IMPLEMENTING THE AFFORDABLE CARE ACT
THE STATE OF THE STATES

JANUARY 2014

Katie Keith and Kevin W. Lucia

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Abstract: The Affordable Care Act is designed to improve access to coverage for millions of Americans. Because states are the primary implementers of these requirements, this report examines the status of state action on the three major components of health reform—the market reforms, the establishment of health insurance marketplaces, and Medicaid expansion. The analysis finds that nearly all states will require or encourage compliance with the market reforms, every state will have a marketplace, and more than half the states will expand their Medicaid programs. The analysis also shows that federal regulators have stepped in where states have been unable or unwilling to take action. These findings suggest that regulators will continue to help ensure consumers receive the benefits of the law—regardless of the state they live in—but raise questions about how this variation might affect consumers as state insurance markets undergo significant transition in 2014.

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EXECUTIVE SUMMARY

The Affordable Care Act has the potential to increase access to coverage for millions of Americans primarily through three mechanisms: 1) the implementation of market reforms; 2) the establishment of new health insurance marketplaces, also known as exchanges; and 3) the expansion of Medicaid eligibility for low-income adults. This report examines the status of state implementation of each of these reforms in all 50 states and the District of Columbia.

Understanding State Implementation of the Affordable Care Act

States varied significantly in their approach to implementing the Affordable Care Act's three major components, but states were most likely to take new action to implement the market reforms. These reforms include access to coverage for young adults, a ban on preexisting condition exclusions, the coverage of a minimum set of essential health benefits, and a ban on lifetime limits for health care coverage, among other critical consumer protections.

To date, 32 states and the District of Columbia have taken new legislative or regulatory action on at least one of the market reforms. Of these, 11 states addressed all of the reforms studied in this report. Although states may not have taken new action to implement each of the reforms, state regulators in the vast majority of states will use their authority or collaborate with federal regulators to require or encourage compliance with the new protections. In the five states that declined to enforce these reforms, federal regulators will do so to ensure that consumers receive the benefits promised under the Affordable Care Act.

Seven states—Connecticut, Hawaii, Maryland, Massachusetts, Minnesota, Oregon, and Vermont—fully embraced all three major components by implementing the market reforms, establishing a state-based marketplace, and expanding their Medicaid program. Other states that have actively implemented the Affordable Care Act—such as California, Colorado, and New York—nearly met this standard. At the other end of the spectrum, five states—Alabama, Missouri, Oklahoma, Texas, and Wyoming—fully declined to play a role in implementing these components.

In the middle of this spectrum, states with state-based marketplaces were more likely to take action on the market reforms and expand their Medicaid programs. But states with federally facilitated marketplaces were also active. Of the 34 states with federally facilitated marketplaces, 18 states took legislative or regulatory action on the market reforms. Eleven states are expanding their Medicaid programs, with an additional four still considering expansion. This variation suggests that states have flexibility in implementing the Affordable Care Act—and are taking advantage of it.

Understanding Market Dynamics

States also amended insurance laws in response to emerging market dynamics. For example, states actively repealed pre-Affordable Care Act protections, enhanced or diminished their authority to review rates, or adopted new requirements for certain products while exempting others from state insurance law. These changes, coupled with the Affordable Care Act's reforms, represent a significant shift for many states, and the effect of these changes remains unclear. Additional analysis will be critical to understand whether such actions promote or undermine the Affordable Care Act's reforms and affect the stability of state insurance markets.

LOOKING FORWARD

Most states have been active in preparing for the significant changes mandated by the Affordable Care Act. More than half took action to implement or enforce at least one market reform, and state regulators in 32 states and the District of Columbia chose to operate their own exchanges or are playing an active regulatory role by conducting plan management.

Where states have been unable or unwilling to implement the Affordable Care Act, federal regulators have stepped in to directly enforce the market reforms and operate the marketplaces. As a result, nearly all states are requiring or encouraging compliance with the market reforms, every state has a marketplace, and more than half of states expanded their Medicaid programs.

By filling gaps and supporting state efforts to enforce the law, federal regulators have helped ensure that the market reforms and marketplaces will be enforced and available in every state. Yet, with no federal backup in the 20 states that declined to expand their Medicaid programs, millions of low-income adults may continue to face barriers to meaningful coverage.

Given the diverse approaches to implementation, this report raises questions about the level of coordination that will be required between state and federal regulators, where consumers in each state should turn with questions about their coverage, whether additional changes to states' regulatory framework will promote or undermine the reforms, and whether states that declined to expand their Medicaid programs will adopt other mechanisms to provide coverage for low-income consumers. The answers are likely to vary by state and suggest that ongoing, holistic analysis of state insurance markets will be critical to ensuring that consumers benefit from the new protections, regardless of the state they live in.

INTRODUCTION

The Affordable Care Act has the potential to increase access to private and public health insurance for millions of Americans primarily through three mechanisms: 1) implementing new market reforms that set minimum standards for coverage; 2) establishing new health insurance marketplaces, also known as individual exchanges and Small Business Health Options Program (SHOP) exchanges; and 3) expanding Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level ($15,856 for an individual and $32,499 for a family of four) (Exhibit 1). This report examines the status of state implementation of each of these reforms in all 50 states and the District of Columbia as of November 1, 2013.

