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Stepping into the Breach: State Options to Protect Consumers and Stabilize Markets in the Wake of Federal Changes to the Affordable Care Act

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Introduction

While federal legislative efforts to repeal the Patient Protection and Affordable Care Act (ACA) face an uncertain future in Congress, the federal executive branch under President Trump has the power to modify the law through new regulations. The current administration could also effectively roll back key provisions by relaxing federal oversight or suspending enforcement of the law's requirements for private health insurers. Indeed, it has already begun doing so.

The range of potential regulatory action and enforcement discretion is significant. The ACA delegates responsibility to the executive branch to interpret and implement numerous key provisions of the ACA. While it is not yet clear how this administration will use this responsibility, early executive actions and statements of senior officials suggest they will reduce regulatory burdens on insurers and give them more flexibility to design benefits, conduct marketing, and set prices.

The effect of such changes on consumers, health plans, and other stakeholders will depend to a great degree on how states respond. States have historically been, and remain, the primary actors in insurance regulation. While the ACA sets a number of minimum standards for insurers, and federal oversight has provided a critical backstop for state insurance regulation, the majority of states have exercised their authority to interpret and enforce federal insurance laws. Many of these states may wish to retain some or all of the insurance reforms required by the ACA, even in the face of federal rollbacks.

This issue brief discusses the scope of state authority and tools available to ensure that consumers living within their borders benefit from the insurance protections promised under federal law. We also discuss specific statutory and administrative options for states in the event of selected possible federal administrative actions, including a:

- Rollback of the essential health benefits;
- Relaxation of marketplace health plan oversight;
- Re-definition of what constitutes minimum essential coverage;
- Loosening of medical loss ratio standards; and
- An expansion of off-marketplace enrollment opportunities.

Background

The states have been regulating insurers and insurance products since the late 19th century. The U.S. Congress reaffirmed the state role as primary regulator of the business of insurance in 1945 under the McCarran-Ferguson Act.[1] Over the years, federal laws such as the Employee Retirement Income Security Act (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), and the ACA have resulted in the federal government taking on a greater role, but states continue to have considerable discretion to manage their markets and protect consumers.

The federal-state framework for insurance regulation

Government regulation and oversight of the business of health insurance was borne out of several policy objectives. State insurance laws have sought to keep insurance companies financially solvent (i.e., maintaining sufficient financial reserves to cover medical claims), protect against fraud, ensure that consumers receive the benefits promised under their insurance policies, and promote the spreading of health risks.

State regulation of insurance is grounded in laws enacted by each state, and as a result can vary dramatically. For example, while all states require insurers to be able to pay claims, prior to the ACA only a few states had adopted laws requiring insurers to accept all applicants regardless of health status ("guaranteed issue") or to refrain from charging higher premiums to people with pre-existing conditions ("community rating").[2] In general, most states have conducted stricter regulatory oversight over products sold to small businesses and individuals, who tend to be less sophisticated purchasers of insurance than large employers.

Over the years, federal laws attempted to fill in the gaps in state insurance regulation, beginning with COBRA in 1986, which gave workers for large employers the right to continue job-based coverage for up to 36 months under certain circumstances.[3] Ten years later, Congress enacted HIPAA, which established the first national minimum standard for health insurance regulation.[4] Specifically, HIPAA provided new protections for small businesses and their employees and created new rights for people leaving job-based coverage, allowing them to obtain individual insurance even if they had a pre-existing condition. Later bills such as the 1998 Women's Health and Cancer Rights Act (WHCRA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) continued the expansion of the federal role by setting minimum national standards for women having breast reconstruction after a mastectomy and the coverage of mental health and substance use disorder services, respectively.[5]

Enforcement of these laws requires a regulatory partnership between the state and federal government. While the above federal laws set a minimum floor of consumer protections, the states may enact their own laws that provide at least that level of protection, and most have done so. States can also go beyond the federal standard and provide additional or more enhanced protection. For example, although not required under federal law, states have enacted minimum standards for the adequacy of health plan provider networks and required insurers to offer standardized benefit designs that limit cost-sharing for high-value services.[6]

The federal government relies on the states to be the primary enforcers of federal standards, largely because the agencies responsible for implementing them – the U.S. Departments of Health & Human Services (HHS), Labor, and Treasury – have historically lacked the capacity and personnel to regulate insurers and insurance products across the country.[7] Thus, state departments of insurance (DOIs) are the primary entities that work directly with insurers to ensure compliance with federal and state standards through interpretive state-level regulations and guidance, such as bulletins or instruction manuals. State insurance commissioners and their staff also communicate frequently with the insurers they regulate, through in-person meetings,

phone calls, and emails, in order to field questions and provide regulatory guidance.

