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Hearing on "Building on the ACA: Legislation to Expand Health Coverage and Lower Costs"
U.S. House of Representatives
Committee on Energy & Commerce Subcommittee on Health
March 23, 2021

Good morning, Chairwoman Eshoo, Ranking Member Guthrie, and members of the Subcommittee, and thank you for the opportunity to testify today. I am Katie Keith, an Associate Research Professor and Adjunct Professor of Law at Georgetown University, where I study and teach courses on private health insurance and the Affordable Care Act (ACA). I am also the author of the "Following the ACA" blog series for *Health Affairs*, the leading journal of health policy thought and research, where I am responsible for chronicling federal and state implementation of the ACA.

I am particularly honored to appear before you on the 11th anniversary of the ACA and following enactment of the American Rescue Plan Act earlier this month. As you know, the American Rescue Plan Act expands access to marketplace coverage to millions of uninsured people and increases the affordability of existing coverage for millions more. This expansion of comprehensive health insurance will help improve the health and financial security of families across the country and has never been more important given the pandemic and economic crisis.

My testimony focuses on progress made under the ACA, the law's role in the nation's pandemic response, the importance of the American Rescue Plan Act's enhancements to the ACA, and additional opportunities to increase access to affordable, comprehensive coverage. The views I express today are my own and do not reflect those of Georgetown University or *Health Affairs*.

Significant Progress Has Been Made Under the Affordable Care Act

The ACA has resulted in historic coverage gains: more than 20 million people have gained coverage since the law was enacted in 2010, and the uninsured rate among the non-elderly population reached a record low in 2016.[1] Millions more have benefited from the law's consumer protections, which require guaranteed availability, the coverage of preventive services without cost-sharing, a cap on annual out-of-pocket expenses for care, and no more lifetime and

[1] Jennifer Tolbert et al., Key Facts About the Uninsured Population, Kaiser Family Foundation (Nov. 2020).

annual dollar caps on care. The law also narrowed racial and ethnic disparities in insurance coverage and access to care, although more work remains on this front.[2]

Black and Hispanic people had the highest uninsured rates prior to the ACA and have seen the largest coverage gains under the law. The uninsured rate for Black adults dropped from 24.4% in 2013 to 14.4% in 2018 while the rate for Hispanic adults fell by almost half—from 40.2% to 24.9%—over the same period.[3] Improved access to coverage has led to improved access to health care. Black and Hispanic adults reported fewer cost-related access problems and were more likely to have a usual source of care (such as a primary care physician) in 2018 compared to 2013.[4] These gains have not closed, but have helped narrow, the gap between the uninsured rate and access to care for Black and Hispanic adults compared to white adults.

These gains notwithstanding, progress in insuring more Americans has reversed. After reaching record lows, the uninsured rate began rising since 2017—long before the pandemic—and significant racial and ethnic disparities in coverage and care remain. The rising uninsured rate was exacerbated by Trump administration policies that eroded access to high-quality, comprehensive coverage. Several of these policy decisions are discussed below.

Importance of the Affordable Care Act During the COVID-19 Pandemic

The ACA has served as a critical part of the safety net throughout the pandemic. Estimates vary about the severity of coverage losses during this time,[5] but any coverage loss would undoubtedly be higher if the ACA were not in place. Congress also leveraged existing ACA standards—such as the requirement to cover evidence-based preventive services without cost-sharing—to quickly mandate the coverage of COVID-19 testing and vaccines for those with comprehensive coverage. These requirements were included in prior pandemic relief packages and provide access to COVID-19 tests and vaccines without cost-sharing or other out-of-pocket costs. Thus, thanks to the ACA, millions of would-be uninsured people have been able to instead enroll in Medicaid or marketplace coverage that covers COVID-19 testing, vaccines, and treatment.

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[2] *See e.g.*, Jesse C. Baumgartner et al., How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care, The Commonwealth Fund (Jan. 2020); Thomas C. Buchmueller & Helen G. Levy, "The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care," *Health Affairs* (2020) 39(3): Samantha Artiga et al., Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018, Kaiser Family Foundation (Mar. 2020); Susan L. Hayes et al., Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference? The Commonwealth Fund (Aug. 2017); Thomas C. Buchmueller et al., "Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage," *American Journal of Public Health* (2016) 106(8): 1416-21.

[3] Baumgartner et al. *supra* note 2.

