

# Implementing Health Reform: Federal Rules & State Roles



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HEALTH REFORM

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The Patient Protection and Affordable Care Act (PPACA, now also known as ACA) enacted by Congress on March 23, 2010, provides many challenges and opportunities to federal agencies and the states in implementing the provisions contained in its more than 2000 pages. The three primary federal agencies involved in implementation are the Department of Health and Human Services (HHS), the Department of Labor and the Department of the Treasury.

In the summer of 2010, the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, began a series of Capitol Hill briefings to examine implementation of the health reform law. The first briefing in the series provided an overview of federal policymaking and the efforts by stakeholders and others to affect final policies. Panelists were: Katherine Hayes, George Washington University Department of Health Policy and former professional staff, Senate Finance Subcommittee on Health; Gail Wilensky, Project HOPE and former administrator of what is now the Centers for Medicare and Medicaid Services; and Linda Fishman of the American Hospital Association. The second briefing covered the role of states and the federal government as they jointly work to implement various provisions of the new law. Panelists were: Jay Angoff, HHS Office of Consumer Information and Insurance Oversight, Len Nichols, Center for Health Policy Research and Ethics, George Mason University; Brian Webb, National Association of Insurance Commissioners (NAIC) and Lorez Meinhold, Colorado director of health reform implementation.

## Fast Facts

- There are three types of federal rulemaking—formal, informal (also called “notice and comment,”) and negotiated. Informal rulemaking will be the type most commonly used in implementing the health reform law.
- Federal regulations fill in details left vague in a law, either because lawmakers wanted a federal agency to make these decisions or because lawmakers couldn’t reach agreement about an aspect of the legislation.
- Federal regulations carry the full force of law.
- The federal government and state governments have roles and responsibilities spelled out in the Patient Protection and Affordable Care Act.
- Among the roles states may choose to accept is setting up a pre-existing condition insurance plan and/or a health insurance purchasing exchange. A state can leave these tasks to the federal government. In 23 states, the federal government (rather than the states) is operating the pre-existing condition insurance plan.
- New minimum eligibility standards for Medicaid will require changes to the Medicaid program in most states.

All 50 states have responsibilities under the new law, but states have their own legislative, revenue, political and administrative hurdles to jump as they consider the required and optional aspects of reform. This issue brief will explore federal and state policymaking tools and how they are being applied to implementing the health reform law.

One important policymaking tool available to federal agencies is rulemaking, the process of translating sometimes vague statutes into more detailed regulations. Rulemaking is guided by the Administrative Procedures Act and has a number of technical aspects to it.

**The key is that regulations carry the weight of law once they are in place.** They serve to “clarify vagaries that were intentionally left there by the lawmakers either because they preferred to leave the details to the agency or because they couldn’t

come to agreement,” according to Katherine Hayes of George Washington University.

Informal rulemaking, also known as “notice and comment,” is the process most often used. It involves publishing proposed rules in the Federal Register and allowing for a comment period before regulations are finalized.

Stakeholders—physicians, hospitals, insurers, employers and consumers, to name just a few—will be affected not only by the wording of the new health reform law but also by how the law is put into effect. Most stakeholder groups have been commenting to the federal agencies involved, including as members of advisory groups. They will also take full advantage of the rulemaking process to offer their opinions about the proposed regulations.

Other tools available to federal agencies include executive orders, letters, manuals, policy statements and



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## Some Reform Provisions Implemented Since March 2010\*

- Small business tax credits to help defray insurance costs
- \$250 rebate to Medicare beneficiaries who reach Part D coverage gap in 2010
- No denying coverage for children because of pre-existing condition or excluding pre-existing condition from coverage
- No lifetime limits on value of coverage
- No rescinding (canceling) coverage except in case of fraud
- Coverage without cost-sharing for certain preventive services (for new health plans beginning plan or policy year after Sept. 23)
- Children up to age 26 eligible for dependent coverage (plan or policy year beginning beginning on or after Sept. 23)
- Federal pre-existing condition insurance plan created for qualifying individuals in states opting out of this program

\* as of October 2010

issuing guidances. Except for executive orders, these do not carry the full force of law, but they can influence the direction of health reform and the public perception of the law.

The implementation timeline set forth in the law requires HHS and the other regulatory agencies to move quickly. Some provisions required immediate implementation, others by September 2010, and others by January 2011. Project HOPE's Gail Wilensky wrote recently, "The constrained time available for implementation and the lack of clarity in terms of congressional intent make the rule-writing for health care reform particularly difficult."