One major exception to the broad scope of states' authority is self-funded employee health plans. These are governed entirely by ERISA; state laws regulating self-funded plans are preempted by federal law. Under these plans, the sponsor (usually the employer) assumes the financial risk of paying for covered services under the plan.[8] The federal Department of Labor is responsible for oversight of these plans.

However, for employer group plans and individual policies for which an insurance company assumes the risk, states generally have primary regulatory authority. For these companies and policies, the range of regulatory and oversight tools provided via state law is broad, including:

- ***Licensing.*** All 50 states require insurance companies operating in their state to apply for a "certificate of authority" (COA). To receive one, insurers must submit information about the company's officers and business plan, as well as detailed financial information. This information must demonstrate that the company is financially solvent and capable of paying claims. While not all states have a license renewal process, insurers are required to submit financial information to the state department of insurance on a regular basis. This financial information, in turn, informs the state's review of insurers' proposed plan premium rates.
- ***Rate review.*** Most state DOIs have the authority to review premium rates before they are implemented.[9] While states' approaches to the rate review process can vary, depending on statutory review authority, motivation, and resources, most states can require insurers to submit detailed justifications for requested premium rates, including data on medical cost trends, changes in utilization, benefits and cost-sharing, financial reserves, administrative expenses, and medical loss ratios (MLR) and review rates for compliance with permissible rating factors and practices.[10]
- ***Policy review.*** Most state DOIs review and approve insurers' policy forms before they can be sold. This form is the document that represents the contractual relationship between the insurer and the plan purchaser. It typically lists the benefits covered under the plan, any exclusions or restrictions, and associated cost-sharing. Most states review these forms for compliance with state and federal laws on mandatory benefits, member rights, and grievances and appeals processes.
- ***Network adequacy.*** Some states require insurers to meet network adequacy standards before receiving a HMO license. Others impose a network access standard on a broader range of health plans, including PPOs. In those states with authority to do so, DOIs may require insurers to submit lists of network providers and assess plans' network adequacy based on both quantitative and subjective standards.[11]
- ***Marketing practices.*** Almost all states have authority to regulate insurers' marketing materials and practices to

protect consumers against "unfair" and "deceptive" acts, fraud, and the false advertising of insurance policies. Most states also require insurers' marketing materials to provide for the "clear and truthful disclosure of the benefits, limitations and exclusions" of their plans. All states also set standards for the conduct of insurance agents and brokers.[12]

- ***Market oversight.*** Once health plans are being sold and used by consumers, state DOIs have the authority to track insurers' conduct and make sure they are complying with laws relating to network access, utilization review, covered benefits, and payment of claims. In addition to monitoring consumer complaints, states typically conduct this assessment through a market conduct exam, which can include an on-site examination of a company's policies and procedures. Some states may conduct an exam of all companies operating in the state on a multi-year cycle; more commonly, states perform a targeted exam in response to consumer complaints or other evidence of trouble at a company.
- ***Enforcement.*** When problems are found, DOIs have a range of mechanisms to address them. Issues are often resolved informally, i.e., by asking the insurers to take corrective action or working out a remedial action plan. Less often, the DOI may impose civil penalties, issue a cease and desist order, or ask a court for an injunction to stop the marketing of a product. In the face of egregious misbehavior, a DOI could rescind a company's COA.

The Affordable Care Act: an evolving federal-state partnership

As with HIPAA, WHCRA, and MHPAEA, the ACA depends on states to be the primary entities providing oversight and enforcement of the new standards for health insurance sales, premium rates, and benefit design. The law also created new expectations of state DOIs, along with the opportunity to apply for federal grants to support their expanded role.[13]

Even with such grants, implementing and enforcing the many new insurance standards established by the ACA has not always been easy for state DOIs. For example, federal rules requiring insurers to issue policies to children under 19, regardless of health status, caused many insurers to announce they would no longer sell "child only" policies in 2010, meaning that some families would have been unable to buy an insurance policy at any price for their child. When that happened, 22 states and the District of Columbia (DC) responded with new laws or guidance to insurers to ensure that child only coverage would still be available to the families that needed it.[14] These actions demonstrated that, in many cases, states had a nimbleness and flexibility to respond to market instability and engage with insurers and other affected stakeholders in a way that the federal government cannot.

