



The Need for Continued Consumer Protections and Stability in State Insurance Markets in a Climate of Federal Uncertainty

APRIL 2017

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Contributors

Bailey Acevedo

Health Attorney
Community Service Society of
New York
633 Third Ave., 10th Floor
New York, NY 10017
bacevedo@cssny.org

Ashley Blackburn

Senior Policy Analyst
Community Catalyst
One Federal Street
Boston, MA 02110
ablackburn@communitycatalyst.org

Bonnie Burns

Training and Policy Specialist
California Health Advocates
21 Locke Way
Scotts Valley, CA 95066
bburns@cahealthadvocates.org

Lucy Culp

Consultant, State Advocacy
American Heart Association
American Stroke Association
Washington, DC 20036
lucy.culp@heart.org

Anna Howard

*Principal, Policy Development,
Access to and Quality of Care*
American Cancer Society Cancer
Action Network, Inc.
Washington, DC 20004
anna.howard@cancer.org

Elizabeth M. Imholz

Special Projects Director
Consumers Union of
United States, Inc.
San Francisco, CA 94103
bimholz@consumer.org

Timothy Stoltzfus Jost

*Virginia Organizing
Emeritus Professor,*
Washington and Lee University
School of Law
Harrisonburg, VA 22802
jostt@wlu.edu

Debra Judy

Policy Director
Colorado Consumer Health Initiative
1580 Logan Street, Ste. 340
Denver, CO 80203
djudy@cohealthinitiative.org

Katie Keith

Steering Committee Member
Out2Enroll
45 W. 36th St, 6th Floor
New York, NY 10018
katie@out2enroll.org

Amy Killelea

Director, Health Systems Integration
National Alliance of State & Territorial
AIDS Directors
444 North Capitol St., NW, Ste. 339
Washington, DC 20001
akillelea@nastad.org

Michelle Lilienfeld

Senior Attorney
National Health Law Program
3701 Wilshire Blvd., Ste. 750
Los Angeles, CA 90010
lilienfeld@healthlaw.org

Sarah Lueck

Senior Policy Analyst
Center on Budget and Policy Priorities
820 First Street, NE, Ste. 510
Washington, DC 20002
lueck@cbpp.org

Claire McAndrew

Director of Campaign Strategy
Families USA
1201 New York Ave., NW, Ste. 1100
Washington, DC 20005
cmcandrew@familiesusa.org

Lincoln Nehring

President and CEO
Voices for Utah Children
747 E. South Temple, Ste. 100
Salt Lake City, UT 84102
lincoln@utahchildren.org

Jesse Ellis O'Brien

Health Care Advocate
U.S. Public Interest Research Group
1536 SE 11th Ave., Ste. A
Portland, OR 97214
jesseo@pirg.org

Brendan Riley

*Policy Analyst,
Health Advocacy Project*
North Carolina Justice Center
P.O. Box 28068
Raleigh, NC 27611
brendan@ncjustice.org

Andrew Sperling

Director of Legislative Advocacy
National Alliance on Mental Illness
3803 North Fairfax Drive, Ste. 100
Arlington, VA 22203
asperling@nami.org

Harper Jean Tobin

Director of Policy
National Center for
Transgender Equality
1400 16th St., NW
Washington, DC 20036
hjtobin@transequality.org

Lorri Unumb

*Vice President,
State Government Affairs*
Autism Speaks
863 Corley Mill Rd.
Lexington, SC 29072
lorri.unumb@autismspeaks.org

JoAnn Volk

Research Professor
Center on Health Insurance Reforms
Georgetown University
Health Policy Institute
Washington, DC 20007
joann.volk@georgetown.edu

Jackson Williams

Director of Government Affairs
Dialysis Patient Citizens
1012 14th St., NW, Ste. 905
Washington, DC 20005
jwilliams@dialysispatients.org

Silvia Yee

Senior Staff Attorney
Disability Rights Education and
Defense Fund
3075 Adeline St., Ste. 210
Berkeley, CA 94703
syee@dredf.org

Cindy Zeldin

Executive Director
Georgians for a Healthy Future
100 Edgewood Ave. NE, Ste. 1015
Atlanta, GA 30303
czeldin@healthyfuturega.org

Table of Contents

Executive Summary 4

Introduction 6

What Consumers Want 8

Significant Progress Has Been Made Under the ACA 10

Policymakers Should Avoid Market Disruption and Maintain Coverage Gains and Consumer Protections 13

The Impact of Proposed Changes on Consumer Access to Affordable, High-Quality Coverage 16

Ensuring Access to Coverage for Consumers in Every State 16

A return to incompletely funded high-risk pools would result in higher uninsured rates and substantial costs to state budgets and consumers. 16

Coverage for preexisting conditions and access to affordable coverage is critical for all Americans, not just those who can maintain continuous coverage. 18

Promoting Affordability for Consumers in Every State 19

Policymakers should prioritize market stability through continued market rules and financial assistance for consumers. 19

Consumers do not want higher out-of-pocket costs through products such as high-deductible health plans and health savings accounts. 20

Policies that contribute to risk segmentation, such as association health plans, lead to unbalanced risk pools and higher rates. 21

Continuity of state Medicaid programs will help keep rates down. 22

Providing High-Quality Coverage for Consumers in Every State 22

Consumers need access to comprehensive benefits, including the essential health benefits, state benefit mandates, and limits on out-of-pocket costs. 22

State-level consumer protections should not be undermined through proposals that allow insurance to be sold across state lines or association health plans. 23

Consumers need continued protections against discrimination on the basis of health status and other factors. 24

Conclusion 25

References 26

Executive Summary

As federal policymakers contemplate changes to the health care system, few understand more what is at stake for consumers and insurance markets than state insurance regulators. To date, nearly all proposals to replace or amend the Affordable Care Act (ACA) would give significant flexibility to state officials and rely heavily on implementation by state insurance regulators.

As the leading authorities on insurance regulation, we encourage state insurance regulators and the National Association of Insurance Commissioners (NAIC) to offer your counsel to policymakers as changes are contemplated to help ensure that further reforms, if enacted, do no harm to consumers, minimize market disruption, and maintain common-sense consumer protections. Doing so is critically important to the millions of individuals and families we represent, especially low-income consumers and individuals with high-risk medical conditions.

Like you, we are highly concerned about nongroup market destabilization if the ACA is repealed without a responsible replacement plan in place, if the House prevails in *House v. Burwell*, if the Trump Administration terminates funding to reimburse insurers for cost-sharing reductions or opts not to enforce the individual mandate, or if risk mitigation programs are not fully funded. If any of these occur, millions of consumers are expected to drop their coverage, leading to significant premium increases, threats to insurer solvency, withdrawals from the marketplaces or individual market, and, potentially, the collapse of state insurance markets.

This report discusses the need for consumers to access high-quality health insurance products—regardless of whether and how changes are made at the federal level—and the likely impact that some proposed ACA replacement policies will have on state insurance markets and consumers. We also describe the progress that has been made in reducing the uninsured rate since 2010 and identify guiding principles that we urge policymakers to apply when considering further changes to the market.

