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# ARTICLE

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## REFLECTIONS ON THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND THE IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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TIMOTHY STOLTZFUS JOST<sup>†</sup>

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### INTRODUCTION

One of the most common criticisms of the Patient Protection and Affordable Care Act (PPACA)<sup>1</sup> is that it constitutes a government takeover of America’s health care system. By this, of course, is meant a *federal* government takeover. PPACA will certainly increase the federal government’s presence in health care. It imposes new federal regulations on insurers, creates a new federal program for funding health insurance for uninsured middle-income Americans, dramati-

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<sup>†</sup> Substantial portions of this Article are based in whole or in part on the author’s personal experience as a National Association of Insurance Commissioners consumer representative.

<sup>1</sup> See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

cally expands the Medicaid program, and in all likelihood will increase the influence of the Medicare program on the organization of the overall health care delivery system.

Yet PPACA also expands the responsibility and authority of the states. The states, for example, are primarily responsible for enforcing PPACA's insurance regulatory reforms.<sup>2</sup> They are also responsible for establishing the exchanges—the entities through which Americans will purchase insurance and apply for subsidies<sup>3</sup>—and for managing reinsurance and risk adjustment programs.<sup>4</sup> According to the Act, states will be responsible for reviewing health insurance premiums and for assisting consumers with complaints against their insurers.<sup>5</sup>

However, PPACA not only increases the authority of the federal and state governments, it also empowers and assigns significant responsibility to a private agency: the National Association of Insurance Commissioners (NAIC). The NAIC is a private, nonprofit organization that has coordinated the activities of the nation's state and territorial insurance commissioners since 1871.<sup>6</sup> Its members are the insurance commissioners of the states and territories.<sup>7</sup> Traditionally, the NAIC has drafted model statutes and regulations for the states, served as a clearinghouse for insurance data, and provided a forum for insurance commissioners to discuss and address regulatory issues.<sup>8</sup>

This Article discusses the role of the NAIC in health care reform. It first describes the role of the NAIC in the reforms initiated by PPACA, then considers why Congress gave the NAIC significant responsibility for health reform, and finally examines how the NAIC has carried out

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<sup>2</sup> *Id.* § 1321(a)–(b), 42 U.S.C.A. § 18041(a)–(b) (West Supp. 1B 2010).

<sup>3</sup> *See id.*

<sup>4</sup> *See* § 1311(b), 42 U.S.C.A. § 18031(b) (requesting that each state establish an “American Health Benefit Exchange” to facilitate the purchase of individual health plans and assist small business owners in providing health plans to their employees); *id.* § 1341, 42 U.S.C.A. § 18061 (inviting states to enact reinsurance programs to provide reinsurance payments to insurance issuers that cover “high-risk individuals”); *id.* § 1343, 42 U.S.C.A. § 18063 (requesting states to assess a charge on “low actuarial risk plans” and provide payment to “high actuarial risk plans”).

<sup>5</sup> *See id.* sec. 1002, § 2793, 42 U.S.C.A. § 300gg-93 (West Supp. 1A 2010) (providing grants to states for the creation of “independent office[s] of health insurance assistance” to respond to complaints about coverage); *id.* sec. 1003, § 2794, 42 U.S.C.A. § 300gg-94 (inviting states in conjunction with the Secretary of Health and Human Services to establish a process for reviewing “unreasonable increases” in insurance premiums).

<sup>6</sup> *About the NAIC*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/index\\_about.htm](http://www.naic.org/index_about.htm) (last visited Mar. 15, 2011).

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

these responsibilities. It contends that Congress found in the NAIC not only a very effective partner for involving the states in health care reform, but also a vehicle for gaining access to the technical expertise and public engagement that is necessary for effective health care reform implementation.

#### I. THE NAIC IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Ten provisions of PPACA refer to the NAIC.<sup>9</sup> Several of these sections require the Department of Health and Human Services (HHS)—which is primarily responsible for establishing the regulations that will implement PPACA—to consult with the NAIC. One provision, for example, requires HHS to consult with the NAIC in developing a summary of benefits and a coverage disclosure document;<sup>10</sup> another requires HHS to define permissible age bands by conferring with the NAIC;<sup>11</sup> yet another requires HHS to work with the NAIC to establish regulations to govern compacts for the interstate sale of insurance.<sup>12</sup> Section 1341 instructs HHS to develop standards in consultation with the NAIC in order to establish an interim reinsurance program and mandates that assessments from insurers for funding the reinsurance fund be based on NAIC estimates.<sup>13</sup> Section 1321—the central provision of PPACA that authorizes HHS to implement the Act's insurance market reform provisions—directs HHS to consult with the NAIC in establishing regulations to implement the exchanges, qualified health plan requirements, risk-adjustment and reinsurance provisions, and the regulations that will create the insurance exchanges and other insurance reforms of the Act.<sup>14</sup>

Other sections of PPACA give the NAIC a more direct role in PPACA's implementation. The exchanges, for example, must adopt a uniform enrollment form that takes into account criteria submitted by

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<sup>9</sup> See *infra* notes 10-22.

<sup>10</sup> PPACA sec. 1001(5), § 2715, 42 U.S.C.A. § 300gg-15.

<sup>11</sup> *Id.* sec. 1201(4), § 2701(a)(3), 42 U.S.C.A. § 300gg(a)(3).

<sup>12</sup> *Id.* § 1333, 42 U.S.C.A. § 18053 (West Supp. 1B 2010).

<sup>13</sup> *Id.* § 1341(b)(1), (b)(3)(B)(iii), 42 U.S.C.A. § 18061(b)(1), (b)(3)(B)(iii).

