



**STATEMENT OF
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**HEARING ON IMPLEMENTATION OF THE AFFORDABLE CARE ACT
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH**

NOVEMBER 14, 2013

Good morning, Mr. Chairman, Ranking Member Pallone, Members of the Committee. I am Sabrina Corlette, a Senior Research Fellow and Project Director at Georgetown University's Center on Health Insurance Reforms. I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA).

I thank you for the opportunity to testify before you today, and for the leadership of this Committee in conducting ongoing oversight of the implementation of the ACA. This hearing today is a timely one, as we are now slightly less than 6 weeks into open enrollment into health plans that will meet sweeping new standards for access, affordability, and adequacy.

In my testimony, I will focus on how the individual health insurance market has worked until now for consumers, and how it will change upon implementation of the ACA's market reforms, some of the most significant of which go into effect on January 1, 2014. The ACA has a particular focus on the individual market because of its well-documented systemic problems, which include:

- 1) Lack of access to coverage because of health status discrimination
- 2) Inadequate coverage
- 3) Unaffordable coverage
- 4) Lack of transparency and accountability

Having affordable, adequate health insurance coverage is essential to the health and financial vitality of American families. People without health insurance are significantly less likely to receive necessary care, and a lack of meaningful coverage has resulted in medical debt being a primary cause of personal bankruptcies.¹

Yet today, approximately 48 million non-elderly Americans are uninsured, and approximately 11 million Americans under age 65 obtain their health insurance through the individual market, meaning they do not have coverage through their employer or public programs such as Medicare and Medicaid. Anyone can find themselves at any time in the position of being uninsured, or required to buy coverage in the individual market. A recent survey found that in 2012, 30 percent of adults under age 65 did not have health insurance for some period of time.² And people who buy health insurance on their own can be self-employed entrepreneurs, farmers and ranchers, early retirees, part-time workers, widows, and young people "aging off" their parents' plans. The individual market tends to be a last resort when people do not have an offer of employer-based coverage or are ineligible for public coverage. As *Business Insider* magazine recently put it, the individual insurance market is a "basket case."³

To date the individual market has been an inhospitable place, particularly for people in less than perfect health.⁴ That's a lot of us. According to one estimate, between 50 and 129 million non-elderly Americans have at least one pre-existing condition that would threaten their access to health care and health insurance.⁵ These include a wide range of conditions, from back pain and prior sports injuries to chronic illnesses such as diabetes and asthma, as well as diseases like cancer. But until now, in most states, applicants for health insurance can be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors. Insurers can also issue policies that don't cover critical medical services like pharmacy benefits, mental health benefits, maternity coverage or any of the care required to treat a person's pre-existing condition. And before enactment of the ACA in 2010, insurers could – and did – drop (or rescind) an individual's coverage if they got sick, and often imposed annual and lifetime dollar limits on covered benefits.

The ACA includes numerous reforms intended to address the shortcomings in the individual market. These set a minimum federal standard for an individual's access to affordable and adequate health insurance, with state flexibility to enact stronger consumer protections if they wish.

The ACA has already begun improving people's coverage options, and how it will continue to improve access to health care and families' financial security when all the reforms are in full effect.

AVAILABILITY OF COVERAGE

Until the ACA is fully implemented, one of the many ways health insurers are able to maximize revenue is to make use of aggressive underwriting practices to deny coverage to individuals with pre-existing conditions.⁶ In most states, when an individual wants to buy health insurance, they must fill out and submit a voluminous application that includes detailed information about their health history and status.⁷ Insurers then “underwrite” the application by reviewing the individual's health history and assessing the likelihood he or she will incur future health costs. A Georgetown University study from 2001 found that even people with minor health conditions, such as hay fever, may be turned down for coverage, and more recent studies have found that these practices have only increased over time.^{8,9} Health insurers maintain underwriting guidelines that can list as many as 400 medical conditions as reasons to trigger a permanent denial of coverage.¹⁰

According to a study by the U.S. Government Accountability Office (GAO), average denial rates in the individual market are 19 percent, but they can vary dramatically market-to-market and insurer-to-insurer.¹¹ For example, across six major health insurers in one state, denial rates ranged from 6 to 40 percent. Unfortunately, access is probably even more difficult for people

with health conditions than these data suggest, because of a common industry practice known as “street underwriting,” in which an insurance company agent or broker asks a consumer questions about their health history and steers them away from the plan before they fill out or submit an application.

