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The Unintended Federalism Consequences of the Affordable Care Act’s Insurance Market Reforms

Joshua Phares Ackerman*

I. Introduction

After the passage of the Patient Protection and Affordable Care Act (“ACA”) in 2010, the front lines in the political controversy over the Act shifted from Washington to the states.¹ One of the ACA’s signature provisions was the creation of health insurance marketplaces, termed “exchanges,” that consumers can use to purchase coverage under the Act.² Under the banner of “state flexibility,” the ACA delegated authority to set up and administer the exchanges to the states.³ The federal government, however, is responsible for operating an exchange in any state that does not create one of its own.⁴ The states’ role in creating exchanges provided a focal point for continued political wrangling over the Act. Resisting the creation of an exchange in their state became a cause célèbre among Republican governors, who denounced the exchanges as an encroachment on states’ rights.⁵ While refusing to set up an

* Law Clerk to the Honorable Paul J. Watford, United States Court of Appeals for the Ninth Circuit. I am grateful to thank Rich Chen, John Major, Anup Malani, Garrett Rose, Graham Safty, and Julia Schwartz for their helpful advice and comments on drafts of this Article. I would also like to thank the editorial staff of the PACE LAW REVIEW for their work on this piece.

1. *But see 40th Repeal Vote Unlikely To Be Charm for House Republicans*, KAISER HEALTH NEWS (Aug. 2, 2013), <http://www.kaiserhealthnews.org/Daily-Reports/2013/August/02/house-repeal-vote.aspx>.

2. *See* 42 U.S.C. § 18041 (2012).

3. *See id.*

4. *Id.* § 18041(c).

5. *See* Robert Pear, *Majority of Governors Refuse to Set Up Health*

exchange may have political benefits, it also has a significant impact on states' regulatory authority under the ACA. Put simply, those who opposed the creation of state exchanges as a means of protesting the expansion of federal government may have won a battle at the expense of losing a much larger war over the scope of federal authority.

For the most part, the controversy over the exchanges broke along predictable partisan lines. But in Mississippi, the decision whether to create a state-run exchange bitterly divided the state's governor and insurance commissioner, both of whom are Republicans. Like many of his GOP colleagues, Governor Phil Bryant opposed the creation of an ACA exchange, arguing that it would be "a portal to a massive and unaffordable new federal entitlement program."⁶ However, Mike Chaney, the state's elected insurance commissioner, supported the creation of an exchange. Claiming that the Governor was "full of crap," Chaney argued that a state-run exchange would allow Mississippi to maintain control over health plan regulation.⁷ In Chaney's view, a federally run exchange would impede the state's control over plan pricing, selection, and distribution.⁸ Believing that he had authority under state law to move forward independently, Chaney submitted a plan for an exchange to the Department of Health and Human Services ("HHS").⁹ Governor Bryant wrote

Exchanges, N.Y. TIMES, Dec. 15, 2012, at A13; Louise Radnofsky, *Six More States Reject Role In Health-Care Exchanges*, WALL ST. J. (Feb. 15, 2013), http://online.wsj.com/article/SB10001424127887324432004578306680100309950.html?mod=mw_streaming_stream#articleTabs%3Darticle.

6. *Governor Bryant Issues Statement on Health Care Exchange*, GOVERNOR PHIL BRYANT (Feb. 7, 2013), <http://www.governorbryant.com/governor-bryant-issues-statement-on-health-care-exchange/>.

7. Geoff Pender, *Mississippi Insurance Commissioner Mike Chaney Virtually Alone, Miffed*, CLARION-LEDGER (Feb. 13, 2013), <http://www.clarionledger.com/article/20130120/COL0601/301200032/>.

8. See Louise Radnofsky, *State's Health Exchange Rejected Amid GOP Rift*, WALL ST. J. (Feb. 8, 2013), <http://online.wsj.com/news/articles/SB10001424127887324906004578292271269356316>; see also Caleb Bedillion, *Chaney Outlines Health Care Future*, DAILY LEADER.COM (Apr. 18, 2013, 2:15 PM) (source on file with the author).

9. Chaney relied on an opinion from the state's attorney general (a Democrat) that concluded he had authority to submit the exchange application. See Radnofsky, *supra* note 8.

separately to HHS, stating that he was opposed to a state-run exchange and would take steps to block it if HHS approved Chaney's application.¹⁰ HHS denied Chaney's application, citing "a lack of support from your Governor and no formal commitment to coordinate from other state agencies" as the basis of its decision.¹¹ Chaney continues to maintain that the federal exchange will be detrimental to the state, and that Governor Bryant's opposition to the exchange was rooted in political, rather than policy, considerations.¹²

The family feud in the Mississippi GOP highlights an unintended—and unexplored—consequence of federal health reform. On their face, the exchange provisions of the ACA purport to give states options. By allowing states to determine whether to establish an exchange and how it should be run, the Act vests a degree of control over the implementation of health reform in the states. This delegation stands in contrast with other provisions of the ACA, which impose federal standards in areas traditionally subject to state regulatory authority.¹³ The exchange provision seems an ideal compromise—states may elect to establish an exchange under their own terms, or opt into a set of federal default rules if they see fit. By this account, the exchanges are a pro-federalism aspect of the ACA, in that they preserve a prominent role for the states in regulating a crucial component of federal health reform.

Developments since the passage of the ACA have cast considerable doubt on this characterization of the exchanges as protective of state regulatory authority. The exchanges have become a political hot potato to be avoided by Republican governors (and some of their Democratic counterparts) at all

10. *See id.*

11. Press Release, Mississippi Insurance Department, Official Statement from Mississippi Insurance Commissioner Mike Chaney (Feb. 8, 2013), available at http://www.mid.ms.gov/press_releases/2013/pressrel020813.pdf (reproducing letter from Gary Cohen, Director of HHS Center for Consumer Information and Insurance Oversight, to Chaney).

12. *See* Bedillion, *supra* note 8.

13. *See, e.g.*, 42 U.S.C. § 300gg-12 (2012) (prohibiting rescission of health insurance policies); *id.* § 300gg-15 (preempting state disclosure requirements that conflict with the ACA's disclosure requirements); *id.* § 300gg-16 (prohibiting the use of employee salary as an eligibility criterion for joining a group health plan).

costs. Only twenty-four states (and the District of Columbia) opted to create exchanges, leaving the other twenty-six states with some form of a federal exchange.¹⁴

This political opposition to the exchanges comes at a significant cost. Much of the ACA's substantive regulation of health insurance plans is tied to rules set and administered by the exchanges; by opting not to create state-run exchanges, states have ceded the ability to set these rules to the federal government. Thus, by accident or by design, a provision that purports to preserve a role for state regulation has stripped states of a significant portion of their traditional prerogative to regulate health insurance within their borders.

This Article, which is the first to examine the relationship between the ACA's insurance market reforms and state regulation of insurance, argues that states' decisions to forego creating their own exchanges may mark the beginning of an important shift of regulatory authority from the states to the federal government. This shift will have broad consequences in health care, effectively creating a new federal regulator with authority to specify the products health insurers may sell, how they may sell them, who must be able to purchase them, and what they may charge.

Such a shift to greater federal regulation is a mistake. State-based regulation of health insurance has a number of advantages over a federal alternative. It provides greater opportunity for regulatory experimentation, which is critical given the lack of consensus regarding how best to solve the cost-access-quality tradeoffs that plague American health care. Moreover, health care is a local industry. A great deal depends on the interaction between providers and insurers within a local market, and state regulators are better suited to regulate with sensitivity to these dynamics. State regulators also have

14. See *What is the Marketplace in my State?*, HEALTHCARE.GOV, <https://www.healthcare.gov/what-is-the-marketplace-in-my-state/> (last visited Feb. 8, 2014), for information on which states opted to create exchanges. Of the states that elected to create an exchange, fifteen opted to share some of the responsibility for operating their exchange with the federal government. See U.S. GOVERNMENT ACCOUNTABILITY OFFICE, PATIENT PROTECTION AND AFFORDABLE HEALTH CARE ACT: STATUS OF CMS EFFORTS TO ESTABLISH FEDERALLY FACILITATED HEALTH INSURANCE EXCHANGES 3, 9-10, 14-15 (2013), available at <http://www.gao.gov/assets/660/655291.pdf>.

superior institutional expertise in insurance regulation. At the very least, it would be unwise to jettison state regulation, and its accompanying benefits, without considering whether a federal alternative would be superior. But the ACA's exchange provisions will result in exactly this sort of blindfolded transformation.

The shift toward an increased federal role in health insurance regulation may also have consequences beyond health care markets. Specifically, it may open the door to greater federal involvement in insurance regulation generally. In recent years, insurance companies and scholars have begun to question the States' decades-old allocation role as the primary regulators of insurance. Some have proposed creating an alternative scheme based on federal chartering of insurance carriers. These proposals have touched off a broader debate about the propriety of state-based insurance regulation.¹⁵ The federal exchange may be a test run of sorts for such a program, and if it overcomes its initial hiccups,¹⁶ could generate further momentum for federal chartering. But proponents of regulatory reform in non-health insurance markets should not rush to trumpet the ACA as a model regulatory structure. As the result of states' unexpected reaction to the exchange provisions, the ACA's allotment of regulatory authority is haphazard, and not the product of deliberative institutional design. Any reform in other markets should be informed by a debate—which was sorely lacking in the ACA context—about the pros and cons of federal regulation.

The Article begins by sketching the historical antecedents

15. See, e.g., Jonathan R. Macey & Geoffrey P. Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role of Insurance Regulation*, 68 N.Y.U. L. REV. 13, 18-20 (1993) (arguing that the basic structure of insurance regulation is sound, and proposing modest reforms); Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 664-69, 686-87 (1999) (arguing that traditional federalism arguments do not justify state regulation of insurance); Daniel Schwarcz, *Regulating Insurance Sales or Selling Insurance Regulation?: Against Regulatory Competition in Insurance*, 94 MINN. L. REV. 1707, 1708-11, 1716-17 (2010) (discussing proposals to reform insurance regulation, and arguing that proponents of reform overstate the benefits of regulatory competition).

16. See, e.g., Eric Lipton, Ian Austen, & Sharon LaFraniere, *Tension and Flaws Before Health Website Crash*, N.Y. TIMES, Nov. 23, 2013, at A1.

of the current allocation of state and federal authority over insurance regulation. The aim of this discussion is to highlight the unique role states play in the regulation of insurance as opposed to other financial products. Part III explains the pre-ACA structure of health insurance regulation. It discusses both the objectives of health insurance regulation and the substantive and institutional frameworks states have evolved to meet those objectives. Part III also explains the reasons why states are well suited to regulate health insurance. Before turning to the regulatory structure introduced by President Obama's health reforms, Part IV explains the federal government's involvement in health plan regulation before the ACA. Part V details the relevant ACA provisions, explaining the new rules that will apply to health plans and carriers. It pays special attention to the application of these rules—some apply to all health plans, regardless of how they are sold, while others apply only to plans sold through the exchanges. These latter rules are particularly important to this Article's analysis, as they represent the regulatory functions that the federal government will assume—via its exchange—in states that elect not to create exchanges. Part VI explores the effect the ACA's exchange rules will have on the balance of state and federal regulatory authority, and highlights how the opt-in character of the exchanges will alter this balance. Lastly, it offers observations about the impact increased federal regulation of health insurance may have on the regulation of other lines of insurance.

II. Insurance Regulation as a Core State Competency

Insurance is unique among financial services industries in that it is the only industry subject to plenary state regulation.¹⁷ Other financial services firms, including commercial banks, investment banks, securities firms, and broker-dealers are all subject to some form of federal regulatory authority. This Part first explains the historical development of states' role as the primary regulator of the insurance. It then turns to a

17. JONATHAN R. MACEY & GEOFFREY P. MILLER, *COSTLY POLICIES: STATE REGULATION AND ANTITRUST EXEMPTION IN INSURANCE MARKETS* 1 (1993).

discussion of the competencies state regulators have developed in this capacity.

A. *Insurance Regulation and the States: A Brief History*

The states' role in insurance regulation is rooted in the Supreme Court's historical interpretation of the Commerce Clause. The insurance business was originally a local concern. The first firms to offer insurance policies were local and regional fire and life carriers, which were often formed as local stock companies or associations set up for the purpose of providing mutual protection for their members.¹⁸ As one would expect, these local entities were chartered by state governments.

As the business expanded and carriers began to operate across state lines, these local licensing regimes became a subject of dispute. In *Paul v. Virginia*, the Supreme Court considered a challenge to Virginia's licensure regime brought by an out-of-state individual who wished to operate as an insurance broker in Virginia.¹⁹ Paul, the plaintiff, challenged Virginia's decision not to allow him to operate in the state even though he complied with all of its regulatory requirements except a bond deposit provision.²⁰ The Court held that insurance contracts—which were the objects of the state regulations—were not articles of interstate commerce, and that the dormant Commerce Clause therefore did not limit state authority over them.²¹ Thus, insurance contracts were within the states' exclusive control, and states were accordingly free to use this power to regulate the business of insurance as they saw fit. This understanding of insurance contracts as a state

18. See Robert W. Klein, *The Insurance Industry and Its Regulation: An Overview*, in *THE FUTURE OF INSURANCE REGULATION IN THE UNITED STATES* 13, 13-16 (Martin F. Grace & Robert W. Klein eds., 2009).

19. *Paul v. Virginia*, 75 U.S. 168, 168-69 (1869).

20. *Id.* at 169.

21. *Id.* at 183. A second strand of the Court's holding related to the constitutional protections owed to corporations. The Court held that corporations are not citizens for constitutional purposes, and that states were therefore free to set licensing conditions as they saw fit. See *id.* at 177, 181.

concern persisted for nearly a century.²²

The Supreme Court revisited the issue in *United States v. South-Eastern Underwriters Association*.²³ That case arose from an indictment filed against South-Eastern Underwriters Association (“South-Eastern”) alleging violations of the Sherman Act. The indictment charged that the association had engaged in conspiracies in restraint of trade and attempted monopolization.²⁴ South-Eastern’s only defense was that it was not subject to the Sherman Act because its business—insurance—was not “trade or commerce” among the states.²⁵ South-Eastern argued that the entire business of insurance, including interstate transactions, was beyond the reach of the Commerce Clause and, therefore, the Sherman Act.²⁶

South-Eastern’s argument forced the Court to squarely confront—for the first time—whether Congress had the authority to regulate interstate insurance transactions. The Court characterized the prior cases on the subject, including *Paul*, as dealing with the related but distinct question of whether the Dormant Commerce Clause permitted the *states* to regulate interstate insurance transactions.²⁷ The Court held that the regulation of interstate insurance contracts was within the scope of the Commerce Clause power and that the Sherman Act applied to the insurance industry.²⁸

South-Eastern Underwriters threatened the structure of insurance regulation that had prevailed for nearly a century. In response to the decision, Congress quickly passed the McCarran-Ferguson Act, which substantially returned the allocation of regulatory authority to the pre-*South-Eastern*

22. See *N.Y. Life Ins. Co. v. Deer Lodge Cnty.*, 231 U.S. 495 (1913), *aff’g Paul*, 75 U.S. 168; *Hooper v. California*, 155 U.S. 648 (1895), *aff’g Paul*, 75 U.S. 168.

23. 322 U.S. 533 (1944).

24. See *id.* at 534-35 (summarizing the claims under sections 1 and 2 of the Sherman Act). In an interesting twist, the indictment alleged that the terms of the conspiracies were “policed,” *i.e.*, enforced, “by inspection and rating bureaus in five . . . states, together with local boards of insurance agents.” *Id.* at 536.

25. *Id.* at 536.

26. See *id.* at 537-38.

27. See *id.* at 544-45.

28. See *id.* at 553, 561.

Underwriters status quo.²⁹ The Act reflected Congress' judgment that the regulation of insurance should remain with the states: "[T]he continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such businesses by the several States."³⁰ In support of this judgment, the Act contained a unique reverse-preemption provision that nullifies federal statutes insofar as they conflict with state regulations.³¹ The basic structure put in place by McCarran-Ferguson persists to this day. Although Congress has removed some powers from the states,³² the vast majority of insurance regulation is state imposed.

B. *State Insurance Regulation Competencies*

State insurance regulations exhibit considerable breadth and complexity. Generally speaking, however, the regulations fit into three broad categories—solvency, rate regulation, and market conduct. A brief summary of the types of regulations states impose in these areas, as well as their justifications, is useful to set the stage for an exploration of health-insurance-specific regulations.

Protecting the insured public from the risks posed by insolvent insurers was one of the earliest state interventions into the insurance business, and the motivating force behind the creation of state insurance regulators.³³ The need for

29. See MACEY & MILLER, *supra* note 17, at 12; JOSEPH F. ZIMMERMAN, REGULATING THE BUSINESS OF INSURANCE IN A FEDERAL SYSTEM 27 (2010); see also *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429 (1946) ("Obviously Congress' purpose [in passing McCarran-Ferguson] was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance.").

30. McCarran-Ferguson Act § 1, 15 U.S.C. § 1011 (2012).

31. *Id.* § 1012(b).

32. For examples of where Congress has increased federal regulatory authority over health insurance, see *infra* Part IV.

