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Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market

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Abstract The Affordable Care Act contains numerous consumer protections designed to remedy shortcomings in the availability, affordability, adequacy, and transparency of individual market insurance. However, because states remain the primary regulators of health insurance and have considerable flexibility over implementation of the law, consumers are likely to experience some of the new protections differently, depending on where they live. This brief explores how federal reforms are shaping standards for individual insurance and examines specific areas in which states have flexibility when implementing the new protections. We find that consumers nationwide will enjoy improved protections in each area targeted by the reforms. Further, some states already have embraced the opportunity to customize their markets by implementing consumer protections that exceed minimum federal requirements. States likely will continue to adjust their market rules as policymakers gain a greater understanding of how reform is working for consumers.

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OVERVIEW

While the Affordable Care Act (ACA) ushers in many reforms designed to improve private health insurance, its changes are likely to be felt most dramatically by consumers in the individual, or nongroup, market. For the millions of Americans ineligible for employer-based health benefits or public coverage, the individual market has long functioned as a critical access point. Unfortunately, this coverage routinely proved inadequate to consumers' health and financial needs and often was inaccessible to those with even minor health problems.

Individual market policies historically covered far fewer benefits and came with more out-of-pocket costs than employer-based insurance.[1] Consequently, those who bought such policies were much more likely to rate their coverage as fair or poor, and more frequently experienced access and affordability problems, than did those with employer-sponsored plans.[2]

In addition, millions of Americans could not obtain individual coverage because of their medical history.[3] In the years immediately preceding health reform, more than half of those who searched for insurance in the nongroup market were unable to buy a policy.[4] Some went without because the coverage they found cost too much; others, because it insured too little.[5] For many with a preexisting condition, individual insurance could not be purchased at any price.[6]

The ACA established numerous consumer protections designed to make it easier for people to find individual coverage and to improve its affordability, adequacy, and transparency. These provisions took effect in stages, with the most transformative changes occurring recently, for most policies that began on or after January 1, 2014.[7] The law's reforms include guaranteed access to coverage, a ban on preexisting-condition exclusions, restrictions on the use of health status, gender, and other factors when setting premium rates, and coverage of a minimum set of essential health benefits (Exhibit 1).[8]

Exhibit 1. Key Individual Market Reforms Under the Affordable Care Act

Reform	Description
Accessibility	
Guaranteed issue	Requires insurers to accept every individual who applies for coverage.[a,b]
Dependent coverage to age 26	Requires plans that already provide dependent coverage to make it available until a child turns 26.
Rescissions	Prohibits plans from retroactively cancelling coverage, except in the case of a subscriber's fraud or intentional misrepresentation of material fact, and requires prior notice to the insured.
Affordability	
Rating requirements	Prohibits health status and gender rating; allows rates to vary based solely on four factors: family composition, geographic area, age, and tobacco use.[a,b]
Adequacy	
Preexisting-condition exclusions	Prohibits insurers from imposing preexisting-condition exclusions with respect to coverage.[a,b]
Essential health benefits	Requires coverage of 10 categories of essential benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[a,b]
Actuarial value	Requires plans to meet a minimum actuarial value standard of at least 60 percent of total plan costs; requires plans to meet one of four actuarial value tiers–bronze (60%), silver (70%), gold (80%), or platinum (90%)–as a measure of the portion of costs covered by the plan, on average.[a,b]
Annual cost-sharing limits	Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles.[a,b]
Annual dollar limits	Prohibits annual limits on the dollar value of essential health benefits.[a]
Lifetime dollar limits	Prohibits lifetime limits on the dollar value of essential health benefits.
Preventive services without cost-sharing	Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider.[a]
Transparency	
Summary of benefits and coverage	Requires insurers to provide standardized, easy-to-understand summaries of the benefits, cost-sharing, limitations, and exclusions of a plan; summaries must including specific coverage examples that illustrate how the plan covers common benefits scenarios.

[a] Does not apply to grandfathered plans (those in existence before the Affordable Care Act that have not made significant changes since March 23, 2010).
[b] Does not apply to policies renewed pursuant to the Obama Administration's transitional policy for expiring coverage.

Health reform enshrined these and other safeguards in federal law, thereby protecting consumers nationwide. However, because states remain the primary regulators of health insurance, they play critical roles in the implementation of the federal protections and their policy choices affect how their residents experience these reforms.[9] For example, states can choose whether to serve as the primary enforcer of the market changes—all but five are doing so—and may calibrate their approach to implementation, deciding whether to adopt federal standards or craft state-specific solutions that meet or exceed ACA requirements.[10]

This brief explores how the federal reforms are shaping standards for individual insurance and examines specific areas in which states have flexibility when implementing the new protections. We find that consumers across the country will enjoy improved standards for the availability, affordability, adequacy, and transparency of coverage. At the same time, because states have flexibility under reform, people will likely experience some of the new protections differently, depending on where they live. Analysis of four areas—guaranteed access to coverage, rating rules, benefit design, and plan transparency—reveals that some states already have begun to customize their markets by implementing protections that exceed federal minimum standards.

