Recommendations for States' Efforts to Mitigate Harms Caused by Federal Policy Actions

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Executive Summary

Recent federal legislative and regulatory changes will result in more than 10 million people losing either Medicaid or Affordable Care Act (ACA) Marketplace coverage over the next decade; an additional 4 million people are expected to become uninsured because of Congress's failure to extend enhanced premium tax credits (PTCs). State insurance commissioners, working within their authority and in partnership with state-based Marketplaces and other state officials, can mitigate these harms in meaningful ways. This document outlines a set of state-level strategies to help protect consumers' access to affordable, high-quality coverage and access to care.

Ways State Insurance Regulators Can Mitigate Coverage Losses

State-level policy and operational actions can improve coverage affordability, reduce red tape, improve consumer education and assistance, and help maintain markets that provide comprehensive health insurance. These include:

1. **State-funded Financial Help**

   The most straightforward way to mitigate coverage loss is to provide state-funded financial assistance to defray premiums and/or cost-sharing for Marketplace enrollees. While state funds are unlikely to fully make up for the loss of enhanced PTCs, a state "subsidy wrap" can significantly improve affordability and help improve the individual-market risk pool.

2. **Basic Health Programs (BHPs)**

   BHPs have the potential to improve the affordability and comprehensiveness of coverage for low-income people, although states' available funding, implementation choices, and operational systems will determine a BHP's impact.

3. **Marketplace Eligibility and Enrollment Processes**

   In the face of increased red tape imposed by the federal government, state-based Marketplaces (SBMs) can streamline the consumer experience by leveraging previous interactions and information sharing between eligible individuals and state agencies; conducting "sludge audits" to identify friction points that inhibit consumers from completing enrollment; and adopting special enrollment periods (SEPs) that facilitate consumers' enrollment in Marketplace coverage.

4. **Consumer Communications and Engagement**

   Given finite resources, states should engage in data-driven, targeted strategies to identify and reach consumers who most need assistance. States can foster stronger connections with diverse communities by understanding the cultures of the people they serve, expanding language access to meet the needs of a wider range of enrollees, and leveraging trusted communications channels and messengers. SBMs will likely need to invest in personalized assistance to ensure that consumers have the support they need to navigate changing eligibility and enrollment rules and documentation requirements. State departments of insurance (DOIs) should also consider educating consumers about the risks of switching to products or arrangements that are unregulated or do not meet ACA standards.

5. **Plan Management**

   Marketplace plan certification standards give state regulators the opportunity to protect consumers and support enrollment by improving affordability and reducing friction in the enrollment process. This can include active purchasing by SBMs and optimizing consumer decision-making through standardized benefit design.

6. **Insurance Regulation**

   States can use their regulatory authority to close new federal loopholes that could result in eligible consumers going without coverage. They can also leverage rate review to support "silver loading" (i.e., raising silver-plan premiums to compensate for the loss of cost-sharing reduction payments) and plan actuarial value standards that ensure robust coverage within the Marketplace.

7. **Market Oversight and Enforcement**

   As federal policy changes have reduced the affordability of ACA Marketplace health insurance, consumers are more vulnerable to aggressive, often deceptive marketing tactics by sellers of products that could leave them at considerable financial risk if they get sick or injured. State insurance regulators and SBMs will need to protect consumers from deceptive marketing tactics to ensure compliance with state standards and preserve market stability.

Documenting the Effect of Federal Policy on Consumers and Insurance Markets

As legislative and regulatory changes to insurance standards and Marketplace eligibility and enrollment processes take effect, states will want to collect, analyze, and share the impact of these changes on the accessibility and affordability of health insurance coverage. Such efforts could take on even greater importance if the Centers for Medicare & Medicaid Services (CMS) fails to provide robust data about the impact of Marketplace changes.

All states can take steps to mitigate the coverage loss likely to follow from federal-level policy changes. Some of the recommendations in this report are primarily applicable in states that operate their own Marketplaces; most can be implemented by state insurance regulators, either on their own or in partnership with other state policymakers and officials.

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Introduction

Recent federal policy changes, combined with Congress's failure to extend Affordable Care Act (ACA) Marketplace enhanced premium tax credits (PTCs), will result in more than 14 million people losing either Medicaid or Marketplace coverage over the next decade and will also increase consumers' cost and administrative burdens in obtaining and keeping affordable, comprehensive health insurance.[1] These changes will have a detrimental effect on families at all income levels and in all states, but those most likely to become uninsured will be low-income individuals and people of color.[2] State insurance commissioners, working within their authority and in partnership with state-based Marketplaces and other state officials, can mitigate these harms in meaningful ways. This document outlines a set of state-level strategies to help protect consumers' access to affordable, high-quality coverage and access to care.

Federal policy changes will result in more than **14 million** people losing either Medicaid or Marketplace coverage over the next decade.

Federal Marketplace Changes Will Contribute to Unprecedented Coverage Losses in All States

In 2024, 8 percent of people went without health insurance in the United States, a rate that hovers near an all-time low.[3] An estimated 22 million people enrolled in ACA Marketplaces in 2025, more than double the number who enrolled in 2020.[4] Much of this enrollment growth is attributed to enhanced PTCs enacted by Congress in 2021 and extended in 2022 under the Inflation Reduction Act. Enhanced PTCs have reduced the number of uninsured individuals by an estimated 14 percent, largely by lowering premiums for the lowest-income Marketplace enrollees by 50 to 100 percent. For higher-income Marketplace enrollees, enhanced PTCs reduced premiums by approximately 25 percent.[5]

Without congressional action, enhanced PTCs are scheduled to expire at the end of 2025, which will result in premium increases of more than 114 percent for the average Marketplace enrollee. Some enrollees will see their premiums triple or quadruple.[6] The Congressional Budget Office (CBO) has estimated that this will result in 3.8 million current Marketplace enrollees becoming uninsured over the next ten years.[7]

Further, in June 2025 the Centers for Medicare & Medicaid Services (CMS) promulgated the "Marketplace Integrity and Affordability" final rule, which included numerous policy and operational changes for the ACA Marketplaces.[8] Although several of its provisions have been temporarily blocked by a federal district court, the rule includes policies that will increase premium costs for the vast majority of Marketplace enrollees while also making it more challenging for consumers to obtain and keep Marketplace coverage.[9] CMS projects that between 725,000 and 1.8 million people will lose health insurance as a result of this rule.[10]

Meanwhile, H.R. 1, the budget reconciliation bill President Trump signed into law on July 4, 2025, doubles down on the regulatory changes, with provisions that eliminate PTCs for many Marketplace enrollees and dramatically increase red tape for consumers.[11] The CBO estimates that almost 3 million current Marketplace enrollees will become uninsured due to the provisions in H.R. 1.[12]

Reduced Affordability

The Marketplace Integrity regulation includes provisions that will increase premiums and cost-sharing for all Marketplace enrollees; H.R. 1 further includes provisions that erode affordability and end 1.2 million enrollees' eligibility for any financial help.[13]

- **Increasing net premiums**: The Marketplace Integrity rule modifies a statutory formula called the "premium adjustment percentage," resulting in significantly higher premiums and cost-sharing for consumers. Marketplace enrollees will face

Expiration of enhanced premium tax credits will result in premium increases of more than **114 percent** for marketplace enrollees.

premiums in 2026 that are roughly 4.5 percent higher than they would be under the previous methodology, and could face annual cost-sharing limits that are up to 15.2 percent higher.[14] The CBO estimates this change will result in 200,000 Marketplace enrollees losing coverage.[15,16] Although several provisions of the Marketplace Integrity rule have been blocked by a federal court, this provision has been allowed to go into effect beginning in 2026.