The Affordable Care Act contains significant reforms that apply to private health insurers in the individual, small-group, and large-group markets in all 50 states and the District of Columbia. The "early market reforms," which went into effect on September 23, 2010, include expanded access to coverage for young adults and a ban on lifetime limits on essential health benefits.[1] The "2014 market reforms" went into effect for plan or policy years beginning on or after January 1, 2014, and include guaranteed access to coverage and a minimum set of essential health benefits.[2] These reforms apply to coverage offered in the individual marketplaces and SHOP exchanges (known as the "inside" market) as well as the individual and small-group markets that will continue to operate outside the marketplaces in most states (known as the "outside" market) (Exhibit 2). Previous studies revealed that many states had not yet implemented these reforms and, as a result, some states could face enforcement gaps without new legislative or regulatory action.[3]

States have historically been the primary regulators of private health insurance.[4] Although states continue to play this role, the Affordable Care Act establishes a federal standard for market reforms and allows—but does not require—states to enforce these protections.[5] As a result, states have three primary options for enforcement: direct state enforcement; direct federal enforcement; or collaborative state–federal enforcement (Exhibit 3). Under this framework, states have considerable discretion regarding whether to enforce the Affordable Care Act.

The Affordable Care Act requires the establishment of a new individual marketplace and a SHOP exchange in each state (Exhibit 2).[6] Individual marketplaces are expected to provide a seamless, one-stop experience for individuals to apply for federal premium tax credits and cost-sharing subsidies; compare the

EXHIBIT 1. PRIMARY MECHANISMS TO INCREASE ACCESS TO COVERAGE UNDER THE AFFORDABLE CARE ACT

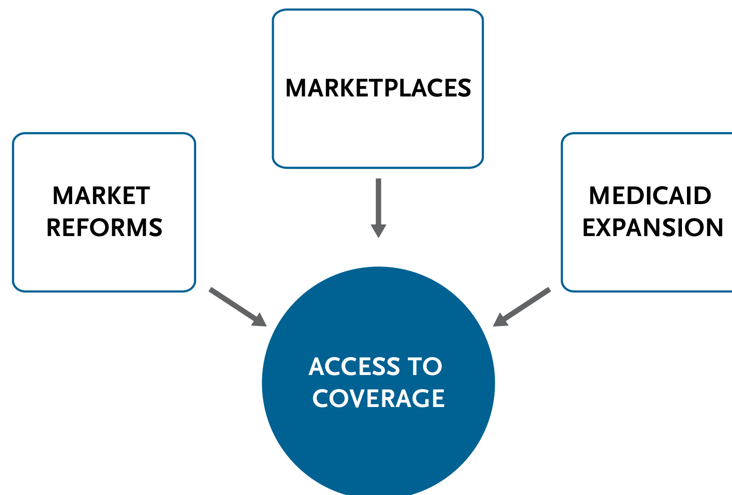
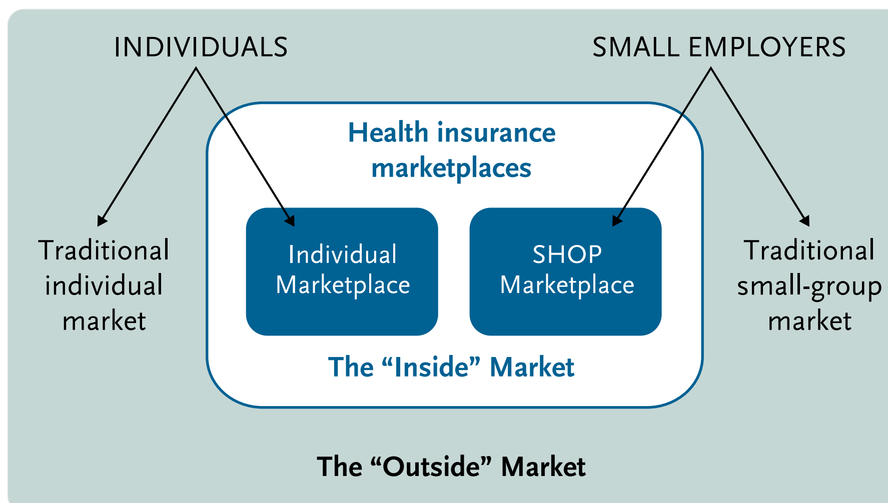


EXHIBIT 2. CONSUMER OPTIONS IN A TYPICAL STATE INSURANCE MARKET UNDER THE AFFORDABLE CARE ACT FOR COVERAGE IN THE INDIVIDUAL OR SMALL-GROUP MARKETS



cost, quality, and value of private health insurance; and ultimately purchase private coverage or enroll in public coverage.[7] Similarly, SHOP exchanges are designed to aggregate the purchasing power of small businesses; enable employers and employees to compare a wider range of coverage choices; and reduce administrative costs.[8]

States can choose to establish a state-based marketplace or default to a federally facilitated marketplace.[9] To date, 16 states and the District of Columbia chose to establish a state-based marketplace (with two of these states opting for a supported state-based marketplace model), while 34 states defaulted to marketplaces run by the federal government with varying degrees of state participation (Exhibit 4).[10] States with a federally facilitated marketplace can opt to play no formal role or enter into a partnership model or a plan management model.[11] States can also adopt a bifurcated model, in which the state operates the SHOP exchange only.[12] Although the market reforms apply to coverage offered inside and outside the marketplaces, plans offered inside a marketplace—known as qualified health plans—must meet additional certification requirements.[13]

EXHIBIT 3. ENFORCEMENT OPTIONS IN THE INDIVIDUAL AND SMALL-GROUP MARKETS

Enforcement Option	Definition
Direct state enforcement	State regulators perform regulatory functions such as collecting and reviewing policy forms for compliance, responding to consumer inquiries and complaints, and taking enforcement action as necessary.
Direct federal enforcement	Federal regulators perform regulatory functions because state regulators lack enforcement authority or fail to substantially enforce all or parts of federal law; requires federal regulators to collect and review policy forms for compliance, respond to consumer inquiries and complaints, and take enforcement action as necessary.
Collaborative state–federal enforcement	Agreement between federal and state regulators in which states perform regulatory functions but lack enforcement authority; typically requires the state to monitor for compliance with state and federal law, respond to consumer inquiries and complaints, and refer violations of federal law to federal regulators for enforcement action if unable to obtain voluntary compliance.

