Health Care Reform Implementation and Enforcement: The Patient Protection and Affordable Care Act (ACA) and Potential State Attorneys General Role

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I. Introduction

The Federal Patient Protection and Affordable Care Act (ACA) of 2010 was enacted to improve health care in the United States and to create a new delivery system that will, over time, create more competition to save and lower costs. The ACA, when fully implemented, will significantly expand affordable health coverage to most of the uninsured, create new market places in each state to help individuals and small businesses get health insurance coverage, and require insurance reforms and transparency that simplifies buying health insurance. The law requires most individuals to have coverage and provides deep subsidies to help them afford it. Medicaid is expanded, with full federal funding initially, to cover those to 133 percent of the federal poverty level. Tax credits are available to individuals up to 400 percent of the federal poverty level who purchase insurance in the newly created marketplaces called American Health Benefit Exchanges (Exchanges) that will operate in each state either by the state or federal government and offer a choice of qualified health plans. Small employers will buy through Small Business Health Options Exchanges (SHOP) and be eligible for tax credits. The ACA and this new program build on the employer-based system and expect employers to continue to offer coverage. If their employees are eligible for tax credits, employers will be subject to a fee to help pay for the costs of coverage in the exchange. Small employers are exempt from this requirement. The law includes numerous demonstration programs to restructure the delivery system and reform payment methods for health services to improve the efficiency and effectiveness of care overall.

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2 The Supreme Court granted petitions for certiorari on three issues: whether the individual insurance mandate is constitutional, whether the individual insurance mandate is severable from the ACA, and whether the Medicaid expansion is constitutional. The Court also instructed parties to brief and argue whether the Anti-Injunction Act bars private individuals and states from challenging the ACA. Florida v. U.S. Dep’t of Health & Human Serv., 648 F.3d 1235 (11th Cir. 2011), cert. granted, (U.S. Nov. 14, 2011) (No. 11-400); U.S. Dep’t of Health & Human Serv., 648 F.3d 1235 (11th Cir. 2011), cert. granted, (U.S. Nov. 14, 2011) (No. 11-398); Nat’l Fed’n of Int’l Bus. v. Sebelius, 648 F.3d 1235 (11th Cir. 2011), cert. granted, (U.S. Nov. 14, 2011) (11-393).


6 § 1421, 124 Stat. 238.

7 A more complete summary of the ACA can be found at the Kaiser Family Foundation website. See www.kff.org.
Opponents of the ACA see its passage in a very different light. Even putting aside the constitutional arguments that were decided by the United States Supreme Court, they see the ACA as an indefensible extension of the federal government into the lives of all Americans. They predict that the ACA will increase health care costs and hold back any economic recovery.

The National State Attorneys General Program at Columbia Law School, with a generous grant from the Ford Foundation, is working to become a resource for state attorneys general and their staffs as they address the ramifications of the ACA for their states. We have identified three major areas of responsibilities for Attorneys General with respect to the ACA. First, there is the responsibility for implementation of the ACA provisions already in effect or required by 2012 that each state faces over the next year. Second, there is planning for potential defensive obligations that will arise in 2012 and 2013 as challenges arise to decisions made by the state to comply (or not comply) with the Act’s requirements. Third, there are the affirmative responsibilities to ensure the bill’s benefits are enforced without fraud and misrepresentation so that they are made meaningful for each state’s residents.

These responsibilities will likely impact different bureaus or attorneys in any office of Attorney General, but the traditional areas of Attorney General expertise that will need to understand the ACA and its implications are:

- Advising state agencies on compliance issues
- Minimizing financial risks to states where compliance is inadequate or incomplete
- General state defensive litigation
- Consumer protection
- Charitable and not-for-profit oversight
- Antitrust enforcement
- State procurement processes
- Insurance issues
- Criminal jurisdiction
- Medicaid compliance and defense

**Recommendation:** The ACA is an integrated statutory effort that will cause all state officials to reconceptualize the way they have been doing business often for many years. Because these responsibilities cut across the existing jurisdictional lines in virtually every office of Attorney General, it is strongly advised that each office designate a senior person to have overall familiarity with the provisions of the ACA. It is also wise to be sure the staff in each of the areas noted above read and understand the intersections between the ACA’s provisions and their unique area of responsibility within the Attorney General’s office.
II. General Planning for the ACA

Attorneys General will play a significant role in the planning and implementation of the ACA. The law and the federal Health and Human Services Department (HHS) passed much of the planning, creation, implementation, and enforcement of the ACA to states. Although the federal government has provided extensive regulatory guidance, state officials are still left a great deal of latitude in statutory interpretation and policy formulation. They will turn to the assistant attorneys general assigned to them for guidance and it is vital that everyone work together to provide the highest quality of legal advice.

While recognizing that Attorneys General have their own unique relationships with the executive and legislative branches within their own states, it is important to understand what type of planning process is happening currently in each state and how best to fit into that process. Most states have a governor-appointed taskforce or workgroup in effect that has members from all executive state agencies, including state insurance departments/divisions and state health departments. In most cases, the taskforce or workgroup is developing the work plan and making policy decisions about how the ACA will be implemented in that state. The work plan and decisions made by the taskforce or workgroup is considered an executive work product that typically needs approval by the Governor’s Office to proceed. These deliberations have significant legal ramifications so that in some states, representatives from the Attorney General’s office sit on the task force while in many other states, they are not currently represented.

In addition, some states have created a legislative committee to oversee the implementation of the ACA and particularly the creation of a state health insurance exchange. That group is usually made up of state legislators as well as representatives from the executive, usually those state agencies that have the biggest role in implementing the ACA; e.g., the state Medicaid unit, the insurance division/agency, and the state department of health. In many states, the executive and legislative groups are including key stakeholders, including the public, consumers and the healthcare industry in their conversations and in making decisions.