33. See *Paul v. Virginia*, 75 U.S. 168, 168 (1869) (discussing Virginia's solvency regulations); EDWIN WILHITE PATTERSON, THE INSURANCE COMMISSIONER IN THE UNITED STATES: A STUDY IN ADMINISTRATIVE LAW AND PRACTICE 192 (1927).

solvency regulation is clear. Because they have no personal assets at risk, insurance company managers may not be properly incentivized to ensure that the carrier's financial reserves are sufficient to pay out any claims that members may make.³⁴ Put differently, managers will be tempted to draw on the carrier's financial reserves to cover their own salaries and perquisites, which may risk the carrier's ability to fulfill its policy commitments. Consumers, for their part, have little means of scrutinizing the solvency of different carriers.³⁵ By the time there is a readily observable solvency problem with a carrier, it may be too late for consumers to arrange alternate coverage. Thus, state solvency standards both reduce the incentive difficulty and counter the information asymmetry faced by consumers.

Solvency is regulated by the carrier's state of domicile.³⁶ Typically, states require that carriers hold specified amounts of fixed and risk-based capital, and regulate the kinds of investments carriers may make.³⁷ These regulations, however, do not appear to be especially burdensome—carriers tend to maintain capitalization levels well above regulatory minimums.³⁸ As a backstop in the event of a carrier's failure, states also maintain guaranty associations designed to honor the claims of insolvent carriers.³⁹

Rate regulation is the second major area of state insurance

34. See Klein, *supra* note 18, at 27.

35. See *id.*

36. See *id.* at 39. States vary considerably in terms of the relative proportion of in-state business that is written by carriers domiciled in other states. See *id.* at 20, 25 (reporting data on the percentage of each state's property-casualty and life-health premiums written by out-of-state carriers). Other states may provide supplemental requirements beyond those required by the carrier's state of domicile. Echoing the debate from the corporate chartering context, some have argued that the domicile system has precipitated a regulatory race to the bottom. See *id.* at 39. Note that some commentators have suggested that carrier solvency regulation is motivated in part by fear of panics that resemble those in other financial industries. It is not clear, however, that the business of insurance poses the same risk of panic found in other financial industries like banking. See *id.*

37. See *id.* at 39.

38. See *id.* at 18-19 & n.12.

39. See *id.* at 40.

oversight.⁴⁰ Interestingly, rate regulation also began as a solvency measure.⁴¹ Rate regulation works in tandem with solvency regulation, as it ensures that carriers charge premiums sufficient to cover their policy commitments.⁴² Today, many states also use rate regulation as a means of ensuring access to coverage—rate review allows carriers to make sure that rates are not “too high” and do not unacceptably discriminate between consumers.⁴³ Although the justifications for rate regulation are disputed,⁴⁴ proponents of these regulations defend them on the ground that free market price competition does not function properly in the insurance industry because consumer search costs are high.⁴⁵ The stringency of rate regulation, which generally involves the definition of permissible rating factors (*i.e.*, the variables that carriers may use to price their products) and direct state review of the actual rates charged by plans—tends to vary with the sophistication of the buyer.⁴⁶ Accordingly, rate regulation in some markets, like the market for individual health insurance, is much more stringent than in others, such as the market for commercial liability policies.

The third major area of state insurance regulation relates to the market conduct of insurers. Rules in this area encompass the approval of policy forms and terms, restrictions on marketing content, and claims processing and adjustment.⁴⁷ Importantly, these regulations also insure insurance agents and brokers, which are an important distribution channel.⁴⁸ The justifications for market-conduct regulation are familiar. The

40. The Supreme Court upheld the constitutionality of state rate regulations in *German Alliance Insurance Co. v. Lewis*, 233 U.S. 389 (1914).

41. See TOM BAKER, *INSURANCE LAW AND POLICY* 639 (2d ed. 2008).

42. See *id.*; see also Klein, *supra* note 18, at 28-29.

43. See ZIMMERMAN, *supra* note 29, at 23.

44. See Robert E. Litan & Phil O'Connor, *Consumer Benefits of an Optional Federal Charter: The Case of Auto Insurance*, in *THE FUTURE OF INSURANCE REGULATION IN THE UNITED STATES*, *supra* note 18, at 145, 148-62 (assessing the impact of certain states' rate deregulation programs on consumers).

45. See Klein, *supra* note 18, at 29.

46. See *id.* at 40-41.

47. See Klein, *supra* note 18, at 30.

48. See *id.* at 41.

regulations are intended to counter the effects of information asymmetries, consumer financial illiteracy, and the superior bargaining position of carriers.⁴⁹

To summarize, more than 150 years of state insurance regulation has left states with a set of core regulatory competencies that apply, generally speaking, across all lines of insurance. Over roughly the past sixty years, these core regulatory functions have been adapted and applied to the special problems posed by health insurance. The next Part explores these health-specific regulations.

III. State Health Insurance and HMO Regulation before the ACA

States have taken the lead role in regulating health insurance plans since they became common in the 1930s. From the outset, state regulation of health plans has sought to balance the competing aims of making health coverage affordable and ensuring that it is widely available—even to those whose health status makes them expensive to insure. Achieving these aims is not a straightforward task. Over time, states have developed rules that regulate nearly every aspect of the health insurance business, from the pricing of plans, to how they may be sold, to what they must contain. The tapestry of state regulations shows that while states agree on the basic mechanisms used to regulate plans, they disagree as to precisely how much regulation is required to create acceptable health plan markets.

This Part highlights, in broad terms, the depth and diversity of state health plan regulation. The goal is not to provide a comprehensive description of the regulatory landscape, but rather to highlight the intricacy and diversity of state regimes. It is important to understand the regulatory diversity in this area, because it represents precisely what is

49. *See id.* at 30 (discussing these problems in the context of property, life, and casualty insurance); *see also* Patricia A. Butler, *The Current Status of State and Federal Regulation*, in *REGULATING MANAGED CARE: THEORY, PRACTICE, AND FUTURE OPTIONS* 29, 32-33 (Stuart H. Altman, Uwe E. Reinhardt, & David Schactman eds., 1999) (discussing these issues in the health insurance context).

valuable about a state-based regulatory system. It encourages regulatory experimentation, which is particularly useful in the health insurance context because of the zero-sum tradeoff between cost, quality of care, and access to care. And it affords both carriers and consumers a degree of choice. Carriers can choose not to do business in states with overly burdensome regulatory schemes. Consumers also benefit, in that it is much easier to influence local regulators' actions than to influence national health care policy. As subsequent parts of the Article make clear, the ACA threatens this diversity.

The discussion in this Part begins with a brief history of the development of health insurance and early state regulatory approaches. It then explains the institutional structure of state health plan regulation before turning to the substance of the regulations themselves. It concludes with a brief discussion of the merits of state-based regulation.

A. The Emergence of Health Insurance and Its Early Regulation

Health insurance is a relatively recent phenomenon. It was unusual before 1930, and only became widespread after World War II.⁵⁰ Accordingly, the regulatory regime governing other lines of insurance was in place well before health insurance became a significant regulatory concern.⁵¹ As is the case with

50. BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 195-96 (4th ed. 2001). In the early 1930s, health care costs began to rise significantly in response to improvements in care quality and increasing physician market power. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 258-60, 295 (1982). Significantly, these cost increases did not affect all patients equally. See *id.* at 259-60. Those who faced hospitalization or other serious illnesses faced significant expenses, sometimes amounting to 30 to 50 percent of their annual income. See *id.* at 260. Those in better health, however, incurred only a fraction of this cost. Health insurance offered a solution to this high variation in expenses by providing a means to spread the risk of health care costs across the population. See *id.* at 258-60.

51. The development of health insurance lagged that of other forms of insurance partly because of the high costs, adverse selection, and significant moral hazards associated with health insurance. See STARR, *supra* note 50, at 294. Carriers partially solved these problems by moving to a model of employer enrollment, which allowed them to secure a larger risk pool. See *id.*

other insurance products, the structure of health insurance regulation is in part a function of the product's historical development. Early health insurance plans closely resembled traditional forms of indemnity insurance—consumers would pay a premium in exchange for a promise that the carrier would reimburse them for certain expenses.⁵² In these early plans, carriers exercised no oversight over consumers' decisions to seek care, and did not contract directly with providers.⁵³ Perhaps unsurprisingly, given their similarity to other lines of insurance, states regulated these early plans much like other indemnity products.⁵⁴

This early regulatory regime distinguished between Blue Cross and Blue Shield plans—which were hospital-sponsored and physician-sponsored health plans—and plans offered by commercial health insurers.⁵⁵ This distinction reflected differences in the way these entities initially priced their products; the “Blues” plans used community rating,⁵⁶ while commercial carriers used experience rating.⁵⁷ This classification persists, in varying forms, in some modern state regulatory regimes.⁵⁸

During the 1970s, a new form of health insurance

52. 3 STEVEN PLITT ET AL., COUCH ON INSURANCE § 1:7 (2010); *see* STARR, *supra* note 50, at 291-92.

53. *See* STARR, *supra* note 50, at 291.

54. *See id.* at 297 (discussing New York's decision to regulate hospital service plans like insurers).

55. *See id.* at 297, 306-07 (discussing Blue Cross plans' efforts to secure exemption from general insurance regulations like reserve requirements, and the emergence of physician-led Blue Shield plans in response to restrictive state regulation of cooperative health plans).

56. Community-rated policies are priced based on the expected claims of the entire pool of those insured. *See id.* at 329. Experience-rated policies are priced based on the claims (actual or expected) of each individual member of the risk pool. *See id.*

57. FURROW ET AL., *supra* note 50, at 195-96. Under this regime, the Blues plans received more favorable regulatory treatment, but were subject to special rules of incorporation that limited their activities. *See id.*; *see also* STARR, *supra* note 50, at 298, 328-29 (cataloging the spread of Blues-specific regulation, and describing its effect on the Blues' ability to compete with commercial carriers). Note that by the end of the 1950s, Blues plans had also begun to use experience rating. *See* STARR, *supra* note 50, at 330.

58. *See, e.g.*, MICH. COMP. LAWS ANN. § 550.1201 (West 2013) (exempting “nonprofit health care corporations” from general insurance laws as part of a separate regulatory scheme applicable to these entities).

emerged. Health maintenance organizations (“HMOs” or “managed care plans”) gained popularity following the passage of the Health Maintenance Organization Act of 1973.⁵⁹ The economic model of HMO plans differs markedly from that of indemnity plans. In an HMO plan, the consumer pays the carrier a fixed fee up-front, and the carrier then arranges and directly pays for all covered care that patient requires.⁶⁰ Importantly, HMO plans perform a number of other functions designed to control the cost of the care they provide. First, they play a gatekeeping role, often termed “prior authorization.” Prior authorization programs require that patients seek the plan’s approval before receiving care.⁶¹ This reduces the significant moral hazard problems that would arise if patients could freely consume care at no marginal cost to themselves. Second, HMO plans generally maintain a limited network of providers. By agreeing to channel their members to these providers, the plans are able to secure concessions in the price of care.⁶² The care management functions pioneered by HMOs represent the biggest difference between health insurance and other forms of insurance, which led some states to create separate regulators for health plans.

B. *The Institutional Structure of Modern Health Plan Regulation*

States have adopted different approaches to the institutional design question of whether to consolidate the regulation of health plans and other forms of insurance in a single agency.

Many states choose to vest regulatory authority over

59. 42 U.S.C. §§ 300e to 300e-14a (2012); see FURROW ET AL., *supra* note 50, at 196.

60. See Jacob S. Hacker & Theodore R. Marmor, *How Not to Think about “Managed Care”*, 32 U. MICH. J.L. REFORM 661, 666-75 (1999), for a discussion of the relationship between HMOs and other forms of health insurance.

61. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 627-31 (5th ed. 2004) (explaining various forms of utilization controls used by managed care organizations) [hereinafter FURROW ET AL., *HEALTH LAW*].

62. See FURROW ET AL., *supra* note 50, at 198, 201.

health plans in the state insurance commissioner.⁶³ Means of selecting insurance commissioners vary significantly by state. Eleven states elect their insurance commissioners.⁶⁴ In twenty-nine states, the insurance commissioner is a gubernatorial appointee, and in the remaining states, a subordinate executive official or committee chooses the commissioner.⁶⁵ Some states require that insurance commissioners have prior experience in the business of insurance.⁶⁶ The status and importance of insurance commissioners relative to other executive branch officials also varies by state. There is wide variation in the size and budget of state insurance departments.⁶⁷

As an alternative to vesting authority to regulate health plans with the insurance commissioner, some states have a separate agency charged with this responsibility.⁶⁸ Usually called departments of managed care or health, the directors of

63. *See, e.g.*, 20 ILL. COMP. STAT. ANN. 1405/1405-5 (LexisNexis 2013) (granting the insurance commissioner authority to execute and administer all laws under chapter 215 of the Illinois code, which includes health insurance and HMO regulation); MISS. CODE ANN. § 83-1-101 (West 2013) (conferring “presumed” jurisdiction over “any person or other entity which provides coverage . . . for medical . . . expenses, whether such coverage is by direct payment, reimbursement, or otherwise” to the State Department of Insurance); TEX. INS. CODE ANN. §§ 31.002, 843.151 (West 2013) (granting the insurance department regulatory authority over the business of insurance generally and HMOs specifically).

64. *See* ZIMMERMAN, *supra* note 29, at 42; *see also* 1 NAT’L ASS’N OF INS. COMM’RS, 2011 INSURANCE DEPARTMENT RESOURCES REPORT 2 (2012), *available at* <http://naic.softlinkliberty.net/liberty/libraryHome.do> (search “insurance department resources report”). For a summary of the debate about the propriety of electing versus appointing insurance commissioners, *see* JUSTIN L. BRADY ET AL., *THE REGULATION OF INSURANCE* 65-66 (1995).

65. *See* ZIMMERMAN, *supra* note 29, at 42; *see also* BRADY ET AL., *supra* note 64, at 64.

66. *See, e.g.*, TEX. INS. CODE ANN. § 31.023 (West 2013).

67. *See* BRADY ET AL., *supra* note 64, at 74-77.

68. *See, e.g.*, Knox-Keene Health Care Services Plan Act of 1975, CAL. HEALTH & SAFETY CODE §§ 1341, 1345(f) (Deering 2013) (creating the Department of Managed Health Care, charged with regulating “[a]ny person who undertakes to arrange for the provision of health care services . . . , or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge”); *see also* 40 PA. CONS. STAT. ANN. §§ 991.2102, 991.2181 (West 2013) (allocating shared authority for the regulation of health plans to the Departments of Insurance and Health); R.I. GEN. LAWS ANN. §§ 23-17.13-2 to 23-17.13-4 (West 2013) (conferring authority to regulate health plans on the department of health).

these departments are appointed officials.⁶⁹

C. *The Substance of State Health Plan Regulation*

Health insurance is a heavily regulated industry. States impose a wide range of rules and restrictions on insurers' conduct, and even before the ACA, insurers were also subject to a number of federal statutes.⁷⁰ Broadly speaking, state regulations of health insurers can be grouped into four categories: rules affecting underwriting and rating practices, rules governing market conduct, rules regulating the content of plans (including coverage requirements, provider contracting requirements, and regulation of utilization management techniques), and rules applicable to insurance agents and other producers. This section will explain the substantive content of each of these sets of state regulations, drawing on the regimes of several states as examples.

1. Health Plan Regulation and Group Size

State regulation of health plans varies by the size of the insured group.⁷¹ State rating regulation, for example, is most stringent in the market for "small-group" and individual health plans. Small-group plans are typically defined as those offered to employers with between two and fifty enrolled employees.⁷² Individual plans are those available for purchase directly by consumers, and offer coverage only for an individual and his or her family.

There are a number of reasons why states regulate the small-group and individual markets more stringently. First, because small groups have fewer members, it is more difficult

69. See, e.g., CAL. HEALTH & SAFETY CODE § 1341; 71 PA. CONS. STAT. § 67.1.

70. See *infra* Part IV.

71. Since most health insurance plans are employer provided, groups are typically composed of a given employer's employees.

72. See, e.g., CAL. HEALTH & SAFETY CODE § 1357(l)(1); CONN. GEN. STAT. ANN. § 38a-564(4) (West 2013); 215 ILL. COMP. STAT. ANN. 5/351B-3 (West 2013); MD. CODE ANN., INS. § 31-101(z)(1) (West 2013); TEX. INS. CODE ANN. § 1501.002(14) (West 2013).

for carriers to spread the risk of loss across the group. One chronically ill employee can incur significant enough medical expenses so as to make the entire employee group unprofitable for the carrier. Accordingly, left to their own devices, carriers would have a very strong incentive to aggressively price discriminate between small groups. Doing so would allow them to charge sicker employees more than their peers, or, perhaps more likely, perhaps setting rates so high as to make coverage unaffordable for the group.

A similar dynamic is present in the individual market. If carriers were to price their individual health plans to accurately reflect the health risk of each potential purchaser, many individuals would be excluded from the market. Carriers would have no reason to offer an affordable plan to a sick individual, preferring instead to focus on healthier consumers. Accordingly, state regulations in the individual market attempt to force carriers to distribute health risks across the entire pool of individual policyholders as a means of facilitating access. In sum, in both the small-group and the individual markets, allowing carriers to rate their products as they wish would have an adverse effect on access to health coverage,⁷³ and most states have thus intervened to prevent this outcome.⁷⁴

A second reason state regulation is more stringent in the small-group context is that federal law effectively preempts state regulation of larger group plans. Once a group reaches a certain size—typically around 250 members—it becomes economical for the group to self-insure.⁷⁵ Self-insuring employers simply collect premiums from their employees, and pay for losses with corporate funds. These employers generally contract with an insurance carrier or a third-party administrator to provide claims processing and other services,

73. See FURROW ET AL., *supra* note 50, at 261.

74. Note that not all states have imposed rating restrictions, and the content of the restrictions varies considerably from state-to-state. See *infra* note 93.