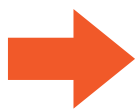
We hope this report will serve as a tool and resource as you advise federal policymakers, work with your state legislature, and continue to exercise your long-standing authority to protect consumers in your state. Highlights from the report include the continued need to:

- » **Ensure Access to Coverage.** Previous state experience suggests that efforts to scale back preexisting condition exclusion protections—to, for instance, apply only to individuals who maintain continuous coverage or obtain coverage through a high-risk pool—are unlikely to adequately cover the millions of people with preexisting conditions who gained coverage through the ACA since 2010.
- » **Promote Affordability.** Consumers depend on a functional individual insurance market to keep premiums stable. Federal changes that would make coverage unaffordable for the vast majority of consumers risk chaos in state insurance markets. The repeal of funding for Medicaid expansion or changes to the federal financing structure of the Medicaid program would further disrupt state insurance markets.
- » **Provide High-Quality Coverage.** Changes that reduce the comprehensiveness of coverage or undermine the authority of state regulators to enact or enforce consumer protections would hurt consumers and result in higher out-of-pocket costs, higher medical debt, and consumer confusion.

Given ongoing and dynamic federal-level discussions about potential changes to the ACA, this report does not include an exhaustive analysis of all proposed ACA replacement policies, and the omission of any particular proposal does not mean we do not have concerns about its impact on consumers. We are concerned, for instance, about emerging issues, such as proposed tax credits that would no longer adjust for people's income and geographic differences in premiums, revisions to the essential health benefits package requirements, and other proposals.

As consumer representatives to the NAIC, we stand ready to support you in protecting the consumers in your state, and we thank you for the opportunity to provide consumer-focused input on critical health policy issues.

Introduction



State insurance regulators have long played a significant role in health reform efforts and will continue to do so if there are changes made to the ACA. As Congress contemplates changes, we note that nearly all replacement proposals would rely heavily on implementation and oversight by state insurance regulators. Regulators may, for instance, need to develop new risk mitigation programs or adjust oversight and regulatory processes to enforce new or changing standards. State legislators may also need to amend state law to align with new federal rules or adopt (if a state has not yet done so) essential market reforms that may or may not be included in a federal replacement plan. At the same time, state insurance regulators will continue to play a primary role in addressing market instability and any effects, including insurer withdrawal and consumer confusion, which may result from a transition away from the ACA.

As Congress and the Trump Administration contemplate broad changes to the health care system, we understand the important role that state insurance regulators play in ensuring that health insurance meets the needs of consumers. Your expertise in overseeing state regulatory systems—and your experience in implementing and adjusting to significant federal changes over the past seven years—will be critical to ensuring that the consumers you serve have access to the high-quality health insurance products they need.

We encourage you, the leading authorities on insurance regulation, to offer your counsel to federal policymakers to help ensure that any reforms, if enacted, do no harm to consumers, minimize market disruption, and maintain common-sense consumer protections. Many state insurance regulators and governors—in states that include Alabama, Arizona, California, Montana, Nevada, Ohio, Utah, and Washington—have already raised concerns about the impact of ACA repeal on state economies and insurance markets without a replacement plan in place. In letters to Congressional leaders, these state policymakers emphasized the need for greater state autonomy and flexibility; the elimination of federal and state regulatory overlap; more robust marketplace stabilization and risk mitigation programs; a significant transition period to implement changes; and additional state-level consumer protections, such as state regulation of air ambulances.

The NAIC will continue to play a significant leadership role in health reform efforts and has offered its expertise to federal policymakers. The NAIC played a major role in implementing the ACA. Over the past seven years, the NAIC has adopted or amended 18 model acts and regulations; published five white papers; submitted nearly three dozen comments to Congress and federal agencies; revised and expanded the System for Electronic Rate and Form Filing system; and extensively revised financial reporting standards and market conduct review standards. As the regulatory and standard-setting body for state insurance regulators, the NAIC will influence ongoing federal and state policy discussions and, ultimately, the decisions that states make in pursuing any new health reform models. NAIC standards also serve as a benchmark for consumer protections.

As consumer representatives to the NAIC and advocates for consumers, including low-income consumers and individuals with high-risk medical conditions nationwide, our shared goal is to ensure that the millions of individuals and families we represent have access to comprehensive, affordable health coverage in every state. This report discusses the continued need for consumers to be able to access high-quality insurance products—regardless of whether and how changes are made at the federal level—and the likely impact that some proposed ACA replacement policies will have on state insurance markets and consumers.

Because federal-level discussions about potential changes to the ACA are ongoing, there may be additional ACA replacement proposals that adversely impact consumers. The omission of any particular proposal from this report does not mean we do not have concerns about its impact on consumers. We look forward to continuing to represent the interests of consumers on these issues before the NAIC.

We hope this report will serve as a tool and resource as you advise federal policymakers, work with your state legislature, and continue to use your long-standing authority to protect consumers in your state. As consumer representatives to the NAIC, we stand ready to support you and thank you for the opportunity to provide consumer-focused input on health policy issues.

What Consumers Want



Consumers across the ideological spectrum share the same concerns when it comes to private health insurance. Most are anxious about higher premiums and cost-sharing, getting and maintaining coverage, whether they will have affordable access to the benefits and prescription drugs they need, balance billing for out-of-network care, and continued access to their doctors.¹ So, unsurprisingly, consumers want policymakers to help keep out-of-pocket costs low, lower the cost of prescription drugs, ensure that benefits are comprehensive, eliminate balance billing, improve network adequacy, and make their insurance much more understandable.² Recognizing that many of these concerns are long-standing needs, the NAIC continues to serve as a forum for regulators and interested parties to address these issues.

Studies show that most consumers also value market protections and rules that require everyone to be treated fairly by insurance companies (Exhibit 1). Regardless of opinions about the ACA, many of the law's major provisions continue to be viewed favorably even across party lines, including the extension of dependent coverage up to age 26, coverage of preventive services without cost-sharing, marketplaces that provide financial help to low- and moderate-income consumers, and the option for states to expand their Medicaid program to cover more uninsured adults.³ Consumers also highly value comprehensive benefits, such as the coverage of prescription drugs, mental health care, substance use disorder treatment, and maternity coverage.



When asked about health care priorities in 2017, 67% of consumers believe that the top priority should be to lower out-of-pocket costs.

At the same time, consumers are skeptical of products like high-deductible health plans and tax-preferred savings accounts. In recent focus groups among people who voted for President Trump in Michigan, Ohio, and Pennsylvania, consumers almost universally rejected the value of these products, voiced fears about becoming uninsurable, and expressed anxiety about the chaos that could result if the ACA is repealed without a replacement plan in place.⁵ Some also recounted positive experiences with marketplace coverage, noting that their plans were affordable and improved in cost over time; others wanted greater simplification of health plan choices and transparency from insurance companies.⁶ Many of these concerns are shared by a majority of consumers: when asked about health care priorities in 2017, 67% of consumers believe that the top priority should be to lower out-of-pocket costs.⁷

EXHIBIT 1**Americans' Opinions of Market Reforms, November 2016⁴**

PERCENT WHO SAY THEY HAVE A FAVORABLE OPINION OF EACH OF THE FOLLOWING PROVISIONS OF THE ACA:	TOTAL	DEMOCRATS	INDEPENDENTS	REPUBLICANS
Allows young adults to stay on their parents' insurance plans until age 26	85%	90%	85%	82%
Eliminates out-of-pocket costs for many preventive services	83%	89%	83%	77%
Creates health insurance exchanges where small businesses and people can shop for insurance and compare prices and benefits	80%	90%	80%	72%
Provides financial help to low- and moderate-income Americans who don't get insurance through their jobs to help them purchase coverage	80%	91%	81%	67%
Gives states the option of expanding their existing Medicaid program to cover more low-income, uninsured adults	80%	90%	79%	67%
Prohibits insurance companies from denying coverage because of a person's medical history	69%	75%	65%	63%
Requires employers with 50 or more employees to pay a fine if they don't offer health insurance	60%	83%	60%	45%
Requires nearly all Americans to have health insurance or else pay a fine	35%	57%	30%	21%

Overall, consumers are afraid that they will be unable to afford health insurance for themselves and their families—and they want better coverage that is more affordable. To address these concerns, any federal or state replacement plan for the ACA should help lower out-of-pocket costs while ensuring that consumers have continued access to the comprehensive coverage and benefits that they need.