Under the ACA, insurers are required to provide coverage to people who apply for it, regardless of their health status. This provision went into effect for children under age 19 in 2010, and for all individuals applying for coverage starting January 1, 2014.

The ACA also prohibits insurance companies from rescinding the coverage of consumers who submit medical claims. Prior to the enactment of this provision, which went into effect in September of 2010, insurers in many states would investigate individual policyholders who made claims in their first year of coverage. If the company found evidence that their health condition was a pre-existing one, and not fully disclosed during the initial medical underwriting process, the company could deny the relevant claims, and in some cases cancel or rescind the coverage.¹² Under the ACA, this practice is now illegal except in a clear case of fraud by the policyholder.

AFFORDABILITY OF COVERAGE

Health insurance is an expensive product, and it is particularly expensive for people trying to buy it on the individual market. Unlike those with employer-sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance must pay the full cost of their premium. According to one national survey, among people buying insurance on their own, 31 percent spent 10 percent or more of their income on premium costs, compared to only 13 percent of people in employer-based coverage.¹³

For many, the cost of premiums can cause them to forego coverage completely. A national survey found that nearly three-quarters (73%) of people seeking coverage in the individual market did not end up buying a plan, most often because the premium was too high.¹⁴ And coverage is the least affordable for people who need it the most – those with pre-existing conditions. The same national survey found that 70 percent of people with health problems reported it “very difficult” or “impossible” to find an affordable plan, compared with 45 percent of people in better health.¹⁵

More often than not, a common life event causes people to lose coverage or enter the individual market – losing or changing jobs, an illness, a divorce, a birthday, or a move. Prior to enactment of the ACA, consumers had some protections to help them transition to new coverage, although those protections were often inadequate. These “safe harbors” under federal law include COBRA, which allows those who lose access to job based coverage to continue their coverage in their former employer’s plan for 18-36 months, and HIPAA, which

was designed to help people obtain a health insurance policy after their COBRA coverage ends. However, these safe harbors have often not been helpful because premiums are priced out of reach, or the coverage offered is inadequate. For example, in most states HIPAA premiums are quite high, and the federal law does little to regulate the content of coverage, allowing insurers to offer bare-bones policies. And while COBRA helps provide a bridge for people leaving employment-based coverage, enrollees can be required to pay the full premium, including the portion their former employer paid, plus an administrative fee. For families who no longer have income from a job, that cost can be prohibitive.

And, in the individual market, older and less healthy individuals have had to pay more because health insurers manage costs by segmenting their enrollees into different groups and charging different prices based on health or other risk factors.¹⁶ In practice, this means that people can be charged more because of a pre-existing condition (even if they've been symptom-free for years), because of their age, gender (women are assumed to use more health care services), family size, geographic location, the work they do, and even their lifestyle. A Georgetown University study of rating practices in states with little rate regulation found rate variation of more than nine-fold for the same policy based on age and health status.¹⁷ People in their early sixties can be charged as much as six times the premium of people in their early twenties, based on age alone. Even young people, when rated based on health status, can be subject to significant costs for coverage. At the same time, those few lucky individuals who have no health problems are, in effect, paying artificially low premiums and profiting from a system that locks out the sickest and forces people with even minor health conditions to pay more.

For older individuals, women, and people with pre-existing conditions, their premiums will become more affordable beginning in 2014. Under the ACA, using health status and gender to set premium rates is prohibited. Insurers are permitted to use only the following factors in setting premiums: age (limited to 3 times the premium of a young person), tobacco use, geographic location, and family size.