FINDINGS

In All States, Consumers Have Guaranteed Access to Individual Market Insurance

Prior to reform, few consumers in the individual market enjoyed the security of knowing that coverage would be available to them if they needed it. In all but five states, insurers were free to—and regularly did—deny nongroup insurance to applicants based on their health status or other factors.[11] Meanwhile, some of those who did obtain coverage faced investigation by insurers seeking to deny health claims or rescind their policies.[12]

The ACA dramatically expands access to individual coverage. The law requires insurers to issue individual market policies to all applicants during specified open enrollment periods and following qualifying events.[13] It also prohibits insurers from rescinding coverage except in cases of fraud.[14] States, in turn, have authority to broaden access further. For coverage offered outside of the new insurance marketplaces, states may, for example, lengthen or add enrollment periods, or identify additional qualifying events that trigger a special enrollment opportunity.[15] For marketplace coverage, states have discretion within federal guidelines to ensure that individuals who encountered obstacles to enrollment have the chance to complete the process (Exhibit 2).[16]

Since passage of the health law, at least eight jurisdictions formally augmented federal standards to give consumers more opportunities to access coverage. Two states, Nevada and Oregon, did so by expanding open enrollment. Nevada requires that individual coverage sold outside of the state's marketplace be available year-round, subject to a 90-day waiting period to reduce the risk of adverse selection.[17] Oregon, meanwhile, received federal permission to extend the 2014 open enrollment period inside its marketplace by an additional month.[18] At the same time, seven states—California, Colorado, Massachusetts, Minnesota, Nevada, Oregon, and Washington—and the District of Columbia expanded consumers' special enrollment rights by adding qualifying events, modifying enrollment timelines, or requiring greater notice of enrollment opportunities.[19] California, for example, enacted legislation that allows an individual who was receiving services from a contracted

Exhibit 2. Selected Areas of State Flexibility over Individual Market Insurance Access

Policy Concept	Federal Framework
Open enrollment period	Insurers must allow individuals to purchase coverage during an annual open enrollment period but are permitted to restrict enrollment at other times. States may require insurers to offer off-marketplace coverage more frequently than the federal standard.[a]
Special enrollment period[b]	Insurers must provide a special enrollment opportunity to individuals who experience a qualifying event, which must last for 60 days following the date of the event. States may extend the enrollment period for off-marketplace coverage or require greater disclosures regarding a consumer's special enrollment rights.[c]
Qualifying event	The occurrence of a qualifying event–such as losing coverage, gaining a dependent through marriage, birth, or adoption, or experiencing an error in enrollment, among others–may make an individual eligible to obtain coverage outside open enrollment by triggering a special enrollment period. States may identify additional qualifying events for off-marketplace enrollment.

[a] Except for the policy years 2014 and 2015, open enrollment periods will run from October 15 to December 7 of the year preceding the policy year. For 2014, open enrollment extended from October 1, 2013, to March 31, 2014; for 2015, the period will run from November 15, 2014, to February 15, 2015.
[b] An individual also may be entitled to purchase a policy outside of open enrollment through a "limited open enrollment period." Though separately defined under federal regulations, "limited open" and "special" enrollment periods function equivalently.
[c] Special enrollment opportunities generally last for 60 days; however, for 2014, an individual enrolled in a non-calendar-year plan that is set to expire outside of open enrollment is entitled to a limited open enrollment period beginning 30 days prior to the policy renewal date.

provider for any of a broad range of conditions to access a special enrollment period if that provider ceases to participate in the consumer's health plan.[20]

Separately, Oregon and six other states took action to preserve uninterrupted access to coverage for people with existing health conditions. Before the ACA, 35 states operated high-risk insurance pools for people unable to obtain individual coverage because of their preexisting conditions.[21] Many states began winding down these programs in 2013, anticipating improvements in individual insurance stemming from the market reforms and new insurance marketplaces.[22] However, in response to technical problems with marketplace websites that initially hampered transitions from the risk pools, these seven states temporarily extended benefits for existing pool enrollees, and one—Maryland—reopened its program to people who had difficulty enrolling in marketplace coverage.[23]

In 10 States and D.C., Consumers' Premiums Are Calculated Under Rating Rules Exceeding Federal Requirements