The ACA imposed several new demands on states, stretching their capacity and expertise in new ways. For example, regulations implementing the ACA's essential health benefit (EHB) standard asked states to designate a statewide benchmark plan to serve as a reference

point for insurers selling individual and small-group market plans. Many states conducted extensive analyses of existing plan options and outreach to stakeholders to inform their selection of the state benchmark.[15]

The ACA also pushed DOIs to expand the scope of their plan and rate review. For example, prior to the ACA, many DOIs assessed network adequacy only for HMOs, and then often only when the insurer initially sought a HMO license. Only a very few states conducted annual reviews of the provider networks for all plans offered in the market. However, the ACA envisioned that the state exchanges (or marketplaces) would annually review and certify that plans participating on the ACA's marketplaces meet network adequacy standards.[16] Similarly, the ACA for the first time established a national prohibition on discriminatory benefit design, meaning that insurers could no longer set benefits or cost-sharing in a way that discriminates against enrollees based on age, disability, or expected length of life. While state DOIs have historically reviewed health plan contracts to ensure that they cover state-required benefits, assessing the entire benefit package for potential discriminatory design is, for most DOIs, a wholly new activity.[17]

The Trump administration has already signaled that they will take a more hands-off approach to insurance company oversight than the Obama administration took. A January 2017 Executive Order directs HHS and other federal agencies to provide greater flexibility to the states to create a "more free and open healthcare market" and to use all "authority and discretion" to "waive, defer, grant exemptions from, or delay the implementation of" provisions of the ACA that could impose a fiscal or regulatory burden on states, insurers, or individuals.[18]

Since publication of that Executive Order, HHS officials have, for example:

- ***Relaxed enrollment and benefit design requirements on insurance companies.*** New federal rules finalized in April 2017 make it easier for insurers to deny coverage to individuals who cannot document eligibility for special enrollment opportunities or who failed to pay premiums in the past. The rule also gives insurers greater flexibility to impose higher deductibles or other cost-sharing than allowed under the Obama administration.[19]
- ***Delegated greater oversight responsibility to the states.*** Under the Obama administration, HHS officials reviewed plan networks for states that deferred to the federal government for the operation of the health insurance marketplace.[20] New HHS policy states that so long as a state has the "authority and means" to conduct reviews of health plan networks, the federal government will accept its certification that they are adequate.[21]
- ***Shortened timeframes for government review of health plan premium rates and forms.*** HHS has delayed previously established deadlines for insurers to submit their marketplace plans for review and certification, leaving less time for federal and state regulators to conduct comprehensive reviews.[22]

- ***Extended the life of non-ACA compliant health plans.*** Obama administration rules had allowed individuals and small employers to renew plans that did not meet ACA requirements through 2017. HHS issued an extension of the policy through 2018.[23]
- ***Solicited public input on ways to reduce health plan regulatory burdens.*** Through a formal "Request for Information," HHS has solicited suggestions for administrative paths to expand consumers' health plan choices, reduce the cost of insurance, and "affirm the traditional regulatory authority of the states."[24]

In the wake of these and other actions by federal regulators, states will have to determine how these changes affect their responsibilities to protect consumers and ensure the maintenance of stable, functioning local insurance markets.

Discussion

The scope of federal administrative discretion may be broad, and can range from proactive rulemaking that would unwind key Obama-era standards or protections to decisions to selectively not enforce certain requirements on insurers or consumers. Below we discuss five areas in which the Trump administration may change ACA policy, their potential effects, and the authority and tools, both statutory and regulatory, that are available to states to respond to those changes. This is not a discussion of possible federal legislative action to change the statute, nor is it an exhaustive review all the potential areas in which the Trump administration could make administrative changes to health insurance standards or the operation of insurance markets.[25] The limited set of examples below is intended to illustrate the breadth – and the limits of – state authority to manage their insurance markets and protect consumers.

1. Essential health benefits: new flexibility for insurers

Prior to the ACA, health insurance plans sold on the individual market often excluded coverage of critical services; for example, one in five adults on an individual plan lacked prescription drug coverage.[26] States mandated at least some level of coverage for certain services, but these standards varied widely, leaving many consumers without access to comprehensive benefits packages.[27] In the individual market, only nineteen states required coverage of mental health care, and only twelve states required coverage of maternity care.[28] Even in states that enacted these consumer protections, individuals often had high cost-sharing and lifetime and annual benefit limits that restricted access to preventive services and lifesaving care. The ACA's EHB requirements aim to make health insurance more comprehensive and access to care more affordable.