75. See KAISER FAMILY FOUND. ET AL., EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY 167 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf> (reporting that 81 percent of firms with more than two hundred employees are at least partially self-insured).

and may contract with an insurance carrier to provide coverage for catastrophic losses. ERISA preempts state regulation of these self-insurance arrangements, effectively clearing states from the field.⁷⁶

2. Restrictions on Rating and Underwriting

States play a significant role in determining the pricing of health insurance products through their regulation of rating and underwriting. Rating is the process by which an insurance carrier assesses the risk involved with issuing a given type of policy.⁷⁷ When rating a policy, the carrier assesses the effect that policyholder attributes are likely to have on the medical expenses the policyholder is likely to incur. For example, the carrier will calculate how much more it is likely to pay in claims to cover a sixty-five year old versus a twenty-five year old. At the end of the rating process, a carrier's actuaries will have developed a baseline premium for a given policy, along with a set of adjustments associated with the specific attributes of the policyholder. Underwriting is the process of soliciting information about a prospective policyholder, and using this information to calculate an individual premium based on those rating factors. Together, rating and underwriting establish the price of a given policy.

Virtually every aspect of small-group rating is subject to state regulation. Most broadly, many states dictate that carriers must use community rating rather than experience rating for small-group products.⁷⁸ That is, carriers must calculate the expected losses, and consequently the premium, based on the claims experience of all the small groups they cover, not based on any one small employer group. This rule

76. *See infra* Part IV.B.

77. *See* PLITT ET AL., *supra* note 52, at § 1:3.

78. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1357.13 (Deering 2013); CONN. GEN. STAT. ANN. § 38a-567(5) (West 2013); MD. CODE ANN., INS. § 15-1205 (West 2013); N.J. STAT. ANN. § 17B:27A-25 (West 2013); N.Y. INS. LAW § 3231(a)(1) (McKinney 2013); *cf.* TEX. INS. CODE ANN. §§ 1501.202 to 1501.205 (West 2013) (implementing a similar system whereby carriers establish a limited number of “classes of business,” not based on group size, calculate an “index rate” for each, and then are allowed to charge rates to individual groups that vary by a fixed percentage from the index rate).

has the effect of spreading claims risk across all employer groups enrolled in a given product, rather than only across a single employer's employees.⁷⁹ Not all states, however, require community rating, and the specific rules vary between the states that do.⁸⁰

States also impose an overall cap on the profitability of small-group health plans. The most common means of imposing such a cap is the imposition of a minimum "medical loss ratio." This ratio is effectively a cap on the plan's gross margin; it dictates that the plan must pay out a certain percentage of its premiums in the form of reimbursement for medical care. As discussed in more detail below, although the ACA mandates that states impose minimum medical loss ratios, such regulations were common before Congress passed the ACA.⁸¹

Beyond specifying rating methods and minimum medical loss ratio, states impose a grab bag of other restrictions on rating practices designed to make coverage more broadly affordable. These measures vary considerably from state to state. The following paragraphs draw on California's Knox-Keene Health Care Services Plan Act to illustrate the depth typical of state rating regulation. Note, however, that California is not perfectly representative of other states given the diversity of approaches from state to state.

79. Community rating is not, however, a panacea for the access problems that plague health insurance markets. While it makes coverage more affordable for certain high-risk individuals, it also increases the cost of coverage for all individuals in the risk pool. Therefore, it has the effect of preventing those who cannot bear these higher costs from obtaining coverage. This conundrum is one of the concerns that motivated the ACA.

80. See *Small Group Health Insurance Market Rate Restrictions*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/small-group-rate-restrictions/> (last visited Feb. 8, 2014) [hereinafter *Small Group Rate Restrictions*].

81. See, e.g., FLA. STAT. ANN. § 627.411 (West 2008); MINN. STAT. ANN. § 62A.021 (West 2013); N.J. STAT. ANN. § 17B:27A-25(g)(2) (West 2013); N.Y. INS. LAW § 3231 (McKinney 2013). Before the passage of the ACA, California imposed an effective cap on the profitability of health plans by capping administrative expenses—which include salaries—as a percentage of premium. See CAL. HEALTH & SAFETY CODE § 1378 (West 2008). California currently mandates that plans offered to small groups have a medical loss ratio of at least 80 percent. See CAL. HEALTH & SAFETY CODE § 1367.003(a)(2) (West 2013).

In addition to requiring community rating,⁸² California imposes the following restrictions on small-group rating. First, the price charged to a given group may be only 10 percent higher or lower than that charged to other small groups enrolled in the same plan.⁸³ This 10 percent variation, in turn, may only be dictated by the age of the plan members, their geographic location, their family composition (*i.e.*, whether they have dependents and spouses), and the employees' benefit choices.⁸⁴ Even within these permissible rating factors, carriers are limited in how they may use the factors to adjust premiums. Adjustments based on age must be made using specified age bands, and carriers may only make family-size adjustments based on marital status and number of children.⁸⁵ For geographic adjustments, carriers are allowed to define nine regions within California, which must be of a certain minimum size, and may only adjust premium rates based on these nine regions.⁸⁶ Moreover, carriers may adjust the risk premium associated with each of these factors only once every six months.⁸⁷ These rating restrictions apply to both new business and renewals. Price increases upon renewal may not exceed 10 percent, and carriers may make such adjustments only once per year.⁸⁸ Plans must disclose all risk-based adjustments to the employer.⁸⁹ Lastly, any rate changed must be filed with the state Department of Managed Care sixty days before of taking effect.⁹⁰ The Department has the power to review the rates for compliance with the law, may reject noncompliant rate changes, and may also take limited actions against rate changes it deems "unjustified."⁹¹

In sum, California exercises a fine degree of control over

82. *See* CAL. HEALTH & SAFETY CODE § 1357.13.

83. *See id.* § 1357.12.

84. *See id.* § 1357(k).

85. *See id.* § 1357(k)(1)-(2).

86. *See id.* § 1357(k)(3).

87. *See id.* §§ 1357(h), 1357.12(3).

88. *See id.* § 1357.12(b).

89. *See id.* § 1357.14(a).

90. *See id.* § 1385.03(a)(1).

91. *See id.* § 1385.11. The statute empowers the Department to post information about "unjustified" rate increases to its public website, and must report such "unreasonable" increases to the state legislature. *See id.*

pricing in the small-group market. This regulation increases the availability of affordable coverage to small groups, but comes at the cost of reduced price competition and, consequently, higher premiums for many groups. This degree of regulation is typical. California has similarly stringent (if not more so) standards governing the individual market.⁹² Other states maintain similar regimes designed to increase availability by forcing carriers to spread risk.⁹³ Importantly, however, states differ in terms of *how* carriers are expected to spread claims risk across small groups. Illinois, for example, allows carriers to define classes of small employers based on how the carrier markets its plans, and carriers are permitted to rate these classes separately.⁹⁴

3. Restrictions on Market Conduct

In addition to regulating the pricing of health plans, states impose broad restrictions on how carriers may sell their plans. Generally speaking, these market-conduct rules specify the terms on which carriers must make their plans available to employers and the general public, the means by which carriers market their plans, and the circumstances in which carriers may terminate or refuse to renew coverage.

California's market-conduct regulations for small-group plans again provide an instructive example. Carriers must market their plans to all small employers in their service area;⁹⁵ they may not, for example, focus their marketing efforts

92. *See id.* §§ 1399.801 to 1399.818.

93. For examples of small-group rating regulation, see CONN. GEN. STAT. ANN. § 38a-567 (West 2013); 215 ILL. COMP. STAT. ANN. 93/1-93/99 (West 2013); N.J. STAT. ANN. § 17B:27A-25(a)(3) (West 2013); N.Y. INS. LAW § 3231 (McKinney 2013); *see also Small Group Rate Restrictions*, *supra* note 80 (summarizing small-group market rating restrictions by state). For examples of individual market rating restrictions, see CONN. GEN. STAT. ANN. § 38a-481; 215 ILL. COMP. STAT. ANN. 97/25, 97/50; N.J. STAT. § 17B:27A-25(a)(3); *see also Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/individual-market-rate-restrictions/> (last visited Feb. 8, 2014) (summarizing individual market rating restrictions by state).

94. *See* 215 ILL. COMP. STAT. ANN. 93/20, 93/25.

95. *See* CAL. HEALTH & SAFETY CODE § 1357.03(a)(1).

on certain industries. Nor can carriers circumvent this rule by contracting with third parties tasked with soliciting business based on designated characteristics,⁹⁶ or by encouraging undesirable clients to seek coverage elsewhere.⁹⁷ Similarly, all plans that the carrier offers to small groups must be made available to all employers.⁹⁸ Once a small employer applies for coverage, the carrier is obliged to provide it so long as the employer agrees to offer the benefits to all its employees, agrees to make payments, agrees to inform employees of enrollment periods, and certifies that its employees reside in the service area.⁹⁹ Moreover, carriers must use the same employee contribution requirements, copays, and premiums for all small-group plans.¹⁰⁰ Plans are also subject to disclosure requirements, both to the employer and to the state.¹⁰¹

In addition to the market-conduct requirements that apply at the level of the sponsoring employer, carriers are subject to restrictions that apply at the level of the individual plan member. California's regulation of the small-group market establishes a general rule that once a carrier offers coverage to an employer group, it must cover all the members of that group that elect to join the plan.¹⁰² In other words, carriers cannot set eligibility rules based on an employee's health status, preexisting conditions, past claims experience, genetics, or disabilities.¹⁰³ In addition to these health-status restrictions, carriers cannot permanently exclude employees from a plan based on their failure to join during an annual enrollment period, although they may exclude them for that year.¹⁰⁴ Other states have similar rules.¹⁰⁵

96. *See id.* § 1357.03(e).

97. *See id.* § 1357.03(d).

98. *See id.* § 1357.03(a)(2).

99. *See id.* § 1357.03(c); *see also* MASS. GEN. LAWS ANN. ch. 176G, § 6A (West 2013).

100. CAL. HEALTH & SAFETY CODE § 1357.03(b).

101. *See id.* § 1357.14 (outlining disclosure requirements that plans must make to prospective purchasers); *id.* § 1357.03(b) (mandating disclosures to the state regulator).

102. *See id.* § 1357.03(f).

103. *See id.* §§ 1357.03(f), 1357.05 to 1357.06.

104. *See id.* § 1357.07.

105. *See, e.g.,* MD. CODE ANN., INS. § 15-1208.1 (West 2013); TEX. INS.

These market-conduct restrictions essentially impose an equal treatment requirement on carriers, such that if they are to enter a market at all, they must be willing to deal on equal terms with all those who seek coverage. Thus, while rating regulations assure that care is relatively affordable to those who have health conditions, the market-conduct restrictions ensure that carriers cannot avoid covering sicker individuals through marketing tactics or eligibility requirements. In sum, market-conduct rules form an important component of states' efforts to ensure access to health plans.¹⁰⁶

4. Regulation of Plan Coverage

The scope of health plans' coverage is another area of significant state regulatory attention. States generally define a menu of health services that plans must cover, and they also impose rules governing provider access and restricting the means by which plans can act as gatekeepers to care.

Turning again to California's small-group market regulations, the state defines a set of "basic health services" that must be included in all small-group plans. The scope of these basic services is actually quite broad.¹⁰⁷ An accompanying regulation elaborates these basic requirements, specifying to a fine degree of detail exactly what the plans must cover.¹⁰⁸

CODE ANN. § 1501.156 (West 2013).

106. Here again, however, there is a tradeoff associated with these rules. By requiring carriers to issue policies to all who seek coverage, market-conduct restrictions raise the cost of doing business in a market. At the margin, these rules may make certain markets unprofitable, and some carriers may decline to offer any coverage in these areas. Under these circumstances, consumers will have fewer choices and may pay higher premiums due to lack of competition. The ACA's universal guaranteed-issue provision is partly an attempt to solve this problem. *See* 42 U.S.C. § 1396b-1 (2012).

107. *See* CAL. HEALTH & SAFETY CODE § 1345(b) (defining "basic health services," which includes physician services, hospital inpatient services, ambulatory care, diagnostic services, home health services, preventative care, emergency health services, and hospice care); *id.* § 1357.08 (stipulating small-group plan coverage requirements).

108. *See* CAL. CODE REGS. tit. 28, § 1300.67 (2013). Consider, for example, the regulatory definition of inpatient hospital services:

Inpatient hospital services . . . shall mean short-term

Beyond prescribing *what* the plans must cover, states also specify *how* the plans must deliver that coverage. Two significant aspects of carriers' businesses are the subject of regulatory attention in this vein—provider contracting and utilization management.

States vary significantly in their approaches to regulating provider contracting. Most states employ some restrictions on the narrowness of a plan's provider network—they require that plans contract with some or all of the providers in the state. As explained by Jill A. Marsteller and her colleagues: "There are two broad categories of statutes that restrict selective contracting. Any willing provider (AWP) laws require plans to include in their networks all providers who agree to comply with plan conditions. Freedom of choice (FOC) laws limit plans' ability to channel patients to those selected providers."¹⁰⁹

Regardless of their choice of approach, state regulation in this area seeks to ensure that patients have access to a relatively wide set of providers, and to prevent carriers from squeezing providers out of the market through unduly restrictive contracting. These goals are somewhat in tension with those of the carrier. Contracting with providers is one of the primary means by which health plans control the cost of

general hospital services, including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early rehospitalization.

Id. § 1300.67(b); see also FURROW ET AL., HEALTH LAW, *supra* note 61, at 360 (summarizing typical coverage mandates).

109. Jill A. Marsteller et al., *The Resurgence of Selective Contracting Restrictions*, 22 J. HEALTH POL. POL'Y & L. 1133, 1138-43, 1152-53 (1997) (explaining differences between approaches, and surveying regulations in place in each state).

care.¹¹⁰ By offering to funnel their patients to a provider through network rules, plans are able to negotiate discounted rates for care.¹¹¹ While these discounts come at the cost of marginal patient choice, cheaper care is also in states' interests, as lower costs indirectly facilitate access to care.¹¹² Given this delicate balance, it is unsurprising that states have pursued a wide range of approaches in this area.¹¹³

In addition to requiring carriers to contract with certain providers, states impose restrictions on the terms of those contracts. The most common of these restrictions prevents health plans from devising incentive programs that induce providers to restrict the care they provide to patients.¹¹⁴ Some states, such as Illinois, have anti-retaliation provisions that prevent carriers from terminating provider contracts based on a provider's role in advocating for a patient's care.¹¹⁵ Another common rule restricts how often and under what circumstances plans can make changes to or terminate their provider contracts.¹¹⁶

Utilization management programs and other care determinations are also an important subject of state regulatory attention. These programs are the means through which plans ensure that consumers do not needlessly incur health care expenses. The most familiar utilization management mechanism is prior authorization, which requires

110. *See id.* at 1134.

111. *See id.*

112. *See id.*

113. *See id.* at 1154-55 (discussing why states have pursued differing approaches to provider contracting regulation).

114. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1348.6 (West 2013); *cf.* MD. CODE ANN., INS. § 15-112.2(b) (West 2013) (limiting carriers' ability to condition non-HMO provider contracts on providers' willingness to join HMO panels); MASS. GEN. LAWS ANN. ch. 176O, § 10 (West 2013); TEX. INS. CODE ANN. § 1301.068 (West 2013).

115. *See* 215 ILL. COMP. STAT. ANN. 134/35 (West 2013); *see also* MD. CODE ANN., INS. § 15-112(e), (g); MASS. GEN. LAWS ANN. ch. 176O, § 4; TEX. INS. CODE ANN. § 1301.066.

116. *See* 215 ILL. COMP. STAT. ANN. 5/368b; CAL. HEALTH & SAFETY CODE § 1375.7; CONN. GEN. STAT. ANN. §§ 38a-478h, 38a-479b (West 2013) (regulating the termination of provider contracts, changes to fee schedules, use of most-favored nation provisions, and payment disputes between carriers and providers); R.I. GEN. LAWS ANN. § 23-17.18-1 (West 2013); TEX. INS. CODE ANN. § 1301.057.

plan members to obtain referrals or other permission before seeking specialist care.¹¹⁷ Typical state regulation of utilization management programs requires that carriers adhere to written evaluation criteria that are developed with physician input.¹¹⁸ States also require that carriers have an internal appeal process in place for members to contest care determinations,¹¹⁹ and some require that members have recourse to independent reviews.¹²⁰ Lastly, some states also impose regulations that restrict the grounds upon which carriers may deny coverage. California, for example, does not allow carriers to deny payment for coverage received on an emergency basis after hours unless the plan maintains a hotline that a member can use to obtain a coverage decision within thirty minutes.¹²¹

5. Producer Regulation

Insurance producers—that is, brokers and agents who sell plans to individuals and employers—are another object of state regulatory attention. States require that agents and brokers obtain a license before engaging in insurance transactions.¹²² In California, obtaining a license requires, among other things, that the agent pass an examination,¹²³ participate in continuing education programs,¹²⁴ and pay a fee.¹²⁵ Once

117. See FURROW ET AL., *HEALTH LAW*, *supra* note 61, at 627-28.

118. See, e.g., CAL. HEALTH & SAFETY CODE §§ 1363.5, 1367.01; CONN. GEN. STAT. ANN. § 38a-591c(2); MASS. GEN. LAWS ANN. ch. 1756O, § 12(a); TEX. INS. CODE ANN. § 4201.151.