Significant Progress Has Been Made Under the ACA



The United States has made significant gains since the law was enacted in 2010 (Exhibit 2). Uninsured rates are at historic lows, most consumers are satisfied with their marketplace coverage, and the burden of uncompensated care on providers, states, and localities has been significantly reduced (Exhibit 3).

Expansion of access to good-quality health insurance helps consumers and the health care system. Insured consumers can take advantage of preventive services and better manage their chronic conditions, leading to improved health outcomes. Peer-reviewed research shows that uninsured and underinsured people are more likely than those with comprehensive health insurance to be diagnosed with cancer at a more advanced stage when treatment is costlier and patients are more likely to die from the disease.⁸ Insured consumers are also better insulated from high medical costs than uninsured consumers who receive less care, have higher medical debt, and have worse health outcomes.⁹ For instance, studies show that people living with HIV who are enrolled in qualified health plans under the ACA are better able to control their disease and have higher viral suppression rates (84.6%) compared to those who are uninsured (78.6%).¹⁰ Continued coverage gains also benefit the health care system: with more people insured, policymakers can prioritize other health care needs such as reducing the cost of health care for consumers, improving the quality of care, and expanding access to primary care while aiming to achieve universal coverage.

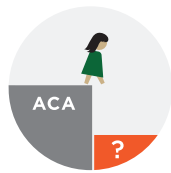
There are ways that the ACA can be improved to work better for consumers, particularly for consumers with moderate to higher incomes, and we encourage Congress to explore bipartisan solutions to making health care more affordable by, for instance, making subsidies more generous, correcting the family glitch, and addressing rising prescription drug costs. However, the data cited, along with consumer polling, indicate that the ACA has largely met its goal of reducing the number of uninsured Americans and improving the quality of private health insurance. As discussed in the next section, policymakers should ensure that any changes to federal law or financing maintain these coverage gains and consumer protections.

EXHIBIT 3

Gains Under the ACA

- **Historically low national uninsured rate.** Between 2010 and 2015, the uninsured rate among the nonelderly population in the United States dropped from 18.2% to 10.5%, the lowest rate in decades.¹¹ Coverage gains were particularly significant after the ACA's coverage reforms went into effect in 2014.¹²
 - **Fewer uninsured adults in every state and fewer uninsured children in 28 states.** Between 2013 and 2015, the percentage of uninsured adults fell in every state and DC, with decreases of at least 3% in all but two states.¹³ During the same period, the number of uninsured children dropped by at least 2% in 28 states.¹⁴
 - **High consumer satisfaction among marketplace enrollees.** Multiple studies have found that marketplace enrollees are happy with their plans. Two-thirds—68%—of marketplace enrollees rated their 2016 coverage as “excellent” or “good.”¹⁵ A separate study found that 77% of adults with marketplace coverage in 2016 were very or somewhat satisfied with their plan; 66% rated their coverage as good, very good, or excellent.¹⁶
 - **Reduced medical debt.** The number of Americans reporting that they had trouble paying their medical bills or paying off medical debt fell from 75 million in 2012 to 64 million in 2014, the first time that there was a decline in this indicator since the question was asked in 2005.¹⁷
 - **Improved consumer access to care.** Between 2013 and 2015, the percentage of adults who reported that they had not gone to the doctor when needed because of costs dropped by at least 2% in 38 states and DC, and 61% of marketplace and Medicaid enrollees reported using their insurance to get care they would not have been able to afford or access prior to enrolling.¹⁸
 - **Declines in uncompensated care.** Uncompensated care fell by \$6 billion—from \$34.9 billion in 2013 to \$28.9 billion in 2014—representing a 17% drop nationwide.¹⁹ Nearly all of this decline occurred in states that had expanded their Medicaid programs.²⁰
 - **Employment opportunities among individuals with disabilities.** Individuals with disabilities are significantly more likely to be employed in states that expanded their Medicaid program.²¹ The number of uninsured adults with disabilities also declined significantly—from 3.7 million to 1.9 million—between 2010 and 2015.²²
-

Policymakers Should Avoid Market Disruption and Maintain Coverage Gains and Consumer Protections



Given the importance of health insurance to the consumers we represent, we are deeply concerned about the possibility of changes in federal law or financing that would reduce the number of Americans with health coverage. This concern—along with concerns about a loss of consumer protections, economic losses, and higher uncompensated care—are outlined in Exhibit 4.

We are particularly concerned about market destabilization—including insurer withdrawal from the marketplaces or individual market and effects on issuer solvency—and the resulting disruption as consumers lose access to the benefits, providers, and prescription drugs they depend on. As outlined by the American Academy of Actuaries in a recent letter to Congress, these concerns about market destabilization remain even if Congress adopts a multi-year transition period before any changes to the ACA go into effect.²³

Congress may, for instance, choose to try to repeal major components of the ACA—such as the individual and employer mandates, marketplace subsidies, and Medicaid expansion—through a budget reconciliation bill as they did in the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 which was ultimately vetoed by President Obama. If Congress pursues a similar pathway now, an estimated 18 million consumers would become uninsured in the first plan year, premiums in the nongroup market would be up to 25% higher, and half of the nation's population would have no participating insurer in the nongroup market in the first year after the repeal of marketplace subsidies.²⁴ Partial repeal of the ACA would immediately trigger adverse selection in the individual market: premiums would increase significantly, an estimated 4.3 million people would drop their coverage, and insurers would suffer \$3 billion in financial losses leading them to withdraw from the individual market or hike premiums for the enrollees who remain.²⁵

Disruption to state markets would accelerate over time. Eventually, full or partial repeal of the ACA would result in virtual collapse of the individual market: enrollment in the individual market nationwide (both inside and outside the marketplaces) would drop from 19.3 million today to 1.6 million people by 2019.²⁶ An estimated 27 million Americans would lose their coverage if marketplace subsidies and Medicaid expansion were to be eliminated.²⁷ Similar widespread disruption is likely if the House prevails in *House v. Burwell* or if federal regulators terminate funding to reimburse insurers for cost-sharing reductions, threatening insurer solvency and likely causing insurers to exit the marketplaces or withdraw from the individual market entirely.²⁸