Specifically, the ACA established a list of ten EHB categories that every non-grandfathered plan sold in the individual and small-group markets must cover, ranging from laboratory services to maternity and newborn care (See table). The law further directs HHS to define the EHB "equal to the scope of benefits provided under a typical employer plan."[29] While the ACA provides clear direction on

the EHB categories that insurers must cover, it gives the Secretary of HHS the power to determine the specific details of benefits included in each category.[30]

The Affordable Care Act's 10 Essential Health Benefits
Ambulatory patient services
Emergency Services
Hospitalization
Maternity & newborn care
Mental health & 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
Pediatric services, including oral and vision care

Source: 42 U.S.C. § 18022(b)(1) (2010).

The Obama administration gave states flexibility to define the EHB by choosing from among ten existing plans to determine a benefit benchmark that other health plans must follow.[31] While states can impose coverage requirements that go beyond the EHB, they must defray the cost of additional benefit mandates.

Redefining essential health benefits

Only Congress can remove one of the ten benefit categories required by the ACA, but the law directs the Secretary of HHS to periodically "update" the EHB. HHS officials have supported reducing the scope of benefits insurers must cover, and providing insurers with greater flexibility to design plan benefits.[32] Under Secretary Price, HHS has scaled back its oversight of the EHB, deferring to state efforts to monitor prescription drug formularies and cost-sharing for discriminatory benefit design.[33]

Current rules require insurers to provide benefits that are "substantially equal" to a state's EHB-benchmark plan. The administration has the authority to update the specifics of those requirements and may attempt to reduce the comprehensiveness of required benefits in each category.[34] The Obama administration used this authority to expand benefits beyond the base benchmark plan in each states. For example, when implementing the EHB benchmark approach in 2013, they found that habilitative services were not typically included in benchmark plans. The administration then gave states the initial opportunity to determine what services should be included in that category; if states did not define the scope of coverage, insurers were responsible for determining what services their plans must cover to comply with the habilitative services requirement.[35] The Obama administration also used rulemaking to add substance to the prescription drugs benefit category. Federal rules require insurers to (1) cover at least one drug in each U.S. Pharmacopeia (USP) category and class (i.e., at least one type of insulin, at least one non-steroidal anti-inflammatory drug), (2) establish a review committee to ensure that the list of covered drugs is regularly updated, and (3) provide for an exceptions process if an enrollee needs access to a non-covered drug.[36] The current administration has similar flexibility to determine how the EHB are defined.

Issues for consumers and state options

If HHS changes the EHB requirements, for example by providing insurers greater flexibility to cover fewer treatments or services within the ten coverage categories,

insurers could use that flexibility to design products that exclude coverage of certain health services, effectively deterring enrollment among consumers who need those services.[37] Although diluting coverage for services such as hospitalization or prescription drugs could lower prices for some individuals, consumers who still need comprehensive coverage for services in that EHB category will face fewer options and higher prices.

States have tools to protect consumers and ensure comprehensive coverage through state-level enforcement and regulation of the insurance market.[38] In anticipation of potential federal deregulation, states could codify the current EHB requirements into their own insurance codes. During their 2017 legislative sessions, Hawaii passed and Rhode Island and Nevada introduced bills to codify the ten EHB categories. New York Governor Andrew Cuomo has directed his Department of Financial Services to issue regulations "safeguarding" the EHB categories.[39]

A number of states have taken action to codify the ten EHB benefit categories during implementation of ACA, while others, such as California and Washington, prescribed the 10 categories into law and required insurers to offer policies equivalent to a state benchmark plan.[40] This helps ensure continued coverage of a comprehensive range of services within each category if the administration rescinds the requirement that insurers adhere to current EHB definitions.[41]

Even without codifying the EHB or a benchmark plan, many state DOIs have existing authority to fill in gaps in federal requirements and ensure that benefit designs meet the health care needs of enrollees. For example, if the administration rescinds Obama-era rules requiring insurers to cover at least one prescription drug in each USP category and class, states could step in to make sure formularies cover a sufficient number of drugs in various categories and classes.