119. See CAL. HEALTH & SAFETY CODE § 1370.2; CONN. GEN. STAT. ANN. § 38a-591e; 215 ILL. COMP. STAT. ANN. 134/45; MD. CODE ANN., INS. § 15-10A-02; MASS. GEN. LAWS ANN. ch. 176O, §§ 12(e), 13; TEX. INS. CODE ANN. §§ 4201.351 to 4201.360.

120. See CAL. HEALTH & SAFETY CODE § 1374.30; CONN. GEN. STAT. ANN. § 38a-591g; 215 ILL. COMP. STAT. ANN. 134/45; MD. CODE ANN., INS. § 15-10A-03; MASS. GEN. LAWS ANN. ch. 176O § 14; TEX. INS. CODE ANN. §§ 4201.401 to 4201.403.

121. See CAL. HEALTH & SAFETY CODE § 1371.36.

122. See, e.g., CAL. INS. CODE § 1626 (West 2013); CONN. GEN. STAT. ANN. § 38a-702b; 215 ILL. COMP. STAT. ANN. 5/500-15; MD. CODE ANN., INS. § 10-103; MINN. STAT. ANN. § 60K.37 (West 2013); TEX. INS. CODE ANN. § 4001.101.

123. See CAL. INS. CODE § 1676.

124. See *id.* § 1749.31.

125. See *id.* § 1750.

licensed, agents are subject to restrictions regarding commission sharing,¹²⁶ and are subject to stringent fiduciary standards.¹²⁷ These regulations reflect the importance states have attached to the insurance distribution process as a means of consumer protection.

D. *The Benefits of State Health Insurance Regulation*

States are well suited to performing the regulatory functions described above. In general, allowing regulatory functions to remain at the state level promotes democratic accountability, creativity, and sensitivity to local interests. Beyond these general benefits that pertain to many industries, there is reason to think that health insurance in particular is an apt candidate for state regulation.

First, the regulation of health plans is inextricably intertwined with the cost, quality, and availability of health care. These connections are relatively easy to see: the rate that consumers must pay to have health insurance affects their ability to receive care. Similarly, the way insurance carriers compensate providers (and especially how they structure their contracts) affects providers' incentives to provide cost-effective, quality care. While these connections are not difficult to see, the relationship between them is complex, and fraught with tradeoffs. By relaxing provider network standards, for example, states may make health insurance more affordable at the margin (by allowing carriers to consolidate their networks and negotiate more aggressively with providers), but these cost savings may aggravate consumers, who may no longer be able to see the doctor of their choice. To the extent that these dilemmas have answers, they are difficult to discern in the abstract. Accordingly, the health care system as a whole benefits from states' willingness to experiment with different regulatory rules. Those that work can serve as a model for other states, and those that do not can be scrapped in favor of a

126. *See, e.g., id.* § 1724 (prohibiting agents from sharing commissions with members of the bar).

127. *See, e.g., id.* §§ 1734, 1734.5.

superior scheme from a neighboring jurisdiction.¹²⁸

Many of these tradeoffs, however, are not amenable to a single solution. Rather, the choices states must make between access, quality, and cost are simply value judgments. One electorate may wish to have richer minimum health benefits, either at the expense of greater cost or provider choice. Another may prefer a more modest minimum set of benefits, with the aim of allowing lower cost, high-deductible plans to be available for those who might otherwise forego coverage. Allowing states to make differing regulatory judgments regarding these kinds of questions affords consumers a greater opportunity to influence regulators' approaches to these tradeoffs.¹²⁹ It is also much easier for consumers to organize and influence a state insurance regulator than a national one.¹³⁰ This is especially true given the movement toward

128. This kind of regulatory cross-pollination is particularly likely to take place in the insurance-regulation context, as the National Association of Insurance Commissioners, a voluntary association of state insurance regulators, provides a mechanism for states to share ideas. See Randall, *supra* note 15, at 636-37.

129. See Martin F. Grace & Hal S. Scott, *An Optional Federal Charter for Insurance: Rationale and Design*, in *THE FUTURE OF INSURANCE REGULATION IN THE UNITED STATES*, *supra* note 18, at 55, 72-73 (arguing that a national insurance regulator would be less responsive to consumers than a local one).

130. The fact that many health plans are purchased by employers may amplify consumers' voices in this context. The employer provides a natural organizing point for consumers, who can readily coordinate lobbying efforts with similarly situated individuals. See William N. Eskridge, Jr., *Politics Without Romance: Implications of Public Choice Theory for Statutory Interpretation*, 74 VA. L. REV. 275, 285-87 (1988) (summarizing public choice literature on interest groups, which suggests that ease of organization is an important predictor of the success of an interest group). Relocation is another—albeit more extreme—means of influencing regulation at the state, but not the national, level. To the extent that the content of insurance regulation is important to consumers or employers who sponsor health plans, they are free to relocate to a state with rules they prefer. Of course, a state's health insurance regulatory policies are unlikely to dictate where an individual will choose to live or an employer will choose to locate. But these policies are likely to be correlated with other issues (such as overall levels of taxation and business climate) that may affect such choices. Accordingly, there is reason to think individuals and firms derive some benefit from state diversity in this regard. See Charles M. Tiebout, *A Pure Theory of Local Expenditures*, 64 J. POL. ECON. 416, 418-20 (1956).

elected state insurance commissioners.¹³¹

A second reason to think state regulation of health insurance is desirable relates specifically to rate regulation. State regulators, particularly in those states with elected insurance commissioners, have a desire to keep insurance rates as low as possible for consumers. The danger of this kind of rate regulation is that states may go too far, setting rates at a level that makes it impossible for carriers to operate profitably. If this happens in a system with a single regulator, carriers have few options. However, if a single state applies this kind of pressure to a carrier, the firm may exit that state's market.¹³² Since consumers have an interest in preventing such exits because they reduce the amount of choice in the market, the ability of carriers to exit a state provides a check against what might otherwise be an overwhelming popular demand for low rates.

A third reason to favor state regulation of health insurance is that many important aspects of health insurance markets are local. Much of the profitability of health insurers turns on the reimbursement agreements they make with providers. This contracting dynamic in turn depends on the relative concentration of providers in a market. For example, if one hospital dominates a small town, a health carrier will have little choice but to reach a reimbursement agreement with the hospital—consumers in that town would not want to have a health plan that didn't cover care in the only hospital. In this situation, the hospital would have a great deal of negotiating leverage over the carrier. State governments are better positioned to take stock of these dynamics when setting

131. See Macey & Miller, *supra* note 15, at 82-83 & n.282 (arguing that structural reforms such as the movement toward election of insurance commissioners and mandated consumer participation in rate setting may give consumers *too much* sway over state regulators). One scholar has argued that consumers "do not participate in insurance issues," and therefore the industry's influence over regulators is greater than that of consumers. See Randall, *supra* note 15, at 669-72. There is reason to think, however, that regulator-industry dynamic is different in the health insurance context. Health insurance issues are much more salient, and the fact that health benefits are employer provided makes it easier for consumers to organize.

132. See Randall, *supra* note 15, at 675-76; Richard A. Epstein, *Exit Rights and Insurance Regulation: From Federalism to Takings*, 7 GEO. MASON L. REV. 293, 300-04 (1999).

insurance regulation rules. Rules related to provider networks and provider-carrier contracting, in particular, may need to be adjusted to reflect the relative positions of providers and carriers in a given market.

The final reason to favor state health insurance regulation is that states have developed considerable institutional capabilities in the general area of insurance regulation. This experience suggests both that states may be more effective regulators (because of the benefits of this experience), and that they may be able to regulate in certain areas more efficiently than a federal regulator due to economies of scale (for example the regulation of insurance agents, who work in both the property-casualty and health markets).

In sum, states devote a significant amount of regulatory energy to managing the conduct of health plans. The broad outlines of these regulations are fairly consistent from state-to-state, which is unsurprising given states share a common goal of providing access to health coverage at reasonable cost. However, there is considerable diversity in the specific means states have chosen to meet those shared ends. These differences are consequential—they have a direct impact on the relative cost of plans. And at bottom, they reflect political economy judgments—some states are more willing than others to accept higher cost of care in exchange for broader coverage.¹³³ Moreover, state-based regulation of health insurance likely allows greater opportunity for consumers to influence their regulators, leads to more efficient rate regulation (by preserving exit options for carriers), encourages sensitivity to local interests, and allows states to capture synergies by consolidating regulation of health and other lines of insurance under a single authority.

By assigning primary regulatory responsibility to the

133. See Robert Detlefsen, *Dual Insurance Chartering: Potential Consequences*, in *THE FUTURE OF INSURANCE REGULATION IN THE UNITED STATES*, *supra* note 18, at 97, 103-08 (characterizing property-casualty insurance as a means of redistributing wealth to achieve social welfare goals, and noting the concomitant political salience of insurance regulation).

states, the current regulatory structure for health insurance suggests a judgment that it is worth preserving states' role in health insurance regulation. Even before passage of the ACA, however, states were not the exclusive regulators of health plans. As the next section explains, certain judgments about plan regulation have long been made at the federal level.

IV. Federal Regulation of Health Plans Before the ACA

Congress did not work from a blank slate when it enacted the ACA. The federal government has played a role in the regulation of health plans since the 1970s, beginning with the enactment of the Health Maintenance Organization Act of 1973 ("HMO Act").¹³⁴ Therefore, to understand the ways in which the ACA affects the state-federal balance of regulatory authority, one must understand the pre-ACA federal regulatory regime. This Part briefly explains the contours of three federal statutes that bear on the regulations of health plans: the HMO Act, the Employee Retirement Income Security Act of 1974 ("ERISA")¹³⁵ and the Health Insurance Portability and Accessibility Act of 1996 ("HIPAA").¹³⁶

A. *The HMO Act*

The HMO Act was the first significant federal statute to directly regulate health insurance. Congress hoped the Act would encourage the development of HMOs, which were seen as an effective way to manage the cost of health care.¹³⁷ As originally conceived, the HMO Act was something of a quid-pro-quo offer to HMOs: HMOs could elect to become federally registered, which entitled them to various forms of federal

134. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e to 300e-14a (2012).

135. Employee Retirement and Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C.).

136. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.).

137. See CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY 1267 (2d ed. 1998).

support (including access to a subsidized loan program), in exchange for compliance with a set of federal regulations.¹³⁸

Some of the rules in the HMO Act touched on traditional areas of state regulation. The Act established a minimum set of benefits that HMO plans are required to offer,¹³⁹ set rules regarding access to care, including both provider contracting and utilization management,¹⁴⁰ and also regulated HMO solvency.¹⁴¹ However, these rules were far from comprehensive, and appear to be geared primarily toward ensuring the integrity of the HMO Act's loan program. Consistent with this observation, the HMO Act did not include a preemption provision, and expressly contemplated that state regulations would continue to apply to HMOs, at least insofar as they did not prevent them from doing business in the state.¹⁴² Thus, while the HMO Act is significant in that it represents the federal government's first steps into substantive health insurance regulation, it did little to alter the balance of federal and state regulatory authority. The same is not true of ERISA, the next major federal statute affecting health plans.

B. *ERISA*

Prior to the passage of the ACA, ERISA was the most important federal statute in terms of defining the boundaries of state and federal regulatory authority over health plans. Given this import, it is odd that Congress did not intend ERISA to be a health care measure at all. Rather, ERISA was intended to prevent fraud and mismanagement in the administration of employee benefit schemes, particularly those intended to provide retirement income.¹⁴³ The statute's definition of

138. *See id.* at 1267-68.

139. *See* 42 U.S.C. § 300e(b)(1); *see also* 42 C.F.R. § 417.101 (1993).

140. *See* 42 U.S.C. § 300e(b)(3)-(4); *see also* 42 C.F.R. § 417.103.

141. *See* 42 U.S.C. § 300e(c); *see also* 42 C.F.R. § 417.120.

142. *See* 42 U.S.C. § 300e-10 (exempting HMOs that "cannot do business . . . in a State" from state regulations that "prevent it from operating as a health maintenance organization").

143. *See* HAVIGHURST ET AL., *supra* note 137, at 66; Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 *LOY. U. CHI. L.J.* 29, 30 (1999).

“employee benefit plan,” however, was broad enough to encompass certain types of employer-provided health coverage, namely plans established by employers that affect interstate commerce.¹⁴⁴

The significance of the fact that some health plans fall under ERISA relates to the Act’s sweeping preemption provision. As currently enacted, the provision provides that ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”¹⁴⁵ In other words, plans subject to ERISA are *not* subject to state insurance regulation. This general provision is, however, subject to an important qualification: “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance.”¹⁴⁶

The Supreme Court has interpreted the insurance regulation exemption to confine ERISA’s reach to self-insured employer health plans—that is, those where the employer, and not an insurance carrier, bears the financial risk of employees’ claims.¹⁴⁷ Under this reading of the provision, third-party administrators (often health insurance carriers) that assist employers with the administration of self-funded plans are also subject to ERISA. Thus, ERISA effectively exempts both

144. See 29 U.S.C. § 1003 (2012). This definition is subject to several exceptions, including a limited one for health insurers. See *id.* § 1003(b).

145. *Id.* § 1144(a).

146. *Id.* § 1144(b)(2)(A). This provision preserving state insurance regulation is in turn subject to a so-called “deemer” provision designed to ensure that the insurance regulation exemption does not swallow the general rule: “an employee benefit plan . . . shall [not] be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies.” *Id.* § 1144(b)(2)(B).

147. See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985) (“Plans may self-insure or they may purchase insurance for their participants. Plans that purchase insurance—so-called ‘insured plans’—are directly affected by state laws that regulate the insurance industry.”). Many employers who run self-funded plans purchase a form of reinsurance known as stop-loss coverage designed to protect the employer should plan expenses rise to catastrophic levels. See Edward Albuo Morrissey, *Deem and Deemer: ERISA Preemption Under the Deemer Clause as Applied to Employer Health Care Plans with Stop-Loss Insurance*, 23 J. LEGIS. 307, 311-13 (1997) (collecting cases). Courts have split over whether the stop-loss products, which closely resemble traditional forms of risk insurance, fall within the scope of ERISA’s preemption provision. See *id.*

employers who provide self-funded plans, along with any insurance company that the employer may hire to *administer* the self-funded plan, from the ambit of state regulation.¹⁴⁸

ERISA thus effectively carves the health insurance market into two distinct spheres with different regulators: federally regulated employer-funded health plans (primarily offered by large employers), and state-regulated “risk” plans (offered to smaller employers and individuals). As the language of ERISA’s preemption provision suggests, state regulators are virtually ousted from the self-funded market.

ERISA’s effect on the overall allocation of state and federal regulatory authority is significant. As of 2012, approximately 89.4 million Americans were enrolled in an employer-funded health plan.¹⁴⁹ This figure represents roughly one-third of the nonelderly (*i.e.*, non-Medicare-eligible) population in the United States.¹⁵⁰ While this still leaves the lion’s share of the insurable population—roughly 60 million people with risk-based group plans, 15 million people with individual plans, and 48 million uninsured individuals¹⁵¹—subject to state regulation, ERISA

148. In holding that an insurance carrier, Provident, was not subject to state regulation in its capacity as a third-party administrator of a self-funded health plan, the Ninth Circuit explained:

The primary features of an insurance contract are the spreading and underwriting of a policyholder’s risk There was no insurance contract or policy involved in [the employee’s] claim. Provident’s role in relation to the [Plan] and [the employee’s] claim was not that of an insurance company but was merely as an administrative overseer. Provident’s privilege to review the administrator’s determination of the amount of a claim and to defend or settle any action on a claim under the Plan does not require a finding that Provident was engaged in the business of insurance in relation to the Plan.

Moore v. Provident Life & Acc. Ins. Co., 786 F.2d 922, 926-27 (9th Cir. 1986) (citation omitted).

149. See KAISER FAMILY FOUND. ET AL., *supra* note 75, at 50, 161 (reporting that 149 million Americans had employer-sponsored health coverage, and that 60 percent of these individuals were enrolled in employer-funded plans).

150. See *id.* at 14.

151. See *id.* at 50; John Holahan & Megan McGrath, *Reversing the*

nonetheless creates a significant role for the federal government.

A curious aspect of ERISA's relation to health plans is that although it displaces state regulation, it imposes very little federal regulation of health plans. The statute contains a number of regulatory provisions, but they do not impose the kind of substantive restrictions on the health insurance business that are commonplace in state regulations.¹⁵² The statute's regulations reflect its orientation toward non-health insurance forms of employee benefits, such as pension plans. For example, the statute imposes restrictions on what employers may do with benefit plan funds,¹⁵³ and imposes fiduciary requirements on plan administrators.¹⁵⁴ Perhaps of more utility to health plan members, the statute provides a private cause of action that members can invoke to enforce the processing of claims.¹⁵⁵ While these provisions may have indirect effects on the management of health plans, one could not characterize them as substitutes for traditional state regulations, such as those that restrict plan rating or marketing.