Most marketplaces will rely on their state's insurance departments to conduct "plan management"—that is, the process in which regulators assess plans' compliance with marketplace standards.[14] State regulators will do so even in states with a federally facilitated marketplace if the state opted for a partnership model, a marketplace plan management model, or a bifurcated model.[15] In states that opted not to conduct plan management, federal regulators will ensure that qualified health plans meet these standards but have indicated that they will defer to state review where possible.[16]

Because the market reforms apply both inside and outside the marketplaces, state decisions to implement the market reforms or operate marketplaces have significant implications for the role of state regulators in implementing the Affordable Care Act.

The Affordable Care Act established a uniform eligibility level for state Medicaid programs by expanding coverage to most adults with incomes up to 138 percent of the federal poverty level ($15,856 for an individual and $32,499 for a family of four).[17] The costs of covering this population will be fully funded by the federal government in most states through 2016, with federal funding phasing down to 90 percent for all states by 2020.[18] Following a decision by the U.S. Supreme Court, states can choose whether to expand Medicaid eligibility to this new population or maintain their traditional eligibility criteria.[19] In states that do not expand Medicaid programs, individuals with income over 100 percent of the federal poverty level will be eligible for federal tax credits and other subsidies to purchase private coverage through the marketplace; however, this assistance will not be available for those with incomes below this level.[20] As a result, many low-income adults may be left without access to affordable public or private coverage.[21]

EXHIBIT 4. TYPES OF MARKETPLACE MODELS UNDER THE AFFORDABLE CARE ACT, JUNE 2013

Marketplace Model	Description of Marketplace Activity
State-based marketplace	State operates all core functions; may use federal services for certain functions
Supported state-based marketplace	State operates most core functions; uses federal information technology infrastructure
Federally facilitated marketplace	Federal government operates all core functions
State partnership marketplace	State conducts plan management and/or consumer assistance, outreach, and education functions on behalf of federal government; federal government operates remaining core functions
Marketplace plan management	State conducts plan management on behalf of federal government; federal government operates remaining core functions
Bifurcated marketplace	State operates all core functions for small-business marketplaces and conducts plan management on behalf of federal government for individual marketplace; federal government operates remaining core functions for individual marketplace

Source: S. Dash, C. Monahan, and K. W. Lucia, *Health Insurance Exchanges and State Decisions* (Washington, D.C.: *Health Affairs* and Robert Wood Johnson Foundation, July 18, 2013).

FINDINGS

Understanding State Implementation of the Affordable Care Act

Implementation of the Affordable Care Act has varied across states (Exhibit 5). In this section, we identify the decisions that all 50 states and the District of Columbia have made in implementing the law's three major components—the market reforms, the establishment of new marketplaces, and Medicaid expansion. We found that nearly all states will require or encourage compliance with the market reforms, every state will have a marketplace, and more than half of states will expand their Medicaid programs.

At one end of the spectrum, seven states—Connecticut, Hawaii, Maryland, Massachusetts, Minnesota, Oregon, and Vermont—implemented all of the market reforms, established a state-based marketplace, and will expand their Medicaid program. Other states that have actively implemented the Affordable Care Act—such as California, Colorado, and New York—nearly met this standard. California and Colorado implemented all but a few early market reforms while New York has not yet implemented all of the 2014 market reforms but had a reformed market prior to the Affordable Care Act. All of these states will expand their Medicaid programs.

At the other end, five states—Alabama, Missouri, Oklahoma, Texas, and Wyoming—declined to play a role in implementing the law's three major components. These states will not enforce the market reforms, will have a federally facilitated marketplace where the state will play no formal role, and declined to expand Medicaid.