Before health reform, the vast majority of consumers in the individual market could expect to pay the full cost of premiums that varied widely based on factors including health status and demographics. In all but seven states, insurers were permitted to charge higher premiums to people with medical conditions; thirty-seven states allowed increased rates based on gender; and few offered financial assistance to defray the cost of coverage.[24] Consequently, premiums frequently were prohibitively expensive for those with even minor medical conditions.[25]

The ACA provides premium tax credits and cost-sharing reductions for middle- and lower-income consumers who purchase coverage through the new insurance marketplaces.[26] It also prohibits insurers inside and outside the marketplaces from charging people more based on health status or use of health services, bans gender rating, and reduces to four the permissible factors by which a consumer's premiums may vary: family composition, geographic area, age, and tobacco use.[27] Within this framework, states have latitude to impose stronger rate restrictions and designate geographic rating areas, among other options (Exhibit 3).[28]

Exhibit 3. Selected Areas of State Flexibility over Individual Market Rate Restrictions

Rating Factor	Federal Framework
Family composition	Insurers may vary rates based on whether the plan covers an individual or a family. States have discretion to define categories of family members that must be included on a family policy.[a]
Geographic rating area	Insurers may vary rates based on where an individual lives within a state. States may establish one or more rating areas based on geographic divisions including counties, three-digit zip codes, or metropolitan statistical areas (MSAs) and non-MSAs. States may limit the differential between the highest- and lowest-rated areas and are urged but not required to align rating areas with plan service areas.[b]
Age	Insurers are prohibited from charging an older adult (age 64 or older) more than three times the rate of a younger adult (age 21 or younger). States may establish their own age rating curve or reduce the rating ratio.
Tobacco use[c]	Insurers may vary rates based on whether a consumer uses tobacco, but by no more than a ratio of 1.5:1. States may reduce the rating ratio or develop a more restrictive definition of tobacco use.

[a] Additionally, community-rated states–those that prohibit age and tobacco rating in their entirety–also may establish uniform "family tier" ratios that specify the rating factor that attaches to particular family sizes (e.g., two adults; two adults and one or more children).
[b] In states that decline to establish their own geographic rating areas, areas are determined using the federal default method, which assigns one area to each MSA within the state and one additional area for the remainder of the state that is not included in an MSA.
[c] Federal regulations define "tobacco use" as the use of any tobacco product four or more times per week, on average, within the past six months. Religious or ceremonial use of tobacco is excluded from this definition.

Already, a majority of states have opted to enforce rating rules that deviate from federal standards. Massachusetts, New York, and Vermont maintained existing laws that further restrict or prohibit age rating.[29] Ten states and the District of Columbia adopted or continued stronger restrictions on tobacco rating, with seven banning the practice entirely (Exhibit 4).[30] Meanwhile, most states customized their rating areas, with only seven relying on the federal default approach.[31]

Exhibit 4. State Individual Market Rating Restrictions That Exceed Federal Requirements

Consumer Protection	States
Age rating restriction (state standard is more protective than the federal ratio of 3:1)	3 states: MA, NY, VT[a]
Tobacco rating restriction (state standard is more protective than the federal ratio of 1.5:1)	10 states + DC: AR, CA, CO, CT, DC, KY, MA, NJ, NY, RI, VT[b]

[a] Age rating is entirely prohibited in New York and Vermont.
[b] Tobacco rating is entirely prohibited in California, the District of Columbia, Massachusetts, New Jersey, New York, Rhode Island, and Vermont. Connecticut prohibits tobacco rating only for plans offered through its insurance marketplace.

Consumers in 12 States and D.C. Can Shop for Plans with Standardized Benefits or Cost-Sharing

Individual market insurance traditionally was far less comprehensive than typical employer-based coverage. Before the ACA, every state permitted insurers to restrict benefits based on an applicant's health history, with 37 allowing carriers to refuse permanently to cover a consumer's preexisting condition.[32] Moreover, even healthy policyholders often had to make do with limited benefits. For example, only 11 states required individual policies to cover maternity care, while the share of adults without prescription drug coverage was four times higher in the individual market, compared with the group market.[33]

The ACA addresses the adequacy of individual insurance by, among other things, banning preexisting-condition exclusions, requiring coverage of 10 categories of essential health benefits, and setting limits on annual out-of-pocket spending.[34] States have significant flexibility in implementing these requirements, starting with the power to define the essential health benefits package through selection of a state-specific benchmark plan.[35] In addition, states may customize coverage by requiring insurers to offer plans with standardized features, prohibiting carriers from substituting benefits within an essential health benefit category, or reducing consumers' exposure to out-of-pocket costs (Exhibit 5).[36]

Exhibit 5. Selected Areas of State Flexibility over Individual Market Benefit Design

