

ACA Implementation—Monitoring and Tracking

**The Launch of the Affordable Care Act  
in Selected States:  
Reforming Insurance Markets  
and Protecting Consumers**

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

## INTRODUCTION

This brief is one in a series examining what a selected set of states is likely to accomplish in terms of implementing the Affordable Care Act (ACA): expanding health insurance coverage, increasing transparency and competition in private insurance markets, providing consumer protections in the purchase of coverage, and addressing issues related to provider supply constraints. We have chosen to compare eight states: five that have chosen to aggressively participate in all aspects of the ACA (Colorado, Maryland, Minnesota, New York, and Oregon) and three that have taken only a limited or no participation approach (Alabama, Michigan, and Virginia). This brief focuses on these states' implementation of the ACA's health insurance market reforms and on their oversight of insurers inside and outside the Health Insurance Marketplaces (HIMs, also known as Exchanges).

In this series of analyses, the study states were chosen from among those participating in a multiyear project funded by the Robert Wood Johnson Foundation (RWJF). The project provides to states in-kind technical support to assist them with implementing the reform components each state has chosen to pursue; the project also provides funds for qualitative and quantitative research to monitor and track ACA implementation at the state and national levels. RWJF selected these states based on their governments' interest in exploring the options related to state involvement in ACA implementation. Some states pursued implementation aggressively, but in others varying degrees of political

opposition to the law prevented full involvement. The result is that the variation in state commitment to health reform among the RWJF states reflects the same variation seen nationally.

Five of the states have been actively pro-reform. These states have adopted several Medicaid expansions in years preceding the ACA, and all have also adopted important insurance reforms. They were quick to adopt the ACA, engaging stakeholders and investing in consumer outreach and education. They have contracted with information technology vendors to develop eligibility and enrollment systems, though not all of them have seen a smooth rollout of their websites. All five states have created State-Based Marketplaces (SBMs) and have adopted the Medicaid expansion.

In the other three states, there has been strong opposition to ACA implementation, at least in some quarters. Because of their current circumstances (e.g., lower rates of employer-sponsored coverage and higher uninsurance rates), they have more to gain from health reform than do the other five states. All three rely on the federal government to develop and run their Marketplaces—Federally Facilitated Marketplaces (FFMs)—although Michigan and Virginia have taken on the oversight and management of health plans in the Marketplace. All are reliant on the federal website, but even as technical problems with the website are resolved, these states will have fewer resources to devote to outreach, education, and enrollment assistance. Of the three, only Michigan has adopted the Medicaid expansion.

# CHANGES IN INSURANCE RULES

All eight states must navigate rapidly changing health insurance markets in which the ACA's reforms are affecting insurers and consumers inside and outside the new HIMs. In five of our states, officials have built and are running their own HIMs; in the remaining three states, the federal government has assumed that role. However, two of those three states—Michigan and Virginia—continue to take an active role as the primary regulator of health insurance.

Seven new insurance rules that go into effect for nongrandfathered health insurance on January 1, 2014 affect not only individuals and small employers seeking new coverage but also current policyholders (see Table 1). Insurance regulators in all of our states but Alabama are

reviewing and approving new plans for sale, monitoring insurers' marketing practices, and working with insurers to help bring their policies into compliance with the new reforms. And states running their own HIM are also engaging in cross-agency collaboration between the department of insurance and the HIM to certify and provide additional ongoing oversight for plans sold through the HIMs.

Under the ACA, the insurance reforms are supposed to be monitored and enforced by state insurance regulators, unless the state is unwilling or unable to do so. In the latter case, federal regulators—the Department of Health and Human Services (DHHS)—will step in. If insurers fail to comply with the ACA's requirements, federal law allows