EXHIBIT 5. NEW STATE ACTION TO IMPLEMENT THE AFFORDABLE CARE ACT, NOVEMBER 2013

	Market Reforms[1]				
State	Early Market Reforms (10 reforms total)	2014 Market Reforms (7 reforms total)	Enforcement of Market Reforms Outside the Marketplace	Marketplace Establishment Decision[2]	Medicaid Expansion[3]
AL	None[4]	None	Federal	Federally facilitated	No
AK	R—1 reform	RR—all reforms	State	Federally facilitated	No
AZ	FR—all reforms[5]	RR—all reforms	State	Federally facilitated	Yes
AR	G—all reforms	R—1 reform	State	Federally facilitated—partnership model	Yes—customized
CA	L—7 reforms	L—all reforms	State	State-based	Yes
CO	L—7 reforms	L—all reforms	State	State-based	Yes
CT	L—all reforms	L—all reforms	State	State-based	Yes
DE	L—7 reforms	L—all reforms	State	Federally facilitated—partnership model	Yes
DC	L—2 reforms	L—3 reforms	State	State-based	Yes
FL	FR—all reforms	RR—4 reforms	Collaborative	Federally facilitated	No
GA	G—all reforms	RR—all reforms	State	Federally facilitated	No
HI	L—all reforms	L—all reforms	State	State-based	Yes
ID[6]	FR—all reforms	G—1 reform	State	Supported state-based	No
IL	R—6 reforms	R—6 reforms	State	Federally facilitated—partnership model	Yes
IN	L—all reforms[5]	G—1 reform	State	Federally facilitated	Undecided
IA	L—all reforms[5]	RR—all reforms	State	Federally facilitated—partnership model	Yes—customized
KS	FR—all reforms	RR—all reforms	State	Federally facilitated—plan management model	No
KY	G—all reforms	R—4 reforms[7]	State	State-based	Yes
LA	L—2 reforms	G—all reforms	Collaborative	Federally facilitated	No
ME	L—all reforms	L—all reforms	State	Federally facilitated—plan management model	No
MD	L—9 reforms, R—1 reform	L—all reforms	State	State-based	Yes
MA	L—all reforms[5]	L—4 reforms, R—3 reforms	State	State-based	Yes
MI	G—all reforms	L—2 reforms	State	Federally facilitated– partnership model	Yes—customized
MN	L—all reforms	L—all reforms	State	State-based	Yes
MS	FR—all reforms	RR—all reforms	State	Federally facilitated—bifurcated model	No
MO	None[4]	None	Federal	Federally facilitated	No
MT	G—all reforms	G—all reforms	Collaborative	Federally facilitated—plan management model	Undecided
NE	L—all reforms[5]	G—5 reforms	State	Federally facilitated—plan management model	No
NV	L—1 reform	L—4 reforms	State	State-based	Yes
NH	L—1 reform	L—1 reform	State	Federally facilitated—partnership model	Undecided
NJ	R—3 reforms	RR—all reforms	State	Federally facilitated	Yes
NM	G—all reforms	RR—all reforms	State	Supported state-based	Yes
NY	L—all reforms	L—2 reforms	State	State-based	Yes
NC	L—all reforms	L—all reforms	State	Federally facilitated	No
ND	L—all reforms[5]	RR—all reforms	State	Federally facilitated	Yes
OH	FR—all reforms	RR—all reforms	State	Federally facilitated—plan management model	Yes
OK	None	None	Federal	Federally facilitated	No
OR	L—all reforms	L—5 reforms, R—2 reforms[7]	State	State-based	Yes
PA	G—all reforms	G—all reforms	State	Federally facilitated	Yes—customized
RI	L—9 reforms	L—1 reform	State	State-based	Yes
SC	G—all reforms	G—all reforms	State	Federally facilitated	No
SD	L—2 reforms, R—8 reforms	R—all reforms	State	Federally facilitated—plan management model	No
TN	FR—all reforms	RR—all reforms	State	Federally facilitated	Undecided
TX	None[4]	None	Federal	Federally facilitated	No
UT	L—8 reforms	L—4 reforms	State	Federally facilitated—bifurcated model	No
VT	L—all reforms	L—all reforms	State	State-based	Yes
VA	L—all reforms	L—all reforms	State	Federally facilitated—plan management model	No
WA	L—2 reforms, R—3 reforms	L—3 reforms, R—2 reforms	State	State-based	Yes
WV	FR—all reforms	G—1 reform	State	Federally facilitated—partnership model	Yes
WI	L—1 reform, R—1 reform	G—2 reforms	State	Federally facilitated	No
WY	None	None	Federal	Federally facilitated	No

Symbol	Definition
L	The state passed a new law on one or more reforms.
R	The state issued a new regulation on one or more reforms.
G	The state did not pass a new law or issue a new regulation, but did issue subregulatory guidance on one or more reforms.
FR	The state did not pass a new law, issue a new regulation, or issue subregulatory guidance, but officials report that they are reviewing insurance policy forms for compliance with one or more reforms.
RR	The state did not pass a new law, issue a new regulation, or issue subregulatory guidance, but officials report that they are reviewing insurance policy forms, rates, and/or other materials for compliance with one or more reforms.
None	The state has taken no noted new action.

[1] 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. In addition, states may have taken action in addition to what is listed above (for example, a state that passed legislation might have also issued a regulation or subregulatory guidance on the same reform); for purposes of this exhibit, we listed the primary state action only. Finally, states may have addressed the provisions differently in each market or may be relying on explicit authority to enforce the early market reforms. For a more detailed description of state implementation of each of the reforms, see the Web tools on The Commonwealth Fund's website.

[2] States can establish their own state-based marketplace or default to a federally facilitated marketplace. States with a federally facilitated marketplace can decline to play any formal role or choose to pursue a partnership model or a plan management model. States may also opt for a bifurcated model. The data in this column are incorporated from S. Dash, C. Monahan, and K. W. Lucia, "Evolving Dynamics of Health Insurance Exchange Implementation," *The Commonwealth Fund Blog,* June 19, 2013.

[3] Following a decision by the U.S. Supreme Court, states can choose whether to expand eligibility for their Medicaid program to individuals with incomes up to 138 percent of the federal poverty level. The data in this column are incorporated from "State Participation in the Affordable Care Act's Expansion of Medicaid Eligibility" (New York: The Commonwealth Fund, Aug. 2013). Some states, such as Arkansas, Iowa, and Michigan, have applied to use the premium assistance model to cover their Medicaid expansion populations; not all of these applications have been approved by federal regulators at this time.

[4] Alabama, Missouri, and Texas previously issued subregulatory guidance regarding the early market reforms. Although this guidance does not appear to have been repealed, the state will not directly enforce the early market reforms and we did not reflect this guidance in the exhibit.

[5] The state passed new legislation that explicitly requires (or allows) state regulators to enforce or issue regulations regarding some or all of the Affordable Care Act's market reforms. Regulators reported that they will rely on this authority for enforcement but the state has not otherwise implemented these reforms.

[6] The governor of Idaho issued Executive Order 2011–03 prohibiting executive agencies from implementing any provisions of the Affordable Care Act.

[7] State action applies only to qualified health plans sold through the marketplace.