2. Relaxing federal oversight: returning plan management to the states

The ACA's health insurance marketplaces are required by law to engage in five core functions: determine eligibility for federal financial assistance, enroll consumers into qualified health plans (QHPs), conduct plan management, provide consumer assistance, and perform financial management.[42] Drafters of the ACA envisioned that most states would establish their own marketplace and conduct the above functions. However, at the time of the marketplaces' launch in 2014, only 17 states and the District of Columbia (DC) took on full responsibility for operating their own marketplace and performing all of the above functions. Thirty-three chose to default to a federally facilitated marketplace (FFM).[43] However, 17 FFM states have taken on "plan management," which includes the certification of QHPs, collecting and reviewing rate and benefit information, managing contracts with QHPs, monitoring ongoing compliance issues, recertifying and decertifying QHPs, and managing open and special enrollment periods.[44] While state DOIs can make recommendations to certify or recertify QHPs, under the law, it is the marketplace that must make the final determination of a QHP's fitness to participate. In the case of the FFMs, the "decider" is HHS.

In running the FFM, the Obama administration encouraged states to perform plan management functions; where they did so, HHS generally deferred to states' judgments about QHPs. However, federal officials took seriously their ultimate accountability for QHP certification, and required insurers to submit rate and plan data to HHS, which conducted its own plan analyses. For example, in the wake of consumer and provider concerns about overly narrow provider networks among QHPs, President Obama's HHS began requiring insurers to submit lists of providers participating in their QHPs and conducting its own reviews.[45]

A new approach to marketplace plan management

Going forward, the Trump administration will no longer conduct network adequacy reviews in states that have the means and authority to do them. More broadly, in guidance to the states, HHS has signaled that they will "further streamline" the QHP certification process by deferring more to states' reviews of plans and rates. Specifically, HHS has declared it will no longer:

- Assess whether QHP insurers are licensed and in good standing in their respective states;
- Conduct network adequacy reviews of QHPs if a state has the "authority and means" to do so;
- Review the service areas of QHPs (in states that conduct plan management); and
- Review QHP's prescription drug formularies or benefit designs to assess whether they discriminate based on individuals' health needs or other factors (in states that conduct plan management).[46]

For the above activities, HHS will accept states' recommendations. However, in states that do not perform QHP plan management, HHS will continue to do its own reviews of plan service areas, formularies, and benefit designs.

Issues for consumers and state options

Potential federal legislative and administrative actions threaten the future viability of the ACA's marketplaces. Consumers enrolled in marketplace plans will continue to depend on government oversight to ensure they receive the full range of protections promised under federal and state law. For example, many insurers are likely to continue to push the envelope towards narrower provider networks in order to deliver more competitive premiums. While many consumers have shown willingness to trade a broad choice of providers for a lower price, overly narrow networks could impinge on their ability to access care in a timely way.

At the same time, new rules governing marketplace enrollment and a perception that the ACA's individual mandate will not be enforced could give some insurers increased incentives to use service areas and drug formulary and benefit designs to deter enrollment among high risk populations. These incentives call for regulatory oversight to ensure that all insurers in the marketplaces are playing by the same rules and that people with pre-existing conditions can obtain coverage that meets their needs.

Many FFM states conduct robust plan management and have expanded their DOI's authority and capacity in response to the

expanded oversight demands of the ACA. However, as many as 18 states have expressly declined to perform plan management on behalf of the ACA marketplaces, lack the authority and/or have extremely limited staff and expertise to perform the requisite data collection and analysis. The Obama administration's HHS conducted the above reviews in order to fill in such gaps in state authority or oversight. In these states, the removal of this federal regulatory backstop could mean that key criteria for QHP certification receive little or no review before these plans are marketed and sold to consumers.

There are no plan management functions that HHS has been doing that states themselves couldn't do. However, to ensure consistent oversight of the individual market, both inside and outside the marketplaces, and clear ability to enforce federal standards, some state DOIs may need explicit statutory authorization. Others, while they may have the legislative authority, have insufficient staff with the necessary expertise and would need new resources, both financial and technological, to perform the needed plan analyses. Similarly, states may need stepped up data collection capacity and resources to conduct post-marketing oversight of plan behavior and compliance with consumer protection standards. These resources are unlikely to come from the federal government and would need to be provided by state legislatures.