**Table 1: Affordable Care Act Insurance Reforms Effective January 1, 2014**

Market Reforms	Description	Application
<b>Accessibility</b>		
<b>Guaranteed issue</b>	Requires insurers to accept every individual and employer who applies for coverage.	Individual market Small group market Large group market
<b>Waiting periods</b>	Prohibits insurers from imposing waiting periods (i.e., the period that must pass before an employee is eligible to be covered for benefits) that exceed 90 days.	Small group market Large group market Self-funded plans
<b>Affordability</b>		
<b>Rating requirements</b>	Requires insurers to vary rates based solely on four factors: family composition, geographic area, age, and tobacco use; prohibits insurers from charging an older adult more than three times the rate of a younger person; prohibits insurers from charging tobacco users more than one and a half times the rate of a non-tobacco user.	Individual market Small group market
<b>Adequacy</b>		
<b>Preexisting condition exclusions</b>	Prohibits insurers from imposing preexisting condition exclusions with respect to plans or coverage.	Individual market Small group market Large group market Self-funded plans
<b>Essential health benefits</b>	Requires coverage of specified benefits that include 10 categories of defined benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	Individual market Small group market
<b>Out-of-pocket costs</b>	Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles, to the level established for high-deductible health plans that qualify as health savings accounts; indexes this level to the change in the cost of health insurance after 2014.	Individual market Small group market Large group market Self-funded plans
<b>Actuarial value</b>	Requires insurers to cover at least 60 percent of total costs under each plan; requires plans to meet one of four actuarial-value (AV) tiers (bronze, silver, gold, or platinum) as a measure of how much costs are covered by the plan.	Individual market Small group market

DHHS to impose significant monetary penalties.<sup>1</sup> Seven of our eight states have maintained their role as primary insurance regulator; only Alabama has declined to enforce the ACA.

All five SBM states have made changes to their individual and small group market health insurance laws in order to implement these seven new standards. For example, prior to the ACA, only New York had a guaranteed issue requirement in the individual market. In Colorado, Maryland, Minnesota, and Oregon, insurers were allowed to refuse to sell a policy to individuals who had preexisting health conditions. In Oregon, respondents estimated that 20 to 30 percent of applicants were rejected for insurance in the individual market because of preexisting conditions. And Maryland has reported rejection rates of 9 to 30 percent, depending on the insurer and the market.<sup>2</sup>

Insurers nationwide will also need to comply with new rating requirements. To effectuate the new national standard, Colorado, Maryland, and Minnesota enacted legislation to implement the ACA's new rating rules, although Minnesota law had previously banned gender rating and Colorado's legislature enacted a similar ban in 2010. New York and Oregon have not had to make dramatic changes to their rating rules, as both states prohibited insurers from adjusting rates based on health status prior to the ACA.

All five states previously allowed insurers to impose preexisting condition exclusions on individual market policies, for up to 18 months. Colorado also allowed insurers to impose elimination riders, which permanently excluded from coverage treatment for any health condition an individual disclosed at the time of application. Consistent with the ACA, all five states have changed their insurance rules to prohibit these kinds of coverage exclusions.<sup>3</sup>

By incorporating the ACA's market rules into state law, these states ensure that their insurance regulators have the full range of tools available to monitor insurers' behavior and

protect consumers. These tools can include premarket review of insurers' rates and policies, as well as postmarket examinations and—should bad behavior occur—the imposition of fines or other sanctions.

By contrast, Alabama has ceded its enforcement authority over the ACA's market rules to the federal government. Alabama regulators note that they lack authority under their state code to enforce federal law, but the Department of Insurance (DOI) has historically enforced pre-ACA federal health insurance laws (such as the Health Insurance Portability and Accountability Act, or HIPAA). In March 2013, Alabama's governor informed DHHS that the state does not intend to enforce any part of federal health care reform, which state officials interpret to include pre-ACA federal law. As a result, DHHS is required to directly enforce both the ACA and pre-ACA federal health insurance laws, inside and outside the Exchange.<sup>4</sup> While individuals and employers in Alabama will still be entitled to the same consumer protections as those in other states, it will be the federal government, not the state, responsible for protecting those rights.