<sup>14</sup> See *id.* § 1321(a), 42 U.S.C.A. § 18041(a) (requiring the HHS Secretary to consult with the NAIC in implementing regulations of health care exchanges).

the NAIC to HHS.<sup>15</sup> Another provision requests the NAIC to develop model standards and forms for private insurers to use in reporting fraud and abuse to state insurance commissioners or other state agencies.<sup>16</sup> Yet another section requests the NAIC to develop standard methodologies and definitions for determining medical-loss ratios.<sup>17</sup>

Finally, PPACA incorporates—or requests the NAIC to amend—existing NAIC model laws. PPACA, for example, provides that procedures for external review of health plans must include the consumer protections in the NAIC Uniform External Review Model Act.<sup>18</sup> It also instructs HHS to request the NAIC to revise its Medicare Supplement insurance standards so as to require at least nominal cost sharing under C and F policies,<sup>19</sup> which currently have almost no cost sharing.<sup>20</sup>

As implementation of PPACA has proceeded, moreover, the NAIC has been given responsibilities even beyond those assigned by the statute itself. HHS has not only consulted with the NAIC to develop the summary of benefits and disclosure document, as PPACA requires, but has also delegated to the NAIC the responsibility for convening the panel of consumers, industry representatives, and regulators responsible under PPACA for drafting that document.<sup>21</sup> The NAIC also developed at the request of HHS a form for insurers to use in fulfilling the obligation PPACA imposes on them to justify unreasonable premium increases.<sup>22</sup> Finally, the NAIC has continued in its traditional role of

<sup>15</sup> *Id.* § 1311(c)(1)(F), 42 U.S.C.A. § 18031(c)(1)(F) (requiring qualified health plans to “utilize a uniform enrollment form . . . that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary”).

<sup>16</sup> *Id.* sec. 6603, § 2794, 42 U.S.C.A. § 300gg-95 (West Supp. 1A 2010).

<sup>17</sup> *Id.* sec. 10101(f), § 2718(c), 42 U.S.C.A. § 300gg-18(c).

<sup>18</sup> *Id.* sec. 1001(5), § 2719(4), 42 U.S.C.A. § 300gg-19(4); *see also* HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (Nat’l Ass’n of Ins. Comm’rs 2010), *available at* [http://www.naic.org/documents/committees\\_b\\_uniform\\_health\\_carrier\\_ext\\_rev\\_model\\_act.pdf](http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf).

<sup>19</sup> *Id.* sec. 3210(a), § 1882(y), 42 U.S.C.A. § 1395ss(y).

<sup>20</sup> *See* CTRS. FOR MEDICARE & MEDICAID SERVS., CMS PRODUCT NO. 02110, CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 11 (2011), *available at* <http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf> (noting that the C and F policies cover one-hundred percent of almost all benefits available).

<sup>21</sup> *See* Letter from Jane Cline, President, Nat’l Ass’n of Ins. Comm’rs, et al. to Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs., and Hilda Solis, Sec’y, U.S. Dep’t of Labor (Dec. 17, 2010), *available at* [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_ppaca\\_letter\\_to\\_sebelius.pdf](http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf) (providing “the standard definitions and standards for the summary of benefits and coverage” to HHS and the Department of Labor).

<sup>22</sup> *See* Nat’l Ass’n of Ins. Comm’rs, Draft Rate Disclosure Form (May 25, 2010), *available at* [http://www.naic.org/documents/index\\_health\\_reform\\_rate\\_review\\_final](http://www.naic.org/documents/index_health_reform_rate_review_final)

creating model statutes for the states. This task is quite important, since PPACA requests that the states implement its regulatory requirements even though many states currently lack the explicit authority to enforce federal law otherwise.<sup>23</sup> The NAIC has, for example, drafted model statutes to implement provisions of the reform law that took effect for plans beginning six months after the effective date of PPACA.<sup>24</sup>

## II. WHY THE NAIC?

There are several apparent reasons that the NAIC was given these responsibilities under the reform law. First, the NAIC asked for a role in implementing the law. The NAIC represented to Congress that its open and transparent model-law development process was the most consumer-friendly approach for implementing PPACA—indeed, that the NAIC’s process was superior to the HHS rulemaking process.<sup>25</sup> Congress responded by giving the NAIC a role.

Second, the NAIC is a natural partner for implementation given the role of the states in the reform legislation. The Senate’s version of PPACA, which was ultimately adopted by Congress, creates a partnership between federal and state governments for implementing the legislation.<sup>26</sup> As noted above, PPACA asks the states to enact and enforce

rate\_filing\_summary.pdf; see also PPACA sec. 1003, § 2794, 42 U.S.C.A. § 300gg-94 (detailing the review process for “unreasonable increases in premiums”). HHS “reviewed and incorporated elements” from this form in developing its own form. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, DEP’T OF HEALTH & HUMAN SERVS., CMS-10379, SUPPORTING STATEMENT FOR PAPERWORK REDUCTION SUBMISSION: RATE INCREASE REVIEW AND DISCLOSURE REQUIREMENTS 6 (2011), available at <http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp> (search for document serial number 10379).

<sup>23</sup> See *Survey on State Authority to Enforce PPACA Immediate Implementation Provisions*, NAT’L ASS’N INS. COMMISSIONERS & CENTER FOR INS. POL’Y & RES. (Aug. 5, 2010), [http://www.naic.org/documents/index\\_health\\_reform\\_section\\_ppaca\\_state\\_enforcement\\_authority.pdf](http://www.naic.org/documents/index_health_reform_section_ppaca_state_enforcement_authority.pdf) (surveying state law on PPACA-related enforcement authority).

<sup>24</sup> These include provisions covering adult children up to age twenty-six, internal and external review of adverse coverage decisions, preexisting conditions for children, lifetime and annual limits on care, and rescissions. For links to NAIC draft model laws, see *Committees & Activities: Regulatory Framework (B) Task Force*, NAT’L ASS’N INS. COMMISSIONERS & CENTER FOR INS. POL’Y & RES., [http://www.naic.org/committees\\_b\\_regulatory\\_framework.htm](http://www.naic.org/committees_b_regulatory_framework.htm) (visited Mar. 15, 2011).