[4] *Id.*

[5] *See, e.g.*, Jessica Banthin & John Holahan, Making Sense of Competing Estimates: The COVID-19 Recession's Effects on Health Insurance Coverage, Urban Institute (Aug. 2020).

Consumers took advantage of these coverage options. Enrollment through HealthCare.gov increased modestly during the 2021 open enrollment period. This was the first and only open enrollment period during which HealthCare.gov enrollment increased under the Trump administration. Enrollment increased even though the Trump administration did little to proactively promote marketplace coverage. Federal officials also refused, despite support from a wide range of stakeholders, to authorize a broad special enrollment period in 2020 so uninsured people could enroll through HealthCare.gov.[6] In contrast, state-based marketplaces that allowed additional enrollment during 2020 reported significant increases relative to prior years.[7]

The Biden administration has already reversed course and authorized a broad, three-month enrollment period from February 15 to May 15. During this time, anyone who qualifies can newly enroll in coverage or change their current plan through HealthCare.gov. Enrollment has already increased as a result: more than 206,000 consumers newly selected a plan in only the first two weeks of this special enrollment period.[8] Increased enrollment underscores the ongoing demand for comprehensive, affordable health insurance in the individual market and the need for continued robust marketing, outreach, and consumer assistance discussed below.

Enrollment will only continue to rise now that the American Rescue Plan Act has been enacted. The new law significantly improves the affordability of marketplace coverage which has been a challenge for many consumers long before the pandemic. In data from the National Health Interview Survey, 74% of respondents cited affordability as the reason for being uninsured in 2019.[9] Even when uninsured people are eligible for subsidized coverage, many do not enroll because costs are still too high.[10] Others may not realize they qualify for financial help or are deterred by the complexity of the enrollment process. The American Rescue Plan Act will help address these affordability challenges.

The American Rescue Plan Will Improve Marketplace Access and Affordability

The American Rescue Plan Act builds on the ACA and will dramatically improve marketplace access and affordability. Among its many other changes, the new law:

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[6] Katie Keith, Access to ACA Coverage in the COVID-19 Crisis, Health Affairs Blog (Jul. 2020).

[7] Rachel Schwab et al., During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured, The Commonwealth Fund (May 2020). While data is not precisely comparable across states, enrollment through Covered California was reportedly 2.5 times higher than the same period during 2019, while Connecticut and DC reported enrollment that was more than 70% and 66% higher relative to 2019, respectively.

[8] Centers for Medicare and Medicaid Services, 2021 Marketplace Special Enrollment Period Report (Mar. 2021). This is more than three times as many consumers as selected a plan during the same two-week period in 2019 (60,000 consumers) and nearly three times as many as in 2020 (76,000 consumers).

[9] Amy E. Cha & Robin A. Cohen, Reasons for Being Uninsured Among Adults Aged 18-64 in the United States, 2019, National Center for Health Statistics, Centers for Disease Control and Prevention, Data Brief No. 382 (Sep. 2020).

[10] Congressional Budget Office, Who Went Without Health Insurance in 2019, and Why? (Sep. 2020).

- Extends marketplace premium tax credits to higher-income people who did not previously qualify for 2021 and 2022;
- Increases marketplace premium tax credits for lower-income people who already qualify for 2021 and 2022;
- Extends marketplace premium tax credits and cost-sharing reductions to individuals who receive unemployment benefits in 2021;
- Provides $20 million to help state-based marketplaces update their systems to deliver these new benefits; and
- Holds harmless from premium tax credit reconciliation taxpayers who faced challenges in accurately estimating their income for 2020.

The legislation also fully subsidizes COBRA continuation coverage for laid-off workers through September 30, 2021 and includes new incentives for states that have not yet expanded their Medicaid programs under the ACA.

Each of these changes help promote access to coverage, care, and financial security at a time when millions are struggling.[11] But this part of my testimony focuses on the impact of the enhanced marketplace premium tax credits for 2021 and 2022. The extension of those tax credits will significantly reduce premium contributions for those who purchase their own health insurance and further enable historically uninsured communities to enroll in coverage.[12]

Extending Premium Tax Credits to More Middle-Income Americans

The American Rescue Plan Act extends, for the first time, marketplace premium tax credits to individuals whose income is above 400% of the federal poverty level (FPL), which is $51,040 for one person, or $104,800 for a family of four. For 2021 and 2022, qualifying individuals who purchase their own coverage will not have to contribute more than 8.5% of their overall household income towards individual market premiums.

