ISSUE BRIEF
JANUARY 2020

States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership

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ABSTRACT

ISSUE: The individual health insurance markets of most states are stable but face ongoing challenges. Federal policies to promote limited-coverage products for sale outside the individual market, concerns about the affordability of comprehensive coverage, and uncertainty about the durability of the Affordable Care Act have put the onus on state policymakers from across the political spectrum to explore options for safeguarding and improving their residents' coverage.

GOAL: Understand actions states have taken to affect access to and affordability of comprehensive health coverage.

METHODS: Analysis of applicable laws, regulations, and guidance of the 50 states and the District of Columbia, as well as of relevant legislation proposed in these jurisdictions during the 2018 and 2019 legislative sessions.

KEY FINDINGS AND CONCLUSIONS: Most states have adopted one or more policy initiatives designed to make comprehensive coverage more affordable, such as a reinsurance program, financial incentives for individuals to maintain coverage, or increased oversight of skimpy, short-term insurance products. However, most effective reforms will require a sustained and significant financial commitment that states may have difficulty securing. Lasting solutions are likely to require federal action.

TOPLINES

- In 2020, states will continue to pursue policies to bring comprehensive coverage within reach of everyone.
- Most states have adopted reforms to make comprehensive coverage more affordable, but long-term solutions will require federal leadership.

The Commonwealth Fund

BACKGROUND

Though the Affordable Care Act (ACA) significantly changed how individual market health insurance is regulated, it preserved states' power to implement policies designed to make that coverage more affordable.[1] Recent regulatory changes by the Trump administration to promote limited-benefit products not governed by ACA rules have provided states still more policy choices to consider.[2]

States have increasing reason to exercise this authority. Though most states' individual markets are experiencing a second year of stability, premiums and cost-sharing continue to impose significant financial burdens on many Americans.[3] The administration's loosening of rules governing limited-benefit products did not just give states additional policymaking flexibility — it also exposed states' insurance markets and consumers to substantial new risks that have drawn policymakers' attention. Meanwhile, uncertainty about the durability of the ACA drags on; a federal lawsuit brought by Republican state officials and supported by the Trump administration seeks to have the courts strike down the ACA's preexisting condition protections, premium subsidies, and Medicaid expansion.[4] Together, these developments have challenged state lawmakers from across the political spectrum to explore options for safeguarding and improving residents' coverage.

In 2018, we examined what states had done to improve access to comprehensive individual market coverage in seven key policy areas over which they exercise authority.[5] At that time, nearly half of states had adopted one or more policy initiatives in these areas, such as a reinsurance program, financial incentives for individuals to maintain coverage, or increased oversight of skimpy, short-term insurance products.[6]

This brief updates our analysis of state efforts to strengthen individual market coverage and finds that at least a dozen states have enacted legislation within the past year to make comprehensive coverage more affordable (Exhibit 1).

Exhibit 1. State Policies Affecting Access to Comprehensive Individual Market Health Insurance

Policy area	Description
Premium stabilization programs	States may draw on federal and state dollars to establish reinsurance programs that reduce market volatility and moderate premiums.
Requirements to maintain adequate coverage	States may impose a financial penalty on individuals who can afford to maintain adequate health coverage but choose to be uninsured.
Financial assistance to improve coverage affordability	States may provide additional premium and cost-sharing assistance to consumers eligible for federal subsidies or extend these benefits to those who do not currently receive federal assistance.
Regulation of non-ACA-compliant coverage	States may establish additional oversight, above minimum federal requirements, for types of coverage, such as short-term and association health plans, which do not comply with the consumer protections of the ACA. Alternatively, states may attempt to encourage enrollment in these plans or in products exempted from insurance regulation by the state.
Rules to promote marketplace competition	States may leverage insurers' participation in public insurance programs or markets to encourage participation in the marketplace. States also may merge their individual and small-group markets or prohibit insurers from bypassing the ACA marketplace when selling individual market coverage.
State coverage options	States may sponsor a public coverage option to be offered through, or outside, the ACA marketplace; permit certain individuals to "buy in" to a public coverage program, such as Medicaid, for which they are not otherwise eligible; or establish a Basic Health Program for lower-income residents, as authorized by the ACA.
Standard plan designs	States may require insurers that offer coverage to adopt uniform cost-sharing parameters for certain plans. States may further require that all health plans offered in the market adhere to these standard parameters.
Open enrollment extensions	States that have chosen to operate their own ACA marketplaces may facilitate enrollment in marketplace coverage by extending the annual open-enrollment window beyond the minimum 45-day period set by federal rules.
Transitional policies	States may prohibit insurers from continuing to offer transitional (or "grandmothered") coverage, which does not satisfy key ACA consumer protections.

Data: Authors' analysis of applicable federal and state statutes, regulations, and guidance.