<sup>25</sup> See Letter from Roger A. Sevigny, President, Nat’l Ass’n of Ins. Comm’rs, et al. to Max Baucus, Chairman, Senate Fin. Comm. (Sept. 30, 2009), available at [http://www.naic.org/documents/testimony\\_0909\\_officers\\_to\\_baucus\\_healthcare.pdf](http://www.naic.org/documents/testimony_0909_officers_to_baucus_healthcare.pdf) (arguing for the benefits of the NAIC model-law development process).

<sup>26</sup> See Timothy S. Jost, *Pro & Con: State Lawsuits Won’t Succeed in Overturning the Individual Mandate*, 29 HEALTH AFF. 1225, 1225 (2010) (noting the Senate bill’s reliance on the states for regulation and enforcement). The House bill, by contrast, would

PPACA's insurance reforms and to create the exchanges and risk-transfer programs.<sup>27</sup> But PPACA assigns to the federal government—more specifically, to HHS—responsibility for adopting regulations to implement the law.<sup>28</sup> Cooperating and consulting with each of the states independently while drafting these regulations would be unwieldy. Furthermore, given the existence of the NAIC, establishing a new institutional framework to coordinate state insurance departments in addressing the technical problems raised by implementation of PPACA's insurance regulations would be redundant and unrealistic.

Of course, a number of associations represent the states: the National Council of State Legislatures (NCSL), the National Governors Association (NGA), and more immediately relevant, the National Council of Insurance Legislators (NCOIL). The NCSL and NGA, however, do not have an established process for drafting model legislation or regulations. NCOIL does draft model legislation, but has less experience with health insurance regulation and less history of working with Congress on regulatory issues.<sup>29</sup> Although all states are considered members of NCOIL, only twenty-eight states are full contributing members.<sup>30</sup> The NAIC, by contrast, has an established program for drafting model laws and regulations and a structure that enables it to draw on state technical staff to work on regulatory issues.<sup>31</sup> All states and territories participate fully in its activities.<sup>32</sup> It was

have established a national "Health Choices Administration" and would have charged this entity with implementing the legislation. See *Affordable Health Care for America Act*, H.R. 3962, 111th Cong. §§ 241–243 (2009) (detailing the responsibilities of the independent agency and its commissioner).

<sup>27</sup> See *supra* notes 2–4 and accompanying text (outlining the general reform provisions as they relate to states).

<sup>28</sup> PPACA § 1321(a)(1), 42 U.S.C.A. § 18041(a)(1) (West Supp. 1B 2010) (allocating responsibility for issuing regulations to meet PPACA's reform requirements to HHS).

<sup>29</sup> NCOIL's basic approach to Congress is one of confrontation rather than cooperation. See *History and Purpose*, NAT'L CONF. INS. LEGISLATORS, <http://www.ncoil.org/ncoilinfo/about.html> (last visited Mar. 15, 2011) (stating that "NCOIL is an adamant, vocal opponent of any Congressional initiative" that runs against its organizational goals).

<sup>30</sup> *NCOIL Member States*, NAT'L CONF. INS. LEGISLATORS, <http://www.ncoil.org/ncoilinfo/member.html> (last visited Mar. 15, 2011).

<sup>31</sup> See *FAQ*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/documents/about\\_faq.pdf](http://www.naic.org/documents/about_faq.pdf) (last visited Mar. 15, 2011) (describing the process of drafting model laws); *Model Law Development Framework: Frequently Asked Questions*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/documents/committees\\_models\\_faqs.pdf](http://www.naic.org/documents/committees_models_faqs.pdf) (last visited Mar. 15, 2011) (setting out the process and criteria for model-law development); *Procedures for Model Law Development: Adopted May 2007, Amended September 2008*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., <http://www.naic.org/>

therefore the obvious agent to collectively represent the states in collaborating with the federal government to address technical issues PPACA raised.

The technical expertise available to the NAIC is a third advantage that it offered for advising HHS on implementation issues. Prior to the adoption of PPACA, HHS had only a handful of staff directly dedicated to the regulation of private insurance.<sup>33</sup> The NAIC, on the other hand, had access through its committee and working group structure to the regulatory staff members of all of the states and territories, including skilled actuaries, accountants, and lawyers.<sup>34</sup> The regulatory staff of HHS has grown dramatically since PPACA's enactment with the creation of the Office of Consumer Information and Insurance Oversight (OCIIO).<sup>35</sup> The OCIIO has recently been moved to the Centers on Medicare and Medicaid Services (CMS) and renamed the Center for Consumer Information and Insurance Oversight (CCIIO).<sup>36</sup> CCIIO's expertise is supplemented by resources and knowledge already existing in CMS, which oversees Medicare Ad-

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documents/committees\_models\_procedures.pdf (last visited Mar. 15, 2011) (describing NAIC's model-law development criteria as well as procedures for developing guidelines, the adoption process, and implementing model laws).

<sup>32</sup> See *Map of NAIC States & Jurisdictions*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm) (last visited Mar. 15, 2011) (showing that all U.S. states and territories are members of the NAIC).

<sup>33</sup> In 2008, HHS had only four people assigned to enforcement of the insurance regulation provisions of the Health Insurance Portability and Accountability Act. See *Business Practices in the Individual Health Insurance Market: Termination of Coverage: Hearing Before the H. Comm. on Oversight and Gov't Reform*, 110th Cong. 74-75 (2008) (statement of Abby L. Block, Director, Center for Drug and Health Plan Choice, Centers for Medicare and Medicaid Services) (reporting that only four federal officials were responsible for ensuring that insurers complied with HIPAA "for the entire United States of America").