Most States Have Taken Legislative or Regulatory Action on at Least One Market Reform

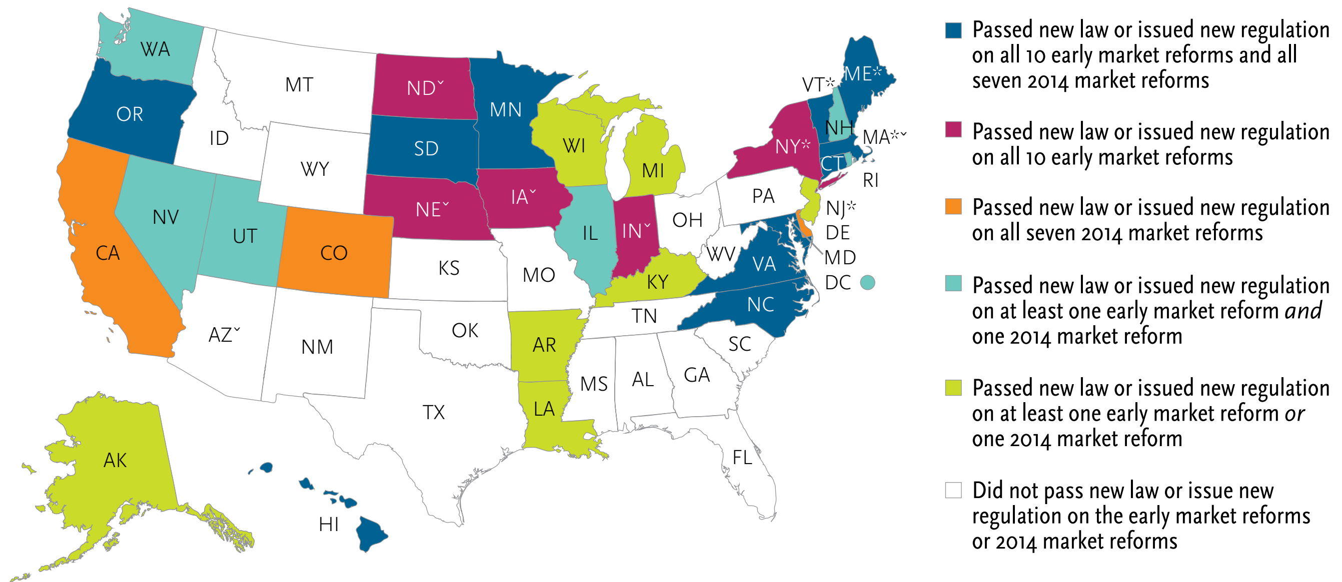
Of the law's three major components, states were most likely to take new legislative or regulatory action to implement the market reforms. To date, 32 states and the District of Columbia have taken legislative or regulatory action on at least one of the Affordable Care Act's market reforms (Exhibit 6). Of these, 11 states—Connecticut, Hawaii, Maine, Maryland, Massachusetts, Minnesota, North Carolina, Oregon, South Dakota, Vermont, and Virginia—addressed all 10 of the early market reforms and all seven of the 2014 market reforms studied.

States were more likely to take action on the early market reforms (29 states and the District of Columbia) than the 2014 market reforms (24 states and the District of Columbia) (Exhibit 7). States are also requiring or encouraging compliance through the form and rate review process. Of the states that did not take new legislative or regulatory action on the reforms, all but five issued subregulatory guidance or reported that regulators are reviewing policy forms, rates, and other materials for compliance.[22]

Despite mixed progress in implementation, 45 states and the District of Columbia will require or encourage compliance with the market reforms. Of these, 17 states passed new legislation that explicitly requires or allows state regulators to enforce or issue regulations regarding some or all of the Affordable Care Act's market reforms.[23] An additional 25 states and the District of Columbia will directly enforce the market reforms. In these states, regulators may not need explicit authority to enforce the Affordable Care Act or the state may have addressed some or all of the market reforms but did not enact enforcement authority.[24]

Three states took advantage of a new option announced by federal regulators in March 2013.[25] Florida, Louisiana, and Montana passed new legislation or issued subregulatory guidance regarding a collaborative enforcement arrangement.[26] In these states, regulators lack enforcement authority but are willing to

EXHIBIT 6. NEW STATE LEGISLATIVE OR REGULATORY ACTION ON THE MARKET REFORMS UNDER THE AFFORDABLE CARE ACT, NOVEMBER 2013



* 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.

ˇ The state did not pass conforming legislation to implement all or some of the early market reforms but is relying on explicit authority to enforce the early market reforms.

Source: Authors' analysis.

For a more detailed description of state implementation of the market reforms, see the Web tools on The Commonwealth Fund's website.

EXHIBIT 7. SUMMARY OF NEW STATE LEGISLATIVE OR REGULATORY ACTION ON THE MARKET REFORMS, NOVEMBER 2013

	Type of Reform		
State Action to Date	**Early Market Reforms**	**2014 Market Reforms**	**Summary**
State passed a new law or issued a new regulation on all of the market reforms	16 states: CT, HI, IA, IN, MA, ME, MD, MN, NE, NY, NC, ND, OR, SD, VA, VT	14 states: CT, CA, CO, DE, HI, MA, ME, MD, MN, NC, OR, SD, VA, VT	**11 states took action on all of the early market reforms *and* all of the 2014 market reforms**
State passed a new law or issued a new regulation on at least one market reform	13 states and DC: AK, CA, CO, DE, DC, IL, LA, NV, NH, NJ, RI, UT, WA, WI	10 states and DC: AR, DC, IL, KY, MI, NV, NH, NY, RI, UT, WA	**10 states and DC took action on at least one of the early market reforms *and* at least one of the 2014 market reforms**
Summary	**29 states and DC took action on at least one early market reform**	**24 states and DC took action on at least one 2014 market reform**	**32 states and DC took action on at least one early market reform or 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. The exhibit does not take into account such existing laws or authority. States may have addressed the provisions differently in each market or may be relying on explicit authority to enforce the reforms. In addition, states may have applied certain requirements only to qualified health plans sold through the marketplace.