**Federal agencies have responsibilities ranging from direct implementation of some provisions in the law to discretionary decision making with regard to other provisions.** One provision implemented immediately by the Centers for Medicare and Medicaid Services (CMS) was the \$250 rebate to beneficiaries who fell into the so-called "doughnut hole" in Medicare

drug coverage. The intent of the law here was clear, and the agency needed only to carry out the logistics.

By July 1, checks were in the mail and soon after, in the hands of seniors, providing some small relief to those who had high out-of-pocket prescription drug expenses this year. Press releases, postcards and letters to beneficiaries, and other publicity measures were used to notify the public that implementation of the law and this provision in particular had begun.

The Internal Revenue Service, part of Treasury, is involved in carrying out several provisions of the law. For example, the IRS mailed over four million postcards telling certain small businesses that they might be eligible for a tax credit if they provide health insurance to their employees. The mailing cost the IRS \$1 million.

**The ACA envisions states assuming a number of new responsibilities in implementing the reform law.** Some provisions, such as new minimum eligibility standards for Medicaid, will be very hard for states

to avoid carrying out. Other tasks, such as establishing high-risk pools and insurance exchanges, states may choose either to undertake themselves or allow the federal government to assume responsibility. The issues around these policy decisions are discussed below.

### *High-Risk Pools*

High-risk pools are intended for individuals who are unable to get coverage in the current individual market due to a preexisting health condition. Insurance companies consider them an undue risk, set prices prohibitively high or refuse to sell them insurance at any price.

The new law establishes a temporary measure to fill the gap until 2014, when preexisting condition exclusions and premiums based on health status will no longer be allowed, and when guaranteed issue will be the law of the land. Until then the states are to create and offer their citizens who have been uninsured for at least six months participation in a high-risk pool. About 35 states already have such pools but rules governing these existing pools may not satisfy the requirement of the ACA.

Some states with already existing high-risk pools have closed them to new enrollees because the states can't afford the added cost. Florida is one such state. Its high-risk pool has been closed since 1991. Twenty-three states have chosen not to build the new federal high-risk pools, even with federal dollars as incentives. For these states, HHS will administer a pre-existing condition insurance plan so that their citizens can take advantage of the protections in the law.

Some states choosing not to set up a new high-risk pool may have been discouraged by the federal statute's 90-day deadline for action. At a time when states are short staffed and low on revenue, this presented a formidable challenge. There were also concerns that the federal dollars appropriated for the pools, a total of \$5 billion dollars, will not be sufficient for the number of enrollees who might be eligible to enroll between now and 2014.

The states might then be left holding the proverbial bag, and would have to make up the difference.

As to technical and financial assistance grants from the federal government, time was also a factor. Though many grants were made available, the turnaround time to complete a grant application was 30 days—another tough-to-meet deadline.

### **Health Insurance Exchanges**

States have the responsibility under ACA, unless they choose to defer to the federal government, to have health insurance exchanges up and running by January 1, 2014. These exchanges will be new entities through which individuals and small businesses can purchase coverage. Exchanges must meet certain basic requirements, according to rules yet to be set by HHS, but they can be administered either by governmental agencies or not-for-profit groups and may vary in other ways from state to state.

Policymakers in some states may see exchanges as marketplaces, perhaps simply web portals through which individuals can compare insurance companies, rates and products for all plans available for purchase in their state. Others see exchanges as more complex and regulatory, setting an elaborate array of rules insurers must meet in order to participate. The variation may include: 1) whether insurers can sell the same products both inside and outside of the exchange and 2) if so, whether the price of a product sold inside the exchange can differ from the price for that product outside the exchange. Rules will also include how exchanges interact with Medicaid and how they handle applications for subsidies.

States can create more than one exchange, one for the individual market and one for small businesses, for example. And they may collaborate with states around them, forming regional exchanges.

While states are grappling with these decisions, HHS is writing rules and deciding what will and

will not be allowable under the federal model for health insurance exchanges. The National Association of Insurance Commissioners, with input from stakeholders and consumers, has been advising HHS and is developing model laws to guide states as they begin to implement the legislation in 2011. In addition, states such as Massachusetts and Utah, with very different models of health insurance exchanges already in use, may serve to guide federal rulemaking and state decision making.

### **The high-risk pools, which went into effect soon after passage of the law, and the exchanges, which are required to be up and running by 2014, present a number of challenges to most states.**

These include setting up new entities (or not); staffing up for health reform while laying off other state employees; and coordinating among state agencies that may not have not previously worked together, such as Medicaid, CHIP and insurance departments.

In addition, state elections this fall

might yield as many as 35 new governors. Current administrations working on health reform must be prepared to hand their plans over to new administrations.