Policy Concept	Federal Framework
Benefit substitution	Insurers are prohibited from deviating from the benchmark plan by substituting one benefit in one essential health benefit category for another in a different category; however, insurers are permitted to substitute within categories, provided the benefits are actuarially equivalent and are not prescription drugs. States may further limit substitution or prohibit the practice entirely.
Plan standardization	Insurers retain discretion to develop varying plan designs, subject to federal requirements regarding benefit package adequacy and prohibitions on discrimination. States may require insurers to offer plans with standardized cost-sharing structures, including predefined deductibles, out-of-pocket maximums, and cost-sharing amounts for specific services, for in-network or out-of-network care.
Annual cost-sharing limitation	The health law establishes an annual dollar limit on the amount a consumer can be required to pay in out-of-pocket costs for essential health benefits accessed within network. States may require that additional types of charges–for example, certain out-of-network services–be included within the spending cap or reduce the overall dollar limit.[a]

[a] Except in 2014, the spending limit will be tied to the out-of-pocket limit for high-deductible health plans, as determined annually by the Internal Revenue Service. In 2014, the limit is set at $6,350 for self-only coverage and $12,700 for family coverage.

States have shown early interest in these options for managing individual market benefit design. Nine states and the District of Columbia prohibited benefit substitution, typically to facilitate apples-to-apples comparisons among plans and to reduce opportunities for insurers to use benefit design to cherry-pick healthier enrollees.[37] While no state acted, post-reform, to completely standardize its individual market, six states required some standardized plans in their marketplaces.[38] One state, Oregon, went a step further and imposed limited standardization in plans outside the marketplace, as well, while New Jersey continued an existing directive requiring all individual policies to be standardized.[39] Finally, two states, Maine and Vermont, set limits on the total out-of-pocket expenses a consumer may be required to pay for receipt of out-of-network prescription drugs (Exhibit 6).[40]

Exhibit 6. Selected State Requirements Regarding Individual Market Benefit Design and Cost-Sharing

Consumer Protection	States
Essential health benefit substitution prohibited (state standard completely prohibits benefit substitution)	9 states + DC: CA, CT, DC, IN, MD, MI, NE, NY, OR, WA[a]
Standardized benefit designs required (state standard requires some standardized benefit designs)	7 states: CA, CT, MA, NJ, NY, OR, VT[b]
Limitations on annual cost-sharing (state standard is more protective than the federal dollar limitation or definition of included charges)	2 states: ME, VT[c]

[a] New York and Oregon prohibit substitution for standardized plans but permit at least limited substitution in nonstandard plans. Washington bars substitution for plans issued or renewed through the end of 2016, but will allow the practice in years thereafter.

[b] New Jersey requires standardized plans in its entire nongroup market. Oregon requires standard silver and bronze plans, marketwide, and mandates additional standardization for marketplace offerings. Vermont requires standardization in its marketplace and has closed the individual market outside the marketplace, meaning that its requirements are effectively marketwide in scope. The remaining states impose standardization within their marketplaces only.

[c] Maine and Vermont impose limits on out-of-pocket expenses for out-of-network prescription drugs.

Consumers in All States Enjoy Greater Transparency of Coverage

Prior to reform, most individual market consumers faced an additional obstacle to obtaining insurance that often exacerbated the market's other shortcomings: they lacked transparent information regarding coverage benefits and limitations. Shopping for health insurance—a notoriously complex and confusing process—could be especially challenging for people in the individual market, who could not count on clear disclosures from insurers to explain important coverage features and often had no effective way to aggregate and compare their insurance options according to standardized measures of value. As a result, consumers frequently selected plans that proved far more expensive, and much less protective, than expected.[41]

The ACA aims to improve transparency by establishing marketplaces in each state that allow consumers to more easily compare and shop for plans that meet minimum value standards.[42] For consumers interested in insurance options outside of the marketplaces, it creates a "Plan Finder" website that helps people identify available coverage and view key information about those offerings.[43] And for the entire individual market—inside and outside of the marketplaces—the law requires insurers to provide a standardized summary of benefits and coverage to help consumers understand and compare plan features.[44] In addition to the considerable discretion states may exercise over marketplace development and operation, they also may mandate additional coverage disclosures, as Colorado has done.[45] Or, they may create state-specific plan comparison tools, as New Jersey did prior to reform (Exhibit 7).[46]

Exhibit 7. Selected Areas of State Flexibility over Individual Market Transparency

Policy Concept	Federal Framework
Summary of benefits and coverage	Insurers must make available a standardized, easy-to-understand summary of the key features and limitations of each of its plans, including a "coverage facts label" that illustrates how the plan covers common benefits scenarios. States may require supplemental disclosures, including additional coverage examples or other summary estimates of a consumer's total out-of-pocket expenses under the plan.
Plan finder and comparison tool	Insurers must report coverage data to the federal Plan Finder, a database consumers may use to search for and compare off-marketplace plans. States may build their own plan comparison tools for coverage outside their marketplace or for insurance options marketwide. Tools should identify plan features including premiums, cost-sharing, and actuarial value and begin to incorporate other useful consumer content, including state supplemental plan disclosures and integrated provider directories.