<sup>34</sup> See *Actuarial & Statistical Department*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/actuarial\\_statistical\\_dept.htm](http://www.naic.org/actuarial_statistical_dept.htm) (last visited Mar. 15, 2011) (describing the actuarial and statistical resources available to the NAIC); *Legal Division*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/legal\\_home.htm](http://www.naic.org/legal_home.htm) (last visited Mar. 15, 2011) (providing an overview of resources available through the NAIC's Legal Division).

<sup>35</sup> See *The Office of Consumer Information and Insurance Oversight*, U.S. DEPARTMENT HEALTH & HUM. SERVICES, <http://www.hhs.gov/ociio/index2.html> (last visited Mar. 15, 2011) (presenting the OCIIO, the new office within HHS created to implement PPACA requirements such as enforcing insurance compliance, providing state guidance, and compiling data on insurance options).

<sup>36</sup> *About Us*, CENTER FOR CONSUMER INFO. & INS. OVERSIGHT, <http://cciio.cms.gov/resources/about/index.html> (last visited Mar. 15, 2011).

vantage and Part D prescription drug plans;<sup>37</sup> the Departments of Treasury and Labor, which are responsible for regulating employee benefit plans;<sup>38</sup> and the Office of Personnel Management, which runs the Federal Employee Health Benefits Program.<sup>39</sup> Nevertheless, the responsibility for regulation of private insurance has traditionally resided with the states, which continue to have the most expertise and experience with such regulation.<sup>40</sup> This was the expertise that the NAIC offered the federal government for health reform implementation.

Federal law has often relied on the technical competence of private organizations to shape and implement regulatory policy. Since its inception, the Medicare program has turned to private accreditation agencies to establish standards for hospitals and other health care providers as well as to certify compliance with these standards.<sup>41</sup> Medicare and Medicaid also rely on accreditation of managed care organizations.<sup>42</sup> The Food and Drug Administration relies on private organizations to inspect facilities where medical devices are manufactured.<sup>43</sup>

<sup>37</sup> See Helen Lee, *CMS Oversight*, 14 J. MANAGED CARE PHARMACY S22, S22 to S23 (2008) (describing CMS oversight of these programs).

<sup>38</sup> See PATRICK PURCELL & JENNIFER STAMAN, CONG. RESEARCH SERV., RL 34443, SUMMARY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) 1 (2009) (noting that the Treasury Department “oversees standards for plan participation, vesting, and funding” and the Labor Department “regulates fiduciary standards and requirements for reporting and disclosure of financial information”).

<sup>39</sup> 5 U.S.C. § 8909(a) (2006).

<sup>40</sup> See Letter from Jane Cline, President, Nat’l Ass’n of Ins. Comm’rs, et al. to Nancy Pelosi, Speaker, U.S. House of Representatives, and Harry Reid, Majority Leader, U.S. Senate (Jan. 6, 2010), available at [http://www.naic.org/documents/testimony\\_100106\\_health\\_reform\\_letter\\_officers.pdf](http://www.naic.org/documents/testimony_100106_health_reform_letter_officers.pdf) (noting that “[s]tate insurance regulators have extensive experience and expertise in regulating health insurance” and that “[t]hey are closer to consumers and have a better understanding of the markets they regulate”).

<sup>41</sup> See Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 840-45 (1983) (detailing the accreditation procedures of the privately run Joint Commission on Accreditation of Hospitals); Timothy Stoltzfus Jost, *Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?*, LAW & CONTEMP. PROBS., Autumn 1994, at 15, 15-17 [hereinafter Jost, *Healthy Relationship?*] (examining Medicare’s reliance on the private Joint Commission on Accreditation of Healthcare Organizations to accredit Medicare-financed health services).

<sup>42</sup> See 42 U.S.C. § 1395w-22(e)(4) (providing that private accreditation organizations may accredit a Medicare Advantage organization that meets applicable standards); *id.* § 1396u-2(c)(2)(B) (allowing states not to duplicate the managed care accreditation requirements of private accrediting organizations).

<sup>43</sup> See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-07-157, MEDICAL DEVICES: STATUS OF FDA’S PROGRAM FOR INSPECTIONS BY ACCREDITED ORGANIZATIONS 6-9 (2007) (detailing the FDA medical-device accreditation process for private organizations).

Private accreditation bodies offer the federal government specialized competence for addressing technical problems, as well as the ability to respond quickly and agilely to regulatory problems as they arise.<sup>44</sup> The Joint Commission on Accreditation of Healthcare Organizations, for example, regularly reviews its accreditation standards and updates them much more frequently and rapidly than HHS updates its corresponding hospital certification requirements, which are used for nonaccredited hospitals.<sup>45</sup> Similarly, the NAIC has the capacity, through state agency staff, to analyze technical issues competently and, when necessary, relatively quickly.<sup>46</sup>

### III. THE NAIC PROCESS

Congress also saw the NAIC as an attractive partner for HHS in the implementation of PPACA because of the NAIC's unusually open and participatory administrative process.<sup>47</sup> Although the NAIC meets together for several days three times a year to carry out its business (and occasionally holds interim meetings to address particular issues), most of its work is carried out through open conference calls.<sup>48</sup> These are scheduled as needed, but when a rule is in the process of being made, committees can meet once or twice a week for one to three hours at a time. A drafting subgroup, composed of technical staff drawn from several state insurance departments, prepares a proposal which is circulated to regulators and to "interested parties" who have registered for participation in the process.<sup>49</sup> The subgroup then presents and discusses the proposal on a conference call. After the

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<sup>44</sup> See Jost, *Healthy Relationship?*, *supra* note 41, at 29-30 (naming cost savings and adaptability as reasons that Congress may rely on private accreditation).

<sup>45</sup> See *id.* at 30-31 (noting that changes in government regulation require both the time consuming notice-and-comment process and "prolonged scrutiny from the Office of Management and Budget," which private accreditation companies can avoid).

<sup>46</sup> See sources cited *supra* note 31.