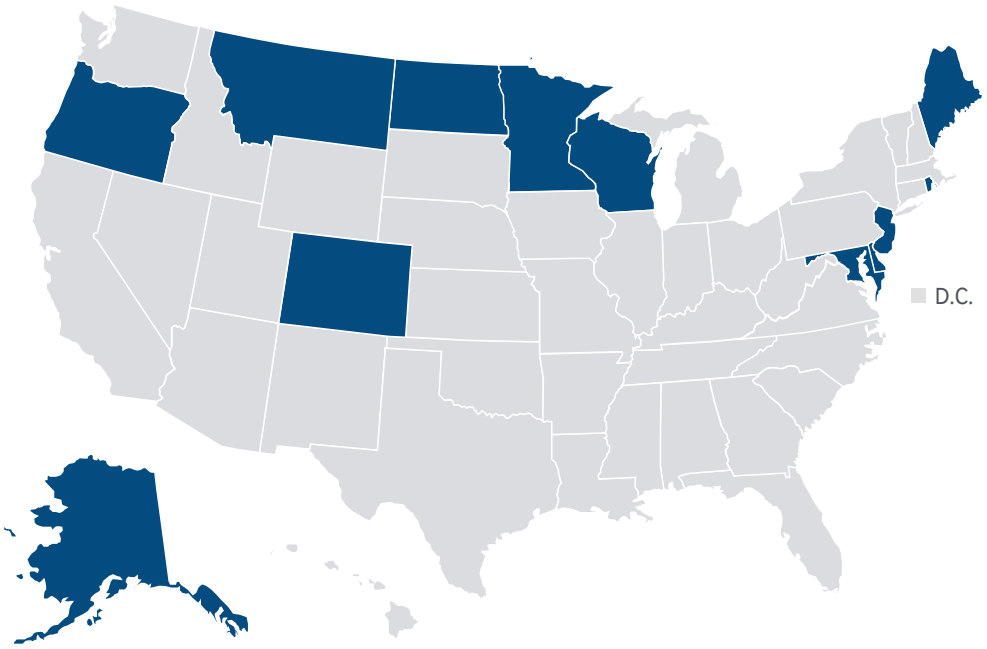
FINDINGS

Reinsurance: Reducing Premiums and Market Volatility

The ACA's temporary federal reinsurance program lowered premiums and stabilized markets between 2014 and 2016; premium hikes in the following year were attributable in part to the program's end.[7] Though many state policymakers and stakeholders have urged that the program be reestablished, proposals to do so stalled in the last Congress.[8] In the absence of federal action, a diverse group of states has moved ahead. In 2017 and 2018, seven states established their own reinsurance programs, funded in part through the ACA's Section 1332 waiver program.[9] These initiatives have lowered individual market premiums by an average of 20 percent, primarily benefiting consumers who are not eligible for federal subsidies and who bear the full brunt of premium increases.[10] During 2019, five additional states — Colorado, Delaware, Montana, North Dakota, and Rhode Island — secured approval to launch their own programs in 2020, while two others (Georgia and Pennsylvania) signaled they will seek federal sign-off for a reinsurance waiver for 2021 (Exhibit 2).

While waiver-supported reinsurance has become a fairly straightforward policy option, states have innovated with implementation and funding. In Colorado, policymakers structured the program to provide the greatest level of assistance to the geographic areas hardest hit by high premiums. The state also initially sought to fund the program by requiring hospitals to bring their reimbursement rates into line with an external benchmark (i.e., Medicare plus a percentage). Because the Trump administration signaled it would not approve a waiver that included such a payment regulation, Colorado ultimately adopted alternative funding mechanisms, including an assessment on hospitals. In Pennsylvania, policymakers enacted bipartisan legislation that directs the state to assume control of its ACA marketplace from the federal government, operate it at a lower cost, and use the savings to cover the state's share of reinsurance program funding.

Exhibit 2. States That Operate Individual Market Reinsurance Programs Supported by Section 1332 Waiver Funding



Notes: Section 1332 of the ACA authorizes states to apply to waive specified provisions of the health law to facilitate state-specific programs for improving coverage. If a state's "innovation waiver" program is forecast to reduce federal spending, the state is entitled to have these savings passed through to it for purposes of implementing the program. The states identified in this map have secured, or are seeking, approval for innovation waivers that use these federal "pass-through" funds to partially finance the state's reinsurance program.

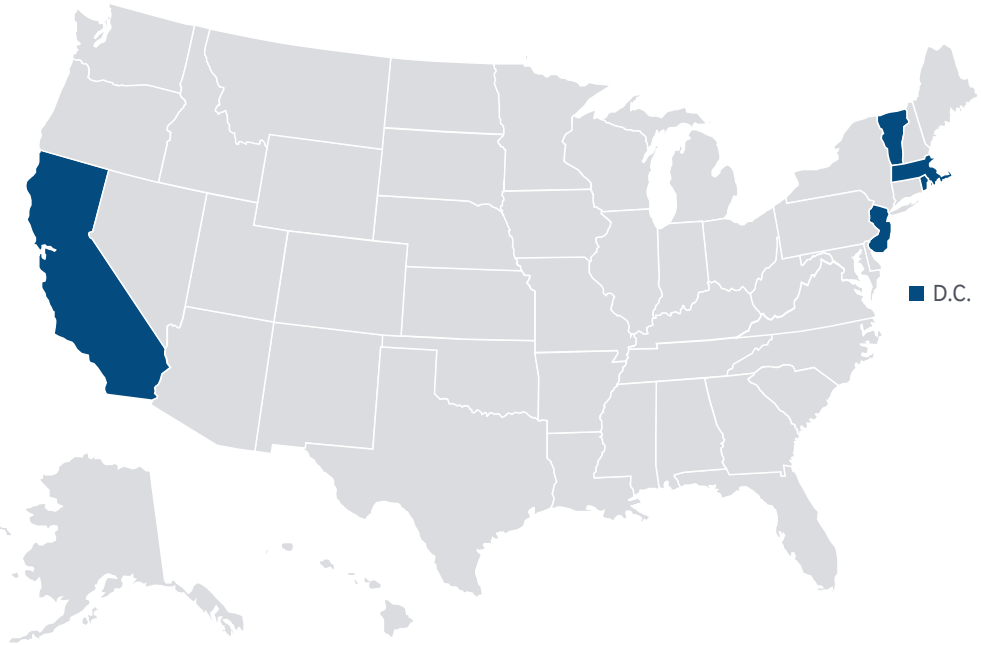
Data: Authors' analysis of applicable federal and state statutes, regulations, and guidance.