- **Creating new financial risks**: H.R. 1 removes the ACA's cap on the amount that low-income individuals must pay back to the Internal Revenue Service (IRS) if their advance PTCs exceed the amount of PTCs they are entitled to based on their actual income. This provision is likely to result in unexpected and potentially significant financial liabilities for low- and middle-income families, and could have a particularly chilling effect on those with variable or uncertain income during the year.[17] The CBO projects that 100,000 people are likely to become uninsured as a result of this provision.[18]
- **Ending eligibility for PTCs**: Beginning in plan year 2026, the budget law terminates eligibility for premium tax credits (PTCs) and cost-sharing reductions (CSRs) for lawfully present immigrants below the poverty line who are ineligible for Medicaid due to their immigration status. This includes refugees, asylees, people who have been granted humanitarian parole (such as Afghans who assisted the US during wartime), certain victims of sex or labor trafficking who help law enforcement bring the perpetrators to justice, and certain victims of domestic violence. In plan year 2027, the law terminates PTC and CSR eligibility for almost all lawfully present immigrants.[19] Combined, these provisions will result in 1.2 million people becoming uninsured.[20]
- **Reducing PTCs and increasing plan deductibles**: The Marketplace Integrity rule would allow insurers to offer Marketplace plans with lower actuarial values than currently permitted, resulting in more plans with higher deductibles and cost-sharing. In addition to reducing the value of Marketplace plans, this change (although temporarily blocked by a federal district court) would reduce PTCs and increase net premiums for Marketplace enrollees by an estimated $1.4 billion by 2029.[21]

Increased Red Tape

H.R. 1 and several provisions of the Marketplace Integrity regulation dramatically increase the bureaucratic hoops consumers must jump through to access and keep affordable Marketplace insurance. New federal policies also shrink the windows of opportunity for consumers to assess their options and enroll in coverage.

- **Requiring consumers to submit new paperwork:** H.R. 1 and the Marketplace Integrity rule impose numerous new paperwork requirements on consumers.
  - H.R. 1 will require consumers to actively confirm their eligibility information or risk losing advance PTCs. Marketplaces will be barred from providing advance PTCs until the verification process is completed. This will eliminate the longstanding practice of annual automatic reenrollment in Marketplace plans, which is a common best practice in the insurance industry. In 2024, 10.8 million people (54 percent of Marketplace consumers) relied on automatic reenrollment to continue their insurance coverage.

- A provision of the Marketplace Integrity rule, though temporarily blocked by a federal court, would eliminate consumers' ability to attest to their eligibility for a special enrollment period, requiring them to submit additional documentation before they can enroll.
- Additional provisions of the Marketplace Integrity rule, temporarily blocked by a federal court, would increase the amount of paperwork consumers must provide to the Marketplace to prove their income if tax data is unavailable or suggests that the consumer's income is under the poverty line. Although CMS estimates that it would take consumers an additional 3.3 *million* hours in 2026 to complete all this extra paperwork, the rule would also shorten by sixty days the amount of time consumers have to submit the necessary evidence.[22]

- **Terminating advance PTCs:** H.R. 1 requires Marketplaces to deny advance PTCs to people who have not filed the correct tax form with the IRS, referred to as a "failure to reconcile." Consumers who fail to file the necessary paperwork within one year will be denied advance PTCs for the next plan year, even though the delays are often caused by IRS staffing shortages. For most people, this will result in loss of coverage, as few can afford to pay their full premiums. Combined with the new paperwork requirements described above, this provision will result in 900,000 additional Marketplace enrollees becoming uninsured.[23]
- **Limiting enrollment opportunities**: The Marketplace Integrity rule would reduce the length of the annual open enrollment period (OEP) for all Marketplaces, including state-based Marketplaces (SBMs) that have historically had autonomy to decide on OEP durations that best suit the customers they serve. Further, H.R. 1 permanently eliminates the opportunity for low-income people (individuals currently earning between $15,650 and $23,475 per year) to enroll year-round. This change extends to the SBMs, which have previously been allowed to establish special enrollment periods appropriate to their local markets.

Combined, these changes are expected to reduce Marketplace enrollment by up to 57 percent and have resulted in an average 26 percent increase in premiums for 2026 individual market coverage.[24,25] The federal policies are accompanied by recent executive branch actions cutting funding by 90 percent for Marketplace Navigators in states with federally facilitated Marketplaces (FFMs).[26]

The coverage loss in the Marketplace is compounded by an unprecedented $990 billion cut to Medicaid and the Children's Health Insurance Program (CHIP) over the next decade.[27] H.R. 1 included numerous provisions designed to roll back the ACA's Medicaid expansion and restrict eligibility and access to care for millions of low-income adults. Among other changes, the new law dramatically reduces state revenue from provider taxes, cuts Medicaid enrollment through work requirements and elimination of coverage for certain immigrant groups, and adds new cost-sharing obligations for enrollees. The law's Medicaid and CHIP cuts will result in an estimated 7.5 million people losing health insurance, while H.R. 1's Marketplace

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cuts will drive 2.4 million people off their insurance by 2034.[28] These changes, combined with Congress's failure to extend enhanced PTCs, will result in an estimated 14 million people joining the ranks of the uninsured.[29] Further, as the NAIC observed in its May 29, 2025, letter to congressional leaders, with fewer people covered under Medicaid or private insurance, H.R. 1 will "result in more uncompensated care for health care providers and higher costs for those remaining in the market."[30]

Additional Federal Policy Shifts Erode the Value of Health Insurance Coverage for Consumers

The recommendations in this report focus on actions states can take to mitigate the coverage loss anticipated as a result of recent federal policy changes. In addition, other federal policies are expected to erode the comprehensiveness of coverage for many consumers, even as their premiums rise. Two such examples, described below, are federal actions to restrict vaccine access and a provision of the Marketplace Integrity rule that curtails coverage for gender-affirming care. Although not the focus of this report, there are a range of policies states can adopt to mitigate the harms from these federal policies and shore up the value of coverage for consumers.

Reduced Access to Free Preventive Care and Vaccines

In June 2025, the US Supreme Court in *Kennedy v. Braidwood* upheld the constitutionality of the ACA's preventive services benefit. The court ruled that the secretary of Health & Human Services (HHS) has plenary authority to determine the membership of federal advisory bodies that recommend preventive items or services that insurers must cover without cost-sharing. The secretary further has broad authority to approve, disapprove, or rescind their recommendations.[31] The current secretary of HHS has removed all members of the Advisory Committee on Immunization Practices (ACIP) and replaced them with several vaccine skeptics; canceled a scheduled meeting of the US Preventive Services Task Force (USPSTF); fired the Senate-confirmed CDC director; and, without evidence, rescinded recommendations for children and pregnant women to receive the COVID-19 vaccine.[32] These actions have raised concerns about consumers' continued access to critical preventive care.