<sup>47</sup> See *Procedures for Model Law Development: Adopted May 2007, Amended September 2008*, *supra* note 31 (prescribing NAIC's process for adopting model laws, which allows interested parties to comment via committee). Much of the following description of the NAIC process is based on my personal knowledge gained from my experience as a funded consumer representative. See *infra* note 54 and accompanying text.

<sup>48</sup> See *NAIC Conference Calls & Interim Meetings Calendar*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/meetings\\_calendar.htm](http://www.naic.org/meetings_calendar.htm) (last visited Mar. 15, 2011) (demonstrating the range of topics and indicating that interested parties may participate in calls).

<sup>49</sup> "Interested parties" are persons or entities, other than regulators, with an interest in the topic under consideration by the NAIC.

subgroup has completed its consideration, the call is opened up—first to other regulators and then to “interested parties”—and a discussion that often involves a number of regulators and interested parties presenting varying perspectives follows. If an issue is resolved, a draft is “exposed,” usually for at least a week, to receive written comments.<sup>50</sup> These written comments, as well as further oral comments, are considered at the next call.

Once all issues are resolved, the working group adopts a proposed model law or regulation, which is then sent onto the appropriate NAIC committee—usually the Health Insurance and Managed Care or “B” Committee if health insurance issues are involved<sup>51</sup>—for revision and adoption. The committee usually considers the proposal on an open call with participation by the working group, other regulators, and interested parties. A proposal will finally be voted on by the NAIC Executive Committee and the “Plenary,” the full body of all commissioners. The committees are composed of the commissioners themselves, as is the Plenary.<sup>52</sup>

“Interested parties” who participate in the process may include insurers and their lobbyists and lawyers, but they also may include insurance agents and brokers, who seem to exercise tremendous influence at the NAIC.<sup>53</sup> Health care providers and vendors of insurance-related products and services may also be interested parties, in addition to representatives of outside experts like the American Academy of Actuaries. But “interested parties” also include consumer representatives.

The NAIC is unusual in that it pays the expenses of a number of consumer representatives to participate in its deliberations. Under its consumer representation program, initiated in 1992, each year the NAIC chooses a number of individuals to serve as “funded” consumer

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<sup>50</sup> See *NAIC Exposure Document Index*, NAT’L ASS’N INS. COMMISSIONERS & CENTER FOR INS. POL’Y & RES., [http://www.naic.org/committees\\_exposure\\_drafts.htm](http://www.naic.org/committees_exposure_drafts.htm) (last visited Mar. 15, 2011) (displaying the list of the most recent “exposed” documents).

<sup>51</sup> For a list of the NAIC’s committees, see *Committees & Activities*, NAT’L ASS’N INS. COMMISSIONERS & CENTER FOR INS. POL’Y & RES., [http://www.naic.org/index\\_committees.htm](http://www.naic.org/index_committees.htm) (last visited Mar. 15, 2011).

<sup>52</sup> See NAT’L ASS’N OF INS. COMM’RS, 2011 COMMITTEE LIST 4-11 (2011), *available at* [http://www.naic.org/documents/committees\\_cmtelist.pdf](http://www.naic.org/documents/committees_cmtelist.pdf) (listing the structure and membership of the Plenary and Executive Committees).

<sup>53</sup> See Press Release, Nat’l Ass’n of Ins. Comm’rs, NAIC Names 2010 Consumer Liaison Representatives (Mar. 2, 2010), *available at* [http://www.naic.org/Releases/2010\\_docs/2010\\_consumer\\_reps.htm](http://www.naic.org/Releases/2010_docs/2010_consumer_reps.htm) (listing the 2010 funded and unfunded consumer representatives).

representatives.<sup>54</sup> During 2010, when the NAIC fulfilled many of its statutory responsibilities under PPACA, eighteen funded consumer representatives were chosen, seventeen of whom were able to serve for the entire year.<sup>55</sup> These consumer representatives may join NAIC conference calls without charge—other interested parties must pay a per-minute fee—and receive an annual budget to cover the cost of attending the NAIC's three annual meetings.<sup>56</sup> The NAIC also has a Consumer Participation Board of Trustees consisting of six consumer representatives and six commissioners. This Board selects the other consumer representatives, appoints a consumer liaison committee, and represents the interests of NAIC consumers.<sup>57</sup>

Funded consumer representatives must represent legitimate consumer organizations that cannot cover the costs of consumer participation and must demonstrate consumer-oriented skills and an expertise in insurance issues.<sup>58</sup> During 2010, the consumer representatives primarily represented state-based consumer advocacy organizations, although some represented national organizations.<sup>59</sup> Four, including the author, were law professors.<sup>60</sup> For 2010, ten additional consumer representatives, representing national disease and consumer advocacy organizations that could afford to cover their expenses, served as unfunded consumer representatives.<sup>61</sup>

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<sup>54</sup> See *Consumer Participation at NAIC*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/consumer\\_participation.htm](http://www.naic.org/consumer_participation.htm) (last visited Mar. 15, 2011) (describing the funded representative program and application process).

<sup>55</sup> See Press Release, Nat'l Ass'n of Ins. Comm'rs, *supra* note 53. One of the consumer representatives was hired to work for CCIIO.

<sup>56</sup> *Consumer Participation at NAIC*, *supra* note 54.

<sup>57</sup> See Agenda, Executive (Ex) Committee, Nat'l Ass'n of Ins. Comm'rs, attachment 1, § 2 (Mar. 27, 2010), available at [http://www.naic.org/meetings1003/ex\\_materials.pdf](http://www.naic.org/meetings1003/ex_materials.pdf) (describing the structure, election process, and term of service for the NAIC Consumer Participation Board).

<sup>58</sup> See *2011 Criteria for Selection, NAIC Funded Consumer Liaison Representatives*, NAT'L ASS'N INS. COMM'RS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/documents/consumer\\_participation\\_funded\\_con\\_Criteria.pdf](http://www.naic.org/documents/consumer_participation_funded_con_Criteria.pdf) (last visited Mar. 15, 2011) (presenting preferences and qualifications for funded representatives).