EXHIBIT 4

Risks of Wholesale Repeal of the ACA

- **Significant increase in number of uninsured Americans.** Partial repeal of the ACA would result in nearly 30 million more uninsured people in 2019 relative to current law.²⁹ This would more than double the total number of uninsured people to 58.7 million.³⁰ Even if Congress opts to delay full repeal or replacement of the law, 4.3 million people would lose insurance immediately due to market destabilization.³¹
- **Destabilization of state insurance markets.** Repeal of some or all of the ACA would destabilize individual insurance markets immediately. Eliminating the individual mandate would increase premiums by 25%.³² Eliminating existing premium tax credits would further diminish enrollment. Even with a transition period, these changes could result in insurers withdrawing from the market, higher premiums, and a death spiral.³³
- **Return to medical underwriting for preexisting conditions.** As many as 133 million people have a preexisting health condition that would limit their access to coverage under pre-ACA medical underwriting standards.³⁴ Other studies have found that up to 52 million adults—27% of all adults—would be uninsurable under pre-ACA underwriting rules, with millions more forced to face higher premiums, exclusions, or other limitations because of a preexisting condition.³⁵ As discussed below, continuous coverage requirements and high-risk pools would likely do little to address this concern.
- **Private sector job loss.** Repeal of the ACA's subsidies and Medicaid expansion, without a replacement plan, would result in a \$140 billion loss in federal funding for health care in 2019, leading to the loss of 2.6 million jobs mostly in the private sector.³⁶ Without a replacement plan in place, state economic losses could rise to \$1.5 trillion in gross state products and a \$2.6 trillion reduction in business output from 2019 to 2023.³⁷
- **Widespread consumer disruption.** Repeal of the ACA would result in a significant volume of complaints and questions for state regulators as consumers experience or fear changes to their coverage. Consumers may also lose access to critical essential health benefits they have come to depend on—such as maternity coverage, mental health care, substance use disorder services, habilitative services, and prescription drug coverage—and half of the nation's population would live in an area with no participating insurer in the nongroup market in the first year after the marketplace subsidies are eliminated.³⁸
- **Higher uncompensated care.** All states would lose significant federal funds if the ACA is repealed, and the demand for uncompensated care would increase by \$1.1 trillion nationwide between 2019 and 2028.³⁹ Partial repeal would result in the loss of nearly \$400 billion in hospital revenues alone between 2018 and 2026.⁴⁰ State and local governments and health care providers would have to bear this cost, contributing to state budget crises and shuttered health care facilities.

Our concerns about market disruption are heightened by the fact that Congress has yet to coalesce around a single plan for changing the ACA. This uncertainty limits the ability of state insurance regulators, state legislators, governors, the NAIC, and the insurance industry to stabilize insurance markets or review and develop new products. At the same time, consumer advocates and agents and brokers are limited in their ability to address consumer needs or adequately inform consumers about new rights or responsibilities. During this period of uncertainty, we urge state insurance regulators and the NAIC to prioritize continued consumer access to good-quality, affordable health insurance by observing these key principles:

» **Insure the same number of consumers with the same quality of coverage.**

More than 20 million consumers have gained coverage under the ACA, and millions more have benefited from new comprehensive benefits and cost-sharing protections. Any future federal or state reform should insure at least the same number of people as currently have health insurance—no consumer should be made worse off by losing their coverage—and coverage should be at least as comprehensive and affordable as it is under the ACA.

» **Maintain critical consumer protections.** The individuals and families we represent cannot go back to a system that leaves tens of millions of Americans uninsured or underinsured because of coverage denials, discriminatory rates, exclusions for preexisting conditions, lifetime and annual dollar limits, less-comprehensive benefits, coverage exclusions, or unlimited out-of-pocket costs. New federal or state reforms should not leave consumers worse off relative to current protections under the ACA.

» **Minimize market disruption.** Making significant changes to coverage, especially without a responsible replacement plan in place, will jeopardize the coverage that millions of Americans depend on. Policymakers should prioritize a stable insurance marketplace, avoid market destabilization and disruption, and help ensure that consumers have continued access to the benefits, providers, and prescription drugs they need.

» **Do not undermine state consumer protections or regulatory authority.**

Federal changes should not restrict state regulation of insurance markets or undermine the authority of regulators to enact or enforce state-level consumer protections. State insurance regulators are best-positioned to enforce state standards and protect their residents.

» **Ensure that consumers are well-informed of changes in advance and promote continued transparency, accountability, and consumer assistance.** Consumer health insurance literacy remains low nationwide. Significant changes to the ways consumers purchase health insurance will require a long transition period to educate and inform consumers of their new coverage options, rights, and responsibilities. Consumers should also have continued access to the tools and resources they have come to rely on, including marketplace websites, hotlines, and in-person assistance through consumer assistance personnel.

The Impact of Proposed Changes on Consumer Access to Affordable, High-Quality Coverage



Based on the principles cited above, this section discusses the need for stable insurance markets that deliver high-quality health insurance, our concerns about some proposed federal changes, and the likely impact that proposed changes would have on state insurance markets and consumers. The proposals identified below reflect a non-exhaustive list of potential federal changes, and additional ACA replacement proposals may arise that adversely impact consumers. The omission of any particular proposal from this report does not mean we do not have concerns about its impact on consumers, and we look forward to continuing to represent the interests of consumers on these issues before the NAIC.

ENSURING ACCESS TO COVERAGE FOR CONSUMERS IN EVERY STATE

The individuals and families we represent will face dire health and financial consequences if our nation returns to a system that leaves tens of millions of people without access to health insurance. Below, we highlight consumer needs and policy concerns to consider as the NAIC and its members advise Congress and the Trump Administration, work with state legislatures, and strive to protect consumers.

A return to incompletely funded high-risk pools would result in higher uninsured rates and substantial costs to state budgets and consumers.

High-risk pools are unlikely to adequately cover the millions of people with preexisting health conditions who gained coverage through the ACA since 2010. Past experiences with high-risk pools are instructive for understanding how consumers with preexisting medical conditions fare in these programs. In 2008, only about 5% of those eligible for high-risk pools were enrolled.⁴¹ By 2011, only about 226,000 people in the 35 states that operated high-risk pools were enrolled in these programs.⁴² Those who did often faced preexisting condition exclusions, lifetime dollar limits, premiums up to 250% of standard rates, and deductibles as high as \$25,000.⁴³ These experiences suggest that high-risk pools will fall far short of ensuring that people with significant health care needs can access coverage that is adequate and affordable.

In recent letters to Congressional leaders, insurance commissioners raised concerns about the viability of returning to high-risk pools to cover individuals with expensive health care needs. Commissioners cited past experiences with high-risk pools as a way to isolate high-risk individuals instead of spread costs across a population, which results in high per-enrollee costs that are difficult to finance.⁴⁴ In California in 2009, for instance, the pre-ACA high-risk pool covered only about 7,000 Californians who faced premiums up to 37.5% higher than standard rates and coverage with a three-month preexisting condition exclusion period, an annual limit of \$75,000, and a lifetime limit of \$750,000.⁴⁵ Commissioners also noted that high-risk pools were difficult to administer and have relatively high administrative costs for the number of enrollees: in California in 2011, the pre-ACA high-risk pool received \$47.6 million in premiums but had \$70.3 million in expenses, resulting in a \$22.7 million loss.⁴⁶

California's experience held true across the country, where high-risk pools resulted in substantial costs to state budgets and consumers. In 2011 alone, net losses for the 35 state-based high-risk pools were over \$1.2 billion.⁴⁷ To be viable, a high-risk pool would require a large and sustainable source of funding. In the past, premiums paid by enrollees—even when up to 250% of standard rates—covered only about half of the cost of operating these pools.⁴⁸ The remainder of funding came from public support such as state general revenues and carrier assessments. In a recent issue brief, the American Academy of Actuaries noted that high-risk pools have been used to facilitate coverage for some high-risk individuals in the past but “enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss.”⁴⁹

If ACA replacement proposals include high-risk pools but do not include sufficient and sustainable funding for them nationwide, states will be forced to fund the pools themselves or impose even harsher restrictions that limit access to care. States may, for instance, need to cap enrollment, increase premiums beyond what many people can afford, exclude coverage of people's preexisting conditions, or only offer coverage with severe limitations. As noted above, prior high-risk pool coverage came with high premiums, limited benefits, deductibles as high as \$25,000, and annual benefit caps as low as \$75,000.⁵⁰ If state high-risk pools were to adopt similar restrictions in the future, consumers with health conditions would experience higher uninsured rates, delayed care, adverse health outcomes, and medical debt.