Recommendation: Attorneys General should consider whether or not to be a part of either or both the state executive and legislative working groups. Such involvement by the attorneys general will ensure appropriate implementation of the law, help state agencies interpret and implement the law correctly, and protect consumers, both individuals and

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9 See Id.
10 See § 1311(d)(6), 124 Stat. 178.
small businesses. Attorneys General should be in a position to press for implementation that ensures maximum consumer protection, particularly with respect to insurance practices.

In addition to planning for implementation, there will clearly be defensive responsibilities for state Attorneys General as they represent state agencies and the state in potential challenges to state action or inaction. For example, as a result of recent activity by some Governors, there are likely to be legal issues regarding the authority of the Executive to act without legislative authority, either in establishing the exchange or in creating compliance with the ACA without legislative action. In addition, the federal government could potentially take affirmative steps, including litigation and potentially loss of federal Medicaid funds against states that fail to comply with provisions of the ACA, thus requiring the Attorney General’s counsel and representation.

Also of note, there are potential affirmative actions for those Attorneys General who may wish to advocate on behalf of provisions of the ACA that benefit consumers and expand health insurance coverage. The expansion of health coverage to one million younger Americans, by virtue of the ACA’s provision allowing young people to stay on their parents’ coverage and the ACA’s prohibition against denial of coverage for pre-existing illness for children, have already made a major difference in health insurance coverage for young Americans. Attorneys General may choose to consider action against insurers who may fail to comply with the consumer protection provisions of the ACA, or against other entities that may violate other provisions of the ACA that impact consumers. This memo makes reference to each of these roles for an Attorney General.

III. What the ACA Means for States

This memo focuses on three major areas that will likely change within each state as a result of the ACA: (1) reforms to the insurance market; (2) changes to the healthcare marketplace; and (3) the expansion of Medicaid to a far greater portion of each state’s population. This memo briefly discusses each of these three areas. In addition, the memo includes a discussion of concrete areas of Attorney General jurisdiction that are implicated


12 § 2722. 2723. 42 U.S.C. 300gg–22. ENFORCEMENT. (penalty against insurers) for failure to comply with insurance provisions

by the ACA, and actions that Attorneys General may want to consider as they deal with the Act.

Obviously, there are far more responsibilities than those identified here. This memo was written in anticipation of the meeting that was scheduled for December 5th, 2011 which provided discussion and insight into the roles of Attorneys General as each state rolls out implementation, compliance and enforcement of the ACA.

IV. Insurance Market Reforms

There are a wide range of insurance marketplace reforms in the ACA, many of which require a state’s legislative enactment or regulatory oversight. The key ones are identified below.

A) State Health Insurance Exchange

The ACA authorizes each state to create its own exchange for the purchase of health insurance.\footnote{\[\text{§ 1311(b), 124 Stat. 173 - 174.}\]} Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each State has the opportunity to establish an Exchange(s) that: (1) facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other requirements as specified in the Affordable Care Act. If a state does not create such an exchange, the Act expressly provides that the federal government will do so.\footnote{\[\text{§ 1321, 124 Stat. 186 - 187.}\]} In addition, the ACA authorizes the creation of Federal/State partnerships to establish an exchange, again to allow state flexibility in determining the specific details of the exchange within that state.

These exchanges will be state-based governmental or quasi-governmental agencies or non-profit entities where individuals and small businesses will be able to purchase affordable private health insurance.\footnote{\[\text{§ 1311(d), 124 Stat. 176 - 178.}\]} States may create a separate exchange for individuals and one for small businesses, may merge them, or may form regional alliances.\footnote{\[\text{§ 1311(b), 124 Stat. 173 - 174; § 1311(f), 124 Stat. 179.}\]}

The benefits of an exchange are: (1) insurance companies will compete for business by the same set of rules and standards; (2) consumers and small businesses will be able to easily compare qualified health plans, and individuals can only receive tax credits by

\footnote{\[\text{§ 1311(b), 124 Stat. 173 - 174.}\]}
\footnote{\[\text{§ 1321, 124 Stat. 186 - 187.}\]}
\footnote{\[\text{§ 1311(d), 124 Stat. 176 - 178.}\]}
\footnote{\[\text{§ 1311(b), 124 Stat. 173 - 174; § 1311(f), 124 Stat. 179.}\]}
purchasing through the Exchange; (3) small business owners will be able to offer their employees health insurance that meets their needs, and 4) some businesses will be eligible for a tax credit for coverage purchased for employees.

Significantly, state or federal exchanges will have a single web portal where a consumer can go to access health insurance information and eligibility status for any type of insurance -- private, Medicaid and the Children’s Health Insurance Program (CHIP), as well as the State Small Business Health Options Program (SHOP). In other words, all consumers will enter through the same portal to purchase insurance, and there must be a seamless system which does not segregate consumers by type of coverage.

State-sponsored exchanges, including the creation of SHOP Exchanges must be operational by January 1, 2014. States must submit plans for HHS approval by January, 2013, which means states will need legislation in 2012 establishing an exchange and complying with new insurance standards so they can seek HHS approval and begin to build and market health insurance products. It was anticipated that many state legislatures would await passage of their own state’s exchange legislation until the Supreme Court’s decision in the spring of 2012. Since the decision some states have indicated that they will forgo further implementation pending the November elections, potentially requiring the Attorney General’s input and counsel regarding deadlines, including the November 16, 2012 deadline to submit proposals to HHS on state run exchanges.

In most states, the State Insurance Department or Division is responsible for making sure the state exchange is in compliance with ACA requirements. If a state exchange is not operational by 2014, the HHS Secretary will establish and operate an exchange in the State and implement all regulatory requirements.

Anticipating potential delays at the state level, HHS is actively engaged in establishing the federal exchange. Should a state fail to implement an exchange by 2013, the federal government will assume all or some of its functions. In so doing, the federal government will also assume liability, responsibility for audits and oversight.