Discrimination in Benefit Design

In the Marketplace Integrity rule, HHS prohibited health insurers from including services to treat gender dysphoria as an "essential health benefit" (EHB) under the ACA.[33] Previously, HHS had only explicitly prohibited EHB status for a very limited number of services: non-pediatric vision services, long-term nursing care, and non-medically necessary orthodontia, arguing that these services were often offered under excepted benefit plans.[34] Although twenty-one states have filed suit to enjoin numerous provisions of the Marketplace Integrity rule, the ban on coverage for gender dysphoria treatment will apply to benefits for plan year 2026.[35]

Options for State Insurance Regulators to Mitigate Coverage Losses Due to Federal Policy Changes

States can pursue a wide range of strategies to help consumers access and keep high-quality, affordable health insurance. These include programs to reduce premiums and out-of-pocket costs, limit the administrative burdens consumers must navigate to obtain coverage, improve consumer communications and assistance, and implement robust plan management and market oversight.

Affordability Improvements

Many Marketplace consumers will face a significant spike in premiums in 2026, prompting them to drop health insurance entirely or sacrifice other necessities to maintain coverage. Those most likely to drop their health insurance will, on average, be younger and healthier than those who make financial sacrifices to maintain it. This, in turn, will leave insurers with a smaller and sicker risk pool, prompting them to increase premiums. Some insurers may decide reduce plan offerings or exit the insurance market altogether. States should consider multiple strategies to help reduce consumers' premium costs, keep them insured, and maintain market stability. Some of these suggestions require a state-run Marketplace; others do not.

State-Funded Financial Help

If the federal government does not act, the most straightforward mechanism to mitigate the increase in the cost of coverage for state residents is state-funded financial assistance to defray premiums and/or cost-sharing for Marketplace enrollees. While state funds are unlikely to fully make up for the loss of enhanced PTCs, a state "subsidy wrap" can significantly improve affordability, reduce coverage loss, help improve the individual market risk pool, and support market stability. For example, in September 2025, Colorado established a $100 million fund to help reduce premiums for Marketplace enrollees impacted by the expiration of PTCs. This prompted the return of two insurers that had previously announced market exits.[36]

States that operate their own Marketplaces are best positioned to provide premium relief that can wrap around federal advance PTCs—but depending on the target population and design of the program, states using Healthcare.gov can also provide funding to improve affordability. State dollars can be used to reduce premiums for lower-income enrollees; eliminate the "subsidy cliff" for individuals just above 400 percent of the federal poverty level (FPL) who do not qualify for any federal PTCs; reduce cost-sharing; or some combination thereof. Eleven states and the District of Columbia currently fund such subsidy programs, and several are further targeting their subsidy dollars to support populations that have historically lacked access to affordable, high-quality health insurance. For example, states are using state-financed subsidies to lower premiums for certain low-income workers, younger adults, and immigrants ineligible for Marketplace coverage.[37]

As provisions from H.R. 1 and the Marketplace Integrity rule go into effect, states may want to consider other uses of state subsidy wraps, such as:

- Financial assistance for lawfully present immigrants who are no longer eligible for federal PTCs or cost-sharing reductions (CSRs).
- Provisional funding of premiums and cost-sharing assistance while a Marketplace applicant awaits an eligibility determination due to a data-matching issue.

State Revenue Sources

The primary challenge to state-funded subsidy wraps and other state programs that help pay for health coverage is financing. In addition to narrowing eligibility and reducing enrollment in federal health care programs, H.R. 1 directly harms states' budget footing in two key ways. First, it dramatically shifts to states the Medicaid and Supplemental Nutrition Assistance Program (SNAP) costs long borne by the federal government. Second, it directly reduces tax revenues in the many states that automatically tie their taxable income definitions to current federal law—an approach known as rolling conformity.[38] Taken together, these changes will force many states to fill their own budget gaps at the same time they are trying to mitigate coverage losses from federal program cuts.[39]

States have several options to make up for this lost funding and support health care programs. Several states have enacted state health insurance assessments, which generally replace the federal health insurance fee that was included in the ACA and then repealed in 2019.[40] Colorado, Maryland, New Jersey, and New Mexico have all used such fees to help support state subsidy programs. Several states also leverage general revenues, tobacco taxes, and Marketplace user fees.[41] States have many other revenue options as well.[42]

The passage of H.R. 1 presents additional financing opportunities. As explained above, H.R. 1 directly cut state taxes in states whose tax codes conform with the federal tax rules on a rolling basis. States in this position can decouple their income tax definitions from federal tax rules, thereby taking back control of their revenue policies.[43] Also, while H.R. 1 takes resources away from the lowest-income families (CBO estimates an average resource reduction of $1,214 for families in the lowest income decile), it significantly increases resources for the highest-income families, on average increasing resources by $13,622 for households in the highest decile.[44] States could therefore consider adopting a more progressive state-level tax structure that increases tax responsibilities for their highest-income residents, effectively reducing their federal tax cut. States could use the revenue this change would generate to make coverage more affordable for lower-income residents.

The Basic Health Program

Minnesota, New York, Oregon, and the District of Columbia have established Basic Health Programs (BHPs). A BHP has the potential to improve the affordability and comprehensiveness of coverage for low-income people, though the effect depends heavily on a state's available funding, implementation choices, and operational systems. Although a BHP may be more easily administered if the state runs its own Marketplace, Oregon was able to stand up its BHP while using the HealthCare.gov platform.

What is a BHP?

Section 1331 of the ACA creates an option for states to establish a BHP.[45] Under the law, states may enroll individuals with annual income up to 200 percent of the FPL ($31,300 for an individual; $53,300 for a family of three) in a BHP instead of the Marketplace. Section 1331 mandates that the BHP premium cannot exceed the enrollee's premium for the second-lowest-cost plan on the Marketplace after PTCs. The BHP must cover at least 90 percent of the costs of covered benefits for people below 150 percent of the FPL and at least 80 percent of the costs of covered benefits for people between 150 and 200 percent of the FPL. Similar to Marketplace plans, BHP plans must cover the full range of the ACA's essential health benefits.

The federal government helps finance BHPs by providing 95 percent of the funds that would have been paid in Marketplace PTCs for each enrollee. Because the size of PTCs is closely tied to Marketplace premiums, a state's federal BHP payments depend heavily on its Marketplace premiums. The federal funds are deposited into a BHP trust fund, which states may only use to cover premiums, cost-sharing, and benefits for BHP enrollees. Federal dollars may not be used to cover a state's administrative costs.[46]

Mileage May Vary: The BHP as a Mechanism to Improve Coverage Affordability

New York and Minnesota established their BHPs in 2015, Oregon launched its BHP in July 2024, and DC's BHP was approved by the Trump administration in September 2025.[47,48,49] All four have leveraged the BHP to provide coverage with lower premiums and cost-sharing for low-income residents than what they would otherwise be eligible for via the ACA Marketplace.

In addition to offering more generous coverage, a BHP can help protect consumers from some of the financial risk and complexity inherent in Marketplace coverage, such as annual premium and PTC fluctuations and plan choice overload. In addition, a BHP can offer relief from the now-uncapped repayments that PTC recipients may face if they misestimate their income.