In this area, the two FFM states partnering with the federal government—Michigan and Virginia—are enforcing the ACA's market reforms and providing review, certification, and oversight of plans offered through the FFMs. Michigan and Virginia have also enacted legislation that gives their state insurance regulators the authority to enforce the ACA's market reforms. Specifically, the Virginia legislature has incorporated the ACA's market reforms into its insurance code and given its regulatory agency blanket authority to enforce the ACA and to conduct plan management for the Exchange.<sup>5</sup> Michigan has incorporated the ACA's guaranteed issue and modified community rating requirements into its state insurance code and has also provided guidance to insurers to encourage compliance with other provisions, such as the ACA's requirement that insurers offer plans at different coverage levels (bronze, silver, gold, and platinum).<sup>6</sup>

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## IMPLEMENTATION OF AN ESSENTIAL HEALTH BENEFITS PACKAGE

Beginning January 1, 2014, insurers selling nongrandfathered individual and small group policies must ensure that they include 10 categories of essential health benefits (EHBs).<sup>7</sup> The ACA called for DHHS to define the items and services covered within each of the 10 categories. However, instead of defining a uniform, national

set of EHBs, DHHS provided that each state could choose a benchmark plan on which to base its EHB package. DHHS asked states to make their decisions in fall 2012. If a state did not make a benchmark selection, then it would default to the largest health plan offered in the largest small-group product in the state.<sup>8</sup>

Of our five SBM states, only Minnesota defaulted to the federally determined benchmark plan, but it did so after a state task force reviewed all the benchmark plan options and concluded that they were not “materially different” from one another. As a result, the task force stated that it had no “significant concern” with the default benchmark, but it did recommend that a body be appointed to conduct a periodic review of the benchmark to ensure that it maintains an adequate “balance of coverage and cost.”<sup>9</sup>

All five SBM states are working with insurers and consumer groups to address EHB implementation challenges. For example, unless prohibited by a state, a health insurer may substitute one benefit for another within a category as long as it submits certified evidence that the benefits are “actuarially equivalent.” In part because substitution can make it more difficult for consumers to make effective

apples-to-apples comparisons among health care plans, and because it can be an opportunity for insurers to engage in risk selection, state officials in Maryland, New York, and Oregon have limited or prohibited insurers’ substitution of items and services within EHB categories, with both New York and Oregon further requiring insurers to market benefit designs with standardized cost-sharing.<sup>10,11</sup>

Of the three FFM states, only Michigan selected an EHB benchmark: Priority Health HMO.<sup>12</sup> Both Alabama and Virginia defaulted to the federal benchmark plan; however, Michigan and Virginia have provided guidance to insurers regarding compliance with the ACA’s EHB standard. In guidance to insurers, Michigan has prohibited substitution of items and services within benchmark categories, while Virginia has strongly discouraged it.<sup>13</sup>

## STRATEGIES TO ADDRESS FIRST-YEAR “RATE SHOCK”

The ACA’s market reforms—enhancing consumer protections and ensuring a more equitable sharing of risk between the healthy and sick—caused concerns about short-term rate shock, or spikes in premiums, particularly for younger, healthier individuals and small groups. Although

the ACA includes a number of strategies to mitigate rate shock, states have considerable flexibility to implement additional strategies to stabilize premiums during the transition to a reformed market. For examples of such strategies, see Table 2.

**Table 2: Selected State-Specific Strategies to Mitigate First-Year Rate Shock**

Strategy	Description	States That Adopted the Strategy
<b>Supplemental or alternative reinsurance program</b>	States have the option of using state funds to increase premium protection provided by reinsurance or to create their own alternative reinsurance program.	Oregon
<b>Supplemental risk corridor</b>	Program that redistributes funds from Exchange-based plans with lower-than-expected costs to those with higher-than-expected costs; states can supplement this program.	None
<b>Alternative risk adjustment strategies</b>	States are allowed to implement their own risk-adjustment mechanism.	None for 2014
<b>Geographic rating areas</b>	States have flexibility to determine rating areas to align with available cost and utilization patterns, thus minimizing premium shocks that might occur due to newly merging geographic areas for rate-setting purposes, or states can default to federally determined areas.	Michigan Minnesota New York Oregon
<b>High-risk pool (HRP) transition</b>	Pools were created to provide coverage for people with preexisting conditions, but these pools are now no longer needed due to market reforms. States can implement policies to transition the sick people out of the HRP to minimize market disruption.	Maryland

In spite of concerns about rate shock, none of our study states are implementing all of these strategies, although Colorado, Maryland, and Oregon are each pursuing one or more. New York, with its highly regulated guaranteed issue and community-rated individual market, had little need to pursue any of these strategies, as the ACA is likely to usher in a healthier—and thus less costly—risk pool for the state. Among our study states, Oregon is the only one to implement a state-based reinsurance program, designed to wrap around the federal program. The state estimates that the state and federal reinsurance programs combined will lower average insurance premiums in the state by about 15 percent (11 percent from the federal program and 3.9 percent from the state program).<sup>14</sup> However, Oregon has not pursued other strategies to mitigate rate shock, such as setting geographic rating areas to make the transition to 2014 as smooth as possible or extending the life of the high-risk pool beyond January 2014.

