ACA Implementation—Monitoring and Tracking

# Cross-Cutting Issues:

## Monitoring State Implementation of the Affordable Care Act in 10 States: Early Market Reforms

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

# INTRODUCTION

The ACA, when fully implemented, will significantly change the regulatory standards that determine the accessibility, affordability and adequacy of private health insurance coverage. Although most of the ACA's comprehensive market reforms do not go into effect until January 1, 2014, a number of consumer protections, often referred to as the "Patient Bill of Rights," went into effect on September 23, 2010. These early market reforms include important consumer protections, such as prohibiting lifetime dollar limits on essential health benefits, prohibiting the denial of coverage for children based on a preexisting condition, and requiring coverage of certain preventive services without cost-sharing, among others. (Table 1)

This paper describes the implementation of the early market reforms in the 10 states participating in the Robert Wood Johnson Foundation's monitoring and tracking project: Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia. Information is drawn from publicly available sources, state legislation, and site visit interviews in each of the 10 states. Site visit interviews were completed for all states by May 2012.

This paper summarizes how the 10 case study states have approached implementation of the early market reforms. Each state took some action to require or encourage insurers to comply with these reforms. Although some challenges were noted, informants in all 10 states reported that insurers are generally complying with the early market reforms; regulators are hearing few consumer concerns, and premiums have not risen substantially because of these reforms. Compliance was largely facilitated through the efforts of state regulators, insurers and consumer advocates. To a large extent, the actions taken by these states reflect the diversity of approaches that exist among states nationwide.[1]

Important consumer protections that are outside the scope of this paper include implementation of ACA's new medical loss ratio requirements,[2] the establishment of new standards for grievances and appeals,[3] new standards for the review and justification of insurers' proposed rate increases,[4] and market reforms scheduled to go into effect January 1, 2014.[5] Though research suggests that the 10 study states have taken action on these protections, they raise different regulatory issues than the 10 provisions analyzed here and warrant a separate discussion.

# BACKGROUND

While the ACA ushers in significant changes in the private health insurance market, it does not change the regulatory framework through which insurers and the products they sell are regulated under state and federal law. Thus, under the ACA, states remain the primary regulator of private health insurance and in this role, enforce health insurance standards, including old and new federal standards. It is only when a state informs the federal government that it will not enforce or fails to "substantially enforce" a federal requirement that the U.S. Department of Health and Human Services (HHS) is authorized to step in and directly enforce that standard.[6] This approach is an extension of the regulatory framework that Congress adopted in 1996 when it passed the Health Insurance Portability and Accountability Act (HIPAA) to improve access, renewability, and portability of health insurance coverage.[7]

## Table 1: Summary the ACA's Early Market Reforms Effective September 23, 2010

| Early Market Reform | Description | Applicability |
|---|---|---|
| **Lifetime Dollar Limits** | Prohibits lifetime limits on the dollar value of essential health benefits. | All plans, all markets |
| **Annual Dollar Limits** | Restricts annual limits on the dollar value of essential health benefits, unless waived by HHS. Waivers to be discontinued in 2014. | All plans, except individual grandfathered plans*, all markets |
| **Dependent Coverage to Age 26** | Requires plans that provide dependent coverage to make it available until a child turns 26. | All plans, all markets |
| **Rescissions** | Prohibits plans from retroactively cancelling coverage, except in the case of a subscriber's fraud or intentional misrepresentation of material fact, and requires prior notice to the insured. | All plans, all markets |
| **Preventive Services Without Cost-Sharing** | Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider. | New plans, all markets |
| **Preexisting Condition Exclusions for Children Under Age 19** | Prohibits plans from imposing preexisting condition exclusions on individuals under age 19. | All plans, except individual grandfathered plans, all markets |
| **Access to Emergency Services** | Requires plans that provide benefits with respect to emergency services to cover such services without prior authorization, and regardless of whether the provider participates in the plan's network; requires equivalent cost-sharing for network and non-network providers; and prohibits requirements or limitations on non-network providers that are more restrictive than those imposed on services provided by network providers. | New plans, all markets |
| **Choice of Primary Care Providers** | Requires plans to allow subscribers to designate any available participating primary care provider (PCP) as their provider. | New plans, all markets |
| **Choice of Pediatricians** | Requires plans to allow parents to choose any available participating pediatrician to be their children's PCP. | New plans, all markets |
| **Access to Obstetrical and Gynecological Care** | Requires plans to provide access without prior authorization or a referral to participating obstetricians and gynecologists. | New plans, all markets |

* Grandfathered plans are those plans in existence before the ACA was enacted that have not made significant changes since March 23, 2010.