In addition to preparation for a federal exchange, HHS has also has proposed several levels of shared responsibility with states as an alternative model to the purely federal exchange. Under this alternative model, the exchange would meet all ACA standards, but

18 § 1103 124 Stat. 146; § 1311(d)(4)(C), 124 Stat. 176
19 § 1311(b)(1), 124 Stat. 173.
selected functions of the exchange would be operated by a state. Attorneys General may well be engaged in these intergovernmental discussions of liability and responsibility, should a federal or shared federal/state exchange be developed.

In another scenario already occurring in some states, a Governor may implement the exchange (or possibly other sections of the ACA) by means of Executive Order, as opposed to legislative action. Whatever the motives, legal questions are inevitably going to be raised regarding the Governor’s authority to act by Executive Order, and whether the Order, even if lawful, meets the ACA requirements.

1) Exchange Governance

Under the ACA, an exchange can have a separate governing board for the individual and SHOP exchanges, a single governing board, or be governed as a state agency. Some exchanges have been created with not-for-profit boards, thus requiring the Attorney General’s approval. Either way, the proposed HHS Rule states that a majority of voting governing board members must have experience related to health care financing or delivery, or related to public health/policy. An exchange must have conflict of interest, ethics and transparency policies. Board members must disclose any potential conflicts of interest. Exchange board meetings must be open to the public and comply with State Open Meetings Acts, which includes a time for public comment.

Depending on the nature of the state’s exchange legislation, Attorneys General may be empowered to bring actions in the event of violations of the law’s governance provisions, or may exercise their non-profit oversight over not-for-profit exchanges if the facts warrant.

2) Qualified Health Plans (QHP)

An exchange must offer plans that are deemed to be “qualified health plans” (QHP) as defined by the statute. Each QHP must comply with a number of requirements – most

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25 Id.

notably existing and new state licensure/insurance regulations.\textsuperscript{27} The ACA requires that a QHP have a standard benefit design, which includes the mandated essential health benefit coverage and cost sharing mechanisms, grievance and appeal procedures, and specific termination of coverage procedures, quality standards and risk-adjustment requirements.\textsuperscript{28} The complete details of the QHP requirements have not yet been established.\textsuperscript{29}

A QHP must set rates for one benefit and plan year and cannot change the rates mid-year. A QHP must also submit a list of data and information to the exchange, the State, HHS, and the public (including claims payment, financial disclosures, data on enrollment, data on disenrollment, data on the number of claims denied, data or rating practices, information on cost-sharing and information on enrollee rights).\textsuperscript{30}

A QHP must also follow state health insurance marketing and advertising laws.\textsuperscript{31} A QHP cannot engage in marketing or advertising practices that discourage enrollment of individuals with special or significant healthcare needs. In addition, there is a clear prohibition of unfair or deceptive marketing or advertising practices to assure that enrollees are not being given improper information.

Finally, a QHP must have an adequate network of providers that includes community providers and providers working in designated underserved communities.

Exchanges have responsibility for determining which plans can be offered through the exchange and eligible for subsidies. In addition the Act anticipates—but does not compel—exchanges to be active purchasers and requires them to hold plans in the exchange

\textsuperscript{27} Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, at 41923.

\textsuperscript{28} The ACA requires the Secretary of the Department for Health and Human Services to “define essential health benefits” for health plans. § 1302(b), 124 Stat. 163. The benefits must “include at least the following general categories and the items and services covered within the categories: 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.” \textit{Id.} The benefits must be “equal to the scope of benefits provided under a typical employer plan.” \textit{Id.} The Secretary of the Department of Labor was tasked conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers.” \textit{Id.} The Labor Department released its survey on April 15, 2011. U.S. DEP’T OF LAB., SELECTED MEDICAL BENEFITS: A REPORT FROM THE DEPARTMENT OF LABOR TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, available at \url{http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf}.


\textsuperscript{30} Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, at 41923.

\textsuperscript{31} \textit{Id.}
accountable for numerous standards including rate justification, standards of network adequacy and quality. These functions are related to existing functions conducted by insurance departments. How they are implemented may cause tensions between exchanges and insurance departments that may benefit from the involvement of the Attorney General.

3) SHOP Exchange

By 2014 each state must have a Small Business Health Option Program (SHOP) exchange that will either be separate or combined with the individual health exchange allowing small businesses to offer qualified health plans from a variety of insurance providers to their employees similar to larger businesses.\(^{32}\) SHOP exchanges will only be open to business with fewer than 100 employees, but states may limit the exchange to business with fewer than 50 employees. Until 2016, plans offered in the SHOP exchange must cover all essential health benefits and will be offered in four “tiers” of coverage. Premiums on SHOP plans will be based on age and smoking history. A SHOP qualified health plan is only allowed to change rates at a uniform time (monthly, quarterly, or annually).\(^{33}\) A SHOP qualified health plan cannot change rates for an employer during a plan year.\(^{34}\)

4) HIPAA Compliance

A state health exchange must comply with all the existing Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules. Clearly, exchange staff will be handling protected health information, especially because the exchange must have a single web portal and application to determine eligibility, and then will enroll an individual or small business into a QHP. There will also be multiple data transmissions of projected health information.

Under the newly adopted Health Information Technology for Economic and Clinical Health Act (HITECH), HHS will now pursue audits of covered entities for HIPAA violations, and fines, penalties and reporting requirements are much more stringent.\(^{35}\) In addition, under HITECH, state Attorneys General now have expanded jurisdiction through specific statutory authority to pursue violations of HIPAA.\(^{36}\)

\(^{32}\) Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, at 41885.

\(^{33}\) Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, at 41887.

\(^{34}\) Id.

5) Individual and Small Business Tax Credits

Beginning in 2014, a tax credit will be available for qualified individual purchasers who are not eligible for Medicaid and earn up to 400 percent of the Federal Poverty Level (FPL) that will cover the difference between household income and the second-lowest cost plan offered in the exchange. In addition, individuals earning between 100 and 400 percent of the FPL enrolled in qualified health plans are eligible for cost sharing assistance.