Other states were similarly selective in the strategies they pursued. For example, Maryland is leaving open the option of maintaining its HRP until 2020, but it will not implement a supplemental reinsurance program in 2014 and has not

acted to set geographic-rating areas. Colorado and New York used cost and utilization data to set geographic-rating areas across the state in order to keep rates as stable as possible, but they are not pursuing risk-mitigation strategies to supplement the federal programs, and Colorado intends to close its risk pool in early 2014 (New York did not have one).

Of our three FFM states, none are implementing supplemental or alternative risk-mitigation programs, such as a supplemental reinsurance program or an alternative risk-adjustment methodology. And only one state—Michigan—is adjusting its geographic-rating areas to maximize market stability and minimize disruption.

Only Alabama has an HRP, which was exclusively available to people previously enrolled in an employer's health plan or in extended COBRA coverage after their employment ended, without a break in coverage for 63 or more days. While the pool closed to new enrollment effective January 1, 2014, as of this writing, Alabama's legislature is debating whether and when to discontinue operations for current enrollees.<sup>15</sup>

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## EARLY RENEWALS AND POLICY TERMINATIONS

Beginning in late 2013, as many as 4.7 million consumers with nongroup health insurance coverage received notices from their insurers regarding their options for transitioning to ACA-compliant coverage.<sup>16</sup> Some of these consumers were given the option to either renew their existing plan early or to enroll in a new, ACA-compliant policy with the company or another insurer on the new health insurance Exchange. The first option, early renewal, effectively allowed policyholders to renew their existing policy ahead of schedule—in December 2013 or sooner. Doing so allowed the insurer to avoid complying with the ACA's market reforms for up to an additional 11 months, because the ACA's insurance market reforms are only effective for policies beginning on January 1, 2014. However, this option was not available in all states—some prohibited or limited the practice of early renewals. Some had also required insurers to cancel or terminate all non-ACA-compliant, nongrandfathered individual market policies by a certain date. For example, of the five SBM states, New York passed legislation prohibiting early renewals in the small group market,<sup>17</sup> and Oregon had told insurers that individual insurance policies issued after April 1, 2013, must end by March 31, 2014.<sup>18</sup> This would have limited insurers' incentive to early renew policies in 2013, because they must come into full compliance with the ACA's market reforms by April 1, 2014.

However, Oregon's policy shifted after November 14, 2013, when the Obama administration proposed extending the option to renew noncompliant individual market policies through September 30, 2014.<sup>19</sup> This proposal was designed to assuage the concerns of policyholders whose policies were being discontinued. The responsibility for implementing this policy depended in large part on state officials, who had to decide whether these renewals were permissible under state law. These officials also had to assess the impact on their insurance market and the new HIMs. States responded in a variety of ways, but among our SBM states there was considerable consensus. For example, Oregon decided to allow insurers to renew 12-month individual market policies through the end of 2013, perhaps in part because of the technical difficulties with their HIM. Oregon will not permit noncompliant policies to be renewed after January 1, 2014.<sup>20</sup> Colorado, Maryland, and Minnesota are similarly permitting insurers to renew policies through the end of 2013, but not after January 1, 2014.<sup>21</sup> New York also permitted individual market policies to be renewed through 2013, but state officials have said they will not allow renewals after January 1, 2014.<sup>22</sup>

Among our FFM states, Michigan will permit insurers to reissue noncompliant individual market policies, consistent

with the president's proposal<sup>23</sup> and Alabama is leaving the decision whether to re-issue cancelled policies to insurers and "will not interfere or take a position, so long as policies sold continue to comply with Alabama law."<sup>24</sup> Only Virginia rejected implementation of the president's "fix," noting that it is "unclear" whether the state has authority under Virginia

law to allow noncompliant policies to be renewed after January 1, 2014. The statement further observes that some of Virginia's insurers have already offered policyholders the option to early renew, and the Bureau of Insurance "encourages those carriers to reoffer this option with coverage extending through the end of 2014."<sup>25</sup>