monitor for compliance with the Affordable Care Act, respond to consumer complaints, and refer violations to federal regulators for enforcement.[27]

Federal regulators will directly enforce the law in five states: Alabama, Missouri, Oklahoma, Texas, and Wyoming.[28] In these states, insurers will submit policy forms to federal regulators who will notify insurers of any concerns, conduct targeted investigations of market practices, and respond to consumer inquiries and complaints.[29] Federal regulators can assess significant fines for violations of the Affordable Care Act.[30]

Variation in Implementation Regardless of State Marketplace Models

States that opted to establish a state-based marketplace were more likely to take new action on the market reforms. But states with a federally facilitated marketplace also took action: we found that 18 of the 34 states with a federally facilitated marketplace took new legislative or regulatory action on the market reforms.

In particular, states that will perform plan management were more likely to have taken action on the market reforms than states that will play no formal role in a federally facilitated marketplace. Of the 16 states with a partnership model, a plan management model, or a bifurcated model, most—11 states—passed new legislation or issued a new regulation on at least one market reform. Of these, Maine, South Dakota, and Virginia addressed all the reforms studied. Only Kansas, Mississippi, Montana, Ohio, and West Virginia took no new legislative or regulatory action.

Of the 18 states that will play no formal role in federally facilitated marketplaces, seven—Alaska, Indiana, Louisiana, New Jersey, North Carolina, North Dakota, and Wisconsin—took new legislative or regulatory action on the early market reforms. In addition, Arizona, Indiana, North Carolina, and North Dakota enacted general authority to enforce the Affordable Care Act while most of the other states addressed only one or two early market reforms. The remaining states issued subregulatory guidance or are reviewing forms and rates for compliance but did not take additional action.

There was also variation among the states with state-based marketplaces. Idaho, Kentucky, and New Mexico, for instance, took no legislative action on the market reforms while Nevada passed legislation that addressed most of the 2014 market reforms. In the District of Columbia, most health insurance will be sold through the marketplace so regulators will enforce the market reforms through marketplace certification standards even though the District has not yet adopted all the reforms.[31]

Medicaid Expansion More Likely in States That Opted for a State-Based Marketplace

To date, 26 states and the District of Columbia are expected to expand their Medicaid programs while 20 states have declined to do so. Of those that will expand their Medicaid programs, 11 states have federally facilitated marketplaces; the remaining 15 states and the District of Columbia have state-based marketplaces. Every state with a state-based marketplace except Idaho opted to expand their Medicaid program. Four states with federally facilitated marketplaces continue to consider the expansion.

States that will perform plan management in a federally facilitated marketplace were more likely to expand their Medicaid programs than states that did not assume this role. Seven of the 16 states that will perform plan management are expected to expand Medicaid; Montana and New Hampshire are still undecided. Of the remaining 18 states with a federally facilitated marketplace, only four—Arizona, New Jersey, North Dakota, and Pennsylvania—will expand their Medicaid program, with ongoing consideration in Indiana and Tennessee.

Of those states that will expand, many will do so by enrolling eligible adults in their traditional Medicaid program while others hope to gain federal approval for a premium assistance model. Under a premium assistance model, states hope to use federal funding for eligible individuals to purchase private coverage through the marketplaces, rather than enrolling them in traditional Medicaid coverage.[32] These states include Arkansas, Iowa, Michigan, and Pennsylvania.

In the 24 states that declined to expand or are still undecided, an estimated 4.5 million people would be eligible for expanded Medicaid coverage.[33] Of these, most have incomes below 100 percent of the federal poverty level and thus are ineligible for financial subsidies to purchase private coverage through the marketplace.[34]

State Action Beyond the Affordable Care Act: Understanding Market Dynamics

The Affordable Care Act brings significant changes to the health insurance market. In response to these emerging market dynamics, states are amending existing insurance laws. For example, some states have repealed pre-Affordable Care Act protections, such as standards related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires guaranteed access to coverage for certain individuals.[35] Because the Affordable Care Act eliminates the barriers that HIPAA was designed to address, states are repealing existing protections, closing high-risk pools, or establishing mechanisms to transition consumers out of HIPAA coverage.[36] And some states have amended their authority to review rates to meet federal standards while others exempted plans from rate approval requirements or lost their designation as “effective” rate review programs under the Affordable Care Act.[37]

States are also changing the way they regulate certain products in the outside market. Some states adopted new requirements to regulate products that are exempt from the Affordable Care Act’s requirements. For example, some states took new action to regulate stop–loss coverage (insurance purchased by self-insured small employers to protect against losses above a certain level) and coverage purchased through an association, which has traditionally been exempt from certain state requirements.[38] States may have done so to ensure that all insurers operate on a level playing field within the state.

While these states imposed additional requirements, others exempted products, such as “health care sharing ministries,” from state insurance law.[39] As a result, health care sharing ministries (where members pay a monthly “share” that is matched with another member’s eligible medical bills with support for current health needs shared among members) do not have to meet state or federal requirements for health insurance, including the Affordable Care Act.