For small businesses, some tax credits are currently available. For small businesses that qualify, tax credits are provided up to 35 percent of the business’ share of employee premiums. Employers are eligible if they employ fewer than 25 full time employees, the average annual salary is less than $50,000, and the employer covers 50 percent or more of coverage costs. For two years, beginning in 2014, employers that purchase insurance through the SHOP exchange will be eligible for a maximum tax credit of 50 percent of their share of employee coverage costs. Eligible tax-exempt employers can receive credits for 25 percent of the employer’s share of premium costs through 2013 and 35 percent of these premium costs for two years starting in 2014.

B) Guaranteed Issue and Community Rating

The ACA includes a requirement that health plans must permit a consumer to enroll regardless of health status, age, gender or other factors that might affect their utilization of health services. This is commonly referred to as, ”guaranteed issue”. While it requires the issuance of insurance, guaranteed issue does not limit how much a health plan can charge once a consumer is enrolled.

"Community rating" requires plans to set rates based on specific factors enumerated in the ACA – age, premium rating area, family composition and tobacco use. The ACA sets

36 § 13410(e), 123 Stat. 274 - 275.
37 The plan must be the second lowest cost "silver" level plan to be eligible for the tax credit. § 1401, 124 Stat. 213 - 220.
38 § 1402, 124 Stat. 220 - 224
40 Id., at 238
41 Id.
42 § 1201, 124 Stat. 156.
limits on how much premiums can vary by these factors. In states where state law currently does not require community rating or guaranteed issue, or where definitions are different than the new federal law, the Attorney General may need to advise the state on the necessary steps to ensure compliance with the ACA, or prepare to defend the state against challenges for its refusal or failure to amend existing insurance law or regulations. The ACA provides that “the Secretary shall enforce (these) provisions” if a state fails to do so but it does not spell out the the actions the Secretary can or will take with respect to states which do not adopt these reforms. Attorneys General may need to prepare for affirmative litigation, either by consumers or possibly by the federal government, to compel the issuance of insurance policies under the terms described in the Act.

C) Grandfathered Plans

Section 1251 of the ACA provides that certain insurance plans are “grandfathered” and are exempt from certain provisions of the bill. The goal of grandfathering existing plans was to provide a smooth transition from existing insurance coverage to coverage that conforms to the ACA with minimal disruption. Fewer plans will be grandfathered as 2014 approaches. Under the grandfathering provisions, most plans that existed on March 23, 2010, the date the law was enacted, are exempt from some of the law’s consumer protections. For example, health plans that are exempt do not have to provide certain recommended preventive services at no additional charge to consumers, or offer protections if a consumer appeals a claim or is denied coverage. Individual health plans do not have to phase out annual dollar limits on key benefits, or eliminate pre-existing condition exclusions for children under 19 years of age. Grandfathered policies need not comply with the ACA provision requiring insurers to have a Medical Loss Ratio (MLR) of at least 80%. But grandfathered plans cannot (1) eliminate coverage for a specific condition; (2) increase the co-insurance percentage; (3) increase the co-payment amount by more than the greater of $5 or medical Consumer Price Index (CPI) plus 15%; (4) or increase deductibles by more than medical CPI plus 15%.

On the other hand, all health plans, whether grandfathered or not, must (1) provide no lifetime limits on coverage; (2) provide no rescissions of coverage when someone is sick and may have previously made an unintended mistake on an application; (3) extend parents’ coverage to young adults 26 and younger; (4) provide no coverage exclusions for children with pre-existing conditions, and (5) provide no restrictions on annual limits. A health plan can lose its grandfathered status if it significantly reduces benefits or raises costs or charges made to consumers.

43 42 U.S.C. 300gg-22; § 2722 9(a) (2)
44 § 1251, 124 Stat. 161 - 162.
In general, most large group/employer health plans will be considered grandfathered by the ACA. Those that are grandfathered may not change benefits once a state or federal exchange is implemented in a state. Presumably this would provide the opportunity for small employers and individuals to change health plans once a state or federal exchange is implemented because it was anticipated that the exchange would create more affordable and consumer-oriented options for both.

Working with their insurance commissioners or acting independently, some Attorney Generals may wish to bring actions against any insurer selling policies as grandfathered that do not meet the grandfather tests, and to ask HHS or a court to order that any such policies comply with the ACA provisions that non-grandfathered policies must comply with, including the medical loss ratio provision described in more detail below.

**D) Pre-Existing Condition Rule**

Under the ACA, health plans can no longer deny or exclude health insurance coverage for children because of a pre-existing condition, including a disability. Starting in 2014, health plans will not be allowed to deny coverage or charge more in premium to anyone (including adults) because of a pre-existing condition.46

**E) Rate Review**

The ACA requires that insurance companies provide disclosure and allow review of unreasonable health insurance premium increases. CMS has issued a final rule to implement this provision.47 The new rule gives CMS (and HHS) and states the authority to review “unreasonable health insurance premiums” to determine whether or not the rate increase was justified. Under the ACA, neither CMS/HHS nor states can reject a proposed rate increase, but the act does give both entities the authority: (1) to ask for background and information on the rate increase before implementation of the rate increase; (2) to review the rate increase; and (3) to disclose the rate increase to the public.48

Under the ACA:

- Starting September 1, 2011, insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets are required to publicly disclose the proposed increases and the justifications for them. Such increases


48 See § 1003, 124 Stat. 139-140.
will be reviewed by either state or federal experts to determine whether they are reasonable.  

- Starting September 1, 2012, the 10 percent threshold will be replaced with a state-specific threshold, using data that reflects insurance and health care cost trends particular to the state. HHS will work with states in developing thresholds.

- States with effective rate review systems will conduct the reviews, but if a state lacks the resources or authority to conduct actuarial reviews, HHS would conduct them.

- If a state or HHS finds the premium rate increase to be unreasonable, the insurer can withdraw the increase, propose a lower increase or implement the proposed unreasonable increase but submit a new and final justification to HHS.

The rule requires the federal and/or state review process of a premium rate increase to provide an opportunity for public comment. State attorneys general who enforce their state’s open meetings laws will need to be mindful of these provisions.