Requirements to Maintain Coverage: Broadening the Risk Pool

Since Congress eliminated the ACA's tax penalty for individuals who fail to maintain coverage in the 2017 tax bill, at least 10 state legislatures weighed whether to adopt state versions of the individual mandate. Though politically divisive at the national level, these requirements help make markets more stable and premiums more affordable by expanding the risk pool.[11] A mandate also can give states flexibility to discourage individuals from switching between skimpy coverage products when healthy and comprehensive coverage when sick. For instance, a state can define the types of coverage that satisfy its mandate by excluding products, such as short-term plans and health care sharing ministries, which discriminate based on health status. Doing so may reduce the risk that such arrangements segment the market between healthy and sick, driving up costs and reducing plan choices for residents who need comprehensive coverage.

Four states and the District of Columbia have now established tax penalties for people who can afford to maintain health coverage but choose not to (Exhibit 3).[12] Taking advantage of the flexibility to craft the penalty to suit state needs, New Jersey and Rhode Island use revenue raised by the mandate to help fund their reinsurance programs, while California will use penalty dollars to provide greater financial assistance to people who buy coverage. In Maryland, efforts to pass an individual mandate foundered. As an alternative, the state adopted a program to facilitate enrollment by allowing uninsured tax filers to begin the process of signing up for ACA marketplace or Medicaid coverage by checking a box on their tax return.[13] The new law also obligates state government to establish processes for implementing a tax penalty in the future and requires study of the issue.

Exhibit 3. States That Require Individuals to Maintain Adequate Health Coverage



Notes: The ACA requires most individuals to maintain "minimum essential" health coverage or pay a tax penalty (the individual mandate). Changes in federal law, effective in 2019, reduced this tax penalty to $0, but did not repeal the underlying requirement to maintain coverage. This map identifies states that require residents to maintain adequate health coverage — whether or not the state imposes a penalty on individuals who fail to do so — notwithstanding the elimination of the federal tax penalty. Vermont has not established a financial penalty or other enforcement mechanism to promote compliance with its coverage mandate.

Data: Authors' analysis of applicable federal and state statutes, regulations, and guidance.

Coverage Subsidies: Improving Affordability

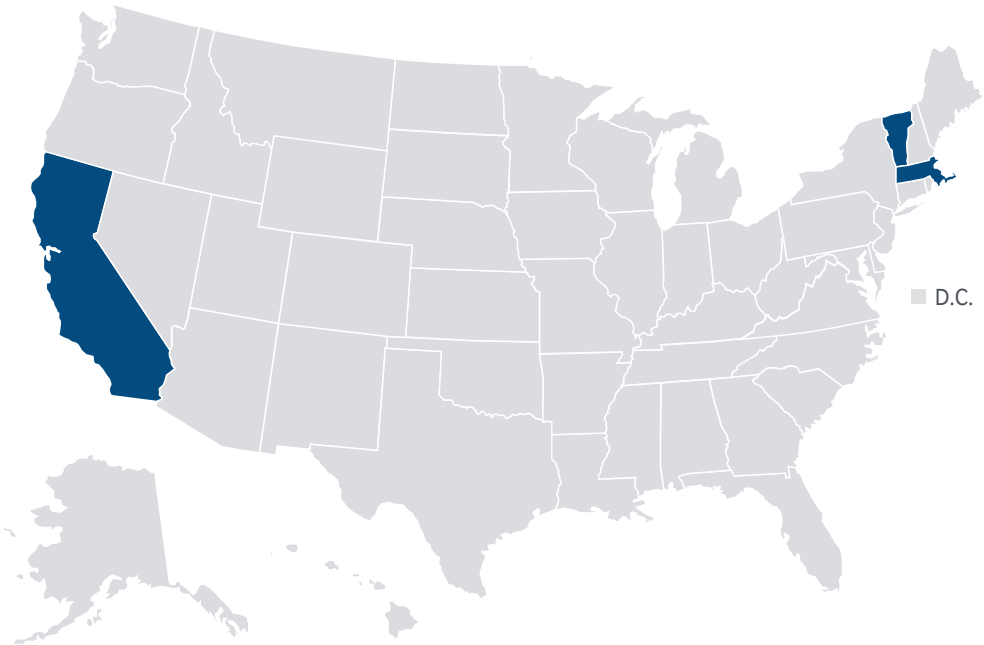
The ACA's premium and cost-sharing subsidies have helped make health insurance more affordable for millions of Americans. But there are funding and eligibility limits: the program provides substantially less generous assistance for those with incomes above 250 percent of the federal poverty level and phases out entirely at four times the threshold. This has meant that many people still face difficulty affording coverage.[14] Accordingly, states have considered whether to provide additional help, by using state dollars to 1) increase the amount of assistance available to low- and middle-income individuals, for whom the current federal subsidy may be insufficient, and/or 2) offer subsidies to residents who are ineligible for federal assistance.