ERISA does contain a handful of regulations specifically targeted at health insurance, but they are modest in scope, and were all added to the original statute by subsequent legislation. For example, provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")¹⁵⁶ require employers to allow employees to retain health coverage, at their own expense, following termination of their employment or other triggering events.¹⁵⁷ Other pieces of federal legislation have imposed mandates that employer-funded plans cover certain

Trend? Understanding the Recent Increase in Health Insurance Coverage Among the Nonelderly Population, KAISER COMM'N MEDICAID & UNINSURED 14 (Mar. 2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8264-02.pdf>.

152. See 29 U.S.C. §§ 1101 to 1112 (2012).

153. See *id.* § 1106.

154. See *id.* § 1104.

155. See *id.* § 1132(a).

156. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986).

157. See 29 U.S.C. §§ 1161 to 1168 (requiring employer-funded health plans to offer coverage, at cost, to employees who satisfy certain criteria).

types of care. These coverage requirements, however, are extremely limited—they apply only to certain maternity and newborn-care services, mental-health coverage, and mastectomies.¹⁵⁸ Significantly, there is no provision requiring that a plan cover a basic package of essential benefits. Lastly, as will be discussed further in the next section, HIPAA imposes several modest reforms related to portability and coverage of preexisting conditions.

Taken together, ERISA’s provisions result in what some commentators have termed a “regulatory vacuum.”¹⁵⁹ The statute displaces state regulation of employer-funded health plans, but does not impose comparable regulations of its own, leaving the self-funded employer market virtually free of the kind of regulation states typically impose in health insurance markets. The major post-ERISA federal forays into health insurance regulation—HIPAA and the ACA—have not altered this pattern, as they are primarily focused on the individual and small-employer markets.

C. *HIPAA*

The 1996 HIPAA statute, primarily known for the privacy standards it imposes on health providers, also contained several modest insurance market reforms.¹⁶⁰ These reforms, which apply to both the group “risk” markets and the individual market, were in some ways precursors to the rules in the ACA—indeed the ACA superseded many of them. The HIPAA rules cover some of the same subjects as the ACA, such as guaranteed issue requirements and preexisting condition exclusions, but their requirements are considerably less stringent.

158. *See id.* § 1185 (maternity and newborn care requirements); *id.* § 1185a (mental health benefits); *id.* § 1185b (benefits for reconstructive surgery following mastectomies); *see also* Strain & Kinney, *supra* note 143, at 43 (recounting the legislative history behind these provisions).

159. *See* Strain & Kinney, *supra* note 143, at 50. For a summary of criticisms that have been levied against ERISA on this score, *see id.* at 40; *see also* Morrissey, *supra* note 147, at 307.

160. *See generally* HIPAA, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.).

In the group market, HIPAA limits, but does not eliminate, carriers' ability to impose preexisting condition requirements.¹⁶¹ Specifically, the Act imposes a number of timing rules that limit the circumstances in which carriers may decline to cover a preexisting condition. For example, the prospective member must have received care for the condition within six months before applying for coverage.¹⁶² HIPAA also caps the length of time that the preexisting condition exclusion may apply.¹⁶³ And it prevents carriers from using patients' genetic information as a means of defining exclusions.¹⁶⁴ In a similar vein, the statute prevents carriers from using health status as an eligibility rule for coverage, or from charging higher premiums based on health risk.¹⁶⁵ These reforms are part of a broader set of rules intended to facilitate patient movement between health plans.¹⁶⁶

HIPAA contains a similar set of provisions affecting the individual market. Carriers were prohibited from declining to extend coverage in the individual market to prospective members who previously had qualifying coverage.¹⁶⁷ HIPAA also obliged individual market plans to renew coverage for all members that requested renewal, absent certain specified circumstances such as nonpayment of premiums, fraud, or termination of the plan.¹⁶⁸

These HIPAA market regulations bear a family resemblance to those contained in the ACA. But they are much more modest in scope. For example, the guaranteed issue provisions in both the group and individual markets are subject

161. *See* 29 U.S.C. § 1181 (2012).

162. *See id.* 1181(a)(1).

163. *See id.* § 1181.

164. *See id.* § 1181(b).

165. *See id.* § 1182.

166. *See, e.g., id.* § 1181 (requiring that plans allow certain individuals who lost other coverage to enroll at any time regardless of enrollment schedule, and imposing similar rules for dependent coverage).

167. *See* 42 U.S.C. § 300gg-41 (2012). This individual market guaranteed-issue provision was subject to an exception available to carriers able to show that accepting additional individual market members would impose an unacceptable stain on their financial reserves. *See id.* § 300gg-41(e) (referring to the first subsection (e), "Application of financial capacity limits").

168. *See id.* § 300gg-42.

to a number of exceptions, and neither applies uniformly to all prospective members. Perhaps more importantly, HIPAA's individual market rules were, in a sense, optional. Section 2744 of the Act contained a state waiver provision that exempted plans in states that had implemented an "acceptable alternative mechanism" from HIPAA's individual guaranteed issue requirement.¹⁶⁹ Among such permissible mechanisms were public solutions, including state-run high-risk pools.¹⁷⁰ Thus, states wishing to avoid the imposition of HIPAA rules on their private individual market carriers could satisfy the statute's requirements by other means. The group market reforms did not contain a waiver provision, but nonetheless preserved ample room for continued operation of state laws that did not prevent the application of the HIPAA rules.¹⁷¹ Therefore, the group market reforms did little to affect the federal-state regulatory balance beyond establishing a limited guaranteed issue requirement.

In sum, while Congress enacted several pieces of legislation that regulated private health insurance markets before the ACA, these statutes—with the exception of ERISA's (unintended) effects in the self-funded market—largely preserved the states' role as the primary regulator of insurance. The ACA, however, fundamentally altered that balance.

V. The ACA's Health Insurance Market Reforms

A significant portion of the ACA's 906 pages is devoted to health insurance market reforms. To understand how these reforms alter the balance of federal and state regulatory authority, it is necessary to understand both the substantive content of the Act's rules and the institutions charged with enforcing them. To that end, this Part first explains the role of

169. *See id.* § 300gg-44(a).

170. *See id.* § 300gg-44(b).

171. *See* 29 U.S.C. § 1191(a)(1) (2012) (“[T]his part shall not be construed to supersede any provision of State law which establishes . . . any standard or requirement solely relating to health insurance issuers . . . except to the extent that such standard or requirement prevents the application of a requirement of this part.”).

health insurance exchanges in the ACA's regulatory architecture. It then discusses the reforms that apply to all health plans, regardless of how they are sold, before turning to the regulations that specifically affect plans sold through the exchanges. It concludes with a brief discussion of the Act's provisions regarding multistate plans.

A. *The Role of Health Exchanges in the ACA's Regulatory Regime*

One of the signature provisions of the ACA is its creation of state-run health plan marketplaces, formally termed "American Health Benefit Exchanges."¹⁷² The exchanges are intended to be the primary means by which individuals and small groups purchase coverage under the ACA. The theory behind the exchanges is straightforward. They seek to simplify health plan purchasing decisions by marrying a streamlined presentation of plan choices with a centralized listing of qualified plans available in the state.¹⁷³ In addition to these consumer-facing attributes, Congress hoped that the exchanges would improve the functioning of the individual and small-group markets by increasing transparency and facilitating consumer choice.¹⁷⁴ The exchanges play a significant role in the regulation of insurance markets because, as discussed in greater detail below, the ACA empowers exchanges to impose or enforce a number of rules regulating the conduct of plans participating in the exchange.

Rather than establishing a single federal exchange, the drafters of the ACA opted to require the states to establish

172. See 42 U.S.C. § 18031(b) (2012). The Act includes separate provisions for small employers, which are to purchase coverage through the "Small Business Health Options Program (SHOP)." These provisions track those for the individual-market exchanges in relevant respects. See *id.*

173. See *Health Plan Information for Individuals and Families*, HEALTHCARE.GOV., <https://www.healthcare.gov/health-plan-information/> (last visited Feb. 8, 2014).

174. See TIMOTHY STOLTZFUS JOST, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 2 (2010), available at <http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>.

exchanges.¹⁷⁵ States' exchange plans are subject to review by the Department of Health and Human Services ("HHS").¹⁷⁶ As of March 7, 2013, HHS has approved twenty-five states' exchange plans.¹⁷⁷ Securing approval of an exchange required submission of an exchange "blueprint" to HHS by January 1, 2013.¹⁷⁸ HHS evaluated these submissions to determine whether the exchange would be able to carry out its required functions and to assess whether it would be able to do so by the applicable deadlines.¹⁷⁹ Importantly, if a state elected not to create its own exchange, or if it failed to submit its blueprint by the January 2013 deadline, the regulations stipulate that "HHS must (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State."¹⁸⁰

Although the ACA envisions that the exchanges will be the primary means by which consumers and small businesses purchase health coverage, the Act does permit the continued operation of other distribution channels.¹⁸¹ This provision

175. See 42 U.S.C. § 18031; see also 45 C.F.R. §§ 155.10, 155.110 (2012). The exchanges must be organized as a state agency or as a not-for-profit corporation. See 45 C.F.R. § 155.110(c). If the exchange is to be run by a nonprofit corporation, that organization must have "demonstrated experience on a State or regional basis in the individual and small-group health insurance markets and in benefits coverage," and cannot be a health insurance issuer. *Id.* § 155.110(a). An insurance agent, for example, would have "demonstrated experience" in health insurance markets, but is not a health insurer.

176. See *id.* § 155.105.

177. See Ctr. for Consumer Info. & Oversight, *State Health Insurance Marketplaces*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cciio.cms.gov/resources/factsheets/state-marketplaces.html> (last visited Feb. 8, 2014). HHS has approved single-state exchanges in the following states: California, Colorado, Connecticut, the District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. See *id.* HHS has approved partnership exchanges in an additional seven states: Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia. See *id.* These regional exchanges are authorized under a separate set of rules, but otherwise function similarly to a single-state exchange. See 45 C.F.R. § 155.140.

178. See 45 C.F.R. § 155.105(a).

179. See *id.* § 155.105(b).

180. See *id.* § 155.105(f).

181. See 42 U.S.C. § 18032 (2012).

allows insurance agents and brokers to continue to find coverage for individuals and businesses and leaves the regulation of these individuals to state authorities.¹⁸² Moreover, these intermediaries are permitted to enroll individuals and businesses in plans offered on exchanges.¹⁸³ They also are able to continue to market plans that are not deemed qualified to be offered on the exchange.¹⁸⁴ Thus, the ACA envisions two markets for health plans operating in parallel: the market for “qualified” plans, which may be sold through the exchange and other distribution channels, and the market for other plans, which may only be sold outside the exchange. However, even these “nonqualified” plans are subject to extensive regulation under the ACA.

B. *The ACA’s Universal Insurance Market Regulations*

As part of its general reform of health insurance markets, the ACA imposes a number of regulations that apply to all health plans, regardless of whether they are sold through the ACA exchanges. These provisions effectively federalize a portion of health plan regulation. Although the provisions do leave room for states to impose additional rules, particularly if the state rules are more stringent than those in the Act, they nonetheless significantly restrict states’ freedom to regulate rating, underwriting, and market conduct.

The most significant of the ACA’s universal regulations pertain to rating and underwriting. First, the Act sharply restricts how carriers may rate their plans. Specifically, the Act allows only four rating factors: family composition, age, geography, and tobacco use.¹⁸⁵ Even within these factors, the

182. *See id.*

183. *See id.*

184. *See id.* § 18032(d)(3)(B).

185. *See id.* § 300gg(a)(1)(B). The ACA also regulates how carriers may use these factors. For example, it stipulates that the variation in pricing for individuals of different ages may not exceed a ratio of three to one, and that HHS has authority to define the age bands carriers may use. *See id.* §§ 300gg(a)(1)(A)(iii), 300gg(a)(3). Similarly, the Act mandates that rates may not vary by more than 1.5 to 1 for tobacco use. *Id.* § 300gg(a)(1)(A)(iv). With respect to rating by geography, the Act requires states to define geographic regions for rating purposes, and grants the HHS Secretary the right to review

Act limits what carriers may do. Beyond limiting carriers to certain rating factors, the ACA also specifies that they must group all individual and small-group applicants in the same risk pool—that is, there must be a single set of rating factor adjustments for the entirety of the individual and small-group markets.¹⁸⁶ Lastly, the Act limits the extent to which employers may share costs with their employees.¹⁸⁷ Specifically, the Act caps deductibles and other employee contributions at specified dollar amounts.¹⁸⁸

The ACA also confers temporary authority on the HHS Secretary to review and approve any rate changes before they take effect.¹⁸⁹ Should the Secretary determine that a given rate increase is “unreasonable,” the Secretary “shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase.”¹⁹⁰ Moreover, the Act requires carriers to post rate-change information to their public websites.¹⁹¹ HHS will initially conduct this annual review process, but it will later be transferred to the states for ongoing administration.¹⁹² Even after this transition, however, HHS retains continuing responsibility to monitor rate changes.¹⁹³

One of the most high-profile market reforms in the ACA is

those areas and impose a substitute set of areas if the state’s efforts are deemed inadequate. *See id.* § 300gg(a)(2).

186. *See id.* § 18032(c).

187. *See id.* § 300gg-6(b).

188. *See id.* § 18022(c). These cost sharing limits do not apply to plans offered in the individual market. *See id.*

189. *See id.* § 300gg-94(a).

190. *Id.* § 300gg-94(a)(2).

191. *See id.* § 300gg-94(a)(2). This provision is one of a number of reporting requirements that apply to all health plans. *See also id.* § 300gg-15a (requiring that carriers operating outside the exchange provide the public with the information listed in 42 U.S.C. § 18031(e)(3)); *id.* § 300gg-15 (requiring carriers to provide benefit summaries, in a form specified by the HHS Secretary, to all members); *id.* § 300gg-17(a)(2) (requiring carriers to submit care quality reports to HHS); *cf.* Cass R. Sunstein, *Empirically Informed Regulation*, 78 U. CHI. L. REV. 1349, 1368-69, 1379-80 (2011) (championing the ACA’s various disclosure requirements as examples of best practices).

192. *See* 42 U.S.C. § 300gg-94.

193. *See id.* § 300gg-94(b)(2).

its “guaranteed issue” requirement, which obligates “each health insurance issuer that offers health insurance coverage in the individual or group market in a State [to] accept every employer and individual in the State that applies for such coverage.”¹⁹⁴ The guaranteed issue requirement fits closely with four other provisions: a guaranteed renewability requirement,¹⁹⁵ a bar on preexisting condition exclusions,¹⁹⁶ a bar on the use of lifetime benefit caps,¹⁹⁷ and a (duplicative) bar on health-based eligibility rules.¹⁹⁸ Taken together, these rules force carriers to accept groups and individuals that would otherwise have difficulty finding coverage due the poor health status of their members.¹⁹⁹

The ACA also sets a floor of minimum coverage that every health plan must provide. Specifically, it demands that plans sold in the individual or small-group markets offer an “essential health benefits package.”²⁰⁰ The Act defines the essential health benefits package to include coverage for services within ten general categories,²⁰¹ but does not mandate the specific services that must be offered. Rather, the Act requires that the HHS Secretary promulgate specific requirements by rule, with reference “to the scope of benefits provided [by] a typical employer plan.”²⁰² In addition to the essential health benefits requirements, the Act includes a number of other coverage rules related to specific types of

194. *Id.* § 300gg-1(a).

195. *See id.* § 300gg-2(a) (“[I]f a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.”).

196. *See id.* § 300gg-3.

197. *See id.* § 300gg-11.

198. *See id.* § 300gg-4.

199. Another widely reported coverage requirement imposed by the Act is a rule that employer-sponsored plans must extend coverage to employees’ dependents until they reach twenty-six years of age. *See id.* § 300gg-14.

200. *See id.* §§ 300gg-6, 18022.

201. The ten categories are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitation services, laboratory diagnostics, preventative care and disease management, and pediatric services. *See id.* § 18022(b)(1).

202. *Id.* § 18022(b)(2)(A).

care.²⁰³ To ensure that carriers do not circumvent these coverage requirements with unduly restrictive approval requirements, the Act mandates that carriers provide recourse to both internal and external appeals processes.²⁰⁴

Collectively, these rules will impose a significant cost burden on carriers, as they will be required to accept members regardless of health status, must offer them a minimum set of benefits, and are sharply restricted in their ability to charge premiums commensurate to these risks. Unsurprisingly, therefore, the Act also includes a number of provisions intended to address the financial strain that these rules impose on carriers.²⁰⁵

The Act sets up two transitional programs that apply from 2014 until 2016. First, the Act mandates that all self-funded employer plans—that is, those plans offered by large employers—pay a levy that is used to fund a reinsurance plan for the individual and small-group markets.²⁰⁶ The idea behind this reinsurance plan is that it will help stabilize premiums in the individual and small-group markets by providing support for carriers that experience catastrophic losses as a result of taking on high-risk members. Thus, the reinsurance provision is essentially a tax on employees of large companies that is used to fund the ACA’s care expansion. The second transitional program establishes so-called “risk corridors,” which redistribute profits and losses between carriers in the individual and small-group markets.²⁰⁷ Any carrier that runs a

203. *See, e.g., id.* § 300gg-19a(b) (barring the use of prior authorization requirements for emergency stabilization services, and mandating that carriers not impose higher costs on consumers for using out-of-network emergency services); *id.* § 300gg-19a(d) (prohibiting the use of prior authorization for certain gynecological services); *id.* § 300gg-13 (imposing specific preventative services coverage requirements).