This change could benefit up to 3.6 million uninsured people who are estimated to be newly eligible for financial help under the American Rescue Plan Act.[13] Savings will vary, but an uninsured couple that earns more than $70,000 could save more than $1,000 per month on premiums while a family of four that earns $90,000 will see their premiums decrease by $200

[11] Karen Pollitz, How the American Rescue Plan Will Improve Affordability of Private Health Coverage, Kaiser Family Foundation (Mar. 2021).

[12] According to the Department of Health and Human Services, an estimated 730,000 uninsured Latino people, 360,000 Black and African American people, 197,000 Asian, Native-Hawaiian and Pacific Islanders, and 48,000 American Indians and Alaska Natives will be newly eligible for marketplace savings under the American Rescue Plan Act. Many of these individuals will be eligible to enroll in a $0 premium silver marketplace plan. Department of Health and Human Services, Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities (Mar. 2021).

[13] *Id.*; *see also* Daniel McDermott et al., Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums, Kaiser Family Foundation (Mar. 2021).

per month. Older Americans will see significant savings as well: for instance, a 64-year-old whose income is 450% of the FPL will save nearly $8,000 this year, on average.[14]

Increasing Premium Tax Credits for Existing Enrollees

The American Rescue Plan Act increases the amount of marketplace premium tax credits available to those who already qualify for this financial help. For 2021 and 2022, marketplace premium tax credits will be more generous for people who purchase their own coverage and whose income is between 100 and 400% of the FPL. The American Rescue Plan Act reduces the income that an individual must contribute towards premiums as follows:

Income Range (Percent of FPL)	Range of Maximum Income Contribution Towards Premiums (% of Income)	
	Under Prior Law	Under American Rescue Plan Act
100 to 133%	2.07%	0%
133 to 150%	3.10 – 4.14%	0%
150 to 200%	4.14 – 6.52%	0 – 2.0%
200 to 250%	6.52 – 8.33%	2.0. – 4.0%
250 to 300%	8.33 – 9.83%	4.0 – 6.0%
300 to 400%	9.83%	6.0 – 8.5%
400+%	--	8.5%

An estimated 9 million current marketplace enrollees are expected to see savings under the American Rescue Plan Act.[15] This includes those with incomes from 100 to 150% of the FPL (between $12,760 and $19,140 for one person, or between $26,200 and $39,300 for a family of four) who are newly eligible for a $0 premium silver marketplace plan.

The American Rescue Plan Act will also help reduce out-of-pocket costs for millions of consumers. More generous premium tax credits mean many consumers can opt to enroll in more generous coverage—a higher metal level plan with a lower deductible and lower out-of-pocket costs—for no additional monthly cost (relative to their current coverage). Four out of five HealthCare.gov enrollees will be able to find a marketplace plan for $10 per month or less, and more than half will be able to find a *silver* plan for $10 per month or less.[16] This is a significant improvement compared to prior law when 69% of enrollees could find a plan for $10 per month or less and only 14% could find a *silver* plan for $10 per month or less.[17]

[14] Congressional Budget Office, Reconciliation Recommendations of the House Committee on Ways and Means (Feb. 2021).
[15] Department of Health and Human Services, *supra* note 12.
[16] *Id.*
[17] *Id.*

Opportunities to Increase Access to Affordable, Comprehensive Coverage

The American Rescue Plan Act will result in significant savings for millions of Americans and extend affordable, comprehensive coverage to those who need it. But these changes are only temporary. Affordability will become a challenge once again and consumers will face premium hikes unless Congress makes these savings permanent. Beyond adopting permanent subsidy enhancements, there are additional opportunities to increase access to affordable, comprehensive coverage and build upon the ACA. This part of the testimony focuses on the need to: 1) fund outreach and enrollment efforts; 2) protect consumers from non-comprehensive coverage options; and 3) help states expand access to coverage.

Funding for Outreach and Enrollment Efforts

Awareness of the ACA remains low, especially among the uninsured.[18] In 2019, only 5% of uninsured consumers knew the final deadline to enroll in 2020 coverage.[19] A separate survey found that only 43% of uninsured consumers knew that the marketplace had an annual open enrollment period, and some were not aware that the law itself was still in effect.[20]

Low awareness has been exacerbated by Trump administration decisions to halve the length of the annual open enrollment period and cut funding for outreach and education from $100 million to only $10 million annually.[21] These policy changes have had a detrimental impact: as of 2019, HealthCare.gov had an estimated 2.3 million fewer new enrollees—an important indicator of a healthy risk pool—because of cuts under the Trump administration.[22] Enrollment of new consumers for 2021 remains down by about 50% compared to 2016.