# OBSERVATIONS FROM THE 10 STATES

An in-depth analysis of the 10 case study states revealed some differences, but primarily similarities in the implementation of the early market reforms. Despite certain challenges, informants in all 10 states reported that states are requiring or encouraging compliance with the early market reforms; insurers are generally complying with these new requirements, often working collaboratively with their Department of Insurance (DOI); states have heard few consumer concerns regarding the early market reforms; and premiums have not risen substantially because of these reforms.

## States Are Requiring or Encouraging Compliance with the Early Market Reforms

Although there was significant variation in the approaches taken, all 10 states took action to require or encourage insurers to comply with the early market reforms (Table 2).

## Table 2: State Action to Require or Encourage Compliance with the Early Market Reforms

| State | Primary State Action | Reviewing Policy Forms or Requiring Certification of Compliance? |
|---|---|---|
| **Alabama** | Sub-Regulatory Guidance | Yes |
| **Colorado** | Sub-Regulatory Guidance | Yes |
| **Maryland** | Legislation | Yes |
| **Michigan** | Regulation | Yes |
| **Minnesota** | Sub-Regulatory Guidance | Yes |
| **New Mexico** | Sub-Regulatory Guidance | Yes |
| **New York** | Legislation | Yes |
| **Oregon** | Legislation | Yes |
| **Rhode Island*** | Reviewing Policy Forms | Yes |
| **Virginia** | Legislation | Yes |

* In June 2012, Rhode Island passed new legislation implementing most of the early market reforms.

Five of the states—Maryland, Michigan, New York, Oregon and Virginia—passed new legislation or issued a new regulation, legally requiring compliance with some or all of these early market reforms. For example, Maryland passed new legislation and issued a new regulation implementing the early market reforms.[8] In its new legislation, the state required insurers to comply with a list of certain provisions of the ACA, including the early market reforms. Taking a slightly different approach, New York passed new legislation that amended existing state law and adopted new state law that complies with the early market reforms so that the ACA's new protections are reflected in New York's state law.[9] Virginia similarly amended and adopted state law that complies with the early market reforms but included a so-called "sunset provision" that causes the provisions to expire in 2014.[10]

The other states—with the exception of Rhode Island—issued sub-regulatory guidance, typically a form filing bulletin, requiring or encouraging insurers to ensure that their policy forms comply with the new standards. Although bulletins are typically not legally binding, insurers are likely to follow the guidance of the state agency that regulates the marketing of their products and such guidance likely results in a change in practice, if not a change in law. In most of these states, officials from the DOI explicitly instructed insurers to comply with the early market reforms. This was true even in states such as Colorado and New Mexico, where informants suggested that the state did not have the authority to enforce federal law. For example, in Colorado, state officials issued a bulletin stating "[c]arriers are not only required to comply with Colorado's laws, but also all applicable laws, in the

conduct of their business."[11] In New Mexico, the DOI issued a bulletin stating that "[t]he Insurance Division requires all health insurers to file amendatory language to bring their plan/policies into compliance with the [Patient Protection and Affordable Care Act] as amended by [Health Care and Education Reconciliation Act]."[12]

All states reported that regulators were reviewing policy forms or requiring insurers to certify that policy forms are in compliance with the early market reforms. In most states, insurers are not permitted to market new or amended policy forms until they are reviewed and approved by state regulators. Officials in Alabama noted they relied on the state's policy form review approval process to implement health insurance reforms required under HIPAA and, for now, expect to use the same process to compel insurer compliance with the early market reforms of the ACA. Even in Rhode Island—the only state in the study not to pass new legislation or issue a new regulation or sub-regulatory guidance by the time of our site visit—state officials reported that they are closely reviewing policy forms to ensure that insurers comply with the early market reforms. As noted above, Rhode Island has since passed new legislation implementing most of the early market reforms.[13]