As of June 30, 2010, 21 states had enacted or adopted legislation or taken official action concerning health reform implementation—by forming a committee, task force, or board to begin the process. The governor of Colorado, one of the states moving ahead with health reform, issued an executive order that created the Interagency Health Reform Implementing Board, appointed a director of health reform implementation, and established the inter-departmental implementation council specifying which departments will participate.

The governor and the board are planning to cover 4,000 Coloradans in the high-risk pool and they are convening work groups and stakeholders to start the conversation about what kind of health insurance exchange will suit Colorado. Lorez Meinhold, Colorado's director of health reform implementation said, "The goal is that Colorado [will be] a healthier state because we

## **A Simplified Guide to Informal Rulemaking**

- **Advance notice of proposed rulemaking**—The agency requests information needed for developing a rule.
- **Publication of the proposed rule**—The proposed rule appears in the Federal Register.
- **Public comment**—Agencies take written or electronically submitted comments. The standard comment period is 60 days.
- **Preparation of final rule**—An interim final rule may come first, with a request for more public comments. A "direct final rule" goes into effect at a future time, with the agency obligated to withdraw it if adverse comments are received during a set period.
- **Congressional review**—An agency must submit most final rules, interim final rules and direct final rules, with supporting information, to both houses of Congress and the Government Accountability Office before they can take effect.
- **Publication**—Final rules, interim final rules and direct final rules appear in the Federal Register. A final rule must be published in the Federal Register not less than 30 days before taking effect, with a statement of purpose explaining the rule.

Source: ICF Consulting. "The Reg Map: Informal Rulemaking." 2007. Available at [www.reginfo.gov/public/reginfo/Regmap/regmap.pdf](http://www.reginfo.gov/public/reginfo/Regmap/regmap.pdf).

implemented health reform well.”

Ms. Meinhold added that there are many challenges to attaining that goal. Colorado, like many other states, faces a change in administration (Governor Ritter is not seeking another term), as well as revenue challenges and changing relationships among state agencies. It is incumbent upon those currently involved in implementation, she said, to leave a blueprint of what they have done to date for the next administration, the legislature and the community at large.

In addition to the provisions to be implemented in 2010 and 2011, many parts of the new law have deadlines farther in the future. Examples include the individual and employer mandates, the health insurance exchanges and Medicaid expansion, which are timed for 2014. **The success or failure of early implementation will have implications for future collaboration or division of responsibilities between the federal and state governments.**

For example, if a state is not making adequate progress on building its exchange by January 2013, HHS has the authority to organize a federal version

or contract with a local non-profit to run a state-wide or regional exchange.

**The public still is not enthusiastically in favor of the new law; and confusion and misperception regarding the law's provisions persist.**

Successful implementation may be key to moving public opinion in a positive direction. It may also serve to dampen active opposition to the law. In the meantime, it appears that opponents will continue their legal challenges and movement toward repeal of at least parts of the legislation.

The economic climate is also a major factor in how the public views the law and how quickly and fully it gets implemented. There are some signs of improvement in the economy. But will the economic turnaround come fast enough for state revenues to cover the costs of setting up new entities, hiring staff, and covering additional Medicaid beneficiaries?

A related question applies to federal coffers. Will revenue sources in the law be sufficient to cover health

reform implementation expenditures? A recent CBO analysis indicates that health reform could result in a net budgetary savings over the next 10 years of \$143 billion. A great deal of discretion has been granted by the law to the Executive Branch agencies. Many point to the 1,000+ times the words “the Secretary shall” or “the agency shall prescribe such regulations as may be necessary” appear in the law.

However, voices outside the Administration are being heard. The structure of the health reform law and the system for issuing regulations allows for participation by widely disparate groups and individuals. The extent to which the public, the states and health care stakeholders take advantage of the opportunity to make their opinions known will influence the outcome of implementation. “Successful health reform,” said Len Nichols of George Mason University, “is a participation sport.”

*For the sources used in writing this issue brief, email [info@allhealth.org](mailto:info@allhealth.org) or call 202/789-2300.*

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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## Selected Websites

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■ <b>The Commonwealth Fund</b>	<a href="http://www.commonwealthfund.org">www.commonwealthfund.org</a>
■ <b>Health Reform GPS</b>	<a href="http://www.healthreformgps.org/">www.healthreformgps.org/</a>
■ <b>Kaiser Family Foundation</b>	<a href="http://www.kff.org">www.kff.org</a>
■ <b>National Conference of State Legislatures</b>	<a href="http://www.ncsl.org">www.ncsl.org</a>
■ <b>Robert Wood Johnson Foundation</b>	<a href="http://www.rwjf.org">www.rwjf.org</a>

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