DISCUSSION

The Affordable Care Act seeks to remedy persistent problems with the availability, affordability, adequacy, and transparency of individual market insurance by establishing federal minimum standards for consumer protection. In the reformed individual market, consumers can no longer be denied an individual policy because of their medical history, nor be forced to pay higher premiums because of their health or gender. They can expect a richer package of health benefits and clear disclosures for understanding their coverage. And these policies must contain limits on out-of-pocket spending and cover costs at a level that satisfies minimum standards of generosity.

These federal reforms protect consumers nationwide. Still, because states remain the primary regulators of insurance and have considerable flexibility over the ACA's implementation, people in different states are likely to experience some of the law's protections differently.

One way states may tailor their markets is by building on the ACA's requirements (Appendix Table 1). Our findings show that most states declined to make significant changes for 2014. In those that did exceed federal standards, policymakers appear to have maximized their flexibility and made informed decisions at the legislative and regulatory levels about how best to serve consumers in their states. In many cases, policymakers exercised discretion to maintain existing market rules—as New York did for age rating, for example—but some efforts, particularly as to benefit design, were new.

States that did not customize federal standards may have been reluctant to do so for several reasons. During a period of already significant transformation, policymakers may have sought to minimize the risk of further market disruption or chose to allow time to evaluate the new federal requirements in action before introducing changes. Political opposition to reform likely curtailed action in some states as well.

These diverging state approaches suggest that consumers will experience the federal reforms differently, depending on where they live. For example, a low-income smoker in a state that prohibits tobacco rating may find coverage far more affordable than a similar consumer in a state that allows a 50 percent premium surcharge for tobacco use.[47] And consumers from states that ban benefit substitution may have an easier time comparing coverage options than if they lived in states where the practice is allowed.

For now, the true impact of these types of policy choices on critical outcomes—including rates of underinsurance and uninsurance, coverage affordability, and health status—is unknown. As state policymakers gain a greater understanding of how reform is working for their consumers, they

will likely look with increasing frequency to adjust their market rules. Continued tracking and analysis of these developments will be essential to understanding how consumers are experiencing individual coverage in the new health insurance landscape.

Notes

1 S. Corlette, J. Volk, and K. Lucia, *Real Stories, Real Reforms* (Princeton, N.J.: Robert Wood Johnson Foundation, Sept. 2013).

2 D. Young, A. Hammoud, M. Udow-Phillips et al., *Satisfaction with Health Care Coverage: Cover Michigan Survey 2013* (Ann Arbor, Mich.: Center for Healthcare Research and Transformation, July 2013) and K. Davis, K. Stremikis, M. M. Doty, and M. A. Zezza, "Medicare Beneficiaries Less Likely to Experience Cost- and Access-Related Problems Than Adults with Private Coverage," *Health Affairs* Web First, July 18, 2012.

3 S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).

4 Ibid.

5 Ibid.

6 Ibid.

7 The new protections apply to all individual market insurance policies that are new or renewed in 2014 with two exceptions: 1) grandfathered plans and 2) policies existing in 2013 that were continued pursuant to the Obama Administration's transitional rules for coverage that otherwise would have been cancelled by issuers for failing to comply with the ACA's 2014 market reforms. Relatively few individual market policyholders are expected to renew noncompliant coverage under this optional federal transitional policy, in part because many states declined to adopt it. For those consumers who do renew, their policies may remain exempt from the recent market changes through late 2017. U.S. Department of Health and Human Services, "Insurance Standards Bulletin Series–Extension of Transitional Policy through October 1, 2016," March 5, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf; S. R. Collins, "Impact of Extending Policy on Canceled Plans Likely Small," *The Commonwealth Fund Blog,* March 7, 2014, accessed March 12, 2014; K. Lucia, S. Corlette, and A. Williams, "The Extended 'Fix' for Canceled Health Insurance Policies: Latest State Action," *The Commonwealth Fund Blog,* June 10, 2014, accessed June 23, 2014; K. Lucia, K. Keith, and S. Corlette, "Update: State Decisions on the Health Insurance Policy Cancellations Fix," *The Commonwealth Fund Blog,* Jan. 8, 2014, accessed March 12, 2014.