And even though they tend to be healthy, many young adults have been unable to afford health insurance in the individual market, particularly as many are just launching careers and work in part-time or other jobs that do not offer health coverage. However, many young adults are newly gaining access to more affordable coverage because of a provision of the ACA allowing them to stay on their parents' health plans up to age 26. This provision, which went into effect in 2010, has helped lead to a significant decline in the number of young adults who are uninsured: from 13.6 million in 2010 to 11.7 million in 2012, a decline of 1.9 million.¹⁸

More significantly, many of these young adults and millions of other Americans will soon gain access to premium tax credits that will help make coverage more affordable. And

approximately 48 percent of people currently covered through individual health insurance policies will qualify for a premium tax credit, with an average credit of \$2700.¹⁹

ADEQUACY OF COVERAGE

Currently, the insurance coverage available to individuals buying it on their own falls far short of the typical employer-based plan. In addition to paying higher premiums, people buying individual policies face limited benefits and much higher deductibles and other forms of cost-sharing, such as co-payments and coinsurance. They also spend a much larger share of their income on health insurance and health care than those with employer-sponsored coverage.²⁰ A Commonwealth Fund survey found that 60 percent of people with health problems reported it very difficult or impossible to find a plan with the coverage they needed, compared to about one-third of respondents without a health problem.²¹

The number of “underinsured” individuals has risen dramatically over the last decade, such that there are nearly twice as many today as there were in 2003. Further, individuals purchasing coverage on their own were more than twice as likely to be underinsured as those who had coverage through an employer-based plan.²² In general, someone is considered underinsured when they have insurance but because of high deductibles, high co-payments, or non-covered benefits, the insurance offers inadequate financial protection for the health care services people need.²³

One primary reason people buying individual insurance coverage can have high out-of-pocket costs is that many individual market plans - over half according to one study – do not meet the minimum standard of coverage provided for under the ACA.²⁴ Coverage in the individual market today can be inadequate for many reasons, including:

Pre-existing condition exclusions. In many states, insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses on their application for an individual policy. In addition, once coverage begins, if a consumer makes claims under the policy, he or she can be investigated to see whether the health problem was pre-existing. In many states, it’s not necessary for a health condition to have been diagnosed before the consumer bought the policy for it to be considered “pre-existing.” And insurers can look back into a person’s health history to determine whether the current condition was pre-existing. This is sometimes called “post-claims underwriting.”

Under the Affordable Care Act, pre-existing condition exclusions were prohibited for individuals under age 19 in 2010, and will be prohibited for all individuals beginning in January of 2014. People will be able to access the care they need from their first day of coverage.

Limited Benefits. Insurers selling health insurance in the individual market often sell “stripped down” policies that do not cover benefits such as maternity care, prescription drugs, mental health, and substance abuse treatment services. For example, 62 percent of individual market enrollees do not have coverage for maternity services, 18 percent lack mental health services coverage, and 9 percent do not have coverage for prescription drugs.²⁵

To improve the value of coverage, the ACA sets a minimum benefit standard that insurers must cover. This “essential health benefits” package requirement is designed to ensure that consumers have comprehensive coverage that meets their health needs and protects them from financial hardship. These essential health benefits are expected to be included in the coverage of up to 68 million Americans by 2016 and will include – at a minimum – 10 categories of benefits: ambulatory patient services (i.e., doctor visits); emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.²⁶ The essential health benefits give individuals and small employers assurance that their benefits will meet a minimum standard for adequacy.

Lifetime and Annual Limits. Prior to enactment of the ACA, it is estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. And 18 million people were in plans with annual dollar limits on their benefits. Those limits can be a matter of life and death.

The Affordable Care Act ushered in a ban on lifetime limits, and put immediate restrictions on annual dollar limits (banning them completely in 2014).