As an alternative to high-risk pools, policymakers could direct the funding that would have supported external high-risk pools toward a reinsurance program that reimburses plans for the costs of high-risk enrollees. Alaska has already pursued this option to help stabilize its individual market—with one study suggesting that premiums in the individual market in 2018 will be 20 percent lower with the state's reinsurance than without it—and some state insurance commissioners have already come out in support of reinsurance programs in lieu of high-risk pools.⁵¹



High-risk pools have been used to facilitate coverage for some high-risk individuals in the past but “enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss.” —American Academy of Actuaries

Coverage for preexisting conditions and access to affordable coverage is critical for all Americans, not just those who can maintain continuous coverage.

Requiring insurers to cover preexisting conditions is among the ACA's most popular benefits. A return to pre-ACA market rules could affect an estimated 52 million adults—27% of all adults—who would likely be uninsurable under previous medical underwriting standards.⁵² Millions more would be refused coverage or face higher premiums, exclusions, or other limitations under pre-ACA underwriting rules.⁵³ We are, therefore, concerned about efforts to scale back preexisting condition exclusion protections to apply only to individuals who maintain “continuous coverage.” We are also concerned about a recent continuous coverage proposal that would require insurers to impose a premium surcharge of 30% on people who have a gap in coverage and then attempt to access a plan in the individual or small group market. This would actually run the risk of fueling adverse selection, rather than mitigating it.

Continuous coverage requirements are not new and have been in place under some circumstances since 1996 (and even earlier in some states). Although these requirements offer some consumer protections, benefits are only available to individuals who *already* have health insurance. As a result, these requirements do nothing to ensure that uninsured consumers, especially those without access to group coverage, can obtain coverage for preexisting conditions.

Continuous coverage requirements also do not account for a host of scenarios where personal or financial hardships—such as being unable to afford coverage while unemployed, losing health insurance through divorce or death of a spouse, caring for a sick family member, or facing foreclosure—could force an individual into a temporary coverage gap. Such gaps are common for consumers due to changes in employment or family circumstances: between 2004 and 2007, 36 percent of Americans—89 million people—went without coverage for at least one month.⁵⁴ Of these individuals, about one-quarter lost their coverage more than once. These gaps in coverage were observed even during times of economic growth and relative prosperity prior to the 2008 recession. A more recent study found that 44 million consumers with a preexisting condition—nearly one-third—did not have health insurance for at least one month between 2013 and 2015.⁵⁵ Of these, about 87% went without coverage for three months or more.

We agree with the need for strong incentives that encourage all Americans to enroll in health insurance and remain insured: insurance markets cannot function effectively while covering all individuals regardless of health status without such incentives. These incentives—whether through continuous coverage requirements, late enrollment penalties, or waiting periods—should not, however, create undue harm to consumers' health and longer-term ability to obtain health insurance. The American Academy of Actuaries also recently noted that incentives such as late enrollment penalties would be challenging to implement and that continuous coverage requirements could, in effect, return to a pre-ACA environment where healthy individuals would have an incentive to undergo underwriting while less healthy individuals would face higher premiums and less generous or no coverage options.⁵⁶

Consumers who cannot maintain continuous coverage should not face medically underwritten premiums and preexisting condition exclusions—or be denied coverage altogether. Under continuous coverage proposals, these penalties would extend for a significant period of time, limiting consumer access to coverage and care when they need it most. The same is true for

late enrollment penalties or waiting periods: these types of incentives typically increase the cost of coverage, which further incentivizes consumers to delay enrollment, and permanently penalizes consumers. Although the individual mandate is unpopular (and may need to be modified to be more effective), it imposes fewer long-term consequences to consumer health and well-being because its penalty is limited to the tax year and consumers have an annual open enrollment opportunity to obtain coverage.⁵⁷

If policymakers adopt new incentives—especially ones with implications as serious as a 12-month 30% premium surcharge, other late enrollment penalties, or waiting periods—consumers are likely to need significant assistance in understanding these new rules and consequences. Federal and state policymakers should be prepared to fund ongoing education and outreach efforts to explain major changes and to ensure that consumers can make fully informed decisions about their coverage options.

PROMOTING AFFORDABILITY FOR CONSUMERS IN EVERY STATE

The millions of individuals and families we represent are anxious that they will be unable to afford health insurance and health care for their families if the ACA is repealed and the Medicaid program is restructured. In considering any ACA replacement plans, Congress should address this concern by reducing consumer out-of-pocket costs and ensuring that millions of Americans are not underinsured. Below, we highlight consumer needs and policy concerns to consider as you advise federal and state policymakers and protect consumers in your state.

Policymakers should prioritize market stability through continued market rules and financial assistance for consumers.

Coverage gains were particularly high after the ACA's most significant market reforms went into effect in 2014.⁵⁹ These reforms, such as guaranteed issue and the ban on preexisting condition exclusions, were new for the vast majority of states and ushered in new protections that improved the quality of coverage.

These protections, however, are only one of three key components of the ACA's interlocking structure, alongside premium and cost-sharing subsidies and the individual mandate. If the two latter components are eliminated, there is a significant risk that state individual health insurance markets will collapse as millions of healthy consumers drop coverage, leading to premium increases of up to 25% for remaining enrollees and, potentially, a death spiral. That was the experience in a number of states—such as Kentucky, New York, and Washington—that tried to adopt market reforms without financial help or financial penalties.⁶⁰ These efforts largely failed, resulting in the near collapse of some state individual markets. State markets could similarly collapse if the House prevails in *House v. Burwell* or if federal regulators terminate funding to reimburse insurers for cost-sharing reductions or opt not to enforce the individual mandate.

Consumers—both inside and outside the marketplaces—depend on a functional individual insurance market to keep premiums stable. Many consumers also depend on income-based premium subsidies and cost-sharing reductions to keep coverage affordable, and financial assistance must be meaningful to help ensure that consumers are able to access the health insurance they need. We are deeply concerned about federal changes that would repeal the ACA’s main structural components, making coverage unaffordable for the vast majority of consumers and risking chaos and the potential collapse of state insurance markets.



Proposals that, for instance, incentivize or subsidize high-deductible health plans and health savings accounts would shift significant costs to consumers at a time when few consumers can afford higher out-of-pocket costs.

Consumers do not want higher out-of-pocket costs through products such as high-deductible health plans and health savings accounts.

Although more can be done to make marketplace coverage more affordable, most marketplace enrollees are satisfied with their coverage.⁶¹ The ACA has provided subsidies to low- and middle-income individuals and families to afford coverage, required plans to meet minimum actuarial value requirements, and capped annual out-of-pocket costs. Despite these protections, some consumers with high deductibles currently struggle to afford health care.⁶² Any changes to coverage requirements should focus on decreasing, rather than increasing, consumer out-of-pocket costs.