8 Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1001, 1201; Pub. L. 111-152, 124 Stat. 1029 (2010).

9 See, generally, T. S. Jost, "The Regulation of Private Health Insurance" (Washington, D.C.: National Academy of Social Insurance, National Academy of Public Administration and Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2009).

[10] The five states in which the federal government is directly enforcing the market reforms are: Alabama, Missouri, Oklahoma, Texas, and Wyoming. The Center for Consumer Information and Insurance Oversight, "Ensuring Compliance with the Health Insurance Market Reforms," http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html. For state flexibility over implementation, see, for example, Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668, 8669-70 (Feb. 14, 2012), which notes that "State laws with stricter health insurance issuer requirements than those imposed by the [Public Health Service Act, as amended by the ACA,] will not be superseded by [the federal] provisions."

[11] Prior to the ACA, only Maine, Massachusetts, New Jersey, New York, and Vermont required the guaranteed issue of all individual market products to all state residents. U.S. Government Accountability Office, *Report to the Secretary of Health and Human Services and the Secretary of Labor: Private Health Insurance, Data on Application and Coverage Denials*, GAO-11-268 (Washington, D.C.: GAO, March 2011).

[12] See, for example, M. Waas, "Insurer Targeted HIV Patients to Drop Coverage," *Reuters*, March 17, 2010, accessed March 12, 2014, http://www.reuters.com/article/2010/03/17/us-insurers-idUSTRE62G2DO20100317; L. Girion, "Health Insurer Tied to Bonuses to Dropping Sick Policyholders," *Los Angeles Times*, Nov. 9, 2007, accessed March 12, 2014, http://articles.latimes.com/2007/nov/09/business/fi-insure9.

[13] Public Health Service Act § 2702 (codified at 42 U.S.C. § 300gg-1); 45 C.F.R. § 147.104.

[14] Public Health Service Act § 2712 (codified at 42 U.S.C. § 300gg-12).

[15] Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13406, 13417 (Feb. 27, 2013).

[16] For example, see U.S. Department of Health and Human Services, "Guidance for Issuers on People 'In Line' for the Federally-Facilitated Marketplace at the End of the Initial Open Enrollment Period," March 26, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/in-line-SEP-3-26-2014.pdf.

[17] Nev. Rev. Stat. § 687B.480.

[18] Oregon sought the federal waiver to extend marketplace open enrollment pursuant to state legislation enacted in March 2014. Or. H.B. 4154. Once the waiver was granted, the state created a matching "special" enrollment opportunity for Oregonians to access coverage outside of the state's marketplace during the month of April 2014. Or. Admin. R. 836-053-0431.

[19] In addition, every state operating its own marketplace used flexibility built into federal guidance to allow at least some consumers to enroll in coverage after the end of the initial open enrollment period on March 31, 2014. In general, state marketplaces extended these opportunities to consumers who had begun an application for coverage during open enrollment but, through no fault of their own, had not completed the process prior to the period's close. These enrollment opportunities for the state-based marketplaces largely mirrored the options available to consumers in states where the federal government is operating the marketplace. U.S. Department of Health and Human Services, "Guidance for Issuers on People 'In Line' for the Federally-Facilitated Marketplace at the End of the Initial Open Enrollment Period," March 26, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/in-line-SEP-3-26-2014.pdf.

[20] Cal. Ins. Code § 10965.3(d)(1)(G); Cal. Health & Safety Code § 1399.849(d)(1)(G).

[21] National Association of State Comprehensive Nealth Insurance Plans, States with High-Risk Pools, http://naschip.org/portal/index.php?view=article&id=53%3Astates-with-pools&format=pdf&option=com_content&Itemid=1.

[22] R. Adams, "State High-Risk Pool Directors Weigh Extension of Expiring Programs," *Washington Health Policy Week in Review,* The Commonwealth Fund, Nov. 12, 2013, accessed March 12, 2014, http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2013/Nov/November-18-2013/State-High-Risk-Pool-Directors-Weigh-Extension-of-Expiring-Programs.aspx.

[23] States that extended coverage for some or all of existing risk pool enrollees include: Indiana, Maryland, New Hampshire, Oregon, Texas, West Virginia, and Wisconsin. See National Association of State Comprehensive Health Insurance Plans, "State Risk Pool Status Report," http://naschip.org/2013/PoolEnrollmentSurveyFinalDec.pdf; Oregon Medical Insurance Pool, "Temporary Medical Insurance Plan," http://www.oregon.gov/oha/OPHP/TMIP/Pages/default.aspx; Wisconsin Health Insurance Risk-Sharing Plan, "HIRSP Frequently Asked Questions, 2013 Year-End Edition," http://hirsp.org/pdfs/FAQ_year_end.pdf; Maryland Health Insurance Plan, "MHIP Bridge Program FAQs," http://www.marylandhealthinsuranceplan.net/mhip/attachments/MHIP_BRIDGE_FAQs.pdf.