3. Encouraging enrollment in less comprehensive coverage

The ACA requires all individuals to maintain minimum essential coverage (MEC), also known as the individual mandate. If a person is not consistently enrolled in MEC over the course of a year and does not qualify for an exemption, he or she could owe a tax penalty, currently set at 2.5 percent of income or $695, whichever is greater.[47] The requirement safeguards against adverse selection in the individual market and ensures individuals have insurance that provides financial protection when a serious illness or injury occurs.[48] While the language of the ACA defines certain types of health insurance coverage as MEC, including government sponsored programs like Medicaid and Medicare Part A and employer-sponsored insurance, it also authorizes the Secretary of HHS, in conjunction with the Treasury Secretary, to recognize "other benefits coverage" as minimum essential coverage.[49] Under the administrative process that the Obama administration established for this recognition, health plans must comply with "substantially all" of the individual market reforms under Title I of the ACA, which include the prohibitions on lifetime and annual limits, premium surcharges based on health status or gender, and exclusions of coverage for pre-existing conditions, as well as the requirement to cover EHB.[50] The administrative process also allows for a case-by-case review even when a health plan does not meet the "substantially all" standard when the HHS Secretary finds it "reasonable and appropriate" to do so.[51]

A new approach to coverage standards

To date, HHS has used the "substantially all" standard to approve 47 applications for MEC status, most of which are school-sponsored student health plans.[52] The Trump administration has not taken action to modify the MEC standards, but could shift away from the "substantially all" standard meant to ensure MEC covers a minimum set of benefits and does not screen out or

charge applicants higher premiums based on their health status. Doing so would potentially allow a broader range of coverage to count as MEC, including policies that don't cover EHB or use medical underwriting to deter the enrollment of people with pre-existing conditions.

Issues for consumers and state options

Expanding MEC would likely lower premiums for some young, healthy individuals, but enrollees in these plans would face higher out-of-pocket costs and benefit exclusions. Further, to the extent these policies attract significant numbers of healthy people, it would ultimately result in a smaller, sicker risk pool for ACA-compliant policies. This, combined with the Trump administration's efforts to relax enforcement of the ACA's individual mandate, will make insurers much less likely to participate in the ACA's marketplaces.[53] Those that remain will need to increase their premiums to reflect the lack of a balanced risk pool. For example, during implementation of the ACA, states that allowed insurers to maintain pre-ACA, grandmothered (transitional) policies had a sicker marketplace risk pool, and thus higher premiums, than states that did not.[54]

If federal regulators designate plans that fail to substantially comply with ACA coverage standards as MEC, states have a strong incentive to ensure that the consumers buying these plans fully understand the risks of coverage that doesn't meet minimum ACA standards. Further, many states will want to protect the market in which ACA-compliant plans are sold against the adverse selection that would result from stronger incentives for healthy people to avoid marketplace coverage.

Under their authority to regulate the products sold in their markets, states may have statutory or regulatory authority to either prohibit the sale of these less comprehensive products or require such plans to comply with ACA standards for adequacy and access. At a minimum, states could exercise their authority to regulate the marketing practices of insurers by requiring these plans to prominently disclose to consumers the ACA protections from which they are exempt.

4. Loosening the 80-20 rule: Relaxing enforcement of the medical loss ratio

The ACA requires insurers to meet a minimum medical loss ratio (MLR). The MLR, often called the "80/20 Rule," measures how much a health insurer spends on paying for health care, compared to what it spends on administrative overhead and profits to shareholders. Specifically, the ACA requires insurers selling individual and small group policies to maintain a minimum MLR of 80% (meaning 80% of their revenue must be spent on health care or improving health care quality); 85% for insurers selling large group policies.[55] If this target is unmet, insurers must then pay a rebate to consumers and business owners. Since 2011, when insurers were first required to meet the MLR standards, insurers have paid out $2.8 billion in rebates to consumers and employers.[56] The ACA gives HHS the responsibility to enforce the MLR standards. This is unique among the law's insurance reforms, which generally rely on the states to play the primary enforcement role. To implement the MLR requirement, HHS has detailed the methodology for calculating the MLRs, imposed annual reporting requirements for insurers, and established procedures for paying rebates to policyholders.[57] To ensure

insurer compliance with the MLR standards, HHS has also implemented a comprehensive MLR examination program, which includes internal reviews and external audits of insurer data submissions related to MLR.[58]

Relaxing federal oversight or lowering the MLR threshold

HHS could relax federal oversight of the MLR standard by limiting or discontinuing the HHS-administered ongoing MLR examination program. Although the ACA requires insurers to annually report to HHS costs related to their MLRs, there is no statutory requirement that HHS maintain a comprehensive MLR examination program to ensure insurer compliance with the MLR standards.