204. *See id.* § 300gg-19 (requiring that carriers establish an internal review process, and either comply with a state external review process or develop one of their own if no state-run process exists).

205. It warrants mention that the Act also contains a temporary rule, in effect until the end of 2013, which is intended to deal with the opposite problem—that is, to penalize carriers whose plans are too profitable. *See also id.* § 300gg-18 (requiring carriers to issue consumer rebates for plans that have loss ratios below a certain threshold).

206. *See id.* § 18061.

207. *See id.* § 18062.

plan with a loss ratio below 97 percent must pay a percentage of its profits into the risk-corridor program.²⁰⁸ These profits will be used to compensate those carriers who suffer loss ratios above 103 percent.²⁰⁹

Beyond these temporary measures, the ACA requires states to institute risk-adjustment programs, where states transfer funds between plans based on their actuarial risks.²¹⁰ States must measure the state average actuarial risk for a given type of plan, and levy a fee against those plans with below-average risks, and compensate those with above-average risks.²¹¹

To summarize, the ACA sets a number of bounds on all health plans' ability to define plan benefits and set premiums. In aggregate, these provisions have the effect of forcing health plans to take on the risk associated with insuring all who seek coverage. While these regulations substantially duplicate or replace a significant portion of states' traditional regulatory prerogatives, they leave a number of areas of state regulation undisturbed. The ACA's universal regulations, for instance, do not place limits on plan's marketing techniques, provider contracting, or care management practices. Plans sold through the ACA's exchanges, however, are subject to more extensive regulation, which the drafters envisioned would be administered by the exchanges themselves.

C. *Regulation of Health Plans Sold Through ACA Exchanges*

Beyond providing a convenient means for consumers to

208. *Id.* § 18062(b)(2). Plans must pay 1.5 percent of their gross premium, less administrative expenses (the "target amount"), into the risk corridor program if their loss ratios are between 92 and 97 percent. If their loss ratios are below 92 percent, the plan must pay 2.5 percent of its target amount into the program, as well as 80 percent of profits above a defined amount. *See id.*

209. *See id.* § 18062(b)(1). If a plan's loss ratio is between 103 and 108 percent, the plan will receive a 50 percent reimbursement for losses above 103 percent. That is, if a plan experiences a loss ratio of 105, the program will pay the plan 1 percent of the target amount. Higher payouts are available for plans with loss ratios exceeding 108 percent. *See id.*

210. *See id.* § 18063.

211. *See id.* § 18063(a).

shop for health plans, the ACA exchanges also play a significant role in the regulation of health plans. The ACA delegates a substantial amount of regulatory authority to the exchanges, principally by giving exchanges the power to determine which plans may be sold on the exchange. As part of this power, exchanges have the responsibility to scrutinize each plan's benefits, premium, and network—all of which have traditionally been regulated by the states. This section will describe the role the exchanges play in the ACA's regulatory scheme. Part VI will explore the consequences this role has on states' regulatory authority.

1. Certification and Rate Review

Many of the exchanges' regulatory functions relate to the ACA's requirement that only "qualified health plans" ("QHPs") may be sold on the exchanges.²¹² To be certified as a QHP, a plan must: meet the minimum statutory certification criteria; provide the ACA's essential health benefits package; and be offered by a state-licensed health insurer that agrees to additional requirements.²¹³ The exchanges are responsible for certifying that plans meet these requirements.²¹⁴ In addition to verifying that the plans adhere to the statutory criteria, the ACA grants the exchanges broad discretion to approve or deny a certification application: "An Exchange may certify a health plan as a qualified health plan if [the plan meets the statutory requirements] and . . . the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State."²¹⁵

The ACA's statutory criteria for QHPs are phrased in

212. *See id.* § 18031(d)(2)(B)(i) ("An Exchange may not make available any health plan that is not a qualified health plan.").

213. *See id.* § 18021(a)(1); *see also id.* § 18031(e) (providing that the exchanges are responsible for making QHP certifications).

214. The exchanges also have authority to set the procedures that govern their certification processes. *See* 45 C.F.R. § 155.1010 (2012).

215. 42 U.S.C. § 18031(e). Exchanges also have authority to decertify plans as QHPs if they determine that the plan no longer meets the certification criteria. *See* 45 C.F.R. § 155.1080.

broad terms, and include a number of requirements of varying significance. QHPs must “meet marketing requirements,” not discourage enrollment by unhealthy individuals, “ensure sufficient choice of providers,” meet various performance criteria, employ a standard enrollment form, and report various quality metrics.²¹⁶

The statute explicitly contemplates that the criteria will be fleshed out through rulemaking, but the regulations provide little additional specificity. Significantly, however, they condition fulfillment of the statutory criteria on satisfaction of standards set by the exchanges. For example, the rule states that plans are not eligible to be certified if they do not comply with “any provisions imposed by the Exchange . . . that are conditions of participation . . . with respect to each of its QHPs,” or if the plan fails to adhere to the exchange’s certification process.²¹⁷ Similarly, the rules condition certification on compliance with the Exchange’s network adequacy standards,²¹⁸ termination of coverage requirements,²¹⁹ and the carrier-level accreditation standards.²²⁰ In sum, even with respect to the statutory certification criteria, exchanges have significant responsibility to both define the standards that plans must meet and to evaluate their performance against those standards.

The exchanges are also responsible for reviewing QHPs’ proposed rate increases.²²¹ Upon receipt of a proposed rate increase, the exchange must decide whether to approve the increase.²²² Neither the statute nor the proposed rules provide detailed guidance as to how the exchange should make this determination.²²³ The absence of more specific guidance

216. *See* 42 U.S.C. § 18031(c).

217. 45 C.F.R. § 156.200(d).

218. *See id.* § 156.230.

219. *See id.* § 156.270.

220. *See id.* § 156.275. This accreditation process is based on the “local performance” of a plan’s QHPs in a number of areas, including clinical quality measures, patient experience, and utilization management performance. *See id.*

221. *See id.* § 156.210 (requiring that QHPs submit proposed rate increases to the exchange).

222. *See id.* § 155.1020.

223. The statute provides only:

strongly suggests that the exchanges will have significant discretion to determine whether rate increases are sufficiently “justified” to allow a plan to remain on offer.

If consumers participate in the exchanges in significant numbers, exchanges’ certification and rate review powers will give them de facto control over the individual and small-group markets. In essence, the exchanges have the ability, subject only to relatively narrow limits, to control entry into these markets. Viewed this way, the exchanges’ regulatory responsibilities closely resemble the states’ traditional licensing function.²²⁴

2. Distribution

Consistent with their intended function as health plan marketplaces, exchanges also have a significant amount of control over the way individuals purchase health coverage. Here again, the statute itself offers only sparse guidance as to how the exchange marketplaces will function. The few specific statutory requirements are mainly technical. The statute requires that the exchanges use a “uniform enrollment form,” developed by HHS, which may be submitted electronically or in

The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State . . . into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

42 U.S.C. § 18031(e)(2) (2012). The proposed regulation substantially duplicates this guidance. *See* QHP Issuer Rate and Benefit Information, 76 Fed. Reg. 41866-01, 41921 (proposed July 15, 2011) (codified at 45 C.F.R. § 155.1020).

224. *See supra* Part II.

hard copy.²²⁵ Similarly, it mandates that exchanges use a standard format for the presentation of benefits,²²⁶ and that they assign a rating to each QHP offered through the exchange.²²⁷ In terms of how exchanges are to conduct transactions, the statute requires only that they maintain a hotline and a website.²²⁸

HHS' proposed regulations provide additional detail as to how the exchanges must operate. For example, the rules list the minimum amount of information that exchange websites must provide about each QHP, require that the website include a calculator to "facilitate the comparison of available QHPs," and mandate that the website have a "consumer assistance function."²²⁹ Similarly, the rules require that the exchanges include certain information on all correspondence, facilitate payment for coverage directly to the carrier, and meet various privacy standards.²³⁰ The rules also dictate the periods during the year when exchanges must allow consumers to switch between plans.²³¹

Nonetheless, within these relatively broad limits, exchanges enjoy considerable freedom to define the terms of consumers' and plans' interactions with the exchange. The exchanges are presumably free, for example, to staff their call centers as they see fit and to design the operation and appearance of their websites as they wish. Similarly, the exchanges are afforded broad discretion to set up "Navigator" programs, which are designed to create a group of intermediaries that will assist consumers in purchasing plans

225. *See* 42 U.S.C. § 18031(c)(1)(F).

226. *See id.* § 18031(c)(1)(G).

227. *See id.* § 18031(c)(1)(H). The statute requires that plans be rated bronze, silver, gold, or platinum based on their actuarial value. *See id.* § 18022(d).

228. *See id.* § 18031(d)(4).

229. *See* 45 C.F.R. § 155.205 (2013).

230. *See* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866-01, 41916 (proposed July 15, 2011) (codified at 45 C.F.R. §§ 155.230 to 155.260).

231. *See* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866-01, 41917 (proposed July 15, 2011) (codified at 45 C.F.R. § 155.410).

through the exchange.²³² Navigators are charged with educating the public about the exchange, distributing information on health plans, and assisting consumers with enrollment.²³³ Importantly, the exchanges have discretion to decide which organizations receive federal grants to become navigators.²³⁴ While these may seem like relatively mundane responsibilities, they will nonetheless define most of the consumer-facing aspects of the exchanges, and will likely have a significant impact on their ultimate success or failure.

D. *Multistate Licensing Provisions*

The statute also contains two provisions—both closely linked with the exchange-based plan-licensing scheme—that are designed to facilitate the creation of nationwide health plans. Both provisions displace portions of state regulatory authority in order to achieve this end.

The first program, which provides for the creation of “Health Care Choice Compacts” (“HCCCs”) between states, is effectively optional.²³⁵ States can choose whether to enter into these compacts, which allow one state’s QHPs to be offered in all states that signed the compact.²³⁶ In addition to complying with the rules necessary to maintain their status as QHPs,²³⁷ the carriers selling plans under the compact need to be licensed in each state where they offer a plan.²³⁸ Moreover, the plan “would continue to be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating) . . . of the

232. See 42 U.S.C. § 18031(i) (establishing Navigator program); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866-01, 41915-16 (proposed July 15, 2011) (codified at 45 C.F.R. § 155.210).

233. See 42 U.S.C. § 18031(i)(3).

234. See Navigator Program Standards, 76 Fed. Reg. 41866-01, 41915-16 (proposed July 15, 2011) (codified at 45 C.F.R. § 155.210).

235. See 42 U.S.C. § 18053(a).

236. See *id.* § 18053(a)(1). The statute also requires that states wishing to take advantage of these compacts enact an enabling statute.

237. See *supra* text accompanying notes 212-20 (describing the QHP criteria); see also 42 U.S.C. § 18053(a)(2).

238. See *id.* § 18053(a)(1)(B)(ii).

State in which the purchaser resides.”²³⁹ Lastly, the compacts are subject to approval by HHS, which is charged with ensuring that the coverage and cost-sharing terms of the compact are “at least as” stringent as those in the ACA.²⁴⁰ The net effect of these requirements is that the HCCCs provide a means by which the states can effectively delegate their ability to license plans as QHPs to other member states. In other words, the compacts provide a means for states to coordinate with respect to the exchange-related ACA regulations while leaving other state-based regulatory functions intact.

In contrast to the opt-in structure of the HCCCs, the ACA’s second multistate plan provision is mandatory. The statute’s “multi-State QHP” provision allows carriers to offer plans which may be sold in all states in which the carrier is licensed.²⁴¹ In addition to meeting the single-state QHP requirements, these multi-State QHPs must offer a uniform benefits package in all states, must comply with each state exchange’s QHP requirements, and must adhere to all state laws that do not conflict with the multi-State QHP provisions.²⁴² Although the multi-State QHP program does not entirely displace state law, it circumscribes its effect. The Office of Personnel Management, which is charged with administering the multi-State QHPs, has authority to determine whether state laws conflict with the requirements of the multi-State QHP program.²⁴³ Further, plans that meet the multi-State QHP requirement need not obtain QHP certification by every state exchange.²⁴⁴ In sum, the multi-State QHP plan provision enacts a form of national plan licensing

239. *Id.* § 18053(a)(1)(B)(i).

240. *See id.* § 18053(a)(3).

241. *See id.* § 18054.

242. *See id.* § 18054(b). The regulations associated with the multi-State QHP provision impose additional regulation covering benefits, levels of coverage, and network adequacy, among other topics. *See* 45 C.F.R. §§ 800.105 to 800.112.

243. *See* 45 C.F.R. § 800.114(b); *see also* Timothy Jost, *Implementing Health Reform: The Multi-State Plan Program Final Rule*, HEALTH AFFAIRS BLOG, <http://healthaffairs.org/blog/2013/03/02/implementing-health-reform-the-multi-state-plan-program-final-rule/> (last visited Apr. 15, 2014) (characterizing state-law compliance as “the most sensitive issue” addressed by the multi-State QHP rulemaking process).

244. *See* 42 U.S.C. § 18054(d).

that displaces both traditional and exchange-based state regulation as a means of encouraging the development of national health plans.

* * *

A comparison of the health plan regulations in the ACA and the regulations traditionally imposed by states²⁴⁵ reveals a great degree of overlap. To date, however, the relationship between the exchanges and the allocation of regulatory authority over plans has escaped scholarly attention. The next Part of this paper turns to that relationship.

VI. State Health Insurance Regulation after the ACA

By any measure, the ACA heralds a significant shift of health insurance regulatory responsibility from the states to the federal government. As the discussion in Part VI makes clear, the Act touches upon nearly every aspect of the business of health insurance. Even in those areas that were already subject to federal regulation,²⁴⁶ the ACA provisions represent a step change in terms of stringency.

The changes wrought by the Act beg an obvious question—in a post-ACA world, which entities are responsible for which regulatory functions? This Part attempts to untangle this question. After setting out the general contours of the post-ACA regulatory scheme, the balance of this Article turns to its implications. First, it discusses the similarities between the ACA and failed attempts to establish a regime of national insurance chartering, and how the ACA is in many ways a model for such a scheme. The Article concludes by arguing that it is a flawed model. By displacing large swaths of state insurance regulation through the unintended operation of the exchange provisions, the statute will sacrifice many benefits of state-based regulation. The fact that the statute works such significant changes virtually by accident should give proponents of greater regulatory centralization pause before

245. *See supra* Part III.

246. *See supra* Part IV.C.

they celebrate the ACA as a model regulatory regime.

A. *Where Does Regulatory Authority Reside after the ACA?*

The ACA's delegation of authority to administer its regulatory requirements is complex. Table 1 provides a broad overview of where regulatory authority rests under the statute. HHS will assume direct authority over some aspects of health insurance regulation (column 1). In other areas the statute has left matters entirely to the states (column 2). Most important for purposes of this Article, however, are the functions assigned to the exchanges (column 3). States that create their own exchange will retain control of these functions. But in the twenty-six states that elected not to create exchanges, the federal government will assume control of the regulatory activities in column 3.

Table 1: Allocation of Regulatory Authority under the ACA

Regulatory Function	Regulator		
	(1) States	(2) HHS	(3) Exchanges (State or Federal) ²⁴⁷
Solvency regulation			
Carrier reserves	√		
Risk redistribution	√	Temporary measures ²⁴⁸	
Rating & underwriting			
Definition of rating factors		√	
Rate review			√
Market conduct			
Guaranteed issue rules		√	
Cost-sharing practices		√	
Plan content regulation			
Benefits content	Limited authority ²⁴⁹	√	
Provider contracting	√		
Network standards			√
Utilization management	√		
Distribution			
QHP certification			√
Agent/broker regulation	√		
Consumer experience			√
Plan marketing practices			√

247. As discussed above, these functions default to a federally run exchange in the event that a state fails to establish its own exchange. *See supra* text accompanying note 180. As of this writing, twenty-six states have failed to establish an exchange, leaving the federal government to establish an exchange covering half the country. *See supra* note 177.

248. *See supra* notes 212-20 and accompanying text.

249. *See* 42 U.S.C. § 18031(d)(3)(B) (2012) (allowing states to supplement plan content requirements provided they assume the associated cost for certain individuals).

Several things stand out about this new allocation of regulatory authority. First, the areas of authority that remain the sole province of the states are those that are relatively technical in nature. Solvency regulation—which consists primarily of imposing reserve requirements on carriers—is the area that remains most firmly under state control.²⁵⁰ In one sense, this is unsurprising. As described in Part II, solvency regulation is a core competency of state insurance regulators. Solvency regulation is largely the same across different lines of insurance, and was the first aspect of the insurance industry to be subject to regulation. The federal government, by contrast, has relatively little experience regulating the solvency of insurance carriers, which differs in important respects from solvency regulation of other financial services industries.²⁵¹

Provider contracting is another aspect of the health insurance business that remains primarily within the states' regulatory jurisdiction. As is the case with solvency, one could imagine why Congress might have left provider-contracting regulation to the states; provider contracting resembles garden-variety commercial law relationships, which are defined by state law. However, the reality is a bit more complicated. One of the stated goals of the ACA was controlling the costs of health care, and the contractual relationships between insurance carriers and providers are a core driver of those costs. Indeed, many have convincingly argued that reforming these payment relationships is the best way to deal with the problem of rising health care costs.²⁵² Utilization management, which is also left primarily to state regulation, is another

250. The ACA's measures for allocating the risks associated with guaranteed issue between carriers could also be classified as solvency regulations. Insofar as these rules are creations of the ACA, however, they do not disturb states' traditional role. *See supra* notes 210-211 and accompanying text.