[24] Kaiser Family Foundation, "Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)," http://kff.org/other/state-indicator/individual-market-rate-restrictions/; Kaiser Family Foundation, "Health Insurance Subsidies in the Individual Market, as of January 2012", http://kff.org/other/state-indicator/health-insurance-subsidies-individual-market/. The seven states that prohibited health status underwriting prior to the ACA were: Maine, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington.

[25] Collins, Doty, Robertson, and Garber, *Help on the Horizon,* 2011; see also K. Pollitz, *How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?* (Menlo Park, Calif: Kaiser Family Foundation, June 2001).

[26] Generally, premium tax credits are available to individuals with incomes between 100 percent and 400 percent of the federal poverty line who purchase coverage through their insurance marketplace. Consumers with incomes from 100 percent to 250 percent of the poverty threshold may also be eligible for subsidies that defray cost-sharing charges incurred when using services covered under their marketplace plan. Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1401-02 (codified at 26 U.S.C. § 36B; 42 U.S.C. § 18071).

[27] Public Health Service Act § 2701 (codified at 42 U.S.C. § 300gg).

[28] 45 C.F.R. § 147.102.

[29] Mass. Gen. Laws Ann. ch. 176J, § 3; N.Y. Ins. Law §§ 3231, 4317, 4328; Vt. Stat. Ann. tit. 33, § 1811.

[30] The seven jurisdictions that prohibit tobacco rating are: California, the District of Columbia, Massachusetts, New Jersey, New York, Rhode Island, and Vermont.

[31] The seven states that are using the federal default method for selecting rating areas are: Alabama, New Mexico, North Dakota, Oklahoma, Texas, Virginia, and Wyoming.

[32] Kaiser Family Foundation, "Individual Market Portability Rules (Not Applicable to HIPAA Eligible Individuals)," http://kff.org/other/state-indicator/individual-market-portability-rules/. For consumers who lived in the 13 states that prohibited permanent exclusions of preexisting conditions, coverage prospects were not always brighter. Evidence suggests that insurers in these states often charged consumers higher premiums and more frequently declined to issue individual insurance in the first place. Pollitz, *How Accessible Is Individual Health Insurance?* 2001.

[33] M. M. Doty, S. R. Collins, J. L. Nicholson, and S. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* (New York: The Commonwealth Fund, July 2009). Data regarding maternity coverage is on file with the authors.

[34] Public Health Service Act §§ 2704, 2707(a) (codified at 42 U.S.C. §§ 300gg-3, 300gg-6(a)).

[35] 45 C.F.R. § 156.100. Nearly half of states picked a benchmark for 2014, while the remainder declined and were assigned a default option pursuant to federal regulations. S. Corlette, K. Lucia, and M. Levin, *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan* (New York: The Commonwealth Fund, March 2013).

[36] 45 C.F.R. § 156.115; see also C. Monahan, S. Dash, K. Lucia et al., *Realizing Health Reform's Potential: What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces* (New York: The Commonwealth Fund, Dec. 2013); S. Rosenbaum, N. Lopez, D. Mehta et al., *Realizing Health Reform's Potential: How Are State Insurance Marketplaces Shaping Health Plan Design?* (New York: The Commonwealth Fund, Dec. 2013).

[37] Corlette, Lucia, and Levin, *Implementing the Affordable Care Act: Choosing*, 2013.

[38] C. Monahan, S. Dash, K. Lucia et al., *Realizing Health Reform's Potential: What States Are Doing*, 2013.

[39] Or. Rev. Stat. § 743.822; N.J. Stat. Ann. § 17B:27A2 et seq.

[40] Me. Rev. Stat. tit. 24-A, § 4317-A; Vt. Stat. Ann. tit. 8, § 4089i; Vermont Department of Financial Regulation, Insurance Division Bulletin 171, "Out-of-Pocket Maximum for Prescription Drugs." States may provide other cost-sharing protections for individual market consumers. For example, while federal law establishes no direct limitation on the size of a deductible in the individual market, at least two states, Massachusetts and New Jersey, prohibit issuers from imposing an in-network individual market deductible that exceeds a specified dollar limit. 956 Mass. Code Regs. § 5.03; N.J. Admin. Code. § 11:22-5.3.

[41] E. Saly, K. Bailey, and K. Stoll, *Decoding Your Health Insurance: The New Summary of Benefits and Coverage* (Washington, D.C.: Families USA, May 2012).