Depending on how the program is designed and on market conditions, states may find that they can provide eligible individuals with coverage that is more generous than that available via the Marketplaces, without a significant expenditure of state resources. Generally, the most important factors in the fiscal viability of a BHP are the level of Marketplace premiums and the difference between provider reimbursement rates paid in the individual commercial market and under the BHP. If a state has a substantial gap between Medicaid and commercial provider rates and can keep its BHP provider rates on par with Medicaid (or some modest multiple thereof), the state is more likely to be able to rely exclusively on federal dollars to finance its program.

TABLE 1

Key Features of State Basic Health Programs

State	Structure	Provider Rates	Premiums	Cost-sharing	Additional Benefits	Funding
DC	Leverages Marketplace eligibility and enrollment infrastructure	Pegged to Medicaid	$0 premiums for enrollees	No deductibles or other cost-sharing**	N/A**	Fully supported by federal funding
MN	Leverages Medicaid eligibility and enrollment infrastructure	Pegged to Medicaid	Generally lower than for Marketplace plans	Generally lower than for Marketplace plans	Offers additional benefits (eyeglasses)	State contribution required in some years
NY	Leverages Medicaid eligibility and enrollment infrastructure	Pegged to Medicaid (but increase over time)	$0 premiums for enrollees (reduced over time)	No deductibles and minimal cost-sharing	Offers additional benefits (adult vision/dental)	Fully supported by federal funding
OR	Leverages Medicaid eligibility and enrollment infrastructure	Pegged to Medicaid	$0 premiums for enrollees	No deductibles or other cost-sharing	Offers additional benefits (adult dental, eyeglasses, non-emergency transport)	Fully supported by federal funding***

* Federal funds do not cover the administrative costs of operating the BHP. In addition, beginning January 1, 2026, states that cover lawfully present immigrants under 100 percent of the FPL in their BHP must do so using state-only financing.

** DC's BHP plan enrollees will face no cost-sharing unless there are changes to the federal financing structure. Benefits will include vision and dental if Congress extends enhanced PTCs.

***Oregon's BHP uses some state funds to support coverage of services the federal government does not cover.

Sources: Corlette S, Levitis J, Wengle E, Swindle R, "The Basic Health Program Considerations for States and Lessons from New York and Minnesota," April 2023, https://www.urban.org/sites/default/files/2023-04/The%20Basic%20Health%20Program%20Considerations%20for%20States%20and%20Lessons%20from%20New%20York%20and%20Minnesota.pdf; *Oregon Basic Health Program Blueprint,* https://www.medicaid.gov/basic-health-program/downloads/or-basic-hlth-prgm-blprnt.pdf; *District of Columbia Basic Health Program Blueprint,* https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/DC%20BHP%20Blueprint%20Draft%20-%206.16.25.pdf.

However, the success and sustainability of a BHP is highly contingent on the level of Marketplace premiums. State policies that reduce premiums in the Marketplace may have the unintended effect of reducing federal BHP payments, whereas state policies that increase premiums in the Marketplace would increase federal BHP payments.

BHP funding is also sensitive to changes in PTC policy. The enhanced PTCs provided under the American Rescue Plan Act of 2021 resulted in an additional $750 million in federal funding for New York's and Minnesota's BHPs.[50] Conversely, federal policies that reduce spending on PTCs (e.g., the failure to extend enhanced PTCs, and the provisions of H.R. 1 and the Marketplace Integrity rule) will reduce the funds available to the BHP. At the same time, federal policies are increasing Marketplace premiums by creating a smaller and sicker individual-market risk pool.[51] Finally, BHP funding is partly determined by federal regulations, which are subject to change.

State-Based Marketplace Policies and Processes

H.R. 1 and related regulatory actions require SBMs to implement immediate and long-term changes to eligibility and enrollment systems, consumer communications, and health plan certification. Many of these changes will need to be made in coordination or partnership with state departments of insurance. How states implement the new law and regulations could have a significant impact on coverage affordability and consumers' ability to navigate new administrative red tape to gain and keep coverage.

Eligibility and Enrollment

Marketplace eligibility and enrollment processes will undergo significant legislative and regulatory changes because of H.R. 1 and the Marketplace Integrity rule. These changes include the end of automatic reenrollment, new documentation and verification requirements for both reenrollment and new Marketplace applications, and a prohibition on the offer of provisional PTCs while Marketplaces verify new applicants' eligibility. Taken together, these changes pose significant barriers to consumer-friendly eligibility and enrollment processes and are predicted to result in 3.2 million people losing Marketplace coverage.[52] Even with these changes, however, SBMs retain significant authority over their eligibility and enrollment systems. They can respond by adjusting their current practices and embracing new strategies for minimizing friction in their eligibility and enrollment processes. Specifically, SBMs may consider adapting or adopting facilitated enrollment strategies, sludge audits, and special enrollment periods as they seek to reduce enrollment barriers and maintain coverage for eligible people.

Facilitated Enrollment

Facilitated enrollment strategies simplify or automate health insurance eligibility and enrollment processes, often by leveraging previous interactions between the eligible individual and state agencies and sharing state-held data.[53] These approaches draw on elements of ex parte renewal, a set of automated processes that states used to simplify Medicaid enrollment during the unwinding of pandemic-related continuous Medicaid eligibility.[54] While statutory and regulatory changes have placed some facilitated enrollment strategies off-limits for SBM administrators—for example, relying on state-held data to verify PTC eligibility, automatic reenrollment, and automatically effectuating plan selection for individuals who are eligible for free coverage—states can use or modify other approaches to streamline consumers' enrollment experiences.

Facilitated enrollment approaches rely on applicant information that agencies have gathered for other purposes or through previous, perhaps incomplete, applications for health insurance. This information might include contact and income information, immigration status, Social Security numbers (SSNs), and Taxpayer Identification numbers (TINs). With appropriate authority, information-sharing agreements, and consent, data such as individuals' state tax filings, unemployment insurance applications, and applications for income-based benefits (e.g., SNAP, Temporary Assistance for Needy Families [TANF], and Medicaid), can provide the information SBMs need for facilitated enrollment.

For example, Colorado, Illinois, New Mexico, and other states include check boxes on state tax forms that authorize the state tax department to share taxpayers' income information with the state Marketplace.[55] Similarly, California law requires the Employment Development Department to share information on applicants for unemployment compensation and other benefits with the California Health Benefit Exchange (also known as Covered California).[56] States may also have this information for previous Marketplace applicants, even if they did not complete the application process or failed to enroll in a plan. Finally, many states can draw on their integrated eligibility systems for Medicaid and Marketplace coverage or leverage the account transfer procedures they used to streamline the Marketplace application process during the Medicaid eligibility unwinding.

In some cases, H.R. 1 prohibits Marketplaces from solely using third-party data to confirm income or eligibility for a special enrollment period. But with state-derived information in hand, SBM administrators can pursue strategies to make it easier for people to enroll in coverage, from basic outreach to prepopulating applications and providing plan selections.

