordable Care Act and federal regulators may need to undertake at least partial or full enforcement of these reforms in some states.

However, if federal regulators set a standard that demands explicit authority to enforce federal law, states may choose to enhance their existing enforcement and rulemaking authority regarding the 2014 market reforms. Regulators in some states indicated they would favor such legislation to limit federal enforcement of insurance laws and ensure that their consumers are protected. To assist states in making important decisions about enforcement, federal regulators should consider soon establishing an enforcement standard; doing so would provide state policymakers with a clear indication of how much time, energy, and political capital should be used to pass new legislation or issue new regulations in 2013, a critical time period for implementing the Affordable Care Act.

CONCLUSION

Eleven states and the District of Columbia took new legislative or regulatory action on at least one of the 2014 market reforms; one state took action on all seven reforms studied. Most—39 states—have yet to take new legislative or regulatory action to implement the 2014 market reforms. Many could face enforcement gaps if relying solely on existing authority to enforce the 2014 market reforms. These findings suggest that states may need to take new action in 2013 to protect consumers and limit federal enforcement of the reforms. Although states can use some regulatory tools to promote compliance with the 2014 market reforms, questions remain about how effectively states can enforce these requirements in the absence of new legislation and additional state action may depend on the enforcement standard set by the federal government. Our findings also suggest that policymakers will benefit from continued analysis of the actions states take to enforce and implement the Affordable Care Act.

Notes

1 Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1201, 1302; Pub. L. 111-152, 124 Stat. 1029 (2010).

2 Public Health Services Act § 2723 (codified at 42 U.S.C. § 300gg-22); 45 C.F.R. § 150.203.

3 T. S. Jost, "The Regulation of Private Health Insurance" (Washington, D.C.: National Academy of Social Insurance, National Academy of Public Administration; Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2009). Congress reaffirmed this role in 1945, when it passed the McCarran–Ferguson Act, which recognized state authority over private health insurance unless Congress expressed its intent to regulate coverage. See 15 U.S.C. §§ 1011, 1012 (2006).

4 See, for example, "Request for Comments Regarding Section 2718 of the Public Health Services Act (Medical Loss Ratios)" (Washington, D.C.: Departments of Health and Human Services and Labor, and the Internal Revenue Service, April 8, 2010), which notes that "the Secretaries of HHS, Labor, and Treasury have shared interpretive and enforcement authority under Title XXVII of the PHS Act, Part 7 of ERISA, and Chapter 100 of the Code."

5 Public Law 104–191, 110 Stat. 1936 (1996) (codified at 42 U.S.C. §§ 300gg, 1320d et seq. and 29 U.S.C. § 1181 et seq.).

6 Public Health Services Act § 2723(a)(2); 45 C.F.R. §§ 150.203, 150.303.

7 U.S. Government Accountability Office, "Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve," letter to Sen. Jeffords (Washington, D.C., May 7, 2001), http://www.gao.gov/assets/100/90726.pdf.

8 Public Health Services Act § 2723(a)(2).

9 Ibid. § 2723(b)(2).

10 See National Association of Insurance Commissioners, "Survey on State Authority to Enforce PPACA Immediate Implementation Provisions" (Washington, D.C., 2010), http://www.naic.org/documents/index_health_reform_section_ppaca_state_enforcement_authority.pdf.

11 Conn. Gen. Stat. Ann. § 38a-591(b) (2011) ("Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation and health care center licensed to do business in the state shall comply with Sections 1251, 1252 and 1304 of the Affordable Care Act and the following Sections of the Public Health Service Act, as amended by the Affordable Care Act: (1) 2701 to 2709, inclusive, 42 USC 300gg et seq.; (2) 2711 to 2719A, inclusive, 42 USC 300gg-11 et seq.; and (3) 2794, 42 USC 300gg-94.").

12 Personal correspondence with health insurance regulator, Connecticut Insurance Department (Oct. 24, 2012) (on file with authors).

13 Ibid.

14 2011 Ca. A.B. 1083.

15 2012 Ca. A.B. 961; 2012 Ca. A.B. 1461.

16 Personal correspondence with health insurance regulator, California Department of Managed Health Care (Oct. 25, 2012) (on file with authors). In December 2012, California legislators introduced two bills, 2013 Ca. A.B. 18 and 2013 Ca. S.B. 18, that state the intent of the legislature "to enact legislation to reform the individual health care coverage market consistent with the federal Patient Protection and Affordable Care Act."

17 Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1201, 1302 (codified at 42 U.S.C. §§ 300gg-6, 18022 (2006)).

18 The D.C. Health Insurance Exchange recently adopted a recommendation to require all health insurance to be sold through the Exchange; in this case, all health insurance would be considered a qualified health plan and thus new legislation may not be necessary to extend these requirements to plans offered outside the Exchange.

19 2011 Or. S.B. 91.

20 2010 D.C. Laws 18-360 (Act 18-710).

21 2010 Del. H.B. 85; 2010 N.M. S.B. 148. Delaware's law also limits rating based on age.

22 42 U.S.C. § 300gg (2006).

23 Personal correspondence with health insurance regulator, Arizona Department of Insurance (Oct. 15, 2012) (on file with authors).

24 N.D.C.C. § 26.1-02-29; O.R.S. §§ 743.731, 743.758.

25 H.R.S. §§ 431:10A-105.5, 432:2-611, 432:1-107, 432D-28; Utah St. § 31A-2-212; MD Ins. Code § 15-137.1.

26 Iowa Code § 505.8(19) (2011).

27 U.C.A. 1953 § 31A-2-212; MD Code, Insurance, § 15-137.1

28 N.H. Rev. Stat. § 420-N:5.

29 Personal correspondence with health insurance regulator, New Hampshire Insurance Department (Nov. 8, 2012) (on file with authors).

30 National Association of Insurance Commissioners, *Compendium of State Laws on Insurance Topics*, "Filing Requirements: Health Insurance Forms and Rates" (Washington, D.C.: Nov. 2011).

31 K. Keith, K. W. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Action on Early Market Reforms* (New York: The Commonwealth Fund, March 2012).

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