## STRATEGIES TO PRESERVE LONG-TERM PREMIUM STABILITY BETWEEN THE EXCHANGE AND THE OUTSIDE MARKET

States operating their own Exchanges have had considerable flexibility to set market rules that affect plans sold both inside and outside the Exchange. While the ACA includes a number of strategies to protect the Exchange from adverse selection, there remain ways that a state's Exchange could be selected against, resulting in a risk pool without a good balance between the healthy and sick and potentially higher premiums. For example, federal

law does not require insurers to sell the same plans inside and outside the Exchanges, and even subtle differences in benefit design, networks, service areas, and marketing strategies could work to attract healthier people to plans outside the Exchange. Thus, states may wish to pursue a number of additional strategies to reduce the risk of adverse selection (see Table 3).

**Table 3: Selected Strategies to Stabilize the Individual Marketplace**

Strategy	Description	States That Adopted the Strategy
<b>Insurer lockout periods</b>	Precluding insurers who choose not to participate in the first year of the Exchanges from participating in the second or third year of the Exchange.	Maryland New York Oregon
<b>Limits on sale of catastrophic products</b>	Allowing insurers to sell catastrophic plans exclusively outside the Exchanges could draw healthy, young enrollees away from the Exchanges; states have authority to constrain the sale of these plans in order to encourage healthier individuals to purchase through the Exchange and mitigate adverse selection.	Maryland Minnesota New York Oregon
<b>Broker compensation</b>	Standardizing broker compensation inside and outside of the Exchange markets to prevent brokers from steering customers away from one market and toward the other.	Colorado Maryland New York Oregon
<b>Network adequacy</b>	Narrow network plans often have lower premiums and fewer providers, which can attract healthy individuals who have fewer provider needs; states can set similar network adequacy standards inside and outside of the Exchange.	Colorado Michigan Minnesota New York
<b>Service area alignment</b>	Regulating insurers' service areas to ensure they are not cherry-picking healthier service areas within a state.	Colorado Maryland Michigan Oregon
<b>Plan standardization</b>	Mitigating the potential for variations in plan benefit design within coverage levels, as well as plans outside and inside the Exchange, reducing opportunity for benefit designs that may disproportionately attract healthy individuals.	Maryland New York Oregon
<b>Requirements to offer at specified metal levels</b>	Preventing insurers from avoiding higher-risk individuals by requiring them to offer plans at a range of coverage levels.	Maryland Minnesota New York Oregon

Of our five SBM states, Maryland, Oregon, and New York have worked to implement the majority of these strategies, although the other states have implemented one or more. For example, Maryland, New York, and Oregon have implemented rules to discourage insurers from sitting out the first year of Exchange participation (and potentially siphoning off healthier risks in the outside market). And the same three states, plus Minnesota, have set requirements for the sale of catastrophic plans, which are likely to appeal to a younger, healthier demographic. Oregon and New York require that they be sold only through the Exchange, while Maryland requires any insurer selling catastrophic plans outside the Exchange to sell at least one inside. Minnesota requires insurers selling catastrophic or bronze plans outside the Exchange to also offer silver- and gold-level plans outside the Exchange.<sup>26</sup> Maryland, New York, and Oregon have also required insurers to offer plans at coverage levels beyond the minimum federal requirement in order to prevent insurers from avoiding higher-risk individuals.

At the same time, Maryland and Oregon have not set similar network adequacy standards for plans sold inside and

outside the Exchange (although Oregon intends to develop statewide network adequacy requirements).<sup>27</sup> However, Maryland has, along with Colorado and Oregon, established standards requiring insurers to have similar service areas inside and outside the Exchange. Both of these strategies are designed to prevent insurers from cherry-picking healthier, younger enrollees and drawing them away from the Exchanges. In addition, because insurance brokers play such a critical role marketing and enrolling consumers in health plans, all but one of our SBM states (Minnesota) have worked to guard against them steering consumers to plans that offer higher commissions or fees.<sup>28</sup>

Of our three FFM states, Michigan and Virginia are conducting plan management for the federally facilitated Exchange, but they have taken limited steps to protect the Exchange against adverse selection. Only Michigan has attempted to ensure a level playing field on standards for health plan network adequacy and service areas;<sup>29</sup> Virginia has taken no action.