- **Outreach leads:** States can use income and contact information to alert individuals to their likely eligibility for Marketplace coverage via letters, texts, and/or phone calls.
- **Prepopulated applications**: States can create prepopulated enrollment applications using the information they have from Medicaid applications, tax filings and other state sources. States can then share these applications with individuals who are likely eligible for Marketplace coverage, requesting that they correct any errors, verify their income and other information, provide necessary documentation, and return the application for an eligibility determination. Idaho, Maine, and Nevada have used prepopulated Marketplace applications to streamline coverage transitions for individuals who lose Medicaid eligibility but would likely qualify for PTCs to pay for Marketplace coverage.[57] States that already use prepopulated applications may need to adjust their instructions by asking potential applicants to upload documents related to their PTC eligibility, since Marketplaces will no longer be able to rely solely on third-party data to assess eligibility.
- **Plan selection**: Prior to enactment of H.R. 1, states such as Rhode Island, Maryland, and California automatically enrolled individuals losing Medicaid eligibility into Qualified Health Plans.[58] Similarly, SBMs' practice of automatically re-enrolling Marketplace consumers into their existing plans or near equivalents for the next plan year accounted for more than 4 million reenrollments during 2025 open enrollment.[59] For the 2027 plan year, SBMs can exercise their ability to request authority from CMS to use reenrollment hierarchies that support strong plan choices, such as cross-walking enrollees from bronze to silver plans with similar or lower net premiums to reduce enrollees' cost-sharing. Once H.R.1's eligibility verification and documentation requirements take effect for the 2028 plan year, precluding automatic enrollment for new or renewing Marketplace enrollees, SBMs that leverage prepopulated applications could still include an automatic plan selection (identified via a default plan algorithm or from a previous coverage application) on the prepopulated application. Enrollees would be free to choose an alternative plan and would need to pay their first month's premium to effectuate coverage, but this approach could simplify the plan choice and enrollment process for many.

- **Resolving data-matching issues**: Because H.R.1 requires applicants to provide documentation for eligibility verification, states cannot automatically enroll or reenroll individuals who are likely eligible for PTCs. But states can use their own data—from tax sources, wage databases, and benefit applications, for example—to swiftly resolve data-matching issues when they arise. These issues can occur if the applicant fails to provide critical information (e.g., a Social Security number) or if information on the Marketplace application (projected income or other sources of coverage) does not match information available to the Marketplace. Because the Marketplace Integrity rule shortens the time frame for resolving income inconsistencies, states may need to fine-tune their processes for drawing on their own data to solve these issues.

Sludge Audits

Behavioral economics research colorfully describes administrative requirements and other paperwork barriers as "sludge" that inhibits individuals from taking actions or making choices that are in their own best interest.[60] For example, potential health insurance enrollees may find choosing a health plan such a complex task that they end up not enrolling in coverage at all, while employers who require employees to affirmatively enroll in workplace retirement savings programs see significantly lower participation rates than those whose plans are designed using an automatic enrollment and opt-out approach.[61]

Beyond identifying this phenomenon, some researchers have also called for government programs to conduct "sludge audits" to determine how their paperwork requirements, consumer communications, and other program elements create barriers to enrollment or otherwise discourage program participation and identify solutions.[62]

In 2023, for example, the Massachusetts Health Connector assessed administrative burdens to understand the paperwork requirements facing first-time Connector applicants and returning enrollees.[63] Findings from this assessment include:

- Connector applicants found questions about household membership and income confusing and hard to answer, particularly if they held part-time or seasonal employment.
- Applicants struggled to comply with the required processes for proving identity and verifying documents, often leading to individuals filling out paper applications or failing to complete their applications at all.
- Consumer notices can leave applicants confused about their program eligibility and next steps for enrollment.

Consistent with other findings that administrative burdens disproportionately affect communities of color, immigrants, non-English speakers, and individuals with disabilities, this audit found that immigrants, people without credit histories, and people who struggled to understand formal notices were most affected by procedural hurdles in the Health Connector application and enrollment process. These findings have enabled the Massachusetts Health Connector to begin reducing administrative barriers and improve consumer communications.

Marketplace administrators in SBM states could conduct their own sludge audits to identify and dismantle unnecessary administrative barriers to Marketplace enrollment beyond those required by recent federal changes. These audits could take several approaches, including enrollment simulations for program leadership; interviews and focus groups with enrollees, navigators, and assisters; and application data analysis.

Special Enrollment Periods

While H.R. 1 eliminates states' ability to create special enrollment periods (SEPs) for low-income marketplace applicants, SBMs retain the ability to create SEPs that facilitate consumers' enrollment in Marketplace coverage in the face of circumstances likely to undermine their ability to enroll. For example, states could consider a January SEP for those who start a Marketplace application during the OEP but do not finish it. This SEP would give people time to finish their applications and effectuate coverage for the balance of the plan year. Similarly, SBMs could provide a January SEP to enrollees who face significant changes in their net premium amounts, giving them more time to consider their coverage options and rearrange their personal finances to cover the higher monthly premium. Should Congress pass legislation to extend enhanced PTCs after the OEP has closed, this SEP would also provide an enrollment opportunity for consumers who can newly afford to purchase Marketplace coverage. States may also consider giving people who miss the OEP active renewal window an opportunity to re-enroll after January 1, without paying premiums back to that date.

States can also combine SEPs with other eligibility and enrollment strategies. For example, states that facilitate enrollment with information from unemployment insurance applications or tax filings could create SEPs for people who agree to have their information shared with the Marketplace. Maryland law, for example, directs the state Marketplace to create an SEP for unemployment insurance applicants who consent.[64] Similarly, states that create a prepopulated application using information derived from state tax submissions could pair this strategy with an SEP for those who are applying for coverage on the basis of information found on their tax forms.

In addition to identifying and implementing SEPs, states should ensure that they have adopted the full OEP of nine weeks allowed under federal policy for plan year 2027 enrollment. Unless blocked by pending litigation, SBMs must start their OEPs by November 1 and end their OEPs no later than December 31 for plan year 2027 coverage that begins January 1. States, current Marketplace enrollees, and new applicants will need the full nine weeks to ensure that applicants can share required documentation with the Marketplace, the Marketplace can complete an eligibility determination, and eligible individuals can enroll in a plan. SBMs will need to clearly communicate OEP date changes to current and prospective enrollees. For many SBMs, the new OEP will close several weeks earlier than their current OEP windows, and Marketplace enrollees could easily fail to re-enroll thinking they have more time to document their eligibility, choose a plan, and effectuate their coverage.

Consumer Communications and Engagement

Consumers will need clear, actionable information about federal policy and operational changes that affect their ability to obtain and keep health insurance, as well as personalized support to help them navigate a more burdensome eligibility process. Information and support will come from multiple sources, including SBMs, insurance regulators, insurers, and consumer assisters like Navigators and certified application counselors (CACs). People who are or will soon become uninsured will need help identifying affordable sources of health care services.

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Targeted Marketplace Communications

Many consumers remain unaware that federal policies will significantly change the affordability and accessibility of Marketplace insurance. At the same time, the federal government has reduced funding for Navigators and other personnel in states where it operates the Marketplace. Navigators are trained to educate consumers about impending changes and help them through the eligibility and enrollment process. States can also be critical sources of accurate information for consumers, helping them understand why changes are occurring and how to make informed coverage choices.