In June 2019, California enacted a law that does both. Starting in 2020, the state began providing wraparound subsidies to individuals receiving ACA tax credits as well as financial assistance to residents whose incomes (between 400% and 600% of poverty) render them ineligible for the federal subsidy program (Exhibit 4).[15] This measure is expected to make coverage more affordable for nearly a million Californians and, together with the state's other reforms, newly insure more than 200,000.[16]

State Coverage Options: Increasing Access, Reducing Costs

Policymakers in states that have embraced the ACA increasingly have worked to develop a government-sponsored coverage option to achieve more affordable coverage, greater marketplace competition, and improved access to care. More than a dozen states considered whether to establish or study the implementation of a public option or a public coverage "buy-in" program during the most recent legislative session; five states have already published reports analyzing such proposals.[17]

Exhibit 4. States That Provide Subsidies for Individual Market Coverage



Notes: The ACA provides federal subsidies to reduce the cost of individual market health insurance for eligible individuals. Premium tax credits are available to otherwise eligible individuals with household income between 100% and 400% of the federal poverty level (FPL) who enroll in coverage through an ACA marketplace, and cost-sharing subsidies are available to such individuals with incomes between 100% and 250% FPL who enroll in a silver-tier plan. This map identifies states that make available separate, state-funded subsidies to defray the cost of ACA-compliant individual market health coverage: for example, by providing an additional premium subsidy for individuals receiving federal premium tax credits, or a subsidy for individual market consumers whose incomes render them ineligible for federal coverage assistance. In 2017, Minnesota provided premium subsidies for enrollees not eligible for federal premium tax credits, Medicaid, or the State's Basic Health Program (MinnesotaCare).

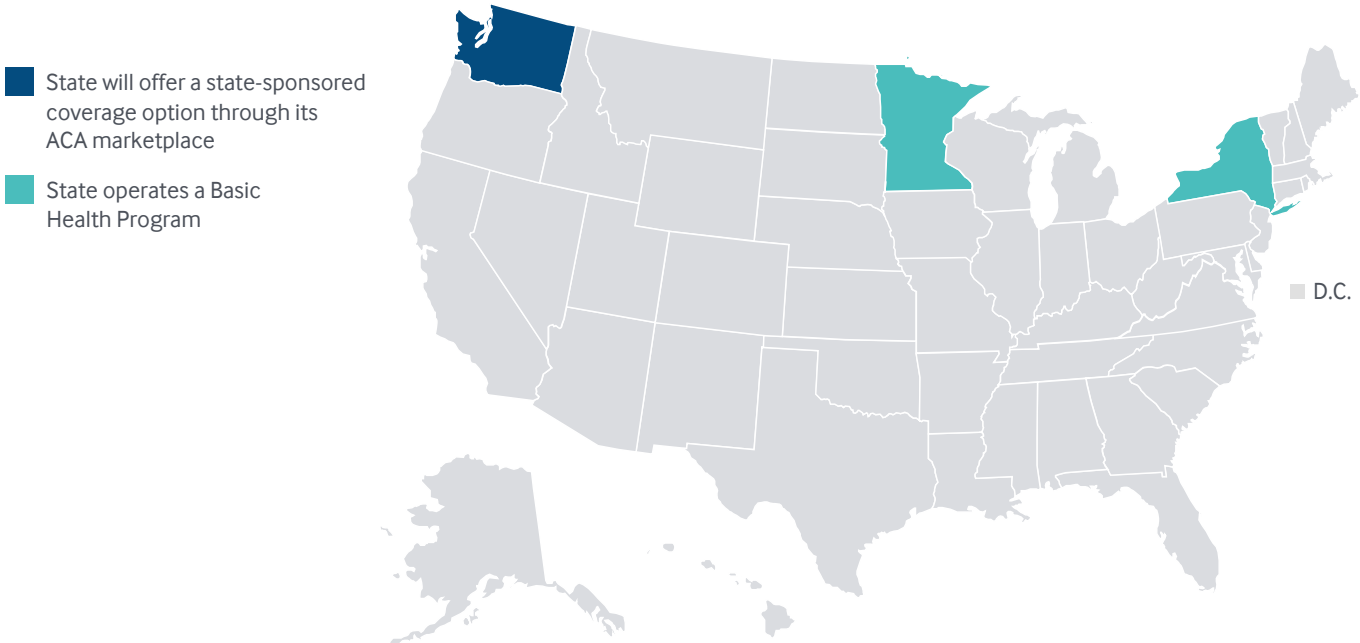
Data: Authors' analysis of applicable federal and state statutes, regulations, and guidance.