The rule states that some of the information submitted by an insurer to justify the premium rate increase is public information and not confidential or protected health or financial information. This is a key issue for attorneys general who oversee and enforce state inspection of Public Records Acts and HIPAA.

### F) Medical Loss Ratio (“MLR”) Rule

Beginning in 2011, insurance companies that issue policies to individual, small employers and large employers are required to report the following information in each state they do business: total earned premiums, total reimbursement for clinical services, total spending on activities to improve quality; and total spending on all other non-claims costs excluding federal and state taxes and fees. In addition, there is a requirement that at least 80 percent of the health insurance premium for plans in the individual and small group market that is collected by the insurance company must be spent on health care and not administrative costs. In the large group market, the requirement is 85%. That means that each insurer must spend at least 80% or 85% of the premium dollars it collects on claims costs and quality-improving activities, and thus no more than 20% or 15% of the premium dollar on administrative expenses and profit. Insurers must report their MLRs on a form they submit to the states and HHS. If an insurer does not attain an 80% or 85% MLR, it

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49 Rate Increase Disclosure and Review, at 29967.

must refund money to its policyholders to the extent necessary to bring its MLR up to that level.

Working with their state insurance commissioners or independently, state attorneys generals may be interested in bringing actions against insurers that improperly calculate their MLRs, and in asking HHS or a court to order that any such insurer refund money to their policyholders to the extent necessary to bring the insurer into compliance with the 80% MLR standard as required under the law.

G) Risk Adjustment and Risk Corridors

The ACA provides for several mechanisms to minimize the risk of adverse selection, which can occur when insurance companies are unable to prepare for and accurately underwrite the costs of health insurance. The "Risk Adjustment" program is intended to amortize risk across insurance plans as the new exchanges are set up; essentially, the program moves funds from health plans than have lower than average risk enrollees to health plans that insure higher than average risk enrollees. This program begins in 2014 and will run indefinitely. It applies to health plans and insurers in the small group and individual markets, inside or outside the exchange, but not to self-insured ERISA plans, large group plans or grandfathered plans. The reason the program includes health plans inside and outside of the exchange is that HHS seeks to discourage "cherry picking" and to provide incentives for health plans to cover higher risk populations of people. HHS will develop a risk adjustment methodology but states can use their own if they are certified by HHS. States must spend some time determining when to collect funds from low-risk plans and apply them to high risk plans. So far HHS has proposed several methods states can use to calculate charges and payments. Health plans are also required to collect and send claims and encounter data to states on a monthly basis. 51

In addition, the ACA provides for "Risk Corridors", managed and operated by HHS to operate from 2014 to 2016. Under the program, HHS will collect funds from qualified health plans with better than expected experience and distribute them to qualified health plans that have worse than expected experience. The purpose of this program is to stabilize qualified health plans risk during the early years of the exchange until health plans are more able to predict their risk. 52

H) Reinsurance Program 53

52 §1342, 124 Stat. 211-212.
53 §1341, 124 Stat. 208-211.
The purpose of the reinsurance program is to protect health plans from cost overruns from high cost enrollees who enter an exchange. The program will be operated mainly by states beginning in 2014 and ending in 2016. The reinsurance program will assess charges against health plans and third-party administrators of group health plans and pay out funds collected to non-grandfathered individual health plans to cover high-risk individuals. 54 Because an exchange could be inundated by individuals with high-cost conditions who were formerly uninsured or covered through the state or federal high-risk pools, the reinsurance program is intended to provide economic stability to plans by stabilizing an individual’s coverage until the exchange can pick up a substantial number of healthy enrollees. Each state that runs an exchange must run a reinsurance program. Most often, it is anticipated that a state will contract with a nonprofit reinsurance entity to operate the program, primarily collecting and distributing collected funds. A national contribution rate will be set by HHS that will give states guidance on distributing funds to health plans. Payments for the reinsurance program will be made to health plans with high cost enrollees based on a percentage of the cost of the high cost claims for essential health care services that exceed an established cost of the reinsurance cap. The HHS Proposed Rule outlines how funds will be allocated from a reinsurance fund based on a percentage of the total premium volume of health plans and total medical costs of self-insured plans. 55

I. Consumer Operated and Oriented Plan (Co-op) Program

Under section 1322(a) of the ACA, CMS was directed to establish the Consumer Operated and Oriented Plan (Co-op) program to further the development of member-governed, non-profit health insurance plans for the individual and small group markets. Co-ops were intended to have a strong consumer focus; all members of the co-op’s Board of Directors must be elected by a majority vote of the other Board members. Co-ops will be operational by July 2013. Loan funds were appropriated to aid in the start-up and capitalization of these companies.

Attorneys General may have particular interest in the establishment of co-ops in their state because they are a newly-authorized non-profit model of health care insurer. They will be subject to the Attorney General’s oversight of non-profit organizations. In addition, they will be required to meet all of a state’s health insurance requirements and thereafter will be able to participate in a state’s exchange. In light of anticipated competition for consumers by health insurers once exchanges.

54 See supra text accompanying note 8.

V. Health Care Marketplace Changes under the ACA

Due to the changes required by the ACA, as well as pre-existing national trends in the delivery of health care services, Attorneys General may anticipate continued shifts in the health care marketplace within each state. The ACA was intended to expand care to the uninsured while controlling cost, and, consequently, it contains numerous provisions that encourage outcome-based provision of care and will likely promote consolidation. These provisions are likely to continue reshaping the health care marketplace towards consolidations and mergers. Several relevant elements are discussed below.

A. Accountable Care Organizations (ACOs) (Medicare Shared Savings Program)

The ACA has several programs that seek to incentivize coordination of care to Medicare and other healthcare beneficiaries and are intended to provide cost savings as well. The intent of these Accountable Care Organizations (ACO), which were created under the ACA, is to provide and deliver a seamless and high quality of care to patients by creating partnerships of existing non-profit health care providers, or to facilitate consolidations and mergers of non-profit health care institutions to improve care while they drive down costs. Under the Medicare Shared Savings Program, there are financial incentives for an ACO that are intended to reduce growth in healthcare costs while meeting performance standards and quality of care guidelines. Some portion of savings obtained through the ACO model can be passed back to the provider, under the CMS rule.57

Those supporting ACO’s argue that they enable providers to both improve quality of care and reduce costs. Opponents—including some insurers—argue that they enable providers to fix prices and engage in other anticompetitive activity that raises costs.