Proposals that, for instance, incentivize or subsidize high-deductible health plans and health savings accounts (HSAs) would shift significant costs to consumers at a time when few consumers can afford higher out-of-pocket costs. Consumers are also skeptical of HSAs, a product that many low- and middle-income consumers have never used before and do not have enough disposable income to fund.⁶³ In recent focus groups among people who voted for President Trump, for instance, consumers did not consider a high-deductible health plan to be “real insurance” and, while supportive of the concept, did not understand how an HSA would work, leading many to prefer to pay higher premiums for lower deductibles over plans with higher deductibles.⁶⁴

Uncertain Future for ACA Leads Insurers to Rethink Participation, Prices

In interviews with executives of 13 insurance companies in late 2016 and early 2017, researchers at Georgetown University found that:

- Insurers would “seriously consider” withdrawing from the individual market in 2018 if the individual mandate is repealed without an effective replacement plan. Insurers that remained in the market would likely increase 2018 premiums significantly.
- Repeal of the ACA without a replacement plan would destabilize the market. Insurers were confident that they could transition to a new regulatory system over time but only if policymakers adopted concrete policies and provided sufficient implementation time.
- Elimination of cost-sharing reduction payments in 2017 would cause significant financial harm to insurers. Most insurers reported that they would be forced to exit the marketplaces or the individual market as quickly as possible—others noted that they would pursue a mid-year premium increase.⁵⁸

Instead of helping the uninsured, HSAs mostly benefit high-income taxpayers who can afford to take advantage of these tax-sheltering accounts. Indeed, 58% of tax returns that claim HSA-deductible contributions and 70% of the total value of HSA contributions come from households with incomes over \$100,000.⁶⁵ In contrast, at least 90% of the uninsured before the ACA were in the zero to 15% tax bracket, meaning they would receive, at most, an income tax benefit of no more than \$0.15 for every \$1 they can deduct, doing little to make premiums more affordable.⁶⁶ Even when low-income people have HSAs, the effect on their use of care is not favorable, resulting in declines in office visits and free preventive care and increases in emergency room visits and hospitalization.⁶⁷

Replacement proposals that rely heavily on the expanded use of credits to fund tax-sheltering accounts, such as an HSA, would mainly benefit high-income taxpayers while doing nearly nothing for those most at risk of losing their coverage. Plans with an even lower actuarial value than a bronze plan would function largely like “mini-med” plans with low monthly premiums but few benefits, and many more consumers would face medical debt if Congress were to eliminate the annual limit on out-of-pocket costs.

Given low health insurance literacy rates—an issue that the NAIC and state insurance regulators have long focused on improving—we are additionally concerned that the complexity of products like HSAs would put consumers at financial risk. This is especially concerning if federal policymakers also adopt new incentives—such as late enrollment penalties or waiting periods—that would impact access to coverage. There is strong evidence that programs with a high degree of complexity, such as Indiana’s Medicaid expansion program, negatively affect participation and consumers’ ability to obtain health care.⁶⁸

Federal and state policymakers should be prepared to fund ongoing education and outreach efforts to ensure that consumers fully understand new coverage options and their rights and responsibilities associated with any changes. Without this support, the burden of educating consumers would likely fall to state insurance regulators who would be implementing new regulatory changes at the same time.

Policies that contribute to risk segmentation, such as association health plans, lead to unbalanced risk pools and higher rates.

Limits on risk segmentation are critical to limiting adverse selection, promoting a balanced risk pool, and moderating premiums for individuals and families. Prior to the ACA, insurers in some states sold health plans through associations, which were exempt from state law that otherwise applied to coverage sold in the individual and small group markets. Offering these association health plans (AHPs) helped insurers to segment the market by siphoning off the healthiest risk and leaving less healthy risk in the traditional insurance market. This risk segmentation led to an unbalanced risk pool and higher rates.⁶⁹

Given the need for balanced risk pools, we are concerned about ACA replacement proposals that encourage AHP coverage without additional consumer protections. The NAIC has consistently expressed concerns about AHPs. Along with the National Governors’ Association and the National Conference of State Legislatures, the NAIC noted that “AHPs would fragment and destabilize the small group market, resulting in higher premiums for many small businesses” and raised concerns that “AHPs would be exempt from state solvency requirements, patient protections, and oversight,” exposing consumers to significant harm.⁷⁰



We urge you to continue to be cautious of federal proposals to expand AHPs and other similar products that will result in risk segmentation and allow for broad preemption of state consumer protections.

These concerns were reiterated in a recent letter to leaders of Congress, where the NAIC noted that “we strongly oppose legislation that would preempt state authority [including] proposals that would preempt state solvency requirements and regulations by creating federally licensed insurance pools called ‘association health plans.’”⁷¹

The National Conference of Insurance Legislators (NCOIL) also opposed previous federal legislation that would exempt AHPs from state law and oversight, noting that such action “would threaten consumers’ access to health coverage and would deny them important consumer protections.”⁷² We urge you to continue to be cautious of federal proposals to expand AHPs and other similar products that will result in risk segmentation and allow for broad preemption of state consumer protections.

Continuity of state Medicaid programs will help keep rates down.

Under the ACA, 14.5 million people nationwide gained coverage through the Medicaid program and the Children’s Health Insurance Program between 2013 and 2015.⁷³ These programs provide low-income children and adults with critical access to primary and preventive care to maintain and improve their health. Expanded Medicaid coverage also affects private health insurance markets: in states that expanded their Medicaid program, marketplace premiums were about 7% lower compared to states that did not expand their program.⁷⁴ Given the positive impact on state insurance markets, we remain concerned that the repeal of funding for Medicaid expansion or changes to the federal financing structure of the Medicaid program through block grants or per capita caps could further disrupt state insurance markets, shift costs to states, and negatively affect state health care systems by leaving many more people uninsured.

PROVIDING HIGH-QUALITY COVERAGE FOR CONSUMERS IN EVERY STATE

The individuals and families we represent rely on continued access to the medical benefits, prescription drugs, and providers they need—and cannot afford to return to a system that works only for consumers when they are healthy. Below, we highlight consumer needs and policy concerns to consider as you advise federal and state policymakers and protect consumers in your state.

Consumers need access to comprehensive benefits, including the essential health benefits, state benefit mandates, and limits on out-of-pocket costs.

For the nearly 133 million consumers with a preexisting condition—and the millions more who may develop a medical condition or need treatment in the future—access to comprehensive health insurance is critical.⁷⁵ Without comprehensive coverage, consumers face high out-of-pocket costs and medical debt even with insurance. Under the ACA, most plans in the individual and small group markets must cover a minimum set of 10 essential health benefits. These requirements improved the adequacy of private health insurance, requiring some plans to cover prescription drugs for the first time and key services such as treatment for substance use disorder, which has been critical to addressing the opioid crisis. These benefit categories were established by statute but states had flexibility to further define and exceed these standards, which many states did.⁷⁶

Given the importance of access to a range of health benefits, including but not limited to the 10 essential health benefits, we are concerned about potential changes that would reduce the comprehensiveness of coverage for consumers, resulting in lower premiums but higher out-of-pocket costs and a higher underinsured rate. In particular, we are concerned that proposals to eliminate the essential health benefits requirement, the actuarial value metal level tiers, and the annual limit on out-of-pocket costs would result in state markets being flooded with skimpy coverage—such as indemnity coverage, short-term policies, or discount policies—that fail to meet consumer needs, especially when mistaken for a major medical policy. As state insurance regulators, we urge you to be prepared to vigorously regulate these products if such changes are made.

As discussed in more detail below, we are also concerned about proposals that would limit states' ability to enact or retain benefit mandates. These protections are critical for vulnerable consumers, such as children with developmental disabilities and other special needs. We urge you to be wary of proposals that undermine or preempt mandates or other state-level protections.

State-level consumer protections should not be undermined through proposals that allow insurance to be sold across state lines or association health plans.