In May 2019, Washington became the first and only state to approve a public option (Exhibit 5). The Washington model — known as Cascade Care — is effectively a hybrid public–private coverage program in which the state will contract with private insurers to administer and sell standardized health plans on the ACA marketplace. The public-option plans are intended to reduce health care costs by capping payments to providers at an average of 160 percent of Medicare rates. This benchmark pricing mechanism is expected to produce modestly lower plan premiums when the coverage becomes available in 2021, helping individual market consumers who are not eligible for coverage subsidies. Subsidized consumers also may benefit, because the plans will follow standardized designs that ease cost-sharing requirements for high-value care and, over time, increase plan competition because of the expanded risk pool.

Standard Plan Designs: Promoting Value-Based Care, Helping Consumers Shop for Coverage

The ACA requires all individual market health plans to cover broadly similar benefits, adhere to limits on cost-sharing, and fall within standard actuarial value tiers. This is in large part to ensure coverage meets consumers' needs, but also to make it easier for consumers to understand and choose among their coverage options. Back when these protections were first implemented, six states and the District of Columbia decided to require plans to incorporate standardized cost-sharing parameters, such as uniform deductibles and copayments for certain services (Exhibit 6).[18] States hoped the standard designs would further improve consumers' experiences by facilitating apples-to-apples comparisons of plans' premiums, networks, and quality. Some policymakers also viewed standardization as an opportunity to ensure plans provide sufficient up-front value to enrollees by, for example, requiring that high-value services, such as primary care, not be subject to a deductible.

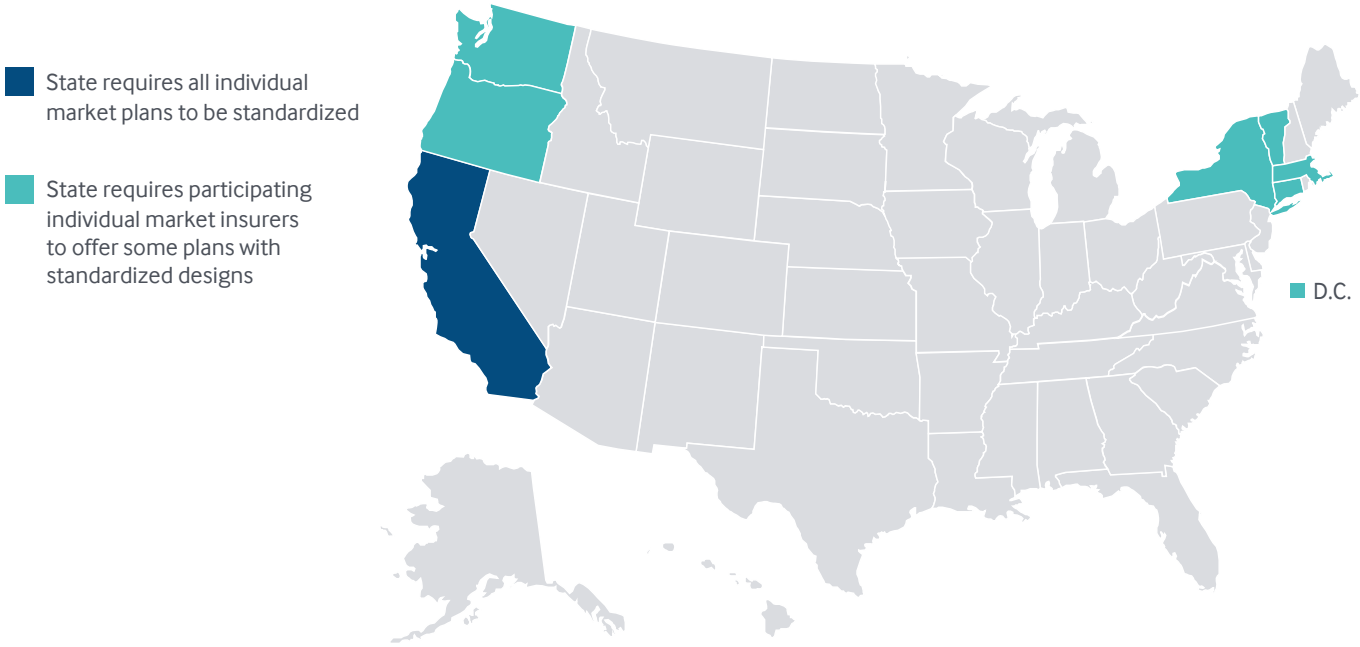
Exhibit 5. States with Public Coverage Options for Individual Market Consumers



Notes: States may adopt a program, such as a "public option" or "Medicaid buy-in," which offers individual market consumers the option of enrolling in coverage that is sponsored and/or administered by the state. Under Section 1331 of the ACA, states may also establish a Basic Health Program (BHP) for individuals with incomes up to 200% of the federal poverty level who would otherwise be eligible for individual market coverage. The BHP, which is funded by a combination of state and federal dollars, must provide coverage that is at least as comprehensive and affordable as subsidized ACA marketplace coverage. This map identifies states that have established a public option, Medicaid buy-in, or other similar program, or that operate a BHP. The map does not include state actions related to the ACA's Medicaid expansion. Washington's public option program will begin operation in 2021.