Given finite resources for outreach and consumer assistance, states should engage in data-driven, targeted strategies to identify and reach consumers in the most need of assistance. State-based Marketplaces—and DOIs in federal Marketplace states—can foster connections with diverse communities by understanding the cultures of the consumers they serve, expanding language access to meet the needs of a wider range of enrollees, and leveraging trusted communications channels and messengers. For example, Covered California's marketing team has adopted a "Culture First" messaging approach grounded in the values, traditions, and perspectives of their target audiences.[65]

Effective Consumer Support

State-based Marketplaces will likely need to increase their investments in personalized assistance to ensure that consumers have support to navigate changing eligibility and enrollment rules and new documentation requirements. This might include expanding call center capacity and boosting funding for Navigator grantees. In states that use the federal Marketplace, insurance regulators can encourage hospital providers to fund CACs as part of their community benefit obligations, and can partner with (and appropriately regulate) insurance brokers. Navigators and CACs, in particular, are well positioned to help people understand forthcoming changes to Medicaid policy.

At the same time, because resources for consumer assistance are finite, SBMs may want to focus on ensuring that on-the-ground assisters are embedded in, and trusted by, populations at highest risk for losing coverage in light of expected shifts in enrollment. For example, in July 2025 the Washington Health Benefit Exchange announced that it has partnered with eight new organizations to provide multilingual consumer assistance in counties with diverse populations.[66]

States will also need to provide consumer assisters with additional training and resources to ensure they have the latest information about federal- and state-level policy and operational changes, including new paperwork for consumers to enroll in and maintain Marketplace and Medicaid coverage.

Accurate and Nondiscriminatory Insurer Communications

The ACA Marketplaces will continue to be buffeted by policy change and uncertainty, which could result in insurers using marketing tactics that discriminate against people with high health care costs and encourage healthier consumers to enroll in non-ACA-compliant products without a full understanding of the risks. State insurance regulators should therefore monitor and assess how insurers communicate with current and prospective enrollees, and should further consider providing insurers with language for nondiscriminatory consumer notices and marketing materials that provide clear, consistent information.

Resources for the Uninsured

Few states will be able to fully replace the federal financial assistance cuts due to the expiration of enhanced PTCs and H.R. 1. Even in states able to provide state-only dollars to defray the cost of health insurance, many families will become uninsured.

People who are uninsured are more likely to lack access to a regular source of primary and preventive

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care, and to delay or forgo necessary health care items and services.[67] Uninsured people have higher mortality rates than those who are insured, and are more likely to require unplanned surgeries and rely on hospital emergency rooms.[68] Lack of insurance is also tied to higher rates of medical debt, which remains one of the leading causes of bankruptcy in the US.[69] States will therefore need to develop a plan to help ensure that these families can access health care services. At a minimum, SBMs and state DOIs should provide information and resources to guide people to sources of free and low-cost health care outside of the emergency room.

State DOIs should also consider educating consumers about the risks of switching from ACA plans to products or arrangements that are either unregulated or do not meet ACA standards, such as excepted benefit products bundled to mimic major medical insurance; short-term, limited-duration insurance; and health care sharing ministries. For example, the Office of the Insurance Commissioner in Washington has created a consumer-facing website explaining key differences between ACA and non-ACA-compliant products.[70]

Plan Management

To participate in the federally facilitated Marketplace and SBMs, health insurance companies must secure Marketplace certification that confirms their health plan offerings are Qualified Health Plans (QHPs). Certification requires QHPs to comply with a range of plan requirements including licensure, benefit design standards, and any state conditions of participation. Certification standards protect consumers and support QHP enrollment by improving affordability and reducing friction in the enrollment process. Specific strategies available to state regulators include active purchasing and standardized benefit design.

Active Purchasing

Marketplaces that use their regulatory power and market position to require insurance companies to meet Marketplace rules (on price, benefit design, and other elements) can improve affordability by reducing prices and protecting PTC value, and can also reduce enrollment friction.

SBMs that act as active purchasers aggressively negotiate rates with health insurance companies, resulting in average silver Marketplace premiums that are 15 percent lower than large group premiums.[71] Active purchasers can also prevent plans from artificially lowering the value of PTCs by ensuring that the benchmark plan is priced appropriately. Enrollees' PTC values are based on their income and the price of the benchmark plan in their market, defined as the price of the second-lowest-cost silver plan.

In most cases, this calculation leads to PTC values that are generous enough for Marketplace enrollees to have a reasonable choice of health plans at the silver metal level and potentially in other metal tiers. But if an insurance company lowballs its silver plan premiums—perhaps in a bid for customers upon entering a new market—it can drive the benchmark artificially low, thus reducing the dollar amount enrollees will receive in PTCs. This pricing strategy lowers consumers' relative buying power and increases their net premiums for any plan other than the benchmark. Overall enrollment is likely to fall as net premiums rise and coverage becomes less affordable for Marketplace participants.

By actively managing price and benefit and cost-sharing designs through the QHP certification process, SBM administrators can avoid this outcome. Similarly, DOIs in both SBM and FFM states can leverage their rate-review authority to ensure that proposed premiums are adequate to finance covered benefits, thereby preventing plans with artificially low premiums from destabilizing the Marketplace.

Active purchasing by SBMs can also mitigate enrollment friction by providing consumers with a limited list of carefully chosen QHPs. For example, Covered California uses its purchasing power to vet insurer participation, resulting in fewer insurance companies participating in the SBM and fewer QHPs for consumers to sift through. In markets with a robust supply of health insurance companies, consumers can face an overwhelming number of choices and have difficulty determining which plan best meets their needs. A significant body of literature has shown that consumers experience choice overload when they face too many health plan options—particularly if those options are not carefully curated—and may make suboptimal enrollment decisions that lead to higher out-of-pocket costs.[72] An SBM that acts as a strong active purchaser can minimize these accidentally expensive choices by offering a smaller number of stronger QHPs.

Standardized Benefit Design

In response to federal policymakers increasing the red tape and consumer burden associated with QHP enrollment, states can provide consumers with easier plan selection experiences by requiring QHPs to offer standardized benefit designs. QHPs must currently offer standard benefit packages in the FFM and a number of SBMs. Some states, such as California, limit insurers to offering only QHPs with standardized benefit designs, while the FFM and other states allow insurers to offer other plan designs in addition to required standard benefit designs.[73]

Standard benefit designs typically require insurers to standardize cost-sharing amounts across plans at the same metal level. For example, the FFM requires all 2026 standard silver plans to include a $6,000 deductible, $8,900 annual cost-sharing limit, 40 percent cost-sharing on inpatient hospital visits, and $40 copayments for primary care visits.[74] States may also use standardized benefit design to improve patients' access to prioritized services, such as primary care or diabetic care, through reduced or no cost-sharing.

Standard designs simplify enrollees' efforts to comparison shop by reducing the range of variation insurers can apply as they design their QHP offerings. This simplification, in turn, can improve enrollees' shopping experiences by addressing the confusion and poor decision-making that can result from an overly large number of choices.[75] Standard benefit designs also ensure that plans have less ability to engage in risk selection via their cost-sharing designs and benefit packages, thus supporting a less discriminatory and more balanced market. This will be particularly important as federal policy changes—such as PTC eligibility changes that will result in millions of relatively young and healthy legally present immigrants losing the ability to enroll in Marketplace coverage—lead to an older and sicker enrollee population in the ACA Marketplaces.