High Out-of-Pocket Costs. Individual policies often come with high deductibles - \$10,000 or more is not uncommon – and high cost-sharing. In fact, deductibles can be about three times what they are in employer-based plans.²⁷ As a result, many of these plans are very low value, below the minimum standard in the Affordable Care Act.²⁸ One study in California found that individual policies pay for just 55 percent of the expenses for covered services, compared to 83 percent for small group health plans.²⁹ Thus, these policies have fewer covered services and cover a smaller share of the costs associated with the services they do cover. It is not surprising then that medical debt is a primary cause of personal bankruptcies, with an estimated 20 percent of Americans reporting problems paying medical bills. Of those, approximately 40 percent had some form of health insurance.³⁰ Medical debt can have significant, long-term financial consequences for families. Many lose their good credit, eat up retirement savings to pay off debt, or take on credit card debt at high interest rates.³¹

For the first time, the ACA sets new standards to ensure that insurance coverage does what it should: provide real financial protection to individuals and families. The law sets coverage levels, with Platinum plans being the most generous (enrollees will pay, on average, 10 percent of the out-of-pocket costs) and Bronze plans being the least generous (enrollees will pay, on average, 40 percent of the out-of-pocket costs). The ACA also sets new limits on the total amount of out-of-pocket spending consumers must incur, based on their income. For 2014, those limits are set at \$6,350 for individuals and \$12,700 for families. In addition, for individuals earning up to \$28,725 annually (up to \$58,875 for a family of four), the ACA provides cost-sharing subsidies that will reduce their out-of-pocket spending.

TRANSPARENCY OF COVERAGE

Transparency and accountability are critical to a well-functioning insurance marketplace. Shopping for health insurance is a complex and confusing task for consumers, most of whom do not understand important components of the products being sold to them, or how their coverage works. For people shopping on the individual market, they must undergo medical underwriting, which requires them to complete voluminous application forms, and agree to allow insurers to investigate their medical history. Health insurance policies are written in legalese and difficult for even highly educated consumers to understand. It is little wonder that Americans rate reading up on their health insurance policy as a less appealing activity than preparing their income taxes or going to the gym.³²

Prior to enactment of the Affordable Care Act, individuals attempting to buy insurance coverage in the individual market faced confusing choices, with little transparency about what their policy would actually cover – and what it would not. They have had almost no ability to effectively compare health plans on an apples-to-apples basis.

The ACA ushers in a number of critical changes to improve consumers' ability to shop for and compare plans in a manner that allows them to make informed choices and select a plan that best meets their needs. First, it creates state-based health insurance exchanges, or "marketplaces," that will help consumers make apples-to-apples comparisons among health plan options, and allow them to shop with confidence, knowing that all participating plans have met minimum quality standards.

In addition, the ACA requires insurance companies to provide a new Summary of Benefits and Coverage. These standardized, easy-to-read summaries of the benefits, cost-sharing, limitations and exclusions in a plan can help consumers understand their coverage and make better choices. Consumer testing by Consumer Reports has found that consumers rated their Summary of Benefits and Coverage more helpful than other sources of plan information, such as employer guides and health insurers' brochures.³³

The law also includes new expectations for insurer accountability. The law improves state rate review practices, and authorizes the federal government to review unreasonable rate increases if a state is unwilling or unable to do so. Insurers proposing new premium rate increases must provide detailed and public justification for those increases. Insurers must also spend at least 80 percent of individual market premiums on health care and improving health care quality. If they don't meet that standard, they must issue rebate checks to enrollees. This policy was in effect for 2011, and in 2012 nearly 12.8 million Americans received rebates totaling more than \$1.1 billion.³⁴ The aggregate amount of rebates declined in 2013, to \$504 million, largely because insurers are beginning to moderate their premium increases and operate more efficiently. As a result, an estimated 77.8 million consumers are saving \$3.4 billion in up front premium costs.³⁵

ADDRESSING POLICY "CANCELLATIONS"

There has been a lot of breathless journalism lately about people with individual health insurance policies receiving policy cancellations from their insurance companies. First, having an insurance company cancel a policy is nothing new. Insurance companies have long been able to discontinue individual insurance policies when it is no longer in their business interest to maintain them. They've also long been able to hike premiums and modify coverage for current policyholders by changing provider networks and drugs covered under their formularies.