States have been in the business of regulating health insurance for decades and are experienced in balancing consumer protections and individual choice. Many consumers depend on state benefit mandates and other regulatory protections that have long been adopted by states. We are concerned about federal replacement proposals that would undermine state regulation of individual markets and the authority of regulators to enforce these protections. Allowing insurers to sell plans across state lines or exempting AHPs from state regulation, for instance, would undermine state regulators' ability to protect consumers in their state.

The NAIC has expressed similar concerns about the sale of health insurance across state lines, noting that there would be a “race to the bottom” as a result of interstate sales because insurers would be able to choose their regulator and would flock to states with weaker standards.⁷⁸ Insurers would be able to skirt state consumer protections to cherry-pick the healthiest consumers—resulting in higher premiums for everyone else and fewer health insurance options in a given state—and regulators of one state would have no authority to enforce the laws of another state.⁷⁹ In particular, the NAIC noted that “consumers will have to hope that the regulator in a distant jurisdiction has the ability and resources to assist consumers nationwide.”⁸⁰

Other stakeholders, such as NCOIL, support each state's right to freely enter into compacts but oppose federally directed across state lines sales, citing similar concerns about “domicile state shopping and cherry picking risks.”⁸¹ And the American Academy of Actuaries recently noted that allowing across state lines sales “could threaten the viability of the insurance market in states with more restrictive rules and create a situation in which states would have incentives to reduce insurance regulations and consumer protections,” thereby reducing the ability of individuals with preexisting conditions to obtain coverage.⁸²

Evidence also suggests that such proposals do not work: in states that have already pursued across state lines legislation or tried to form interstate compacts, none resulted in a single insurer entering a new market or the sale of a single new insurance product.⁸³ We are concerned that federal replacement proposals regarding across state sales would be ineffective at best and undermine state sovereignty and consumer protections at worst.



We are concerned that federal replacement proposals regarding across state sales would be ineffective at best and undermine state sovereignty and consumer protections at worst.

Selling Health Insurance Across State Lines: A Case Study

As of 2012, six states—Georgia, Kentucky, Maine, Rhode Island, Washington, and Wyoming—had enacted legislation to require, encourage, or study the feasibility of selling health insurance across state lines or the formation of interstate health insurance compacts. An analysis of these laws and interviews with state insurance regulators and insurers in these states revealed that:

- Across state lines proposals have been unsuccessful at meeting their stated goals. In the three states that had implemented across state lines laws—Georgia, Maine, and Wyoming—no out-of-state insurers had entered their markets or indicated their intent to do so.
- The most significant obstacle to selling across state lines was the difficulty that out-of-state insurers face in building a network of local providers. This was described by insurers as a more significant barrier to market entry than a state's regulatory environment.
- State regulators reported being hesitant to relinquish their authority to enforce state standards and protect their residents. They also noted that the complexity of health insurance products was a limiting factor in establishing interstate compacts.⁷⁷

Consumers need continued protections against discrimination on the basis of health status and other factors.

One of the ACA's most significant changes was to enable all consumers, including those with health risks, to access the health insurance and care they need. In particular, the law prohibited discrimination based on health status, disability, age, race, gender, gender identity, and sexual orientation, among other factors. These protections apply at the point of enrollment, in benefit design, and in health care more broadly under Section 1557 of the ACA.⁸⁴

Comprehensive nondiscrimination protections are critical to ensuring that consumers receive the full benefits of coverage. Such protections have already been used to, for instance, better ensure that consumers with high-risk conditions such as HIV have access to affordable prescription drugs and eliminate the use transgender-specific exclusions.⁸⁵

We are thus concerned about any federal and state changes that would not incorporate these same nondiscrimination standards or that would allow insurers to actively discriminate against consumers based on these or similar factors. People with preexisting conditions, loved ones struggling with complex medical needs, and other vulnerable consumers should have continued access to good-quality, affordable, nondiscriminatory health insurance options.

Conclusion

State insurance regulators and the NAIC will play a significant role in shaping the future of health reform, implementing major changes, and addressing market instability that may result from any transition away from the ACA. As federal policymakers contemplate changes to the health care system, we urge state insurance regulators and the NAIC to help ensure that additional reforms do no harm to consumers, minimize market disruption, and maintain common-sense consumer protections. As consumer representatives to the NAIC, we urge state insurance regulators and the NAIC to prioritize continued consumer access to high-quality, affordable health insurance and stand ready to support you in protecting the consumers in your state.

References

1. Drew Altman, "The Health Care Plan Trump Voters Really Want," New York Times (Jan. 5, 2017); Ashley Kirzinger et al., *Kaiser Health Tracking Poll: Health Care Priorities for 2017*, Kaiser Family Foundation (2017); Jennifer Tolbert & Larisa Antonisse, *Listening to Trump Voters with ACA Coverage: What They Want in a Health Care Plan*, Kaiser Family Foundation (2017).
2. Altman, *supra* note 1; Tolbert & Antonisse, *supra* note 1.
3. Ashley Kirzinger et al., *Kaiser Health Tracking Poll, November 2016*, Kaiser Family Foundation (2016).
4. *Id.*
5. Tolbert & Antonisse, *supra* note 1.
6. *Id.*
7. Kirzinger et al., *supra* note 1.
8. Elizabeth Ward et al., "Association of Insurance with Cancer Care Utilization and Outcomes," *CA First Look* (2008) 58:1 (Jan./Feb.): 9-31.
9. Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured*, Kaiser Family Foundation (2002); Michelle M. Doty et al., *Seeing Red: Americans Driven into Debt by Medical Bills*, The Commonwealth Fund (2005).
10. Kathleen A. McManus et al., "Affordable Care Act Qualified Health Plan Enrollment for AIDS Drug Assistance Program Clients: Virginia's Experience and Best Practices," *AIDS Res. Hum. Retroviruses* (2016) 32(9): 885-91.
11. Kaiser Family Foundation, *Key Facts About the Uninsured Population* (2016).
12. *Id.*
13. Susan L. Hayes et al., *A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013-2015*, The Commonwealth Fund (2016).
14. *Id.*
15. Liz Hamel et al., *Survey of Non-Group Health Insurance Enrollees, Wave 3*, Kaiser Family Foundation (2016).
16. Sara R. Collins et al., *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*, The Commonwealth Fund (2016).
17. Sara R. Collins et al., *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect*, The Commonwealth Fund (2015); Robin A. Cohen, *Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates from the National Health Interview Survey, 2011-June 2014*, National Health Interview Survey Early Release Program (2015).
18. Hayes et al., *supra* note 13; Collins et al., *supra* note 16.
19. Peter Cunningham et al., *Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes*, The Kaiser Commission on Medicaid and the Uninsured (2016).
20. *Id.*
21. Mike Krings, "Individuals with Disabilities More Likely to be Employed in States with Expanded Medicaid," University of Kansas (Dec., 21, 2016).
22. Analysis from the Disability Rights Education and Defense Fund.
23. Shari Westerfield, "Consequences of Repealing ACA Provisions or Ending Cost-Sharing Reduction Reimbursements," Letter to Congress from American Academy of Actuaries (Dec. 7, 2016).
24. Congressional Budget Office, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums* (2017).
25. Linda J. Blumberg et al., *Implications of Partial Repeal of the ACA through Reconciliation*, The Urban Institute (2016); Congressional Budget Office, *Repeal the Individual Health Insurance Mandate* (2016).
26. Blumberg et al., *supra* note 25.
27. Congressional Budget Office, *supra* note 24.
28. JoAnn Volk et al., *Loss of Cost-Sharing Reductions in the ACA Marketplace: Impact on Consumers and Insurer Participation*, The Commonwealth Fund Blog (Dec. 21, 2016); Tim Jost, *House v. Burwell and Qualified Health Plans for 2017*, The Health Affairs Blog (Sept. 22, 2016).
29. Blumberg et al., *supra* note 25.
30. *Id.*
31. *Id.*
32. Congressional Budget Office, *supra* note 24.
33. *Id.*
34. Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act*, U.S. Department of Health and Human Services (2017).
35. Gary Claxton et al., *Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, Kaiser Family Foundation (2016).
36. Leighton Ku et al., *Repealing Federal Health Reform: Economic and Employment Consequences for States*, The Commonwealth Fund (2017).
37. *Id.*
38. Congressional Budget Office, *supra* note 24.
39. Matthew Buettgens et al., *The Impact on Health Care Providers of Partial ACA Repeal through Reconciliation*, The Urban Institute (2017).
40. Allen Dobson et al., *Estimating the Impact of Repealing the Affordable Care Act on Hospitals: Findings, Assumptions and Methodology*, Dobson DaVanzo (2016).
41. John E. Dicken, "Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools," U.S. Government Accountability Office (Jul.22, 2009).
42. Jean P. Hall & Janice M. Moore, "Realizing Health Reform's Potential: The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform," The Commonwealth Fund (2012).
43. Jean P. Hall, *Why High Risk Pools (Still) Won't Work*, The Commonwealth Fund Blog (Feb. 13, 2015); Drew Altman, "High-Risk Pools as Fallback for High-Cost Patients Require New Rules," Wall Street Journal (Jan. 23, 2017).
44. See, e.g., Commissioner Teresa Miller, *Letter to Majority Leader Kevin McCarthy*, Pennsylvania Insurance Department (Jan. 4, 2017).
45. Commissioner Dave Jones, *Letter to Majority Leader Kevin McCarthy*, California Insurance Department (Jan. 12, 2017).
46. *E.g., id.*
47. Karen Pollitz, *High-Risk Pools for Uninsurable Individuals*, Kaiser Family Foundation (2016).
48. Hall, *supra* note 43.
49. American Academy of Actuaries Individual and Small Group Markets Committee, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes*, American Academy of Actuaries (2017).
50. Hall, *supra* note 43.
51. Tim Jost, *Alaska Reinsurance Plan Could Be Model for ACA Reform, Plus Other ACA Developments*, The Health Affairs Blog (Jun. 16, 2016); Commissioner Teresa Miller, *supra* note 44; Tammy Tomczyk et al., *Alaska 1332 Waiver Application: Actuarial Analyses and Certification*, Oliver Wyman (2016).