The United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) have issued a policy statement that describes the conditions under which the agencies do not view an ACO as anticompetitive and will not seek to challenge it.58 One can reasonably expect that some ACOs will not meet the conditions set forth in the Policy Statement and will engage in anticompetitive activity that is not protected by the Policy Statement. Attorneys General may be interested in seeking to enjoin such activity, and seeking to obtain monetary relief on behalf of direct purchasers of the ACO’s services.

56 § 3022, 124 Stat. 395 - 399.


VI. Medicaid Expansion

The ACA mandates that by 2014, adults under the age of 65 with incomes up to 133 percent of the federal poverty level (or $14,500 for an individual and $29,700 for a family of four) be deemed eligible for Medicaid coverage, thus greatly expanding the pool of Medicaid beneficiaries.\(^{59}\) In addition, in 2014, the mandatory Medicaid income eligibility for children 6 to 19 years of age increases from 100 percent to 133 percent of the federal poverty level. Finally, from 2014 to 2016, FMAP (the federal matching share paid to cover the cost of state Medicaid) to states will be 100 percent of the cost of covering newly eligible individuals; thus states will receive significant additional funding for incremental expansion of their Medicaid population.\(^{60}\) FMAP percentages to states will decline after 2016 and all states will be required to pay 10% of costs of new eligibles, a much higher federal match than the current program.\(^{61}\) As a result, some claim that state budgets should not feel the impact of expanding Medicaid coverage through the early years after 2014, although some portion of the costs of enrollment of persons previously eligible but not yet enrolled will be felt by the states.

Under the Act’s requirements, states would expand Medicaid eligibility further through the filing of a new state plan amendment. In addition, eligibility rules for both Medicaid and the Children’s Health Insurance Program (CHIP) will become simple income-based rules, and new systems will be required by CMS to make the processing of applications easier, more standardized, and coordinated with the exchange.\(^{62}\)

Importantly, while the ACA required states to implement this expansion (failure to do so would result in loss of all federal funds supporting the entire state Medicaid program), the mandatory expansion provision has been determined by the Supreme Court to be unconstitutional. Attorneys General may seek to advise state agencies of the potential financial consequences of any refusal to expand eligibility as provided for in the ACA.\(^{63}\) The extent to which the Supreme Court’s ruling will affect Medicaid expansion is still being examined.


\(^{61}\) Id.


\(^{63}\) Supra text accompanying note 2.
A) Charities and non-profit oversight

Under their traditional common law authority, most Attorneys General have the responsibility to supervise not-for-profit entities including those involved in health care delivery. The ACA includes significant new incentives for mergers and provider collaborations to improve delivery of care and almost all of them will involve not-for-profit entities. Changes that occur as the health system is transformed are likely to require additional attention to these shifts to ensure that the public interest is served. In many states, the primary responsibility for this review will continue to fall on state Attorneys General.

The ACA also imposes several new obligations on tax exempt non-profit hospitals that clearly intersect with traditional charitable oversight functions of Attorneys General, and in some states, may supersede state laws regarding non-profit hospital requirements. New section 501(r) of the Internal Revenue Code requires that these hospitals 1) conduct a community health needs assessment every three years; 2) establish a financial assistance policy and policy related to emergency medical care with details about the basis for charges; 3) limit charges for medically necessary care to persons eligible for assistance pursuant to their hospital’s financial assistance policy and 4) a requirement that hospitals forego extraordinary collection actions against some individuals who may be eligible for financial assistance.64

In addition, the ACA indirectly expands the charitable oversight functions of Attorneys General by authorizing the creation of new non-profit entities subject to state non-profit laws. For example, under the ACA, Attorneys General will need to consider charitable oversight over any newly authorized Consumer Oriented & Operated Plans (“Co-Ops”) that are intended to be alternative not-for-profit insurance plans that provide better coordination of care, while keeping some competition in the marketplace.65 The co-ops are created as non-profit entities and must be majority controlled by consumers.66 As non-profit entities, they are subject to the Attorney General’s oversight and adherence to state law. These co-ops may face predatory pricing practices by competitive for-profit insurance companies within the exchange, which may require consumer protection activity by Attorneys General.

B) Antitrust Authority

64 § 9007, 124 Stat. 855-859
66 Id.
Attorneys General already have extensive independent anti-trust authority under state and federal statutes. Their role in enforcing antitrust laws in the formation of ACOs, or in the review of other healthcare mergers or consolidations, will require greater discussion. It is safe to say, however, that reconfiguration of the healthcare sector, whether reviewed under anti-trust, consumer or not-profit laws, will involve Attorney General consideration.\(^{67}\) Institutions or parties who are potentially aggrieved by consolidations and mergers may seek the Attorney General’s intervention, and it is likely that review under state and federal antitrust laws may be necessary.

Under the provisions of the ACA, the DOJ and FTC will facilitate the creation of ACOs by giving providers clear and practical guidance to form a new, innovative and integrated healthcare delivery model which will be deemed not to violate federal antitrust laws.\(^{68}\) Although the Joint Statement does not reference state antitrust laws and state Attorneys General, it is clear that a state-by-state analysis will be required to understand the full impact of state and federal anti-trust laws on ACOs.\(^{69}\)

The broad authority of State attorneys general in antitrust must operate within the broader mandate of ACA implementation. It is important that state antitrust enforcers cooperate closely with other staff within Attorney General offices in order to assure consistent implementation.