These changes to a state’s regulatory framework, coupled with the Affordable Care Act’s reforms, represent a significant shift for many states. As of now,

it is unclear what effect these types of changes will have on the state's insurance market. For example, will a state's decision to close its high-risk pool result in higher enrollment of sicker individuals in the state's marketplace? Will we see increased enrollment in self-insured plans or health care sharing ministries as a way of avoiding the Affordable Care Act's requirements? If so, what effect will this have on the sustainability of marketplaces? Additional analysis will be critical to understanding how other state action may promote or undermine implementation of the Affordable Care Act and the stability of state insurance markets.

POLICY IMPLICATIONS

The Affordable Care Act ushers in significant changes that are designed to improve access to coverage for millions of consumers. Despite variation in their approaches, most states have actively prepared for these changes. In particular, a core group of states—including California, Colorado, Connecticut, Hawaii, Maryland, Massachusetts, Minnesota, New York, Oregon, and Vermont—has committed to systematic implementation of the most significant aspects of health reform. Another set of states—including Maine, South Dakota, and Virginia—emerged as leaders in implementing the market reforms even though each will have a federally facilitated marketplace and will not expand their Medicaid program. And still another group—including Arizona, New Jersey, and West Virginia—opted to expand their Medicaid programs but did not take action on all of the market reforms or establish their own marketplaces.

Where states have been unable or unwilling to take action to implement the Affordable Care Act, federal regulators have stepped in. Indeed, federal regulators will directly enforce the market reforms in five states, collaborate with state regulators in an additional three states, and operate the marketplaces in 34 states. By filling gaps in state implementation or supporting state efforts to enforce the law, federal regulators have helped to promote two of the law's mechanisms to increase access to coverage—the market reforms and the marketplaces—in every state. Yet, federal regulators cannot play a similar role with respect to the third mechanism—Medicaid expansion. As a result, millions of low-income adults may continue to face coverage gaps and experience barriers to obtaining coverage.

Questions remain as stakeholders experience these changes. What level of coordination will be required between state and federal regulators to ensure that the market reforms are enforced consistently in both the inside and outside markets? Where should consumers in each state turn to raise issues or ask questions about their coverage? Does this vary based on a state's marketplace model and whether state regulators are enforcing the market reforms? Will states make other changes that promote or undermine the reforms? How will these changes affect critical outcomes, such as enrollment, cost, and marketplace sustainability? And, for those states that chose not to expand Medicaid, will policymakers adopt other mechanisms to provide coverage for low-income consumers or will these individuals be left without access?

The answers are likely to vary by state, suggesting a continued need for ongoing, holistic analysis of state insurance markets. With much at stake for regulators, insurers, and consumers, ongoing analysis will be critical to ensuring that consumers benefit from the new protections regardless of the state they live in.

METHODOLOGY

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 November 1, 2013, to implement or enforce the Affordable Care Act's market reforms. The market reforms studied include 1) the "early market reforms," often collectively referred to as the "Patient's Bill of Rights," which went into effect for health insurance plan or policy years beginning on or after September 23, 2010; and 2) the "2014 market reforms," which include seven of the Affordable Care Act's most critical consumer protections that went into effect for health insurance plan or policy years beginning on or after January 1, 2014. Our review included new state laws, regulations, and subregulatory guidance.

The resulting assessments of state action were confirmed by state regulators in all but seven states.

A state may not have taken action on the market reforms if existing state law is consistent with the Affordable Care Act, or if the state already has authority to enforce federal law. 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.

We incorporated previously published data on states' decisions to establish health insurance marketplaces and expand their Medicaid programs. These data are cited where they appear.

NOTES

[1] Pub. L. 111-148, 124 Stat. 782 (2010) §§ 2711-2714, 2719A, 10103; Pub. L. 111–152, 124 Stat. 1029 (2010). Most of the early market reforms were included in legislation introduced and debated in prior congresses, such as S.2706/H.R. 6528, "Health Insurance Coverage Protection Act" (2008) (restricting lifetime limits), S.3115/H.R. 2842, "Children's Health Protection Act of 2007" (prohibiting preexisting condition exclusions for children under 19), and S.114/H.R. 1668, "KIDS First Act of 2005" (requiring coverage for young adults on a parent's health plan). In addition, some of the reforms dated to provisions included in earlier legislation generally known as the "Patient Bill of Rights." J. P. Hearne and H. R. Chaikind, *Patient Protection and Managed Care* (Washington, D.C.: Congressional Research Service, Oct. 25, 2002); and President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Appendix A: Consumer Bill of Rights and Responsibilities*, www.hcqualitycommission.gov/final/append_a.html.

[2] Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1201, 1302 and Public Health Service Act §§ 2701 *et seq.*; Pub. L. 111-152, 124 Stat. 1029 (2010).

[3] K. Keith, K. W. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Action on the 2014 Market Reforms* (New York: The Commonwealth Fund, Feb. 2013); and 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).

[4] 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).

[5] See, for example, "Request for Comments Regarding Section 2718 of the Public Health Service 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."

[6] Pub. L. 111-148, 124 Stat. 782 (2010) § 1321 (codified at 42 U.S.C. § 18041 (2012)).

[7] T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

[8] S. R. Collins, K. Davis, J. L. Nicholson et al., *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Sept. 2010).

[9] Pub. L. 111-148, 124 Stat. 782 § 1321(c) (codified at 42 U.S.C. § 18041); 45 C.F.R. §§ 155.100 *et seq.*

[10] S. Dash, C. Monahan, and K. W. Lucia, *Implementing the Affordable Care Act: State Decisions About Health Insurance Exchange Establishment* (Washington, D.C.: Georgetown University Health Policy Institute, April 2013). See also S. Dash, C. Monahan, and K. W. Lucia, *Health Insurance Exchanges and State Decisions* (Washington, D.C.: *Health Affairs* and Robert Wood Johnson Foundation, July 18, 2013).