Insurance Regulation

In the wake of the final Marketplace Integrity regulation and H.R. 1, state DOIs can take important steps to protect residents' ability to secure and retain coverage in the Marketplace. First, DOIs can ensure that existing consumer protections clearly address new regulatory loopholes that could result in eligible individuals going without coverage. They can also leverage their rate review authority to support robust coverage within the Marketplace.

Guaranteed Issue

The final Marketplace Integrity regulation permits states to decide whether health insurance plans may deny new coverage to individuals with past-due premiums if the past-due amounts and initial premium amounts for an upcoming plan year are not fully paid.[76] While a Maryland federal court has stayed implementation of this provision, DOIs can update their guaranteed issue regulations to specify that this protection applies to applicants with past-due premiums. Alternatively, DOIs could clarify that insurance plans cannot deny coverage for applicants that owe only a de minimis amount of past-due premium. They could also limit the look-back period for past-due premiums (e.g., to a 90-day time frame) to prohibit coverage denial for past-due amounts from prior quarters or even plan years.

Rate Review

In partnership with their SBMs, insurance commissioners can leverage rate and form review to ensure that QHPs meet state and federal requirements. In some cases, states may consider amending health plan requirements to facilitate potential enrollees' choice of generous benefit designs at the lowest possible net premium.

Silver Loading

One approach for improving affordability and plan generosity for Marketplace enrollees is for states to require insurance companies to include and price for cost-sharing reductions in silver-tier plans, which they can do through their rate review processes. This "silver loading" strategy, which the first Trump administration encouraged when it terminated separate payments to insurance plans for cost-sharing reductions, increases the price of silver plans (including the benchmark plan). It therefore also increases the dollar value of PTCs, improves enrollees' buying power, and improves affordability.[77] Because the actuarial value of silver plans with reduced cost-sharing can exceed the actuarial value of gold plans, this approach can lead to benchmark premiums that exceed premiums for gold plans. In turn, this can result in enrollees being able to choose gold plans for no or very low net premiums. If enhanced PTCs sunset at the end of the 2025 plan year as scheduled by current law, silver loading could mitigate premium increases for enrollees who are open to changing plans.

Boosting Actuarial Value

Insurance regulators or SBMs can require QHPs to offer benefit designs within a defined range of actuarial values for each metal level. While the Marketplace Integrity rule allows insurers to reduce the minimum actuarial value for each metal level, this regulatory provision is currently stayed while litigation against the rule works through the judicial system. Regardless of how this litigation is resolved, state regulators can require plans to offer benefit and cost-sharing designs with a higher actuarial value than the minimum permitted by the new regulation. Higher actuarial value requirements for each metal level will reduce consumer cost-sharing and increase plan value, allowing for optimization of PTCs and encouraging enrollment.

Market Oversight and Enforcement

The market headwinds created by federal-level policy change will require state insurance regulators to engage in robust and proactive market monitoring, oversight, and enforcement. In particular, as federal policy changes have reduced the affordability of ACA Marketplace health insurance, consumers will be more vulnerable to aggressive and often deceptive marketing tactics by the sellers of products that could leave them at considerable financial risk if they get sick or injured.

Proliferation of Non-Comprehensive Insurance Products

Several types of insurance or insurance-like products and arrangements market themselves as alternatives to ACA-compliant health insurance offered in the individual market, but do not meet the same consumer protection standards. These include fixed indemnity insurance; short-term, limited-duration insurance (STLDI); health care sharing ministries (HCSM); Farm Bureau plans; Association Health Plans (AHPs), and certain quasi-employer arrangements offered to individuals that claim exemption from state regulation under the Employee Retirement Income Security Act (ERISA).

Major Types and Key Characteristics of Non-ACA Products

All of the following products and insurance-like arrangements are exempt from some or all of the ACA rules that apply to issuers in the individual market.

Excepted benefit policies: Consumers pay a fixed amount for specified covered services, such as $200 per day for a hospital stay or up to $5,000 for a procedure. Originally designed to supplement major medical insurance, these policies may be marketed on their own or "bundled" with other products to mimic traditional health insurance.

Short-term, limited-duration insurance (STLDI): Designed to provide temporary medical insurance for people experiencing a gap in coverage options—for example, those who are between jobs or are within an employer's waiting period. Not subject to ACA patient protections and typically cover a limited set of benefits.

Health care sharing ministries (HCSMs): A coverage-like arrangement in which members—who sometimes share religious beliefs—make monthly payments to cover the health expenses of other members. HCSMs are not considered insurance and do not guarantee payment for health care services.

Farm Bureau plans: Products sold by the Farm Bureau that are marketed as providing coverage similar to major medical insurance but are specifically not considered insurance in several states, thus exempting them from federal and state rules that apply to insurance.

Association health plans (AHPs): Previous federal rules, anticipated to be reissued in 2026, would enable certain associations to offer health insurance exempt from the full range of consumer protections and standards that apply to ACA-compliant insurance offered in the individual market.

Data marketing partnerships (DMPs) and similar arrangements: A dubious arrangement whereby individuals download tracking software that allows a DMP to collect and sell their data to third parties. The consumers become "limited partners" or "working owners" that are part of a single employer, and are thus sold a self-insured group health plan that is exempt from state insurance regulation.

Many consumers purchase these products believing they provide comprehensive coverage, when in fact they are exposed to significant financial liability if they get sick.[78] Numerous studies have documented misleading and even deceptive STLDI and hospital/fixed indemnity marketing practices.[79] Marketing materials often do not disclose that these plans do not cover preexisting conditions or essential benefits, or that they pay only a fraction of the actual cost of medical services.

For example, a Texas consumer who believed he was enrolled in a comprehensive insurance policy received a $67,000 hospital bill after a heart attack. In fact, he had a fixed indemnity policy that provided a cash benefit of less than $200 per day of hospitalization.[80] One study found that the actuarial value of STLDI is 49 percent, compared to the 87 percent applied actuarial value of a Marketplace plans.[81] According to NAIC data, the medical loss ratios of fixed indemnity policies averaged 42 percent, compared to 84 percent for ACA-compliant individual market plans.[82]

Although enrollment in these alternative products has been relatively limited in recent years, there are reasons to believe that enrollment could grow, placing consumers at risk of greater financial liability and leaving many providers with unpaid medical bills. First, the Trump administration is expected to roll

> Many consumers purchase these products believing they provide comprehensive coverage, when in fact they are exposed to significant financial liability if they get sick.

back federal rules that have helped keep aggressive and deceptive marketing of these products at bay.[83] On August 7, 2025, the administration announced it would no longer enforce these rules for STLDI, and that it would soon be promulgating new rules that modify the definition of STLDI.[84]

Second, the expected expiration of enhanced PTCs, the Marketplace Integrity final rule, and several provisions of H.R. 1 are likely to increase premiums for most individual market enrollees. As ACA-compliant coverage becomes less affordable, many people will seek alternative options. Indeed, it is well documented that the companies marketing non-ACA-compliant products often take advantage of consumer confusion and policy changes in the individual market to aggressively and often deceptively market their products as ACA alternatives.[85] Because these products can use underwriting practices to screen out people with pre-existing conditions, the proliferation of these plans is likely to attract a younger and healthier group of people, leaving the issuers of ACA-compliant products with a smaller, sicker risk pool. This in turn will prompt these carriers to raise premiums even further.