**C) Consumer Protection Role**

Attorneys General have the opportunity to weigh in on behalf of consumers in the new pro-consumer insurance reforms required by the ACA, using a range of tools including litigation and other traditional consumer protection approaches. They could work closely with state Insurance Commissioners to set up the state process for insurers to disclose and

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\(^{67}\) On January 6, 2012 the Governor of Kentucky, Steve Beshear, followed the recommendation of Kentucky Attorney General, Jack Conway, by rejecting a proposed hospital merger that would have created the largest health service provider in the state. That recommendation was based on a report conducted by the attorney general and release on December 30, 201. Press Release, Governor of the Commonwealth of Kentucky, Gov. Beshear’s Statement Regarding University Hospital’s Revised Merger Proposal (Jan. 6, 2011) (on file with author) available at [http://migration.kentucky.gov/Newsroom/governor/20120109hospmergerstatement.htm](http://migration.kentucky.gov/Newsroom/governor/20120109hospmergerstatement.htm); Press Release, Office of the Attorney General of Kentucky, Statement from Attorney General Jack Conway (Dec. 20, 2011) (on file with author) available at [http://migration.kentucky.gov/Newsroom/ag/hospitalmergerstatement.htm](http://migration.kentucky.gov/Newsroom/ag/hospitalmergerstatement.htm).


\(^{69}\) See id. at 17-18.
justify a premium rate increase, and then ensure that health insurers are meeting all regulatory requirements. Attorneys General may seek to weigh in publicly in cases where a rate increase appears unjustified or exceptionally large, or may consider using their consumer protection jurisdiction to determine whether they have the ability to challenge unreasonably high rate increases on standard consumer protection grounds, particularly if there is evidence of deceptive business practices. State Attorneys General also may wish to file comments opposing state petitions to permit insurers to allocate more of their premium dollars to administrative expenses and profit than would be permitted by the Medical Loss Ratio as discussed earlier. Some other specific consumer protection issues that may arise are identified below.

Summary of Benefits and Coverage Explanation Requirements: A set of HHS Proposed Rules require group health plans and other insurers offering group and individual health insurance coverage to provide a summary of benefits and coverage explanation to all applicants, enrollees and policyholders. 70 The summary of benefits and coverage explanation must accurately describe the benefits and coverage being offered under a health plan. HHS requires new uniform and standard definitions of insurance coverage and medical terms used in describing the insurance coverage. In addition, health plans must clearly and accurately describe and give examples of the types of coverage and the cost associated with that coverage available to a consumer.

The National Association of Insurance Commissioners (“NAIC”) has drafted a sample and standard summary of benefits and coverage explanation for health plans to use. The purpose of the Rule is to give consumers a better, simpler and more standard way of understanding benefits and coverage, which in turn will allow them to better comparison shop when purchasing health insurance. The Rule applies to individual plans and insured and self-insured group plans regardless of being grandfathered by the ACA. Sanctions will be imposed if a health plan fails to create the required summary of benefits and coverage and if the health plan fails to provide the summary to a consumer in the required time period set by the Rule. Attorneys General may choose to work with their Insurance Commissioners or independently to ensure that disclosures to consumers are accurate and adequate in light of state and federal law.

Wellness Program Issues: Sections 2705(j)-(n) of the Public Health Service Act (PHSA), enacted in section 1201 of the ACA, substantially codify in statute the language of a pre-ACA regulation allowing insurers to raise or lower their rates by up to 20% based on an individual’s compliance with a “wellness” program. 71 That language authorizes insurers to vary rates based on compliance with a wellness program only if the program “is not a subterfuge for discriminating based on a health status factor.” It is possible that insurers


may establish wellness programs that are surrogates for health status, thus violating the statute. Attorneys General may wish to seek to enjoin such programs as deceptive and/or unlawful, and perhaps to seek monetary relief on behalf of policyholders who were surcharged based on wellness programs that are surrogates for health status.

**Disparities in Coverage Issue:** Another potential consumer protection issue stems from provisions in the ACA that prohibit employers from offering insurance plans to their highly paid executives that they do not offer to their rank and file employees. Prior to the enactment of the ACA, section 105 of the Internal Revenue Code already prohibited such discrimination by employers offering self-insured coverage; section 2716 of the PHSA extends this rule so that it also applies to insured coverage. Attorneys General may wish to work with state Insurance Commissioners to determine if this activity exists in their state and seek to enforce this section.

**Low Annual Limits:** Attorneys General may consider the practices of insurers who sell policies with extremely low annual limits who fail to obtain the required waivers for limits below the federal requirements. Section 2711 of the PHSA, enacted in sec. 1001 of the ACA, prohibits lifetime limits in health insurance policies effective Sept. 23, 2010, and prohibits annual limits effective in 2014. It permits the Secretary to establish a minimum annual limit that policies issued before 2014 must provide, and provides that in setting that minimum “the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.” HHS has promulgated a regulation that sets the minimum annual limit at $750,000 for 2011, at $1.25 million for 2012, and at $2 million for 2013, while also providing that these required minimums may be waived if complying with them “would result in a significant decrease in access to benefits or a significant increase in premiums.” HHS has also established a process through guidance pursuant to which any insurer selling a policy with limits of less than $750,000 may seek a waiver from the $750,000 minimum annual limit established in the regulation. Most insurers selling policies with extremely low annual limits have applied for and been granted such waivers. Some insurers selling such policies, however, have not applied for a waiver, and thus are violating the statute. As in all matters dealing with insurance, state Attorneys General should consider working with insurance commissioners in seeking to enjoin the sale of such policies.

**Navigators:** The ACA requires that exchanges utilize “navigators” to assist consumers with obtaining insurance through the exchange. The navigator is intended to be an impartial guide to help consumers understand their choices and responsibilities. Although the ACA does authorize agents and brokers to serve as navigators, it does not allow them to be paid by insurance companies “in connection with the enrollment of any qualified

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72 § 1001, 124 Stat. 135.

73 § 1001, 124 Stat. 131.

74 75 Fed. Reg. 37191 (June 28, 2010)
individuals or employees of a qualified employer in a qualified health plan.” Attorneys General may wish to seek injunctions prohibiting paid agents from acting as navigators or indirectly acting to circumvent this limitation.