Second, the ACA doesn't require insurers to drop policies. Rather, it requires individuals to maintain insurance that meets basic standards. The ACA also specifies that enrollment in a grandfathered plan satisfies the requirement to have health coverage. Individuals who first purchased their policy after March 23, 2010, will be required to transition to new coverage that meets new market standards as their current policy reaches its anniversary date, on or after January 1, 2014.

Anticipating the need for their non-grandfathered policyholders to make this transition, insurers have taken different approaches: (1) some have offered an opportunity to "early renew" so that non-grandfathered policyholders can remain in current coverage for up to one more year; (2) some have notified non-grandfathered policyholders they will need to transition to new coverage as their current policy approaches the anniversary date of coverage; (3) some have decided to discontinue some of their current policies as of December 31, 2013 and have notified policyholders so they could take advantage of Open Enrollment and carefully review new health plan options and the new financial assistance that will be available.

Had the exchange websites been operable on October 1, the reaction to insurer notices likely would have been much less dramatic than that reported in the press. But consumers who receive these notices have been justifiably anxious and alarmed, particularly when the insurer

notice doesn't lay out all the new coverage options or provide estimates of subsidies for which millions of policyholders will be eligible. Hopefully soon, all exchange websites will be working smoothly and efficiently so that consumers can see a new set of coverage options that will likely be a better value than anything they have been able to obtain on the individual market.

Unfortunately, some policy proposals to help these individuals – such as the bill introduced by Chairman Upton – would actually make the problem worse. First, Mr. Upton's bill doesn't actually address the problem it purports to solve. Nothing in it prohibits insurers from discontinuing policies they don't want to maintain. Second, by segmenting the risk pool between healthy and less-healthy, this bill will set up an insurance "death spiral" for the exchanges, resulting in higher premiums and less choice for millions of Americans.

CONCLUSION

The insurance marketplace as it exists before full implementation of the ACA does not work for the people who need it most. Anyone with any health condition at any point in their lives can face difficulty obtaining insurance coverage, particularly in the individual insurance market. People in this market have problems with access, with affordability, and, if they can obtain a health insurance policy, it is often not adequate to meet their needs. In addition, until enactment of the ACA, the complex and confusing process of comparing and buying plans discouraged many consumers from obtaining coverage.

The ACA ushers in common-sense reforms that will soon improve Americans' experience buying insurance and, most importantly, provide them with more meaningful access to health services and help protect them financially when they get sick or injured. These changes are transformative – and some changes will cause some disruptions, particularly for young, healthy individuals. But over time, millions of Americans will benefit from a system that is fairer and more accountable.

¹ Sara R. Collins, Ruth Robertson, Tracy Garber, and Michelle M. Doty, "Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act," April 2013. Available from: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Apr/1681_Collins_insuring_future_biennial_survey_2012_FINAL.pdf.

² *Supra* n. 1.

³ Josh Barrow, Here's the Real Reason People Hate their Individual Market Health Insurance, Business Insider, Nov. 8, 2013. Available from: <http://www.businessinsider.com/heres-the-real-reason-people-hate-their-individual-market-health-insurance-2013-11>.

⁴ Karen Pollitz, "How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect-Health?" Kaiser Family Foundation, June 2001. Available from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumers-in-less-than-perfect-health-executive-summary-june-2001.pdf>.