52. Claxton et al., *supra* note 35.
53. *Id.*
54. Pamela Farley Short et al., *New Estimates of Gaps and Transitions in Health Insurance*, The Commonwealth Fund (2012).
55. Office of the Assistant Secretary for Planning and Evaluation, *supra* note 34.
56. American Academy of Actuaries Individual and Small Group Markets Committee, *supra* note 49.
57. Linda J. Blumberg & John Holahan, *The New Bipartisan Consensus for an Individual Mandate*, The Urban Institute (2015).
58. Sabrina Corlette et al., *Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices*, The Urban Institute (2017).
59. Kaiser Family Foundation, *supra* note 11.
60. Justin Giovannelli & Kevin Lucia, *State Experiences Show Why Repealing the ACA's Premium Subsidies and Individual Mandate Would Cripple Individual Health Insurance Markets*, The Commonwealth Fund Blog (Jan. 20, 2017); Leigh Wachenheim & Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets*, Milliman (2012); Adele M. Kirk, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *J. Health Politics, Pol. & Law* (2000) 25.1: 133-73.
61. Hamel et al., *supra* note 15; Collins et al., *supra* note 16.
62. Abby Goodnough & Robert Pear, "Unable to Meet the Deductible or the Doctor," *New York Times* (Oct. 17, 2014); Tracy Jan, "Critics Say High Deductibles Make Insurance 'Unaffordable,'" *Boston Globe* (Nov. 16, 2015).
63. Altman, *supra* note 1; Tolbert & Antonisse, *supra* note 1.
64. Tolbert & Antonisse, *supra* note 1.
65. Edwin Park, *Trump, House GOP Health Savings Account Proposals Would Mostly Help Wealthy, Not Uninsured*, Center on Budget and Policy Priorities (2016).
66. *Id.*
67. Paul Fronstin & M. Christopher Roebuck, *The Impact of an HSA-Eligible Health Plan on Health Care Services Use and Spending by Worker Income*, Employee Benefit Research Institute No. 425 (2016).
68. Judith Solomon, *Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved*, Center on Budget & Policy Priorities (2016).
69. See Kevin Lucia et al., *Federal and State Policy Toward Association Health Plans in Oregon*, The Urban Institute (2014).
70. National Association of Insurance Commissioners, *Consumer Alert: Association Health Plans are Bad for Consumers* (2001); National Governors Association, National Conference of State Legislatures, National Association of Insurance Commissioners, *Letter to Congress re: Association Health Plans* (2001).
71. National Association of Insurance Commissioners, *Letter to Congress re: ACA Repeal* (Jan. 24, 2017).
72. National Conference of Insurance Legislators, *NCOIL Urges Congress to Oppose AHP Legislation, Cautions Against Harm to Consumers*, News Release (2005).
73. Namrata Uberoi et al., *Health Insurance Coverage and the Affordable Care Act, 2010-2016*, Office of the Assistant Secretary for Planning and Evaluation (2016).
74. Aditi P. Sen & Thomas DeLeire, *The Effect of Medicaid Expansion on Marketplace Premiums*, U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (2016).
75. Office of the Assistant Secretary for Planning and Evaluation, *supra* note 34.
76. Justin Giovannelli et al., *Implementing the Affordable Care Act: Revisiting the ACA's Essential Health Benefits Requirements*, The Commonwealth Fund (2014).
77. Sabrina Corlette et al., *Selling Health Insurance Across States Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage*, Georgetown University Health Policy Institute Center on Health Insurance Reforms (2012).
78. National Association of Insurance Commissioners, *Interstate Health Insurance Sales: Myth vs. Reality*, The Center for Insurance Policy and Research.
79. *Id.*
80. *Id.*
81. National Conference of Insurance Legislators, *Principles on Healthcare Reform*, NCOIL Executive Committee (2009).
82. American Academy of Actuaries Individual and Small Group Markets Committee, *supra* note 49.
83. Corlette et al., *supra* note 77.
84. 45 C.F.R. §§ 147.104(e), 156.125(b), 156.225.
85. See, e.g., 45 C.F.R. § 92.201 et seq.; National Health Law Program & The AIDS Institute, *Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida*, Administrative Complaint to HHS Office for Civil Rights (May 29, 2014); Sally McCarty, "Regulatory Activity in Two States Restricts How Plans Structure Specialty Drug Coverage," *CHIIRblog* (Jan. 21, 2015); Florida Office of Insurance Regulation, *Humana Agrees to Consent Order Regarding HIV/AIDS Medications and Conduct of Exams* (Feb. 17, 2016); Florida Office of Insurance Regulation, *PPACA Guidance to Insurers – 2016 Filings HIV/AIDS Drugs Safe Harbor*; Ron Hurrubise, "State Tells Insurers to Limit Co-pays for HIV/AIDS Drugs," *Florida Sun Sentinel* (Jul. 1, 2015).