In addition, the ACA gives HHS broad discretion to adjust the MLR 80/20 threshold if the Secretary determines that it might "destabilize" the insurance market.[59] As the MLR provision was being implemented by the Obama administration, HHS gave insurers in seven states temporary relief from the MLR standard, although many more had submitted waiver requests.[60]

Issues for consumers and state options

Insurance companies have proposed significant premium rate increases for the 2018 plan year, reflecting growing uncertainty over potential federal policy changes under the new administration. These include threats that insurers will no longer be compensated for cost-sharing reduction plans and the risk that weak enforcement of the individual mandate will result in a smaller and sicker risk pool for the individual market.[61] While there is no doubt that insurers are justified in adjusting premiums to reflect the current policy uncertainty, to a large extent the precise level of premium needed for 2018 is unknown. Most insurers are likely to take a conservative approach and propose significant hikes in order to mitigate their risk. At the same time, HHS and many states have shortened the time available for the regulatory review of proposed premium rates, making it more challenging for many state DOIs to conduct a robust, independent examination of the data and assumptions underlying the proposed rate increases.[62]

Ordinarily, the MLR would provide an important backstop to the rate review process. If an insurer overshoots and implements an unreasonable rate increase that results in a MLR below 80 percent, the ACA requires the company to issue rebates to its enrollees at the end of the plan year. However, the effectiveness of the MLR as a consumer protection depends upon HHS enforcement.

If HHS relaxes federal oversight of MLR standards by limiting or discontinuing the MLR examination program, state DOIs could act on their own to ensure that consumers are protected from excessive rate increases. DOIs currently have sufficient authority to conduct reviews of MLR-related reports submitted by insurers and audit MLR-related data. Recognizing states' long history of expertise in performing financial examinations related to insurer solvency, federal law allows HHS to accept the findings of a state examination of an insurer's MLR reporting and payment of rebates.[63] If HHS fails to require the distribution of rebate payments to enrollees, states can, if they wish to, enact their own MLR standard and rebate program.

Lastly, under the ACA, states have the authority to implement a higher MLR

threshold than the federal standard. That means, for example, if HHS lowers the MLR standard below 80% for the individual market, state legislatures could step in and require insurers to maintain the heightened standards. In fact, at least one state, New York, requires individual and small-group market insurers to maintain an 82% MLR, 2% above the federal standard.[64]

5. Bypassing the health insurance marketplaces: encouraging direct enrollment

Since the first open enrollment for ACA plans, consumers have been able to enroll in marketplace plans in the federally facilitated marketplace either through healthcare.gov or through web-based broker sites, a pathway designated in federal rules as "direct enrollment." Federal rules established under the Obama administration require web-based brokers enrolling consumers into marketplace plans to meet certain requirements. For example, web-based brokers must display all marketplace plans available to consumers in a given area, not just those for which the brokers would receive a commission. Plans must also be displayed in a manner similar to the plan display on healthcare.gov – that is, they cannot be displayed in a way that steers consumers to certain plans – unless federal regulators approve a display that is different.[65] In addition, agents and brokers using the web-based enrollment site must register with healthcare.gov, receive training on marketplace plan options and ACA financial assistance available to qualifying consumers, and comply with marketplace privacy and security standards. And consumers must be able to withdraw from enrolling through the broker site at any time and instead use healthcare.gov to complete their enrollment.[66]

In order to apply for financial assistance for a marketplace plan, consumers using web-based brokers are currently re-directed to healthcare.gov to submit their household and financial information and receive an eligibility determination, and then can return to the broker site to complete their enrollment into a plan. Responding to concerns that web-based brokers were losing consumers to healthcare.gov once they were directed there to apply for financial assistance, the Obama administration considered but ultimately decided not to implement a more streamlined approach to direct enrollment that would allow web-based brokers to retain consumers on their web site throughout the process.[67] Administration officials pointed to concerns that technical limitations could compromise the accuracy of eligibility determinations and the security of sensitive personal information.[68]

A new approach to direct enrollment

The Trump administration has released guidance to implement the streamlined process considered under the earlier proposed rules.[69] Calling the revised process "Proxy Direct Enrollment," HHS is allowing web-based brokers who enroll consumers beginning with the open enrollment period for 2018 coverage to collect household and financial information from consumers and transmit the information to healthcare.gov to obtain an eligibility determination. Under the new guidance, consumers need not leave the web-based broker site for any part of the application and enrollment process for marketplace coverage, although consumers retain the right to leave the broker site at any time.