[11] Ibid.

[12] Ibid.

[13] These requirements include implementing a quality improvement strategy and meeting network adequacy standards which are used to ensure that plans include a sufficient number and type of health care providers, among other certification requirements.

[14] Dash, Monahan, and Lucia, *Implementing the Affordable Care Act: State Decisions,* 2013.

[15] Although state regulators will play this role, the federal government retains ultimate authority over operation of the exchange.

[16] Center for Consumer Information and Insurance Oversight, *Letter to Issuers on Federally Facilitated and State Partnership Exchanges* (Washington, D.C.: U.S. Department of Health and Human Services, April 5, 2013). See, for example, Center for Consumer Information and Insurance Oversight, *Completing the Network Adequacy Portion of the QHP Application* (on file with authors), which describes whether insurers must comply with existing state standards on network adequacy or new federal standards in order to participate in federally facilitated exchanges; in most states, federal regulators have deferred to existing state standards or review.

[17] Pub. L. 111-148, 124 Stat. 782 § 2001(a)(1) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)).

[18] Ibid. § 2001(a)(3) (codified at 42 U.S.C. § 1396d(y)(1)).

[19] See *National Federation of Independent Businesses v. Sebelius,* 132 S. Ct. 2566 (2012).

[20] G. M. Kenney, S. Zuckerman, L. Dubay et al., *Opting in to the Medicaid Expansion Under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?* (Washington, D.C.: Urban Institute, Aug. 2012).

[21] G. M. Kenney, L. Dubay, S. Zuckerman et al., *Opting Out of the Medicaid Expansion Under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid?* (Washington, D.C.: Urban Institute, July 5, 2013).

[22] States are also leveraging the System for Electronic Rate and Form Filing (SERFF)—an automated system developed by the National Association of Insurance Commissioners which allows electronic submission and review of insurer form and rate filings. States have amended their SERFF materials, adopted SERFF filing requirements such as compliance summaries, and provided guidance to insurers on how to amend their filings for compliance with federal law.

[23] These states are Arizona, Colorado, Connecticut, Hawaii, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, North Carolina, North Dakota, Oregon, Utah, Vermont, and Virginia.

[24] Some states rely on inherent authority to regulate insurance or prevent unfair trade practices while others report general authority to execute all insurance laws, including federal law.

[25] K. Keith and K. W. Lucia, New Guidance: Federal Regulators Allow "Collaborative Arrangements" for ACA Enforcement, *The Commonwealth Fund Blog,* April 5, 2013.

[26] 2013 Fla. S.B. 1842 (codified at Fla. Code § 624.06); Louisiana Department of Insurance, *Enforcement Authority of the Commissioner Regarding the ACA and MHPAEA*, Bulletin 2013-03 (April 16, 2013); and Montana Commissioner of Securities and Insurance, *2014 Health Plan Form Filings, Including Recommendations Regarding Qualified Health Plan Certification,* Advisory Memorandum (March 18, 2013).

[27] Center for Consumer Information and Insurance Oversight, *Ensuring Compliance with the Health Insurance Market Reforms* (Washington, D.C.: CCIIO).

[28] Ibid.

[29] Ibid.

[30] Public Health Service Act § 2723 (codified at 42 U.S.C. § 300gg-22 (2012)); 45 C.F.R. § 150.203.

[31] The District of Columbia established a single marketplace for all individual coverage in 2014 with a transition period for some small-group coverage through 2015. The small-group coverage that is offered outside the exchange must meet the same standards as qualified health plans sold through the exchange.

[32] J. Piotrowski, *Premium Assistance in Medicaid* (Washington, D.C.: *Health Affairs* and Robert Wood Johnson Foundation, June 6, 2013).

[33] We calculated this estimate based on the state-specific data displayed in Exhibit 2 of Kenney, Dubay, Zuckerman et al., *Opting Out of the Medicaid Expansion,* 2013.

[34] Ibid.

[35] 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.*).

[36] At least 12 states—Arkansas, Colorado, Florida, Indiana, Louisiana, Maryland, Minnesota, Montana, Texas, Utah, Washington, and Wisconsin—passed legislation to close or consider closing their high-risk pool, with some scheduled to close as early as December 2013. And some states—such as Colorado, Georgia, Maryland, Minnesota, and Ohio—repealed or suspended existing requirements related to conversion plans.

[37] Some states—such as Alaska, Iowa, Montana, and Virginia—took new action that resulted in the designation of an "effective" rate review program in the individual and small-group markets. Center for Consumer Information and Insurance Oversight, *State Effective Rate Review Programs*, www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html. In contrast, Oklahoma and Texas lost their designation as "effective" rate review programs and federal regulators will now review certain rates. Ibid. In addition, Florida passed legislation that exempts plans that must comply with the Affordable Care Act in the individual and small-group markets from undergoing rate approval or reasonableness determinations for 2014 and 2015. 2013 Fla. S.B. 1842.

[38] Some states—such as Arkansas, Colorado, Connecticut, Delaware, Idaho, New Hampshire, Rhode Island, and Utah—adopted new requirements to regulate stop–loss coverage. Of these, Arkansas, Colorado, Rhode Island, and Utah required stop–loss insurers to meet minimum levels of financial protection (known as attachment points) and Delaware prohibited stop–loss coverage for small employers with fewer than 15 employees. Other states, such as Oregon, Utah, and Washington, addressed association health plan coverage.

[39] At least 12 states—Alabama, Arizona, Arkansas, Georgia, Illinois, Indiana, Maine, Michigan, New Hampshire, North Carolina, South Dakota, and Washington—exempted health care sharing ministries from state insurance law since 2010.

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