<sup>59</sup> See Press Release, Nat'l Ass'n of Ins. Comm'rs, *supra* note 53 (providing names and professions of the funded representatives).

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* For the list of 2011 unfunded representatives, see *2011 NAIC Unfunded Consumer Representatives*, NAT'L ASS'N INS. COMMISSIONERS & CENTER FOR INS. POL'Y & RES., [http://www.naic.org/documents/consumer\\_participation\\_unfunded\\_reps.pdf](http://www.naic.org/documents/consumer_participation_unfunded_reps.pdf) (last visited Mar. 15, 2011).

At least a dozen of the NAIC consumer representatives have been directly and continuously involved in the PPACA implementation process.<sup>62</sup> The PPACA-mandated task force that was formed under the auspices of the NAIC to develop uniform definitions of coverage documents and other standardized definitions also included several consumer representatives.<sup>63</sup> Consumer representatives were present at all open meetings discussing implementation of the legislation and on the approximately 200 hours of conference calls discussing implementation issues. In fact several consumer representatives were usually present. Consumers regularly submitted written comments on draft proposals. These comments typically went through several internal drafts and were submitted as a joint product signed by a number of consumer representatives. Consumer advocates were also able to pool their resources and hire an actuary to advise them on the technical issues raised by various proposed model laws and rules.

Public participation in rulemaking and regulation is not, of course, unique to the NAIC. Under the federal Administrative Procedure Act (APA), an agency must publish a proposed rule, accept comments on the rule, consider the comments, and publish a final rule with a response to the comments.<sup>64</sup> Consumer advocates often submit comments to agencies. Attempts have been made in the past to fund or to institutionalize consumer advocacy in the rulemaking process,<sup>65</sup> and public representatives have also played a role in negotiated rulemaking.<sup>66</sup>

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<sup>62</sup> The details of the consumer-representative process included herein are based on my own personal knowledge.

<sup>63</sup> See Attachments to Letter from Jane Cline, President, Nat'l Ass'n of Ins. Comm'rs, et al. to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs., and Hilda Solis, Sec'y, U.S. Dep't of Labor (Dec. 17, 2010), available at [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_ppaca\\_final\\_materials.pdf](http://www.naic.org/documents/committees_b_consumer_information_ppaca_final_materials.pdf) (listing membership of the consumer information subgroup).

<sup>64</sup> See 5 U.S.C. § 553 (2006) (prescribing the administrative rulemaking process).

<sup>65</sup> See 1 C.F.R. § 305.71-6 (1991) (providing recommendations attempting to balance meaningful public participation with effective agency performance); Carl Tobias, *Great Expectations and Mismatched Compensation: Government Sponsored Public Participation in Proceedings of the Consumer Product Safety Commission*, 64 WASH. U. L.Q. 1101, 1102-10 (1986) (describing an approach that reimbursed individuals for costs of participating in administrative proceedings).

<sup>66</sup> See, e.g., Henry H. Perritt, Jr., *Negotiated Rulemaking Before Federal Agencies: Evaluation of Recommendations by the Administrative Conference of the United States*, 74 GEO. L.J. 1625, 1687-88 (1986) (reporting on "consumer interest representatives' involvement" in an FTC rule revision).

But public participation in APA rulemaking is inherently limited. Agencies certainly receive input from the public in the rule-drafting process. HHS, for example, solicited public comments very early in its process with respect to the various issues raised by PPACA, such as the definition of “unreasonable premium increases” or how to implement PPACA’s minimum medical-loss ratio requirement.<sup>67</sup> A federal agency, however, may not disclose the contents of a proposed or final rule until it is published in the federal register.<sup>68</sup> The process allows no explicit opportunity for an open give-and-take discussion of regulatory alternatives. Once a proposed rule is issued, moreover, it is often too late to alter the rule’s content substantially.<sup>69</sup> The NAIC process—in which interested parties are involved at every step of the process—permits much increased public participation.

Greater public involvement might simply amplify the voice of regulated parties absent the direct involvement of consumers. Funding consumer involvement in a regulatory process, on the other hand, insures that consumer voices are heard. Most importantly, assuring a critical mass of consumer participants in a regulatory process makes it much more likely that consumers will actually affect the regulatory product. Regulatory boards often include token consumer representation, but consumer advocates tend to be outnumbered and their voices drowned out.<sup>70</sup> A critical mass of consumer advocates is necessary to provide mutual support, develop and articulate ideas and positions, and avoid burnout. The NAIC consumer involvement program during 2010 achieved these goals.

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<sup>67</sup> See *Medical Loss Ratios*, 75 Fed. Reg. 19,297 (Apr. 14, 2010) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 48 C.F.R. pts. 146 & 148) (inviting public comments on implementing PPACA’s minimum medical-loss ratio requirement); *Premium Review Process*, 75 Fed. Reg. 19,335 (Apr. 14, 2010) (to be codified at 48 C.F.R. pts. 146 & 148) (inviting public comments on defining unreasonable premium increases); see also *Requests for Comment*, U.S. DEPARTMENT HEALTH & HUM. SERVICES, <http://www.hhs.gov/ociio/regulations/requests/index.html> (last visited Mar. 15, 2011) (requesting public comments on other health care-related regulatory issues).

<sup>68</sup> See 1 C.F.R. § 17.1 (2010) (explaining that the Office of the Federal Register holds documents confidentially until publication).

<sup>69</sup> Although an administrative agency may change a proposed rule before it is finalized, if the rule is changed too substantially, the agency must conduct a second round of notice-and-comment rulemaking. See *Chocolate Mfrs. Ass’n of the U.S. v. Block*, 755 F.2d 1098, 1104 (4th Cir. 1985) (requiring the agency to be “sufficiently descriptive” about potential changes to allow fair comment).