**Recommendation:** In order to ensure that state insurance products are sold in compliance with the law and that the regulations provide protection to the insured in each state, state Attorneys General may consider participating in the various executive branch commissions and legislative committees dealing with the establishment of exchanges in each state and working closely with their state Insurance Commissioners during planning and implementation. In particular, Attorneys General may seek to ensure that the exchanges are structured to facilitate competition by, for example, standardizing policies and conducting a competitive bidding process, and not allowing further entrenchment of carriers that already have dominant market power.

**D) Medicaid Expansion**

The primary responsibility for Medicaid expansion is the state Medicaid director and the state agency responsible for the Medicaid program. Medicaid directors will need to rely on their counsel, who are often assistant attorneys general, in managing the expansion and the resulting changes. Attorneys General can work with their State Medicaid Agency to ensure the state plan amendment specifics meet the federal requirements to maximize coverage and draw down federal funds. They are also in the position to encourage public support for the expansion of coverage for adults and children and work with the state Medicaid agency to ensure seamless transition within expanded coverage provisions.

Attorneys General who provide counsel to Medicaid directors will want to understand the fiscal and programmatic implications of the Medicaid expansion in their state. For example, the ACA provides that states may not reduce Medicaid eligibility below pre-ACA levels, although there are exceptions being granted by HHS in waivers. Attorneys General should be familiar with the impact of ACA changes on Medicaid eligibility within their state budgets. They also will need to understand the fiscal impact of additional federal dollars flowing to their states as the number of uninsured individuals who become eligible for Medicaid under the Act grows. Significant overhauls of state computer eligibility systems is required by the Act to meet its simplification goals and to coordinate with exchanges. Issues may arise around procurement and the timeliness of these changes.

It will be a challenge to be sure that the exchanges work and are accessible to Medicaid recipients. Coordination among assistant attorneys general assigned to these different agencies has the potential to cut through administrative road blocks that always emerge in times of great change. Defensively, Attorneys General are likely to be required to defend against federal or advocacy group action if either seeks penalties or give-backs from the States for errors or violations of the ACA Medicaid requirements, should that occur. Given the technical issues raised with respect to the Medicaid expansion provisions of the ACA, Attorneys General may choose to utilize outside counsel in defensive litigation. It will still be useful for key staff to understand the Act’s requirements and the anticipated challenges a state may face as the Medicaid expansion issues are considered.
E) Medicaid Fraud

There is no question that these sweeping changes will result in opportunities for fraudulent behavior. Attorneys General each have Medicaid Fraud Units (MFU) that are primarily responsible for the detection, investigation and prosecution of Medicaid Fraud. By federal law, these units are organized separately from the offices of Medicaid Directors. Because of their funding, they are also often separate from the ordinary organizational overview of senior attorney general staff.

It is essential that Medicaid Fraud units be familiar with the new ACA rules and the new Medicaid payment suspension provisions in the ACA. They should also be cognizant of provisions requiring improved technology to help fight fraud, enhanced screening and other enrollment requirements for Medicaid providers and suppliers, provisions for improved coordination for fraud prevention efforts, the sharing of data to fight fraud and the ability to obtain tools to target high-risk entities. 75

F) Criminal Jurisdiction

Some state attorneys general have criminal authority for enforcement of some provisions of the ACA, particularly those that limit insurance company action in violation of the statute (or state statutes) or which deceive or mislead consumers. If the Attorney General possesses broad criminal authority, it is likely there will be substantial demand for action, based on non-compliance or violation of the state’s criminal laws.

G) Defensive Issues

1) Failure of State to Adopt Required Provisions of Law

The ACA will require significant modifications in many state’s laws and regulations governing the commercial insurance market. State insurance commissioners and legislators must work with other state officials to assure that their insurance regulations in the entire individual and small group markets comply with federal law. An exchange can operate only when those laws are consistent with the requirements of the ACA. Although the ACA provides that the federal government will operate the exchange if a state fails to provide one, the law is silent on failure to adopt other ACA requirements. For example, what will happen if a state does not adopt required pro-consumer reforms to the private insurance market? Will the federal government be able to modify state insurance markets when it

operates an exchange? If not, how will state citizens eligible for tax credits under the ACA access them through a federal exchange? Attorneys General may want to affirmatively ensure that these issues are on the table while their states debate insurance marketplace reforms and provide guidance regarding the implications if they are not adopted.

Attorneys General are also likely to be directly involved if their state fails to comply with the ACA’s requirements to establish an exchange in compliance with the federal requirements. Under the Act’s provisions, if the exchange is not established, HHS will either operate the exchange within the state, or allow states to propose a shared model of governance between states and HHS. The details of both processes have not yet been clarified. In the event the exchange is not established in time, or is not in compliance with the requirements, the Attorney General is likely to be representing the state in defensive litigation.

Little has been written about the impact of state failures to adopt guaranteed issue or community rating, as required under the ACA. It is reasonable to assume, given the current climate, that some state legislatures simply will not comply with the law’s requirements and that the federal government or individual plaintiffs will commence legal action against states for their failure to comply with federal law. In addition, in some states, it is likely that governors or insurance commissioners will seek to apply the new requirements through administrative process, and that their power to do so is likely to be challenged. Attorney General staff should be cognizant of executive action seeking to comply with the ACA that may or may not meet the state’s own requirements or process.

VIII. Conclusion

The ACA is a complex, lengthy statute which includes multiple new provisions that require state compliance. Although the statute rarely mentions state Attorneys General specifically, there is no question there will be substantial involvement by Attorneys General, both in planning and implementation, over the next several years. This introductory memo is not intended to be inclusive or complete, but simply provides offices with review of the key areas that are likely to require greater knowledge and understanding.

For further information, contact the Health Law Initiative at the National State Attorneys General Program at Columbia Law School: (212) 851-1061.

76 § 1321(c), 124 Stat. 186 - 187.