Data: Authors' analysis of applicable federal and state statutes, regulations, and guidance.

Exhibit 6. States That Require Standardized Individual Market Health Plans



Notes: The ACA requires all individual market health plans to cover broadly similar benefits, adhere to overall limits on cost-sharing, and fall within standard actuarial value tiers. This map identifies states that also require participating individual market insurers to offer plans that incorporate standardized cost-sharing parameters, such as uniform deductibles and copayments for certain services. Washington's standardized plan requirement will take effect in 2021.
Data: Authors' analysis of applicable federal and state statutes, regulations, and guidance.

Though initial attempts to operationalize standardized designs during the rollout of the ACA marketplaces seemed to have little effect on consumers' shopping experiences, states have continued to refine their approaches. For its part, the federal government unveiled standard plan designs and shopping tools on HealthCare.gov in the fall of 2016 before a new administration changed course and eliminated the policy in 2018.

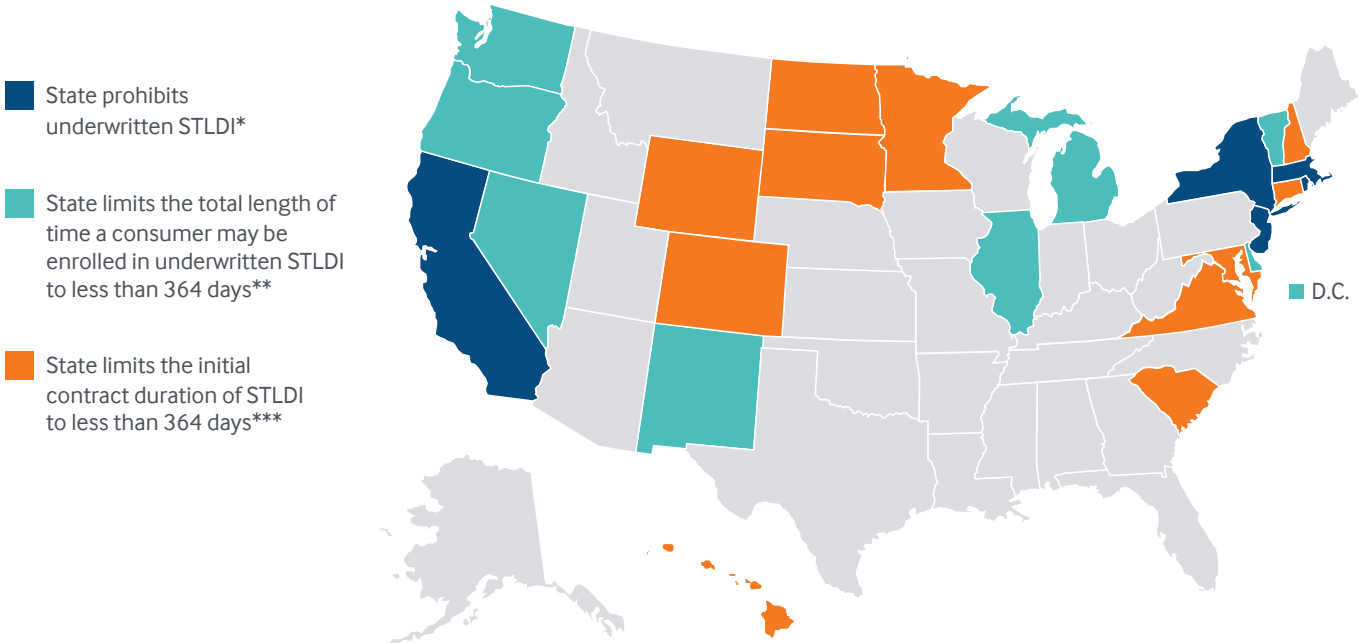
Still, cost-sharing standardization continues to attract state interest, particularly as a way of addressing affordability challenges and promoting high-value care. Washington became the eighth state to adopt this policy, making standard plan designs a pillar of its Cascade Care reforms. Meanwhile, Colorado policymakers also hope to implement standard plan designs as part of a public option program that the state's legislature will consider in early 2020.

Regulation of Non-ACA-Compliant Coverage: Reducing Market Segmentation and Consumer Confusion

Short-term, limited-duration insurance is exempt from the ACA's reforms. These products can deny coverage, limit benefits, or charge a higher premium to consumers with a preexisting condition. Because of these limitations, healthy people who enroll generally incur a lower upfront cost than they would with unsubsidized ACA-compliant coverage. In 2018, the Trump administration relaxed federal regulations to allow these short-term products to have an initial term of 364 days and, with renewal, last for up to 36 months.