[42] Pub. L. 111-148, 124 Stat. 782 (2010) § 1311 (codified at 42 U.S.C. § 18031). The law's insurance marketplaces are designed to perform many other functions that can substantially improve the consumer experience and that may be implemented differently, state to state. S. Dash, K. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).

[43] Pub. L. 111-148, 124 Stat. 782 (2010) § 1103 (codified at 42 U.S.C. § 18003); U.S. Department of Health and Human Services, "Find Insurance Options," http://finder.healthcare.gov/.

[44] Public Health Service Act § 2715 (codified at 42 U.S.C. § 300gg-15).

[45] Federal regulations explicitly recognize the authority of states to impose disclosure requirements separate from and additional to those mandated by the ACA's summary of benefits and coverage provision. Summary of Benefits and Coverage and Uniform Glossary, 77 Fed. Reg. 8668, 8678-79 (Feb. 14, 2012). Colorado exercised that authority to develop a new "Colorado Supplement" to the federal disclosure form that must be made available for all individual market policies. 3 Code Colo. Regs. § 702-4-2-20. Other states, including Montana, have acted to harmonize existing state disclosure requirements with the new federal standard. Montana Commissioner of Securities and Insurance, July 6, 2012, "Advisory Memorandum: Federal and State Consumer Disclosures," http://www.csi.mt.gov/news/bulletins/FederalandState_ConsumerDisclosures.pdf.

[46] New Jersey Department of Banking and Insurance, "New Jersey Individual Health Coverage Program Rates," http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm. In states that choose to close their outside market and permit the sale of individual coverage only through the marketplace, the marketplace portal itself will function as a market-wide plan finder and comparison tool. To date, the District of Columbia and Vermont have structured their individual markets in this fashion.

[47] The ramifications of tobacco rating for a consumer's finances and coverage status are amplified by the fact that federal regulations require the tobacco user to bear the full, unsubsidized cost of any tobacco-related surcharge. See 26 C.F.R. § 1.36B-3(e) (stating that premium subsidy amounts are based on plan premiums calculated prior to the application of any tobacco rating factor). Analysis suggests that lower-income smokers who experience tobacco rating under this default federal framework may face unaffordable premiums and the risk of uninsurance. R. Curtis and E. Neuschler, "Tobacco Rating Issues and Options for California Under the ACA," Institute for Health Policy Solutions, June 21, 2012, http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf.

Appendix Table 1. States with Requirements for Individual Market Insurance That Vary from Affordable Care Act Default Standards (2014)

	Access		Affordability			Adequacy			Transparency	
State	Open enrollment periods	Special enrollment periods	Age rating	Tobacco rating	Geographic rating	Benefit substitution (prohibited)	Standardized benefit designs (required)	Limitations on annual cost-sharing	Summary of benefits and coverage	Plan finder and comparison tools
Alabama										
Alaska					X					
Arizona					X					
Arkansas				X	X					
California		X		X	X	X	X*			
Colorado		X		X	X				X	
Connecticut				X*	X	X	X*			
Delaware					X					
District of Columbia		X		X	X	X				
Florida					X					
Georgia					X					
Hawaii					X					
Idaho					X					
Illinois					X					
Indiana					X	X				
Iowa					X					
Kansas					X					
Kentucky				X	X					
Louisiana					X					
Maine					X			X		
Maryland					X	X				
Massachusetts		X*	X	X	X		X*			
Michigan					X	X				
Minnesota		X			X					
Mississippi					X					
Missouri					X					
Montana					X					
Nebraska					X	X				
Nevada	X^	X			X					
New Hampshire					X					
New Jersey				X	X		X			X
New Mexico										
New York			X	X	X	X*	X*			
North Carolina					X					
North Dakota										
Ohio					X					
Oklahoma										
Oregon	X*	X^			X	X	X			
Pennsylvania					X					
Rhode Island				X	X					
South Carolina					X					
South Dakota					X					
Tennessee					X					
Texas										
Utah					X					
Vermont			X	X	X		X*	X		
Virginia										
Washington		X			X	X				
West Virginia					X					
Wisconsin					X					
Wyoming										

Notes: The table identifies instances of state legislative, regulatory, or subregulatory action, in discrete areas described more fully in the text, that apply to individual coverage offered during policy year 2014 and vary from federal default requirements contained in the ACA. States may have taken other actions to implement or otherwise apply federal standards in ways not specifically identified in this brief. Except where designated, instances of state action apply to a state's entire individual market, inside and outside its insurance marketplace. See the text and exhibits for additional notes and information.

* State action applies only to coverage offered inside the state's individual insurance marketplace.

^ State action applies only to coverage offered outside the state's individual insurance marketplace.

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