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## CONCLUSION

Among the eight states studied, all but Alabama are taking on the responsibility of managing a dramatic market transition and providing oversight of the health insurance products sold both inside and outside the new HIMs. Only Alabama has ceded its role as insurance regulator to the federal government. However, the seven states took widely varying approaches in their regulatory approaches and responses to market challenges. All seven states have taken some action to implement and enforce the ACA's new market rules, but they did not all incorporate all the rules into their own state laws. And all seven states took some action to implement and provide guidance to insurers regarding the ACA's new essential health benefit standard, but, here again, each state approached the transition to the new standard in a unique way. It is only with their approaches to policy cancellations, rate shock, and adverse selection

between the HIM and outside market that clear differences begin to emerge between the SBM and FFM states. There was considerable consensus among our SBM states in their response to the president's policy cancellation "fix," while among our FFM states only Virginia declined to adopt it—and then primarily because of restrictions in underlying state law. And all five of our SBM states adopted at least one or more strategies to mitigate premium rate shock and adverse selection against the HIM, whereas among our FFM states only Michigan took any action. While it is not yet clear what implications the variation in state action will have, it does appear that states that have built and are operating their own HIM have, to date, been the most proactive in managing the transition in their markets and ensuring the HIM's long-term sustainability.

# ENDNOTES

1. Public Health Services Act § 2723 (codified at 42 U.S.C. § 300gg-22).
2. US Government Accountability Office. "Private Health Insurance: Data on Application and Coverage Denials." March 2011. <http://www.gao.gov/assets/320/316699.pdf>.
3. Minn. Stat. § 62A.65; Md. INS § 15-137.1; Co. Stat 10-16-118; NY CLS Ins § 4318(g); ORS 743.731.
4. Center for Consumer Information and Insurance Oversight. "Compliance." <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html>.
5. Keith K, K.W. Lucia, "Implementing the Affordable Care Act: State of the States," The Commonwealth Fund. (January 2014). [http://www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2014/Jan/1727\\_Keith\\_implementing\\_ACA\\_state\\_of\\_states.pdf](http://www.commonwealthfund.org/-/media/Files/Publications/Fund%20Report/2014/Jan/1727_Keith_implementing_ACA_state_of_states.pdf). Plan management includes a broad range of functions, including: certifying Qualified Health Plans (QHPs), collecting and reviewing rate and benefit information, managing contracts with QHPs, monitoring ongoing compliance issues, recertifying and decertifying QHPs, and running an open enrollment process.
6. 2013 S.B. 62, Michigan 96th Session (2013).
7. The 10 categories of benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
8. 45 C.F.R. § 156.100(c).
9. Minnesota Department of Commerce. "Essential Health Benefits Activity to Date." <http://mn.gov/commerce/insurance/topics/medical/health-insurance-reform/essential-health-benefits/essential-health-benefits-activities.jsp>.
10. Corlette, S., K. W. Lucia, and C. Monahan. "Cross Cutting Issues: Moving to High Quality, Adequate Coverage: State Implementation of New Essential Health Benefit Requirements." The Urban Institute and Georgetown University Center on Health Insurance Reforms. August 2013. [http://chir.georgetown.edu/pdfs/MONI%20EHB%20Report%20-%20fnl%20-%208.20%20\(1\).pdf](http://chir.georgetown.edu/pdfs/MONI%20EHB%20Report%20-%20fnl%20-%208.20%20(1).pdf).