Since this change was announced, 12 states and the District of Columbia have strengthened consumer protections and set a tighter duration limit for short-term products (Exhibit 7). They have done so to guard against the likelihood that such plans will siphon healthy risks from their ACA markets, potentially raising prices and decreasing choice for those who remain, and to protect consumers from inadequate coverage and misinformation. Most of these states have limited the duration of these products so consumers may use them as a short-term coverage option and not a long-term replacement for comprehensive insurance. Some states also have required the plans to comply with additional consumer protections, cover specified benefits, or adhere to marketing restrictions. For example, Maine requires

Exhibit 7. State Regulation of Short-Term, Limited-Duration Insurance



Notes: STLDI = short-tern, limited-duration insurance. Short-term policies are not subject to the federal consumer protections of the ACA. Under federal regulations finalized in August 2018, short-term policies may provide coverage for a period of 364 days and may be renewed, at the discretion of the insurance company, for up to 36 months. This map identifies states that, by limiting the maximum duration of short-term coverage to less than 364 days, or by applying state law consumer protections to such coverage, impose limitations on the sale of short-term plans than are more strict than those mandated under the default federal approach.

* The states identified in blue entirely prohibit short-term coverage or bar short-term insurers from discriminating on the basis of an applicant's health status. California prohibits the issuance of of any health insurance policy with a duration of less than 12 months.

** A state is identified as having limited the total length of time a consumer may be enrolled in underwritten short-term coverage to less than 364 days if it prohibits the issuance of multiple short-term policies consecutively, closing a loophole that otherwise may permit continuous enrollment in such plans. Delaware prohibits insurers from: 1) issuing the same short-term policy to an enrollee for back-to-back terms; and 2) from issuing a different short-term policy to the same individual more than once in any given year. Washington prohibits the issuance of a short-term policy during the annual open enrollment period, for coverage beginning in the upcoming year.

*** A state is identified as having limited the initial contract duration of underwritten short-term coverage to less than 364 days if a short-term plan lasting longer than a specified duration would become subject to one or more of the following state consumer protections: guaranteed issue, guaranteed renewability, or required coverage of essential health benefits. Such states typically impose limitations on the renewal of short-term policies, but, in most cases, do not prohibit insurers from issuing multiple new short-term policies consecutively. Connecticut makes consecutive short-term policies subject to certain preexisting condition coverage requirements. Hawaii prohibits the issuance of a short-term policy to an individual who was eligible to purchase coverage through the ACA marketplace during an open or special enrollment period in the previous calendar year.

Data: Authors' analysis of applicable federal and state statutes, regulations, and guidance.

in-person sales to address concerns about online and phone sales, while Washington prohibits the sale of short-term products during the annual enrollment period for ACA plans.[19] California and Rhode Island have gone further and effectively ban short-term products, joining three states — Massachusetts, New York, and New Jersey — that prohibited the plans even before the federal rule change. In contrast, three states — Arizona, Indiana, and Oklahoma — opted to embrace the opportunity to promote these skimpier products by revising state law to conform with the new, more permissive federal rule.[20]

DISCUSSION

The individual markets of most states are stable. Rates have continued to moderate and, in many places, decrease, while insurer participation on the marketplaces increased again in 2020.[21] Still, comprehensive coverage remains unaffordable for many and there is no indication that the federal government will implement policies to address this issue. To the contrary, the administration remains committed to policies likely to increase market segmentation, making comprehensive coverage more expensive.

Against this backdrop, an increasing number of states have acted in ways likely to improve affordability and plan choice. In 2020, states will continue to pursue reinsurance, respond to the effects of skimpy coverage products on their health insurance markets, and study other states that have undertaken broader reforms to bring comprehensive coverage within reach of all residents.

But there are limits to states' authority and resources. While the Trump administration has encouraged federal waivers to promote skinny plans, it has made clear in agency guidance and the statements of high-ranking officials that such flexibility is not available for states interested in offering residents a public coverage option. Meanwhile, many effective state reforms will require a sustained and significant financial investment. California's groundbreaking efforts to improve coverage likely will cost more than $400 million. While the cost of other states' reforms will not likely approach this magnitude, state budgetary constraints make financing coverage improvements difficult in many places. Lasting solutions are likely to require federal commitment.

NOTES

1. Sara R. Collins and Jeanne M. Lambrew, *Federalism, the Affordable Care Act, and Health Reform in the 2020 Election* (Commonwealth Fund, July 2019).

2. Justin Giovannelli and Kevin Lucia, "Court Strikes Down a Trump Administration Rule Designed to Circumvent the Affordable Care Act," *To the Point* (blog), Commonwealth Fund, Apr. 5, 2019; Kevin Lucia et al., "In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets," *To the Point* (blog), Commonwealth Fund, Nov. 27, 2018; and Dania Palanker, JoAnn Volk, and Kevin Lucia, "Short-Term Health Plan Gaps and Limits Leave People at Risk," *To the Point* (blog), Commonwealth Fund, Oct. 30, 2018.

3. Rachel Fehr, Cynthia Cox, and Larry Levitt, *Individual Insurance Market Performance in Early 2019* (Henry J. Kaiser Family Foundation, June 2019); and Cynthia Cox, Rachel Fehr, and Larry Levitt, *Individual Insurance Market Performance in 2018* (Henry J. Kaiser Family Foundation, May 2019).