Issues for consumers and state options

Streamlining enrollment through web-based brokers raises a number of potential issues for consumers. First, it is not clear that all participating brokers have the capability to protect the privacy and security of consumers' sensitive financial information. Second, brokers are not obligated to provide consumers full information for all their marketplace plan options as long as they provide a notice to consumers that additional information is available at healthcare.gov. Third, consumers using a web-based broker may become disconnected from their healthcare.gov account, especially if an account was created on their behalf, and may therefore miss out on important notices from the marketplace. Fourth, many web-based brokers sell policies other than marketplace plans, and may have financial incentives to steer healthy consumers to other products such as short-term duration policies that fail to provide critical consumer protections.

Protecting consumers

States can help address some of these concerns – and provide guidance to insurers, brokers and consumers in areas where HHS fails to provide it – consistent with their traditional core functions of protecting consumers from fraud and misleading marketing and managing their health insurance markets. All states have enacted some version of the National Association of Insurance Commissioners' (NAIC) model Uniform Trade Practices Act (UTPA), which gives state departments of insurance the authority to regulate insurers' marketing materials and practices to protect consumers against false or misleading advertising.[70] State regulators could use the authority of their UTPA to ensure web-based brokers display all marketplace plan information with full plan details and in a manner that does not steer consumers to particular plans. In addition, every state has enacted a version of the NAIC model Producer Licensing Act, which regulates the qualifications and procedures for obtaining an agent or broker license.[71] Web-based brokers are required to be licensed in the states in which they sell insurance products; states could use this leverage to require web-based brokers to provide marketplace plan enrollees with marketplace-specific information such as tax liability implications of premium tax credits and direct access to their healthcare.gov account.

With respect to the privacy and security of consumers' sensitive personal and financial data, state DOIs can partner with other state agencies, such as their attorneys general, to ensure that web-brokers have adequate safeguards and appropriate procedures in place if and when consumer data is compromised.

States can also ensure that consumer complaints are coded to identify those that apply specifically to web-based brokers. This would allow them to have a clearer picture of consumer experiences with these entities and target future guidance and enforcement activities. State regulators could also require web-based brokers to provide notice to consumers using their sites of key protections afforded under federal and state laws, so that consumers are aware of their rights and are more likely to report sites that fall short of compliance. Such a notice could advise consumers, for example, that they have a right to see all marketplace plans; clear notice of what personal information direct enrollment entities collect from consumers and how that information is used; and the need to have

direct access to their healthcare.gov account.

Managing markets

State regulators have an interest in ensuring that healthy consumers are not steered away from marketplace plans and into medically underwritten alternative products, such as short-term plans. For those web-based brokers that market such products, states can impose additional disclosure requirements to ensure that consumers fully understand that these plans are exempt from many consumer protections and may not count as coverage for purposes of the individual mandate. In addition, states can require brokers to display the commissions they receive from sales of non-ACA compliant products in comparison to marketplace plans so that consumers are aware of potential financial incentives to promote one product over another.

Conclusion

Regardless of the outcome of current federal legislative efforts to repeal and replace the ACA, the Trump administration has set in motion a series of administrative actions to unwind or relax some of the law's insurance regulations, with more likely to come. The extent to which these actions affect insurers and consumers, however, largely depends on whether and how states step in to set their own standards or fill a regulatory or enforcement vacuum. Many states will have an interest in picking up a greater role in health plan enforcement and oversight of federal protections in order to ensure that consumers continue to receive the benefits promised under the ACA, as well as to promote stable, well-functioning insurance markets.

This paper provides a primer on the evolution of the state and federal roles in the regulation of private health insurance and the ambit of state authority to protect consumers and manage their markets in the wake of changes at the federal level, assuming the ACA itself is not repealed. Through specific examples of potential federal administrative action, we highlight the broad authority that most states have to set comprehensive standards for minimum essential health benefits, conduct reviews and ongoing oversight of health plans, reject or limit the sale of products that fail to comply with the ACA, ensure that a minimum amount of premium revenue is allocated towards medical care, and clamp down on unfair or deceptive marketing tactics. At the same time, we note that many states may be limited by resource or other constraints, and new actions will require an ongoing dialogue between state regulators and their legislatures. Ultimately, consumers are best served when states and federal regulators work in tandem to ensure they receive the full range of insurance protections promised under federal and state laws.

About Georgetown University - 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. For more information, visit www.chir.georgetown.edu.

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