11. Monahan, C.H., S. J. Dash, K.W. Lucia, and S. Corlette. "What States are Doing to Simplify Health Plan Choice in the Health Insurance Marketplaces." The Commonwealth Fund. (December 2013). [http://www.commonwealthfund.org/-/media/Files/Publications/Issue%20Brief/2013/Dec/1720\\_Monahan\\_what\\_states\\_are\\_doing\\_simplify\\_rb.pdf](http://www.commonwealthfund.org/-/media/Files/Publications/Issue%20Brief/2013/Dec/1720_Monahan_what_states_are_doing_simplify_rb.pdf).
12. Letter from Governor Snyder to Secretary Kathleen Sebelius. September 28, 2012. [http://www.michigan.gov/documents/lara/EHB\\_Gov\\_Benchmark\\_400142\\_7.pdf](http://www.michigan.gov/documents/lara/EHB_Gov_Benchmark_400142_7.pdf).
13. Michigan Department of Insurance and Financial Services Bulletin 2013-07 INS. March 18, 2013. [http://www.michigan.gov/documents/difs/Bulletin\\_2013-07\\_INS\\_415032\\_7.pdf](http://www.michigan.gov/documents/difs/Bulletin_2013-07_INS_415032_7.pdf); Virginia Bureau of Insurance website: "Essential Health Benefits Market Rules and Requirements (2014)." March 5, 2013. <http://www.scc.virginia.gov/boi/co/acafileinfo/files/ehbmarket.pdf>.
14. Blumberg, L., S. Corlette, S. Dash, and S. Rifkin. "Stabilizing Premiums under the Affordable Care Act: State Efforts to Reduce Adverse Selection." Urban Institute and Georgetown University Center on Health Insurance Reforms. November 2013. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf408881](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf408881).
15. Ibid; H.B. 66; S.B. 123 Alabama Regular Session (2014).
16. Associated Press. "Policy Notifications and Current Status, By State." December 26, 2013. <http://news.yahoo.com/policy-notifications-current-status-state-204701399.html>.
17. S.B. 2606, New York 236th Session (2013).
18. Oregon Insurance Division Bulletin INS 2013-1. February 22, 2013. <http://www.cbs.state.or.us/ins/bulletins/bulletin2013-01.pdf>.
19. Center for Consumer Information and Insurance Oversight, Letter to Insurance Commissioners. November 14, 2013. <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.
20. Oregon Department of Consumer & Business Services, Insurance Division. News Release. November 18, 2013. [http://www.cbs.state.or.us/external/ins/news\\_releases/2013/111813-CommissionerExtensionGuidance.pdf](http://www.cbs.state.or.us/external/ins/news_releases/2013/111813-CommissionerExtensionGuidance.pdf).
21. Maryland Insurance Administration. Bulletin 13-30. November 19, 2013. <http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/bulletin-13-30-early-renewal.pdf>; *MinnPost*. "Dayton Says Minnesota Will Not Adopt Obamacare 'Fix.'" November 18, 2013. <http://www.minnpost.com/political-agenda/2013/11/update-dayton-says-minnesota-will-not-adopt-obamacare-fix>.
22. *Buffalo News*. "Governor Declines to Resurrect Cancelled Health Insurance Policies." November 19, 2013. <http://www.buffalonews.com/city-region/politics/governor-declines-to-resurrect-cancelled-health-insurance-policies-20131119>.
23. Michigan Department of Insurance and Financial Services. "Michigan to Allow Health Insurers to Reinstate Canceled Plans." November 22, 2013. [http://www.michigan.gov/difs/0,5269,7-303-13222\\_13250-317016--00.html](http://www.michigan.gov/difs/0,5269,7-303-13222_13250-317016--00.html).
24. Haskell, Jennifer. Email to Justin Giovannelli, Georgetown University Center on Health Insurance Reforms. (December 17, 2013).
25. Virginia State Corporation Commission. "Statement of the Virginia Bureau of Insurance Regarding Extension of Individual and Small Group Health Insurance Plans." November 20, 2013. [http://www.scc.virginia.gov/boi/pubs/hlthplan\\_renew2014.pdf](http://www.scc.virginia.gov/boi/pubs/hlthplan_renew2014.pdf).
26. Minn. Stat. § 62K.06.
27. While Oregon did not set uniform network adequacy standards for insurers inside and outside the Exchange, the state's existing standard is similar to the federal one, and Oregon intends to develop statewide network adequacy requirements to be applied to all coverage (public and commercial).
28. Blumberg et al., 2013.
29. Michigan Department of Insurance and Financial Services. Bulletin 2013-07-INS.

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