4. MaryBeth Musumeci, *Explaining Texas v. U.S.: A Guide to the 5th Circuit Appeal in the Case Challenging the ACA* (Henry J. Kaiser Family Foundation, July 2019).

5. Justin Giovannelli, Kevin Lucia, and Sabrina Corlette, "To Understand How Consumers Are Faring in the Individual Health Insurance Markets, Watch the States," *To the Point* (blog), Commonwealth Fund, July 18, 2018; and Justin Giovannelli, Kevin Lucia, and Sabrina Corlette, "What Is Your State Doing to Affect Access to Adequate Health Insurance?," Commonwealth Fund, updated Sept. 6, 2019.

6. Ibid. For purposes of tallying state actions in this issue brief, we count the District of Columbia as a state.

7. American Academy of Actuaries, *Drivers of 2017 Health Insurance Premium Changes* (American Academy of Actuaries, May 2016); and American Academy of Actuaries, *Drivers of 2016 Health Insurance Premium Changes* (American Academy of Actuaries, Aug. 2015).

8. See, e.g., American Cancer Society Cancer Action Network et al., *Congress Must Act Now to Prevent Premium Spikes and Coverage Losses for Millions of Americans, Say 20 Patient and Consumer Groups* (American Lung Association, Mar. 2018); America's Health Insurance Plans et al., *Health Care Coalition Letter to Leadership on Market Stability* (AHIP, March 2018); and State Health Exchange Leadership Network, *January 30, 2018 Letter to Senators Alexander, Murray, Collins, and Nelson* (SHELN, Jan. 2018).

9. David Blumenthal et al., "States Take the Lead on Reinsurance to Stabilize the ACA Marketplaces," *To the Point* (blog), Commonwealth Fund, May 22, 2018.

10. Chris Sloan, Neil Rosacker, and Elizabeth Carpenter, *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average* (Avalere, Mar. 2019).

11. See, e.g., Covered California, the Massachusetts Health Connector, and the Washington Health Benefit Exchange, *New Analysis Finds Record Number of Renewals for Leading State-Based Marketplaces, but Lack of Penalty Is Putting Consumers at Risk* (May 2019); Covered California, *Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, with Wide Variation Among States* (March 2018); and Massachusetts Health Connector, *The Massachusetts Individual Mandate: Design, Administration, and Results* (Nov. 2017).

12. Vermont also has enacted a requirement to maintain coverage but has yet to establish an enforcement mechanism.

13. Stan Dorn, "Maryland's Easy Enrollment Health Insurance Program: An Innovative Approach to Covering the Eligible Uninsured," *Health Affairs Blog,* May 13, 2019.

14. In addition, individuals whose incomes otherwise would qualify them for federal financial assistance may be rendered ineligible because of their immigration status. A state could use its own funds to subsidize coverage for this population but could not do so via its ACA marketplace absent federal approval of a Section 1332 waiver.

15. The new law puts California in the company of Massachusetts and Vermont, states that for years have provided wraparound benefits to individuals eligible for federal coverage subsidies. Other states are weighing whether to follow. Minnesota, which provided a one-time premium subsidy to residents in 2017, this year debated a plan put forward by the state's governor to offer more robust coverage assistance. A budget agreement ultimately directed funds towards renewing the state's reinsurance program, instead. Meanwhile, recently enacted legislation directs Washington's state marketplace to develop a plan, to be completed by late 2020, for implementing state premium subsidies for individuals with incomes up to 500 percent of FPL.

16. Covered California, *Covered California Policy and Action Items* (Covered California, June 2019).

17. Delaware, *Senate Concurrent Resolution 70 Study Group: Final Report* (Jan. 2019); Manatt Health Strategies, *A Promising Strategy for an Affordable Medicaid Buy-In Option in Colorado: An Initial Study of a Medicaid Buy-In Plan* (Manatt Health Strategies, Dec. 2018); Chiquita Brooks-LaSure et al., *Evaluating Medicaid Buy-In Options for New Mexico* (Manatt Health Strategies, Dec. 2018); Massachusetts Health Connector, *Massachusetts Medicaid Buy-In: Feasibility of Establishing a Small Employer Premium Sharing Plan for Participation in MassHealth* (Oct. 2018); and Oregon Legislature Legislative Policy and Research Office, *Universal Access to Health Care Workgroup: Medicaid Buy-In Proposals* (Sept. 2018).

18. Connecticut, the District of Columbia, Massachusetts, New York, Oregon, and Vermont require participating insurers to offer some plans that adhere to standardized designs while permitting additional plan offerings that use a nonstandard design. In California, all individual market plans must be standardized.

19. Dania Palanker, Maanasa Kona, and Emily Curran, *States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans* (Commonwealth Fund, May 2019).

20. Arizona Senate Bill 1109 (2019); Indiana House Bill 1631 (2019); and Oklahoma Senate Bill 993 (2019).

21. Centers for Medicare and Medicaid Services, *Plan Year 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States* (CMS, Oct. 2019).

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Editorial support was provided by Deborah Lorber.

ACKNOWLEDGMENTS

The authors thank Sabrina Corlette for her thoughtful comments and suggestions. We also thank Emily Curran, Maanasa Kona, and Rachel Schwab for their valuable contributions to the research for this brief.

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