<sup>70</sup> See, e.g., Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure Quality of Health Care*, 25 HOUS. L. REV. 525, 584 n.331 (1988) (noting that “[t]he usefulness of consumer members of medical boards has been seriously challenged”).

## IV. HOW DID THE NAIC CARRY OUT ITS PPACA RESPONSIBILITIES?

During the spring, summer, and fall of 2010, the NAIC was heavily involved in PPACA implementation activities. It fulfilled its statutory duty to establish definitions and methodologies for calculating minimum medical-loss ratios as required by section 10101 of PPACA;<sup>71</sup> convened a task force that developed uniform definitions of coverage documents and standardized definitions to implement section 1001(5);<sup>72</sup> and developed a form for insurers to use in justifying unreasonable premium increases.<sup>73</sup> The NAIC also drafted model laws to be used by the states to implement PPACA's exchange provisions and other parts of the Act.<sup>74</sup>

As a participant in this process I was struck by several things. First, the NAIC process afforded consumer advocates impressive opportunities to influence its model laws and regulations. Consumer representatives participated in each NAIC PPACA implementation initiative and had an impact in virtually every instance. The NAIC Health Insurance and Managed Care Committee, for example, recommitted a draft of the premium increase justification form to the "Speed to Mar-

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<sup>71</sup> See Letter from Jane Cline, President, Nat'l Ass'n of Ins. Comm'rs, et al. to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Oct. 27, 2010), available at [http://www.naic.org/documents/committees\\_ex\\_mlr\\_reg\\_asadopted.pdf](http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf) (transmitting the uniform definitions and standard methodologies for calculating minimum-medical-loss ratios); see also PPACA sec. 10101(f), § 2718(c), 42 U.S.C.A. § 300gg-18(c) (West Supp. 1A 2010) (laying out the NAIC's obligations in establishing minimum medical-loss ratios).

<sup>72</sup> See Draft Letter from Mila Kofman, Co-Chair, Consumer Info. Subgroup, and Teresa Miller, Co-Chair, Consumer Info. Subgroup, to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Nov. 15, 2010), available at [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_101116\\_docs\\_for\\_adoption.pdf](http://www.naic.org/documents/committees_b_consumer_information_101116_docs_for_adoption.pdf) (describing the NAIC's process of developing the standard definitions and standards for summaries of benefits and coverage); see also PPACA sec. 1001(5), § 2715(a), 42 U.S.C.A. § 300gg-15(a) (providing for NAIC involvement in developing such definitions and standards).

<sup>73</sup> See Rate Filing Disclosure Form (Nov. 10, 2010), available at [http://www.naic.org/documents/committees\\_b\\_rate\\_filing\\_disclosure\\_form.pdf](http://www.naic.org/documents/committees_b_rate_filing_disclosure_form.pdf); see also sources cited *supra* note 22.

<sup>74</sup> These other parts included the early reforms prohibiting preexisting condition exclusions, PPACA §§ 1101, 42 U.S.C.A. § 18001 (West Supp. 1B 2010), lifetime and annual limits, PPACA secs. 1001(5), 10101(a), § 2711, 42 U.S.C.A. § 300gg-11 (West Supp. 1A 2010), and cost-sharing for preventive services, PPACA sec. 1001(5), § 2713, 42 U.S.C.A. § 300gg-13. They also included provisions requiring coverage of adult children through age twenty-six, *id.*, § 2714, 42 U.S.C.A. § 300gg-14, and internal appeal (grievance) and external appeal (utilization review) procedures, PPACA secs. 1001(5), 10101(g), § 2719, 42 U.S.C.A. 300gg-19.

ket Task Force” after consumers objected to the abbreviated nature of the form, and a much more comprehensive disclosure form emerged from the Committee the second time around. The NAIC Executive Committee and Plenary rejected several major changes to the minimum medical-loss ratio rule forcefully advocated by industry lobbyists in the face of consumer resistance.<sup>75</sup> Consumers were able to secure additional drafting notes for a number of the framework laws that suggested consumer-friendly provisions that states could add to the implementing laws.

Second, much has been made in recent decades of the phenomenon of regulatory capture—the tendency of regulated industries to gain influence over their regulators.<sup>76</sup> The insurance industry has certainly been a presence throughout the PPACA-implementation proceedings and was usually able to bring to bear many more resources than were consumers. Regulators are properly concerned about the ongoing solvency of insurers, as, of course, are consumers. There are limits, therefore, as to how far regulators are willing to go in restricting insurance premium increases. Brokers and agents, whom the NAIC calls “producers,” were also a powerful presence in the NAIC proceedings, reflecting their substantial political clout at the state level. Like consumers, insurers and other interested parties succeeded in securing favorable changes to model laws and regulations. However, the process on the whole was balanced and responsive to consumers as well as insurers. The insurance industry certainly did not capture the PPACA NAIC regulatory process.

Third, given the political battles that shaped PPACA and continue to buffet its implementation, the NAIC process was also remarkably apolitical. The commissioners who make up the NAIC are politically accountable actors. Eleven of the state commissioner members are directly elected, and most of the remaining commissioners are appointed by governors.<sup>77</sup> The commissioners can bring their states’ pol-

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<sup>75</sup> See generally Timothy Stoltzfus Jost, *Writing New Rules for Insurers—Progress on the Medical Loss Ratio*, 363 *NEW ENG. J. MED.* 1883 (2010) (explaining NAIC’s role in developing draft regulations to define and calculate PPACA’s minimum medical-loss ratio requirement).

<sup>76</sup> See, e.g., Jean-Jaques Laffont & Jean Tirole, *The Politics of Government Decision-Making: A Theory of Regulatory Capture*, 106 *Q.J. ECON.* 1089, 1090-95 (1991) (explaining interest group politics via an agency framework); George J. Stigler, *The Theory of Economic Regulation*, 2 *BELL J. ECON. & MGMT. SCI.* 3, 3 (1971) (arguing that “regulation is acquired by [an] industry and is designed and operated primarily for its benefit”).