*All states reported that regulators were reviewing policy forms or requiring insurers to certify that policy forms are in compliance with the early market reforms.*

States took a number of other steps to facilitate compliance with the early market reforms. For example, in Maryland, state officials developed template language for insurers to adopt when amending policy forms to come into compliance. In New York, state officials standardized their form review processes for insurers to submit amended policy forms that could be checked quickly and easily for compliance. A number of states, including Oregon and Rhode Island, reported working directly with insurers to answer technical questions surrounding the new reforms.

## Insurers Are Readily Complying with the Early Market Reforms

Informants in all 10 states reported that insurers voluntarily came into compliance with the early market reforms with minimal, if any, difficulties reported by state officials. Two primary factors may have contributed to this voluntary compliance.

First, insurers reported that they intended to fully comply with the new federal standards, and some voluntarily agreed to implement at least one protection, dependent coverage up to age 26, prior to the date required under the ACA.[14] In many of the 10 states, officials worked collaboratively with insurers who began amending policy forms to come into compliance with the new reforms well before the effective date of these standards. For example, in Michigan, insurers reached out to state officials immediately after passage of the ACA and maintained "continuous dialogue" with state officials during implementation, often seeking informal guidance to complex regulatory questions not necessarily answered by federal guidance, but needed to amend policies correctly.

Second, informants reported that many of the standards included in the early market reforms were in place prior to the ACA, at least partially, as required under state law or practice. For example, Oregon already required insurers to provide choice of a primary care provider, and informants in Rhode Island reported that insurers, although not required by state law, had already shifted away from annual and lifetime dollar limits to durational limits on benefits, such as day or visit limits.[15] In a number of states, insurers were already legally required to provide extended dependent coverage well beyond the age of 19. However requirements under most state dependent coverage laws were more restrictive in some respect than the ACA. In New York, for example, state law already required insurers to offer policy-holders the option to include dependent coverage through age 29, but only if a dependent was unmarried.[16]

## Consumers Had Few, If Any, Complaints Regarding the Benefits of the Early Market Reforms

States officials and other informants reported receiving few, if any, consumer complaints regarding the early market reforms. This may be because, as noted above, insurers have largely complied with the early market reforms, and a number of these standards were already required under state law or by practice. However, informants also reported that consumers were generally unaware of the new protections, which may have contributed to the low number of complaints.

In most states, state officials, insurers, and consumer advocates worked to inform consumers of the early market reforms. For example, officials in Maryland developed consumer information sheets on the early market reforms, which they posted on the state's website. In Minnesota, an insurer held webinars for small groups of consumers on the timing of these protections. In Colorado, consumer advocates hosted town hall meetings, created educational materials, and were active in educating consumers and other advocacy groups. In Alabama, an informant reported a collaborative effort between insurers and university officials to send letters to students informing them of the benefit of dependent coverage up to age 26. Despite these and similar efforts in other states, informants in a number of states suggested that additional outreach and education was needed to inform consumers of these protections.

*To understand the relationship between the early market reforms and premium increases, at least some states relied on other regulatory tools, such as the rate review process.*

Although implementation of the early market reforms was largely without incident, informants in some states reported difficulties regarding the requirement that insurers cover certain preventive services without cost-sharing. In particular, in a number of states, such as Oregon and Michigan, consumers voiced confusion when faced with unexpected cost-sharing following what the consumer believed was a screening procedure covered by the ACA. This problem is particularly acute with colonoscopies, a procedure that can cost several thousand dollars. Often the issue was whether the colonoscopy constituted a preventive screening if other services, such as the removal of a polyp, were performed during the procedure. In a number of cases, consumers reported significant and unanticipated charges from deductibles, copayment and other cost-sharing. States have yet to address this issue through sub-regulatory guidance and, despite looking to federal regulators for official guidance, have yet to receive any. At least one state, Oregon, drafted sub-regulatory guidance informing insurers how to properly impose cost-sharing when a polyp is removed. However, officials decided not to issue the guidance and chose to instead work collaboratively with insurers and providers to avoid inappropriate cost-sharing charges.