251. *Cf.* John Patrick Hunt, *Rating Dependent Regulation of Insurance*, 17 CONN. INS. L.J. 101, 104-05, 110-27 (2010) (explaining that the justifications for solvency regulation in insurance are different from the "systemic contagion" risks that animate banking solvency regulation, and highlighting challenges posed by the 2008 financial crisis).

252. *See, e.g.*, Steven A. Schroeder & William Frist, *Phasing Out Fee-for-Service Payment*, 368 NEW ENG. J. MED. 2029, 2029-30, 2032 (2013) ("Controlling rising expenditures for health care will not occur without changing the way that physicians are paid.").

critical means of controlling costs. Much like provider contracting, there does not seem to be a clear technocratic or political economy justification for leaving regulation of this function to the states.

Viewed this way, assigning regulatory authority over these areas to the states seems like an odd choice. If cost control is indeed a key objective of the ACA, it is not clear why Congress would allow the states to continue to control contracting. One possible explanation is that the ACA does not heavily regulate in these areas because the statute, as actually passed, does not attempt to deal as comprehensively with the problem of health care cost as originally imagined. Accounts of the debates over drafts of the ACA support this hypothesis.²⁵³ Perhaps, then, regulation of these areas was to be addressed in a different part of the statute that never came to fruition.

Another common aspect of those areas left to state regulation is that they lack political salience. Insurer rate reserves, provider contracting, and utilization management—whatever their importance to the actual functioning of a health insurance carrier—are not the stuff of headlines.²⁵⁴ If one subscribes to the view that legislating is politically costly—particularly when done in the context of a heated partisan battle—then perhaps Congress simply felt that addressing these areas of regulation was not worth the required political capital.²⁵⁵ Under this account, few voters would notice whether these items were included in the bill, suggesting that any political gains to be had would be modest at best, but that missteps—which would greatly aggravate the insurance industry—would be costly. Conversely, many of the areas that Congress shifted to HHS’ regulatory jurisdiction are politically significant. Plan pricing, guaranteed issue, employer cost sharing, and the benefit design of plans all directly impact

253. See, e.g., Stephen M. Weiner, *Payment Reform After PPACA: Is Massachusetts Leading the Way Again?*, 11 YALE J. HEALTH POL’Y L. & ETHICS 33, 34 (2011).

254. See Detlefsen, *supra* note 133, at 104 (noting that solvency regulation is “technical and straightforward,” and does not implicate the social-welfare questions raised by other aspects of insurance regulation).

255. See Matthew C. Stephenson, *The Price of Public Action: Constitutional Doctrine and the Judicial Manipulation of Legislative Enactment Costs*, 118 YALE L.J. 2, 11-12 (2008).

consumers. Not coincidentally, reforms in these areas were the ones most trumpeted by lawmakers after the passage of the Act.

A third notable characteristic of the ACA's allocation of regulatory authority is that the functions Congress delegated to HHS are those with which the federal government has the most familiarity. As discussed in Part IV, the federal government has had a hand in regulating market conduct in the individual and group markets since at least 1996.²⁵⁶ Congress' experience with HIPAA (and also the carriers' experiences) may have emboldened it to regulate more extensively in this area. As veterans of the HIPAA debates, many of the members of the relevant committees of Congress likely had greater familiarity with these market-conduct issues than with other aspects of the statute. Moreover, HHS had the benefit of fifteen years of promulgating market-conduct regulations, perhaps increasing Congress' confidence in HHS' ability to be an effective regulator. Lastly, the states may have been less likely to resist further incursion into these aspects of their regulatory jurisdiction, as the HIPAA provisions had already reduced their degrees of freedom.

The last thing that stands out about the ACA's distribution of regulatory functions is the significant role of the exchanges. It is not immediately apparent why Congress thought it appropriate to confer these functions—almost of all of which lie within the traditional domain of state regulation—on the exchanges. More significantly, it is unclear whether Congress considered how much of the balance of federal and state regulatory authority effectively rested on states' decisions whether to establish an exchange.

One obvious possibility is that Congress thought it *was* leaving these functions with the states. That is, Congress fully expected most states would decide to operate their own exchange, which would effectively leave them in control of these functions. But this account is unsatisfying. First, if Congress wanted the states to perform these functions, why tie them to the exchanges at all, instead of just remaining silent about them? Second, in light of the political climate

256. *See supra* Part IV.B.

surrounding the passage of the Act, it seems implausible that Congress did not anticipate the possibility that states would opt out of the exchanges. Thus, it seems unlikely that the choice to vest the exchanges with these functions was in any way accidental.

A second possibility is that Congress simply modeled the provisions after the archetypal exchange—the Massachusetts Health Connector—and gave the exchanges these functions because that is what Massachusetts did.²⁵⁷ This too seems unlikely. For one thing, section 1321 of the ACA creates a presumption that exchanges operated by states before January 1, 2010 comply with the ACA's requirements, but it also provides for a review by the HHS Secretary to ensure compliance.²⁵⁸ Thus, Congress at least entertained the possibility that the Massachusetts exchange would differ in meaningful ways from the statutory criteria. Further, the exchanges were a widely publicized and debated aspect of the ACA—it is therefore unlikely that Congress blindly applied the Massachusetts model. A third possibility is that Congress simply decided that these functions would be best performed by the exchanges as independent entities. But the plain terms of the Act, which characterize the exchanges as a state flexibility measure,²⁵⁹ strongly suggest that Congress viewed the exchanges as instrumentalities of the States.

Regardless of its reasons for vesting regulatory authority in the exchanges, the fact that Congress did so raises an important question: how did Congress think this allocation of regulatory authority would interact with the states' freedom to opt out of creating their own exchange? The next section canvasses the legislative history of the ACA for answers to this question.

B. *The Legislative History of the ACA's Exchange Provision*

The ACA's drafting history offers few clues as to how Congress believed the Act's exchange provisions would impact

257. See Weiner, *supra* note 253, at 34-36.

258. See 42 U.S.C. § 18041(e) (2012).

259. See *id.* §§ 18041 to 18044.

state regulatory authority. Much of what one can glean about the exchanges from this history relates to the different versions of the exchange provision drafted by the House and the Senate.

1. The House Bill's Exchange Provisions

The version of the ACA that passed the House, called the "Affordable Health Care for America Act," contained a dramatically different exchange provision than the provision that Congress ultimately enacted. Rather than providing for multiple state-based exchanges, the House bill created a single federal exchange.²⁶⁰ This federal exchange was to perform many of the same functions of the state-based exchanges that were included in the ACA. For example, plans that were to be sold on the exchange had to meet requirements regarding the level of benefits offered,²⁶¹ and the exchange was to perform a plan certification function.²⁶² Like the ACA as ultimately passed, the exchange-related regulatory provisions in the House bill covered both the content of health plans and the manner in which they could be sold. Thus, the bill included requirements affecting cost sharing, enrollment, risk pooling, network adequacy, and compliance with state carrier licensure rules.²⁶³

These provisions were consistent with lawmakers' comments regarding the purpose of the exchange. The House Ways and Means Committee, for example, took an expansive view of the role of the exchange:

A Health Insurance Exchange . . . would be established to facilitate access of individuals and employers to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option. . . . As described

260. *See* Affordable Health Care for America Act (AHCAA), H.R. 3962, 111th Cong. § 301(a) (2009).

261. *See id.* § 303 (requiring, inter alia, that plans be branded in three tiers based on benefit levels, and that plans adhere to cost-sharing limits).

262. *See id.* § 304 (granting the exchange commissioner the power to establish and enforce certification criteria).

263. *See id.* §§ 303 to 304.

in greater detail in the following sections. . . the [Exchange] Commissioner would (1) establish standards for, accept bids from, and negotiate and enter into contracts with entities seeking to offer qualified health benefits plans (QHBP) through the Exchange, (2) facilitate outreach and enrollment of Exchange-eligible individuals and employers, and (3) conduct appropriate activities related to the Exchange, including establishment of a risk pooling mechanism and consumer protections.²⁶⁴

As this quotation makes clear, the House envisioned that the exchange would do more than simply allow consumers to enroll in a plan—it would play a central role in defining the set of choices available to consumers, and would also undertake certain functions—like risk pooling—that had long been the province of state regulators.

Another notable aspect of the federal exchange proposed in the House bill is the extent to which it is intertwined with the proposed “public option.” The public option was a hotly contested aspect of the House bill that created a government-run health plan that would compete with private carriers’ plans on the federal exchange.²⁶⁵ Both the structure of the House bill—which places the exchange and public-option provisions adjacent to each other—and House Committee Reports suggest that the exchange and the public option were closely related.²⁶⁶ This connection is perhaps unsurprising. The

264. REPORT OF THE COMM. ON WAYS AND MEANS ON H.R. 3200, H.R. REP. NO. 111-299, pt. 2, at 229 (2009). Both the House Education and Labor Committee and the Energy and Commerce Committee took a nearly identical view. See REPORT OF THE COMM. ON EDUC. AND LABOR ON H.R. 3200, H.R. REP. NO. 111-299, pt. 3, at 116-17 (2009); REPORT OF THE COMM. ON ENERGY AND COMMERCE ON H.R. 3200, H.R. REP. 111-299, pt. 1, at 402 (2009).

265. See Affordable Health Care for America Act, H.R. 3962, 111th Cong. §§ 321 to 331 (2009) (providing for the creation and administration of the public health insurance option). The public option proved to be one of the most controversial proposals debated as part of the health reform package, and was not included in the Senate bills or the ACA as passed.

266. For a non-exhaustive list of examples where the House highlighted the relationship between the exchange and the public option, see H.R. REP. 111-299, at 318, 470, 402; H.R. REP. 111-299, at 78, 91, 95-96, 126; H.R. REP.

exchange was to be the sole means through which consumers could purchase plans under the public option, suggesting that Congress viewed the national exchange as an indispensable component of the public plan.²⁶⁷

Moreover, the bill suggests that the exchange regulations were to form the basis upon which the public option would be permitted to compete with private plans.²⁶⁸ Congress envisioned that the public option would simply be one choice among many—a federally sponsored plan that would compete on level terms with private offerings.²⁶⁹ In order for this competition to be “fair,” the statute needed a yardstick against which to measure the content of both the public option plan and the private plans. The exchange’s certification processes provided this yardstick.²⁷⁰ Without this shared regulatory framework, it would have been difficult to determine whether public option plans were truly comparable to those offered in the private market.

The House bill did contain an alternative to the federal exchange. Under section 308 of the bill, states could apply for permission to create their own exchanges to replace the federal exchange in their state.²⁷¹ Even this provision, however, conferred only limited authority on the states. The Commissioner in charge of the federal exchange was vested with the power to approve or deny the creation of state exchanges.²⁷² The bill sets out several conditions for this approval, but also grants the Commissioner tremendous discretion to determine whether a state exchange passes muster: it subjects approval to compliance with “[s]uch other

111-299, at 198, 201-02, 229, 239.

267. *See* Affordable Health Care for America Act (AHCAA), H.R. 3962, 111th Cong. § 321(b)(1) (2009) (“The public health insurance option shall only be made available through the Health Insurance Exchange.”).

268. *See id.* § 100(a)(3)(B).

269. *See id.*

270. *Id.* § 321(b)(2) (the “public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost-sharing.”).

271. *See id.* § 308.

272. *See id.*

requirements as the Commissioner may specify.”²⁷³ Moreover, even after the Commissioner approves a state exchange, the Commissioner retains authority to define which functions the state exchange may perform and which will remain under federal control.²⁷⁴

In sum, the House’s exchange provisions suggested a model in which the federal government would use its exchange to exercise a significant degree of control over both the terms of plans available to consumers and the means through which consumers could enroll in them. Far from being a means of allowing states to retain regulatory control or flexibility, the single federal exchange was to be a means imposing uniformity, in part to carry the new public option into operation. Under the House bill, the exchange had little to do with balancing state and federal regulatory authority. Rather, the bill as a whole envisioned a near-complete shift of that authority to the federal government, with the exchange serving as the vehicle through which the federal government would exercise its new authority. By contrast, the Senate bill—and the ACA as eventually passed—eschewed the creation of a national exchange, seemingly intending to vest the exchanges’ powers in the states.

273. *Id.* § 308(b)(1)(E).

274. *See id.* § 308(d). The Bill defines the Commissioner’s relationship to approved state exchanges as follows:

(d) RETENTION OF AUTHORITY.—

(1) AUTHORITY RETAINED.—Enforcement authorities of the Commissioner shall be retained by the Commissioner.

(2) DISCRETION TO RETAIN ADDITIONAL AUTHORITY.—The Commissioner may specify functions of the Health Insurance Exchange that—

- (A) may not be performed by a State-based Health Insurance Exchange under this section; or
- (B) may be performed by the Commissioner and by such a State-based Health Insurance Exchange.

Id.

2. *The Senate Bill's Exchange Provisions*

Perhaps unsurprisingly, given that it formed the basis of the engrossed bill, the Senate bill's exchange provisions closely track those in the ACA as enacted. Indeed, the Conference Committee made no significant changes to the Senate bill's exchange provisions.²⁷⁵ Given this similarity, evidence of what the Senate thought regarding the consequences of states failing to establish their own exchanges is highly probative of the Congress' ultimate views about the ACA and state regulatory authority.

Unfortunately, the history of the Senate bill reveals little about what Congress thought would happen if states did not create their own exchanges. The most useful commentary on this point is from the Senate Finance Committee's report: "If states do not establish these exchanges within 2 years of enactment (or if the Secretary determines the exchanges will not be operational by July 1, 2013), the Secretary would be required to contract with a nongovernmental entity to establish the exchanges within the state."²⁷⁶ This comment suggests that the Committee did not necessarily imagine that the alternative to a state-based exchange would be a federal one; rather, it suggests that the federal government would set up a state exchange to be run by an entity other than the uncooperative state government. This implies that the Committee imagined that exchange regulations would remain state specific, and provides some support for the notion that the Senate did not expect the optional character of the exchanges to have a significant effect on the distribution of regulatory authority between the state and federal government.

This inference is consistent with a provision in the version of the bill reported out of the Finance Committee that provided for contractual allocation of exchange functions between the

275. See Health Care and Education Reconciliation Act of 2010, PUB. L. NO. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 42 U.S.C.); see also Farhana Hossain, *Proposed Changes to the Final Health Care Bill*, N.Y. TIMES, http://www.nytimes.com/interactive/2010/03/19/us/politics/20100319-health-care-reconciliation.html?_r=0#tab=1 (last updated Mar. 22, 2010).

276. S. REP. NO. 111-89, at 18-19 (2009).

federal government, the states, and their exchanges.²⁷⁷ The provision, which was dropped from the version of the bill ultimately approved by the Senate, provided: “The Secretary shall enter into an agreement with each State (in this section referred to as the ‘agreement’) setting forth which of the functions described in this section with respect to an exchange shall be performed by the Secretary, the State, or the exchange.”²⁷⁸ Critically, this sentence was in the section of the bill that described all of the major functions of the exchanges: plan certification, establishment of a call center and internet portal, establishment of tiered ratings for plans, administration of eligibility criteria, and enrollment.²⁷⁹ Neither the bill nor the Committee Report elaborates the required terms of an agreement to allocate these functions.

Whatever its contours, the existence of the agreement provision suggests that the Committee imagined states would have the express option to retain control of the exchange-administered functions. Indeed, under this provision, it appears that a state would have had the option—subject to the federal government’s assent—to pick those exchange functions the state wished to assume and to effectively delegate the others to the federal government. At a minimum, this impulse seems at odds with the way the ACA’s exchange provisions have played out in practice—as a take-it-or-leave-it option that demands states either create their own exchange or forfeit regulatory authority to HHS.

To recap, the legislative history of the ACA reveals little about what Congress understood about the impact of the exchange provisions on state regulatory authority. At best, the differences between the House and Senate bills—which revolved around whether there would be one or more exchanges—suggest that the question of state regulatory jurisdiction was orthogonal to the issues at the fore of Congressional minds. Regardless of what Congress intended, however, the exchange provisions (and the ACA more broadly)

277. *See* America’s Healthy Future Act of 2009, S. 1796, 111th Cong. § 2236 (2009).

278. *Id.* § 2236(a).

279. *See id.* § 2236(b)-(d).

do considerably alter the scope of state regulatory authority. The next section turns to the consequences of this shift.