<sup>77</sup> See *State Commissioners—2009*, NAT’L ASS’N INS. COMMISSIONERS & CENTER FOR INS. POL’Y & RES., [http://www.naic.org/documents/members\\_state\\_commissioners\\_](http://www.naic.org/documents/members_state_commissioners_)

itics to bear on policy development, both through amendments adopted at the committee or plenary level and also through instructions to their staff who participate in the working group process. Many of the important decisions during the NAIC's involvement in PPACA's implementation took place in the fall of 2010 under the shadow of an election in which thirty-seven states were electing governors and four were electing insurance commissioners.<sup>78</sup> Many of the governors ran in opposition to PPACA. Twenty-one of the insurance commissioner members of the NAIC represented states that sued the United States in 2010 to declare parts of PPACA unconstitutional.<sup>79</sup> At least one state commissioner who ran as a Democrat and who was an officer of the NAIC was defeated in her bid for reelection.<sup>80</sup> Of course, the 2010 election moved the states considerably to the right, and whether this development will have an impact on the politics of the NAIC remains to be seen.

Nevertheless, virtually all of the decisions made by the NAIC in the PPACA implementation process were unanimous. A few commissioners made speeches in open meetings criticizing PPACA, while others spoke in its favor. In the end, however, the NAIC followed through with its assignments of advising HHS and drafting model laws that conformed to PPACA's requirements, focusing on technical rather than political concerns. Attempts to undermine or deviate from those requirements were consistently rejected.

It is quite likely that state politics affected the ultimate results of the NAIC process. Some commissioners supported consumers more vocally; some supported industry or producers. But the working groups that drafted the regulations and model acts consisted of state

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elected\_appointed.pdf (last visited Mar. 15, 2011) (listing elected and appointed state commissioners).

<sup>78</sup> *Beyond the Results: Governors*, WASH. POST, <http://www.washingtonpost.com/wp-srv/special/politics/2010-race-maps/governors> (last visited Mar. 15, 2011); see also *Election Will Mean New Faces in Insurance Commissioner Jobs*, INS. J. (Nov. 1, 2010), <http://www.insurancejournal.com/news/national/2010/11/01/114513.htm> (noting that eleven insurance commissioners are directly elected nationwide, and four elections were held in November 2010).

<sup>79</sup> See *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 10-0091, 2011 WL 285683, at \*1 n.1 (N.D. Fla. Jan. 31, 2011) (naming the twenty-five states that joined Florida in challenging PPACA's constitutionality); *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 770-71 (E.D. Va. 2010) (noting that Virginia brought suit to challenge the "Minimum Essential Coverage Provision" of PPACA).

<sup>80</sup> See *Election 2010: Oklahoma*, N.Y. TIMES, <http://elections.nytimes.com/2010/results/oklahoma> (last visited Mar. 15, 2011) (displaying a map of election results).

technical staff rather than political appointees. By the time the regulatory products reached the commissioners, they had already been vetted through a largely apolitical, open, and participatory process. Once the drafting process was completed and recommendations were sent to the commissioners, there was considerable momentum to abide by the process and refuse changes that were obviously motivated by politics. Politics, therefore, largely remained in the background, and the model laws and regulations that emerged from the process seemed to be driven more by a desire to implement the law faithfully and in a technically manageable manner than to score political points.

Finally, the NAIC process represents a striking example of the potential power of the rule of law. PPACA has not proved to be a universally popular law; although results vary from survey to survey, most opinion polls find that a significant number of Americans oppose the law or support its repeal.<sup>81</sup> The law is particularly unpopular in conservative states, as illustrated by the substantial majorities favoring antireform initiatives.<sup>82</sup> But PPACA is federal law, and under our constitutional system the federal law is the supreme law of the land, binding on state officials.<sup>83</sup> Throughout NAIC's involvement in the PPACA implementation process, the regulators involved seemed resolved to implement the law as best they could interpret it. Whether regulators personally believed it was good law or good politics rarely became an issue as the NAIC implementation process proceeded.

Of course, many of PPACA's provisions must still be implemented by the states. The states may or may not enact the model laws recommended by the NAIC, and even states that follow the NAIC models may or may not enforce these laws effectively. Implementation of the exchanges is likely to be particularly contentious. But the NAIC process has addressed and will continue to address many of the technical issues that the states must confront in implementing the law and

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<sup>81</sup> See, e.g., Amanda Gardner, *Like Congress, Americans Split over Health-Care Reform*, BLOOMBERG BUSINESSWEEK (Dec. 6, 2010), <http://www.businessweek.com/lifestyle/content/healthday/646927.html> (reporting November 2010 polling data showing that twenty-eight percent supported repealing PPACA, thirty-one percent supported maintaining it, and twenty-nine percent were undecided).

<sup>82</sup> Ballot issues opposing health care reform have been passed in Arizona, Missouri, and Oklahoma. Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2010–2011*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/?tabid=18906> (last updated Mar. 29, 2011).

<sup>83</sup> See U.S. CONST. art. VI, cl. 2 (“[T]he Laws of the United States . . . shall be the supreme Law of the Land.”).

has moved the law one step closer to implementation. The NAIC also provides a model for the states to follow as they carry out their obligations under PPACA—focusing on the practical problems presented by implementation rather than political rhetoric; effectively involving all interested parties in implementation, including consumers; and attempting in good faith to follow rather than undermine the law.

#### CONCLUSION

The NAIC asked Congress for a role in implementing PPACA. Congress granted the NAIC's request, but by giving the NAIC authority, Congress also entrusted the NAIC with responsibility. On the whole, the NAIC has respected the trust Congress placed in it and carried out its assigned tasks faithful to that trust. The unfolding result is a regulatory product that has increased the likelihood that PPACA will make a positive change in the American health care financing system.