## Early Market Reforms Resulted in Only Minimal Premium Increases

Informants in the 10 states reported that implementation of the early market reforms has had only a minimal impact on premiums. According to informants, premium increases in Alabama, Colorado, Oregon, Rhode Island, and Virginia generally ranged from three to five percent as a result of these protections. For example, analysis by state officials in Colorado suggests that the early market reforms contributed anywhere from zero to five percent of premium increases, as documented in premium rate increase requests for 2011. In Rhode Island, state officials reported that the impact on premiums from these reforms was an increase between one and three percent.

To understand the relationship between the early market reforms and premium increases, at least some states relied on other regulatory tools, such as the rate review process. In response to insurers' suggestion that the ACA was causing a significant increase in premiums, regulators in Oregon were able to use the rate review process to show that the early market reforms resulted in only a minimal increase in premiums. In response, the DOI now requires insurers to submit samples of their communications with enrollees, limiting efforts to attribute premium increases to the ACA without supporting evidence. State officials in Rhode Island also used the rate review process to get insurers to estimate the impact of the early market reforms on premiums.

## Implementation Largely Successful, But Not Without Some Challenges

Although implementation of the early market reforms was largely without incident in the 10 states, some states and insurers reported challenges, particularly in the monitoring of grandfathered plans and the sale of child-only policies.

Grandfathered plans (those in place at the time of the law's enactment and not changed substantially since) are exempt from some of the early market reforms, such as preventive services with no cost-sharing and many of the broader reforms that go into effect in 2014. Although states are interested in monitoring plans with grandfathered status, it is difficult to do because calculations for determining grandfathered status are complex and require comparisons between current coverage and the coverage in place at the ACA's passage.

Informants also noted that the information needed to determine grandfathered status is not necessarily found within the forms insurers traditionally file with state DOIs. For example, certain changes in employee premium cost-sharing could trigger a loss of grandfathered status, but neither state regulators nor insurers are necessarily aware of how employers split premium costs with their employees. One informant reported that small employers often ignored worksheets sent out by their insurers that would allow the insurer to know how premiums are allocated. For now, regulators appear to be relying heavily on self-certification by insurers, even though insurers themselves may not have accurate information. Partly because of the administrative burden of doing so, some insurers in some states, such as Rhode Island and New Mexico, ceased offering grandfathered plans.

A number of states also reported that insurers stopped selling individual insurance coverage for children, often referred to as "child-only" policies, as a result of the ACA's prohibition on preexisting condition exclusions for children, and due to fears of adverse selection from insurers. According to informants, some or all insurers discontinued selling child-only policies in Alabama, Colorado, Maryland, Minnesota, New Mexico, Oregon and Virginia.

## Table 3: State Action and the Availability of Child-Only Policies

| State | Insurers Stopped Selling Child-Only Policies in Response to ACA? | State Action to Promote the Availability of Child-Only Policies | Insurers Currently Selling Child-Only Policies |
|---|---|---|---|
| **Alabama** | Yes, All | None | No |
| **Colorado** | Yes, Some | Required insurers to sell during standardized open enrollment periods | Yes |
| **Maryland** | Yes, All | Established standardized open enrollment periods | Yes |
| **Michigan** | No | None | Yes |
| **Minnesota** | Yes, All | None | No |
| **New Mexico** | Yes, All | None | Yes |
| **New York** | No | None | Yes |
| **Oregon** | Yes, Some | Established a reinsurance mechanism | Yes |
| **Rhode Island** | No | None | Yes |
| **Virginia** | Yes, Some | Established standardized open enrollment periods | Yes |