C. *A Step Toward Federal Insurance Chartering?*

As discussed above, the ACA's assignment of regulatory functions confers authority over most of the politically salient aspects of health insurance regulation to HHS, assigns the bulk of the consumer-facing functions to the exchanges, and leaves several technical areas within state purview. The reasons why Congress wanted to federalize the politically sensitive judgments seems relatively clear—regulation of topics like rating and guaranteed issue is an essential element of the statute's goal of expanding health coverage to the entire population. The legislative history of the exchange provisions suggests that the assignment of the exchange-related regulatory functions was less deliberate, as Congress did not seem to contemplate the possibility that the states would fail to set up their own exchanges. Nonetheless, that legislative history rightly suggests that the functions assigned to the exchanges are important ones, and will have a significant impact on the overall health insurance market. In sum, the ACA has created a system where the federal government controls many of the core aspects of health insurance regulation. And in half of the states—those that have not established their own exchanges—it will control nearly every regulatory function, save solvency, provider contracting, and utilization management.

What then are the implications of this new order? The balance of this paper suggests that the ACA has created a scheme that resembles one envisaged by proposals to create an optional federal insurance chartering system. After briefly summarizing the content of these proposals, the paper concludes with a discussion of the long-term consequences of the ACA's regulatory scheme.

1. Optional Federal Insurance Chartering

For at least the last forty years, there has been an ongoing debate between carriers, states, and the federal government

about whether the insurance industry and consumers are well served by state regulation.²⁸⁰ Specifically, the debate has been about whether the United States should regulate insurance the way it regulates the banking, securities, and other financial industries, all of which are primarily subject to federal regulation.

Criticism of the state-based system proceeds along two lines. First, some carriers contend that state regulation forces them to navigate an unduly complex patchwork of sometimes-conflicting state regulations, which raises costs and makes it difficult to do business across state lines.²⁸¹ Under this view, there are significant economies of scale to be achieved by standardizing regulatory requirements, which would allow carriers to reduce their spending on compliance.²⁸² Moreover, proponents of this view argue that standardizing regulatory requirements would greatly ease carriers' ability to bring new products to market, which will result in innovation that benefits both carriers and consumers.²⁸³ Lastly, the argument goes, society receives little benefit from the heterogeneity of insurance regulations, suggesting that the regulations cost carriers dearly and benefit consumers little.²⁸⁴

The second set of criticisms of state-based insurance regulation comes from a different direction. Some have argued that it has been an uneven protector of consumers' interests. Specifically, the system has been criticized as failing to provide adequate information to consumers, to ensure that insurance

280. The first serious discussion of federal insurance chartering dates to 1969. See ZIMMERMAN, *supra* note 29, at 91; see also Martin F. Grace & Robert W. Klein, *The Future of Insurance Regulation: An Introduction*, in THE FUTURE OF INSURANCE REGULATION IN THE UNITED STATES, *supra* note 18, at 1-4 (situating the federal chartering debate in the context of arguments about the proper allocation of regulatory authority dating to the Civil War).

281. See Elizabeth F. Brown, *Will the Federal Insurance Office Improve Insurance Regulation?*, 81 U. CIN. L. REV. 551, 560-79 (2012) (summarizing, in the context of CDO regulation, criticisms of state insurance regulation); Grace & Scott, *supra* note 129, at 58-66; Ernest T. Patrikis, *Optional Federal Chartering for Property and Casualty Companies*, in OPTIONAL FEDERAL CHARTERING AND REGULATION OF INSURANCE COMPANIES 47, 47-50 (Peter J. Wallison ed., 2000); ZIMMERMAN, *supra* note 29, at 96-101.

282. See Grace & Scott, *supra* note 129, at 60.

283. See *id.* at 66.

284. See *id.* at 61.

markets are competitive, to effectively regulate brokers and other producers, and to enforce regulations when they are violated.²⁸⁵

Many have suggested that the best way to solve these problems would be to create a system of optional federal insurance chartering.²⁸⁶ Under such a scheme, which would be modeled on the system of banking regulation,²⁸⁷ carriers would have the option to either continue under the current scheme of state licensing or to apply for a single federal license.²⁸⁸ Of course, any federal chartering system would enlarge the role of federal regulators at the expense of the states.

A brief overview of the components of an optional federal insurance chartering system suggests the ways in which such a system resembles the ACA. The most recent legislative attempt to establish a federal chartering system provides a useful example of how a federal chartering system would work.

The 2007 National Insurance Act (“NIA”) was a bill considered—and ultimately abandoned—in the United States Senate.²⁸⁹ The NIA, which would have been a major overhaul of non-health insurance regulation, sought “to establish a comprehensive system of Federal chartering, licensing, regulation, and supervision for insurers and insurance producers that is independent of the State system . . . , yet that requires federally chartered and licensed insurers and producers to comply with certain State laws, including State tax laws.”²⁹⁰ The NIA proposed an “Office of National Insurance,” which was to oversee all aspects of federal

285. See J. Robert Hunter, *A Consumer Perspective, in* OPTIONAL FEDERAL CHARTERING AND REGULATION OF INSURANCE COMPANIES, *supra* note 281, at 177, 182-84. *But see* Grace & Scott, *supra* note 129, at 72-73 (noting that a federal regulator may be less attentive to consumer needs than local regulators, which may be held more directly accountable for their responsiveness to citizen queries).

286. *Cf.* Randall, *supra* note 15, at 628, 687 (arguing that in the absence of a move to federal chartering, the current state-based regulatory system should be reformed).

287. See ZIMMERMAN, *supra* note 29, at 94.

288. See *id.* at 96 (summarizing carrier’s licensing options under the proposed 2007 National Insurance Act).

289. National Insurance Act of 2007, S. 40, 110th Cong. (2007).

290. *Id.* § 2.

insurance regulation and issue the new national charters.²⁹¹ The agency would have power to regulate policy forms, which include the definition of policy terms, solvency standards, underwriting standards, and sales and marketing practices.²⁹² In other words, the agency would exercise almost all of the powers traditionally reserved to state regulators. Importantly, the Act would displace state regulation of national insurers in these areas:

Except as authorized by this Act or otherwise authorized under Federal law, national insurers, national agencies, and federally licensed insurance producers shall not be subject to any form of licensing, examination, reporting, regulation, or other supervision relating to—

- (1) the sale, solicitation, or negotiation of insurance;
- (2) the underwriting of insurance; or
- (3) any other insurance operations.²⁹³

The ACA resembles the National Insurance Act system in a number of important respects. As discussed above,²⁹⁴ the ACA contains a provision authorizing the creation of multi-State QHPs. Recall that states are obliged to allow these plans to operate within their jurisdiction.²⁹⁵ Recall also that these QHPs are subject only to regulations imposed by state exchanges and state laws that do not conflict with the ACA's multi-State QHP requirements.²⁹⁶ When considered alongside

291. *See id.* §§ 1101 to 02.

292. *See id.* §§ 1212, 1214 to 15; *see also* ZIMMERMAN, *supra* note 29, at 95-98 (summarizing the key terms of the bill). Interestingly, the agency would not have the authority to regulate rating practices. *See* S. 40, 110th Cong. § 1215(d) (“The Act does not authorize the Commissioner to require a national insurer to use any particular rate, rating element, price, or form.”). Coupled with the Act's preemption provision, this section of the bill would appear to preclude all regulation of property and casualty rating practices. *See id.* § 1703.

293. *Id.* § 1125(a).

294. *See supra* Part V.D.

295. *See supra* note 242 and accompanying text.

296. *See supra* note 241 and accompanying text.

the fact that the federal government will run an exchange serving half the states—making it a natural choice for plans seeking QHP certification—the system very closely resembles the NIA’s federal licensure scheme. To wit, plans can opt either to pursue licensing on a state-by-state basis, either through the individual state exchanges or outside the exchanges through pre-ACA regulatory processes, or may opt to seek certification as a multi-State QHP through the federal exchange.²⁹⁷ Importantly, the fact that the federal government will be running its own exchange means that this power—which would have belonged to the states—is shared with the federal government. Moreover, if multi-State QHP issuers wish to standardize their offerings as much as possible, as the debate about federal chartering suggests they will,²⁹⁸ the federal exchange will have far more influence than any single state, as it will set plan standards in twenty-six states.

Beyond plan licensing, there are other similarities between the ACA and the NIA scheme. Many of the functions performed by the ACA exchanges, which regulate the consumer-facing aspects of the insurance business, resemble functions that would be vested in a federal consumer protection regulator under the NIA.²⁹⁹ The federally run exchange will in effect function as such a federal consumer protection regulator in twenty-six states.

There are, however, several notable differences between the ACA and the NIA. As noted above, the ACA does not undertake regulation of carrier solvency, which represents a significant component of the NIA.³⁰⁰ Further, the NIA does not undertake regulation of health-specific insurance issues, such as guaranteed issue rules or employer cost sharing

297. *See supra* Part V.D.

298. *See supra* notes 281-84 and accompanying text. Note that the ACA’s provision allowing the establishment of multi-State QHPs will also encourage standardization, at least among the largest carriers. *See supra* notes 241-42 and accompanying text.

299. *See* S. 40, 110th Cong. §§ 1105, 1216 (2007) (establishing a “Division of Consumer Affairs” within the Office of National Insurance charged with regulating sales and marketing practices); ZIMMERMAN, *supra* note 29, at 97-98 (summarizing consumer-protection aspects of the NIA).

300. *See supra* notes 247-48 and accompanying text; S. 40, 110th Cong. §§ 1212 to 13, 1601 to 12.

requirements. Lastly, the ACA does not include a sweeping express preemption provision like that in the NIA. Nonetheless, the broad strokes of both statutory schemes are quite similar.

2. A View of the Future?

Situating the ACA in the context of the NIA and broader debates about the propriety of state-based insurance regulation highlights the extent to which the ACA represents a marked change in the health insurance regulatory landscape. As the Act is carried into implementation over the next few years, beginning with the commencement of exchange operations in October 2013, it is likely to have a significant impact on the future of state health insurance regulation and on the regulation of insurance more broadly.

First, the ACA will function as a proof-of-concept of federal insurance chartering. As discussed above, the federally run exchange that will operate in twenty-six states,³⁰¹ along with the Act's multistate licensing provisions,³⁰² effectively create a federal plan licensing option. If this option proves to be popular with carriers and consumers, it will lend support to the proponents of federal insurance chartering, both in health insurance and in other lines. Carriers' perception of this option will be particularly important. If the regime lowers their regulatory compliance costs and makes it easier for them to offer plans across state lines, that experience may embolden non-health carriers to push harder for a similar regime in other insurance markets. With respect to health insurance, if carriers and consumers prefer the federally run exchanges to state-offered options, this may create pressure over the long term to converge on a single federal exchange. This end could be achieved either by amending the ACA to make it more closely resemble the House version of the Act, or by states simply opting to shut down their exchanges. Thus, the ACA will serve as a testing ground for optional federal insurance chartering.

301. *See supra* note 14 and accompanying text.

302. *See supra* Part V.D.

Second, between the functions the ACA directly vests in HHS and those it vests in the exchanges (which the federal government will assume in half the states), the ACA will force the federal government to build competency in insurance regulation. While there have been proposals, like those in the NIA, for the federal government to assume insurance regulation functions, the ACA marks the first time that the federal government will actually have to build these capabilities. If history is any guide, the creation of this expertise at the federal level may lead to a further expansion of federal regulatory authority in the future. Consider, for example, the relationship between HIPAA's insurance market reforms and the provisions of the ACA. Many of the areas where the ACA most dramatically expanded the federal government's role—such as rating, guaranteed issue, and risk pooling in the individual and small-group markets—are areas where HIPAA had already established some form of federal regulation.³⁰³ By contrast, areas where the federal government had no prior regulatory role—such as the regulation of insurance producers—were left to the states. If this pattern holds true with respect to the federal regulatory capabilities created by the ACA, Congress may be more comfortable creating an expanded federal role in these areas through future legislation.

Lastly, the ACA may mark the beginning of a gradual erosion of the role of state insurance regulators.³⁰⁴ If indeed the national licensing provisions and the federal exchange prove popular, an increasing proportion of the individual and small-group business may shift to these federal channels. As noted earlier, these markets are the only significant portions of the health insurance business that remain under state control after ERISA.³⁰⁵ Thus, should these areas shift to a system of federal regulation, states would be left to regulate very little of the health insurance market. Moreover, as suggested earlier,

303. *See supra* Part IV.C.

304. *Cf.* GOVERNMENT ACCOUNTABILITY OFFICE, *supra* note 14, at 17-18 (“The specific activities CMS will undertake in each of the state-based and partnership exchanges may continue to change if states do not make adequate progress toward completion of their required activities.”).

305. *See supra* notes 150-51 and accompanying text.

the success of federal regulation in the health insurance business may generate pressure for federal chartering in property and casualty and other lines of insurance. Currently, regulation of these other lines is the bread-and-butter of state insurance agencies, but it is not implausible—especially in light of the NIA and other federal chartering efforts—that these functions may one day migrate to a federal agency. The ACA may be the beginning of that process.

D. *An Accidental—and Flawed—Model*

Consumers and insurance carriers both stand to lose a great deal by a shift toward federal regulation. The loss is clearest in health insurance. Many aspects of health insurance make it an ideal candidate for state-based regulation. In some ways, the ACA's allocation of regulatory authority reflects this reality. Some of the elements of health insurance regulation that would benefit most from state-based authority, such as rate review, plan certification, and regulation of marketing practices, are assigned to the exchanges.

Allowing these functions to quietly shift to the federal government because of states' failure to create their own exchanges would be a mistake. Federal administration of these functions, even if only in half the states at the outset, will quickly result in greater homogenization. As discussed above, this will stymie the trial-and-error process of regulatory innovation in the states, degrade consumers' and firms' ability to influence the content of regulation, result in less-efficient regulation, and forego the benefits of state experience.³⁰⁶ Worse yet, the benefits normally associated with regulatory standardization, such as reduced compliance costs, ease of doing business across state lines, and consistent consumer protection standards,³⁰⁷ are unlikely to materialize under the ACA. A federal exchange will set standards for roughly half of the states, but the remaining twenty-four states will remain free to adopt their own, potentially conflicting rules. This kind of regulatory clash is all but assured, as the PPACA's exchange

306. *See supra* Part III.D.

307. *See supra* notes 280-85 and accompanying text.

provisions do not contain any preemption clauses that would displace conflicting state laws. Even states served by the federal exchange could, in some areas, adopt conflicting rules. The resulting regulatory collision will blunt any positive impacts of standardization, leaving behind a worst-of-both-worlds outcome in which the benefits of state regulation are sacrificed for naught.

Even those who do not subscribe to the view that there is value in regulatory federalism should be concerned that the ACA's provisions work an *unintended* shift of authority to the federal government. It may be that such a shift is tolerable, even desirable, but it is difficult to say for sure without debating the alternatives. This is particularly true given there is no inherent reason why all of the functions assigned to the exchanges must be administered by the same regulator. For example, one could imagine a regime in which the states maintain control over provider contracting, but the federal government handles consumer-protection issues like plan certification and marketing regulation. The accidental nature of the ACA's allocation of regulatory authority all but precludes consideration of this and other alternatives.

As for non-health lines of insurance, proponents of a federal charter should pause before they trumpet the ACA as a model of what might work elsewhere. If indeed health insurance regulation starts to resemble the NIA scheme, it will be by accident, and not by design. If there is to be a broader shift to federal regulation of insurance, it ought to be deliberate.

* * *

Perhaps, then, Mississippi insurance commissioner Mike Chaney was right: Governor Bryant's refusal to set up a state exchange in an effort to score political points for opposing the implementation of the ACA was shortsighted. What Governor Bryant and others failed to appreciate was that issues of much greater significance turned on the decision whether to create an exchange. Lost in the shuffle of debates about the public option and efforts to stymie the implementation of "Obamacare," the significance of the exchanges to the broader

allocation of insurance regulatory authority seems to have escaped attention. This oversight will prove consequential in the health insurance industry, which will experience a reallocation of authority from the states to the federal government. It may also catalyze a broader erosion of state regulatory authority. There is good reason to think that these changes are wrongheaded. At minimum, however, they should not be undertaken blindly.

VII. Conclusion

The ACA's health insurance regulation provisions make clear that the Act works a transformation of the institutional structure of health insurance regulation. As the ACA takes full effect over the next year, the federal government, either through HHS or the new federal exchange, will assume responsibility for a significant portion of the regulation of health insurance. Rate review, rating regulations, plan benefit design, network standards, market-conduct requirements, and consumer-facing distribution will all come under a significant degree of federal control.

Significantly, much of this authority will be exercised through the new federal exchange. By providing the states the option whether to create their own exchange—a choice made in the name of *preserving* state authority—Congress thus paved the way for a more dramatic shift in regulatory authority than it likely intended. In fact, the defeat of the House's version of the Act—and its overt federalization of the exchange functions—signaled a desire to *avoid* precisely this result.

Regardless of whether it is the product of careful design or unintended consequences, the presence of a federal exchange in half the states, along with the ACA's other regulatory provisions, will represent a clear departure from the past century of insurance regulation. In health insurance markets, this shift will be costly. At best, consumers and carriers will lose the benefits associated with a state-based regulatory regime, but will not gain the benefits of a uniform national system. At worst, they may experience market disruptions caused by an inexperienced federal regulator. And it is likely that the effects of the ACA will not be limited to health

insurance. It may come to pass that Congress' decision to provide states with flexibility, and Republican Governors' attempt to use that flexibility to frustrate federal regulatory expansion, may form the unlikely crucible of a new regime of national insurance regulation.