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- ⁵ U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, “At Risk: Pre-existing Conditions Could Affect 1 in 2 Americans,” November 2011. Available from: <http://aspe.hhs.gov/health/reports/2012/pre-existing/>.
- ⁶ U.S. House of Representatives, Committee on Energy and Commerce, “Memorandum: Coverage Denials for Pre-Existing Conditions in the Individual Market,” October 12, 2010. Available from: http://democrats.energycommerce.house.gov/Press_111/20101012/Memo.Pre-existing.Condition.Denials.Individual.Market.2010.10.12.pdf.
- ⁷ See, e.g. Illinois Application for Individual and Family Health Insurance Coverage. Available from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/illinois-insurance-application.pdf>.
- ⁸ *Supra* n. 5.
- ⁹ *Supra* n. 7.
- ¹⁰ *Id.*
- ¹¹ U.S. Government Accountability Office, “Private Health Insurance: Data on Application and Coverage Denials,” March 2011. Available from: <http://www.gao.gov/assets/320/316699.pdf>.
- ¹² Lisa Girion, “Health insurer tied bonuses to dropping sick policyholders,” *Los Angeles Times*, November 9, 2007. Available from: <http://articles.latimes.com/2007/nov/09/business/fi-insure9>.
- ¹³ *Supra* n. 1.
- ¹⁴ Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, “Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families,” The Commonwealth Fund, July 2009. Available from: http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf.
- ¹⁵ *Id.*
- ¹⁶ Melinda B. Buntin, M. Susan Marquis, and Jill M. Yegian, “The Role of the Individual Insurance Market and Prospects for Change,” *Health Affairs*, November 2004. Available from: <http://content.healthaffairs.org/content/23/6/79.full>.
- ¹⁷ *Supra* n. 5.
- ¹⁸ *Supra* n. 1.
- ¹⁹ Kaiser Family Foundation, Analysis: Tax Credits to Average \$2,700 Per Family Next Year for People Who Now Buy Their Own Insurance. Available from: <http://kff.org/health-reform/press-release/analysis-tax-credits-to-average-2700-per-family-next-year-for-people-who-now-buy-their-own-insurance/>.
- ²⁰ *Supra* n. 15.
- ²¹ *Id.*
- ²² *Supra* n. 1.
- ²³ Cathy Schoen, M.S., Michelle M. Doty, Ph.D., and Sara R. Collins, Ph.D., and Alyssa L. Holmgren, “Insured but not Protected: How Many Adults are Underinsured?” *Health Affairs* Web Exclusive, June 2005. Available from: http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2005/Jun/Insured%20But%20Not%20Protected%20How%20Many%20Adults%20Are%20Underinsured/Schoen_insured_but_not_protected_HA_WebExcl%20pdf.pdf. These researchers measured underinsurance by whether (1) annual out-of-pocket medical expenses amount to 10 percent or more of income, (2) among low-income adults (incomes under 200 percent of the federal poverty level), out-of-pocket medical expenses amount to 5 percent or more of income; or (3) health plan deductibles equal or exceed 5 percent of income.
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- ²⁵ HHS, ASPE Issue Brief, Essential Health Benefits: Individual Market Coverage, Dec. 16, 2011. Available from: <http://aspe.hhs.gov/health/reports/2011/individualmarket/ib.shtml>.
- ²⁶ Sabrina Corlette, Kevin W. Lucia, and Max Levin, “Implementing the Affordable Care Act: Choosing an Essential Health Benefits Plan,” The Commonwealth Fund, March 2013. Available from:

http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Mar/1677_Corlette_Implementing_ACA_choosing_essential_hlt_benefits_reform_brief.pdf.

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²⁸ *Supra* n. 24.

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³¹ *Supra* n. 1.

³² eHealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008. Available from: <http://www.marketwired.com/press-release/ehealth-inc-nasdaq-ehth-806855.htm>.

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³⁴ Centers for Medicare & Medicaid Services (CMS), "The 80/20 Rule: Providing Value and Rebates to Millions of Consumers," June 21, 2012. Available from: <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/mlr-rebates06212012a.html>.

³⁵ Centers for Medicare & Medicaid Services (CMS), "80/20 Rule Delivers More Value to Consumers in 2012," July 2013. Available from: <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf>.