In response, states adopted a variety of approaches which ranged from taking no action to implementing a requirement that insurers offer child-only policies. For example, state officials in Alabama did not take action to encourage insurers to resume offering child-only policies after one insurer made a "business decision" to discontinue offering such coverage. Officials suggested that few child-only policies were sold prior to the ACA. In contrast, Colorado issued sub-regulatory guidance and a new regulation and passed new legislation to encourage the continued sale of such policies. To minimize concerns of adverse selection, state officials first issued sub-regulatory guidance and an emergency regulation that established two annual open enrollment periods, but without a requirement that insurers sell child-only policies. However, raising concerns that this strategy may be insufficient over the long-term, insurers supported new legislation that required all insurers offering individual health insurance policies to also offer child-only policies during the annual open enrollment periods. With the support of insurers and consumer advocates, Colorado passed legislation to that effect in 2011.[17]

Still other states took different approaches to address the child-only market. Regulators in Oregon convened the state's major insurers and negotiated an agreement to establish a reinsurance pool for this specific market. And in New Mexico, although the state did not take official action to encourage the availability of child-only policies, one insurer resumed offering them after the state agreed to allow them to increase the premiums for unhealthy

children to such a level that a child would become eligible for the state's high-risk pool. In general, states that took action to encourage the availability of child-only policies succeeded in meeting this policy goal.

# CONCLUSION

Despite the fact that fewer than half of the 10 study states passed new legislation regarding the ACA's early market reforms, informants in all 10 states indicated that the reforms are being implemented in practice with the encouragement and efforts of state officials, insurers and consumer advocates. In addition, each state took some action to require or encourage insurers to comply with these reforms and is monitoring for compliance through the form review and consumer complaint process. Although some challenges were noted, informants in all 10 states reported that insurers are generally complying with the early market reforms; regulators are hearing few consumer concerns regarding the early market reforms; and premiums have not risen substantially because of these reforms.


### About the Authors and Acknowledgements

Kevin Lucia, Sabrina Corlette and Katie Keith are research professors and project directors at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. The authors benefited from the 10 state reports and interview notes developed from 10 site visits conducted under the auspices of this project. Aside from themselves, these site visits were conducted by Urban Institute colleagues, including: Fiona Adams, Linda Blumberg, Randall Bovbjerg, Vicki Chen, Brigette Courtot, Teresa Coughlin, Stan Dorn, Ian Hill, John Holahan, and Shanna Rifkin.

### About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit **www.rwjf.org**. Follow the Foundation on Twitter **www.rwjf.org/twitter** or Facebook **www.rwjf.org/facebook.**

### About Georgetown University's Health Policy Institute—Center on Health Insurance Reforms

The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace.

# ENDNOTES


1. Katie Keith, Kevin W. Lucia, & Sabrina Corlette, Implementing the Affordable Care Act: State Action on Early Market Reforms, The Commonwealth Fund 8 (Mar. 2012).
2. Pub. L. 111-148, §§ 1001, 10101(f), 10103(d)(3).
3. Ibid. §§ 1001, 10101(g).
4. Ibid. §1003.
5. See, e.g., ibid. §§ 1201, 1562.
6. 42 U.S.C. 300gg-22(a)(2) (2010).
7. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §§ 300gg et seq., P.L. 104-191 (Aug. 21, 1996).
8. H.B. § 170, Maryland 428th Session (2011).
9. S.B. § 5800, New York 234th Session (2011); Chapter 219 of the Laws of 2011.
10. H.B. § 1958, Virginia 2011 Regular Session (2011).
11. Colorado Department of Regulatory Agencies, Bulletin No. B-4.34 (Aug. 4, 2010).
12. New Mexico Public Regulation Commission, Bulletin No. 2010-005 (Sept. 14, 2010).
13. H.B. § 7909, Rhode Island 2012 Legislative Session (2012).
14. For example, Blue Cross and Blue Shield of Alabama. For others examples, see HHS Fact Sheet: Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses, The Center for Consumer Information & Insurance Oversight, available at http://cciio.cms.gov/resources/files/adult_child_fact_sheet.html (last visited 6/29/2012).
15. Or. Rev. Stat. § 743.808(1).
16. N.Y. Insurance Law § 3216(a)(4)(C); §4235(f)(1)(B); §3304(d)(1)(B); §4305(c)(1)(B).
17. S.B. § 128, Colorado 1st Regular Session of the 68th General Assemby (2011).