State insurance regulators and SBMs play a critical role in protecting consumers from deceptive or inappropriate marketing tactics, ensuring compliance with state standards, and preserving market stability and affordable premiums.

For All Non-ACA-Compliant Products and Arrangements

Given the well-documented record of misleading marketing tactics used by companies selling junk plans, state regulators and SBMs should consider:

- Requiring submission of marketing materials for prior review and approval.
- Monitoring marketing and broker activity, including requesting data on commission rates for ACA and non-ACA plans and taking enforcement action against insurers and brokers that engage in illegal activity.
- For SBMs, requiring brokers that also sell non-ACA plans to provide consumers with plain-language, side-by-side comparisons to Marketplace plans, along with the post-PTC price for their Marketplace options.
  - — For example, Covered California–certified agents are required to obtain a consumer's informed consent and assess them for eligibility for PTCs r Medicaid coverage prior to enrollment in a HCSM.

For Excepted Benefit Products

These products are designed to be used as an add-on to major medical coverage. Insurance regulators should require that these plans be sold only to people who have underlying ACA-compliant coverage. At a minimum, states should require strong disclosure requirements to warn prospective enrollees that these plans do not offer comprehensive coverage.

For Short-term, Limited-duration Insurance

States can take a number of steps to limit deceptive marketing of STLDI and protect consumers from unexpected financial liability due to inadequate coverage. Such actions could include:

- Mandating a stronger consumer disclosure than is required by federal regulations, as Delaware, DC, Illinois, Maryland, Vermont, and Washington do.[86]
- Prohibiting the sale of short-term plans during the Marketplace open enrollment period, as Maine, Virginia, and Washington do.

- Limiting the maximum contract term of short-term plans to three months, as do Delaware, DC, Hawaii, Maryland, New Mexico, Oregon, Vermont, Virginia, and Washington. Such action should also include prohibiting plans from stacking multiple STLDI policies to create coverage that skirts duration limits.
- Requiring STLDI plans to comply with a set of patient and consumer protections, such as the following.
  - — Requiring STLDI plans to cover essential health benefits (EHBs), as do Colorado and Connecticut.
  - — Prohibiting short-term plans from rescinding or retroactively canceling coverage, as Colorado, Illinois, Maine, Rhode Island, and Washington do.
  - — Banning plans from using gender rating, as Montana and Minnesota do.
  - — Requiring plans to follow the same rating restrictions as in the ACA, as Colorado does.
  - — Requiring plans to meet a minimum medical loss ratio (MLR) requirement, as Colorado and Rhode Island do.
  - — Providing STLDI enrollees with access to external appeals, as thirty-four states do.

For Health Care Sharing Ministries

There is increasing evidence that many HCSMs have strayed from what was originally a religiously oriented mission to help fellow members of a church or sect.[87] These arrangements often market themselves as cheaper alternatives to comprehensive, ACA-compliant insurance, but leave many members exposed to significant and often unexpected financial liability. States can help protect consumers by:

- Allowing state regulators to collect HCSM data, including marketing practices, broker incentives, enrollment information, and complaint information. For example, Colorado and Massachusetts require HCSMs to report key data to state officials.[88]
- Prohibiting brokers from selling HCSMs and other coverage-like arrangements that are not licensed as insurance under state law. Using brokers to enroll members contributes to consumer confusion and increases enrollment in inadequate coverage.

For Farm Bureau Plans

States with laws that exempt Farm Bureau plans from insurance regulation should consider repealing those laws. Maintaining or reestablishing regulatory authority over all risk-bearing insurance products will help protect consumers, ensure a level playing field, and protect market stability.

For Association Health Plans

States can and should regulate AHPs to help protect consumers from potential fraud and insolvency, and to ensure a level playing field for entities marketing insurance to the same types of enrollees. In particular, states should be:

- Requiring self-funded AHPs to satisfy the same licensure and financial standards required of commercial insurers.
- Ensuring proactive regulatory oversight of AHPs' marketing tactics and solvency.

For Data Marketing Partnerships and Similar Arrangements

- Allowing DMPs and similar types of arrangements to be exempted from state insurance laws exposes consumers to financial risk and providers to more unpaid claims. States should consider investigating these arrangements to determine whether they violate state law.

Documenting the Effect of Federal Policy on Consumers and Insurance Markets

As the legislative and regulatory changes to insurance standards and Marketplace eligibility and enrollment processes take effect, states will want to collect, analyze, and share their impact on the accessibility and affordability of health insurance coverage. Many recent federal policies are likely to discourage enrollment among lower-income enrollees and those from underrepresented groups, who are more likely to be affected by higher premiums, reduced benefits, and administrative barriers to the enrollment process. State efforts to collect and report relevant data could take on even greater importance if CMS fails to provide robust data about the impact of Marketplace changes.

State-based Marketplaces in particular have access to important data that can help document how federal policies affect coverage status and affordability. For example, many state-based Marketplaces already maintain robust, regularly updated, interactive dashboards and publish frequent reports during and after the open enrollment period with key data about plan selections, effectuated enrollment, call center performance metrics, and percentages of enrollees receiving federal PTCs and cost-sharing reductions. Georgia, Nevada, New York, and California's Marketplaces also publish public use data files with these and other key data.[89] In addition to providing real-time snapshots that document the consumer experience, state-based Marketplaces should also invest in longitudinal data that assesses the effect of public policy changes, such as changes in average net premiums and deductibles, the effect of a shorter open enrollment period on total enrollments, changes in application completion rates, and changes in the number of insurers in each service area.

State departments of insurance can also play a vital role. Both SBMs and DOIs can publish reports on specific issues of focus. These reports could leverage research and evaluation partnerships with state universities or other research organizations and incorporate data that could be collected by insurance regulators, such as changes in enrollment in non-ACA compliant products. State agencies can also use consumer surveys to provide insights into consumers' experiences, such as reasons people choose to terminate coverage or decline to enroll, and changes to their ability to access care if they become uninsured.[90] Ultimately, states can use this information to support state-level policies to mitigate the harms from federal action and publicize the impact these new federal barriers are having on access to affordable, high-quality health insurance coverage.

Conclusion

By themselves, states will be unable to fully fill the gaps in coverage, access, and affordability caused by recent federal policy changes such as the expiration of the enhanced PTCs, H.R. 1, and the Marketplace Integrity final rule. However, in partnership with SBMs and other state policymakers, state insurance regulators can adopt and implement numerous strategies to mitigate consumer hardship. These include improving affordability through state-financed programs or leveraging federal programs such as the BHP; reducing the friction consumers face as they navigate Marketplace eligibility and enrollment systems; improving consumer communications and assistance; and exercising more robust and comprehensive plan management and oversight for both QHP issuers and those selling non-ACA-compliant products. SBMs and DOIs can also illuminate the coverage, affordability, and other consumer impacts of these federal policy changes by producing robust state-level data. With this information, they can educate the public and policymakers about changes to consumers' ability to access and maintain high-quality, affordable health insurance coverage.

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