The Biden administration has already committed $50 million to raise awareness of the three-month COVID-19 special enrollment period. But clear standards on funding levels, enrollment targets, and other guardrails will help ensure consistent, robust marketing campaigns for HealthCare.gov in the future. These investments can yield dividends: marketing and outreach has been shown to help maintain lower premiums through a healthier, more diverse risk pool.[23]

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[18] *See, e.g.*, Munira Z. Gunja & Sara R. Collins, Who Are the Remaining Uninsured, and Why Do They Lack Coverage? The Commonwealth Fund (Aug. 2019); Ashley Kirzinger et al., Kaiser Health Tracking Poll – March 2018: Non-Group Enrollees, Kaiser Family Foundation (Apr. 2018).

[19] Joshua Peck, 2019 Open Enrollment Preview, Medium (Oct. 2019).

[20] Karen Pollitz et al., Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need, Kaiser Family Foundation (Aug. 2020).

[21] See Timothy Jost, CMS Cuts ACA Advertising by 90% Amid Other Cuts to Enrollment Outreach, Health Affairs Blog (Aug. 2017).

[22] Oversight Hearing: Impact of the Administration's Policies Affecting the Affordable Care Act of the House Comm. on Appropriations, 116th Cong. (2019) (statement of Joshua Peck, Co-Founder, Get America Covered).

[23] Covered California, Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets (Sep. 2017).

Beyond marketing and outreach, consumers want and need enrollment assistance. About 7 million individuals who actively sought coverage for 2020 received consumer assistance.[24] Of these, four in 10 consumers said it was somewhat or very unlikely that they would have enrolled in coverage without consumer assistance.[25] But nearly 5 million consumers tried to find enrollment assistance and could not.[26] Consumers did not receive help because of limited availability of in-person assistance in their area, because help was unavailable in Spanish, or because they did not have internet access at home, among other reasons.[27]

Funding for the navigator program could help fill this need for consumer assistance. The ACA's navigator program was modeled after other successful outreach efforts for Medicaid, CHIP, and the State Health Insurance Assistance Programs for Medicare. Historically, navigator grantees have been trusted local organizations such as United Way affiliates, primary care associations, universities, legal aid societies, community health centers, and patient assistance organizations.

Navigator organizations undertake a range of activities. They provide fair and unbiased information about coverage options, help eligible consumers enroll in Medicaid or CHIP, support post-enrollment activities (such as help with appeals), and offer information in a manner that is culturally and linguistically appropriate. Navigator grantees also provide year-round outreach and education to vulnerable, hard-to-reach, or disproportionately uninsured communities. Recent data released by the Trump administration underscores the broader role that navigators play in assisting consumers and shows the degree to which navigators help with post-enrollment assistance, health insurance literacy, and referrals in addition to enrollment.[28] Because they often serve different primary populations, navigator efforts complement the important work of agents and brokers in enrolling consumers in marketplace coverage.

Despite the need for consumer assistance, the Trump administration reduced funding for the navigator program by 84% since January 2017.[29] It also scaled back the navigator program through regulatory changes to the program. Recent rules eliminated the requirement that navigators maintain a physical presence in a marketplace service area and have at least one community and consumer-focused nonprofit navigator entity, among other changes.[30] In the wake of these cuts and changes, two states and many major counties were left without any

[24] Pollitz et al., *supra* note 20.
[25] *Id*.
[26] *Id*.
[27] *Id*.
[28] Centers for Medicare and Medicaid Services, Navigator Funding and Enrollment Data, PY 2016-2020 (2021).
[29] Karen Pollitz & Jennifer Tolbert, Data Note: Limited Navigator Funding for Federal Marketplace States, Kaiser Family Foundation (Oct. 2020).
[30] Katie Keith, CMS to Maintain Navigator Funding at $10 Million for 2020, 2021, Health Affairs Blog (May 2019).

navigators at all.[31] Unsurprisingly then, consumers were more likely to be helped by navigators in states with state-based marketplaces (18%) compared to states that use HealthCare.gov (6%).[32]

The Biden administration has already provided an additional $2.3 million in funding to current navigator grantees. But increased and consistent funding would help navigator grantees better support the communities they serve and could help further close coverage disparities. The role of navigators will be especially important in educating consumers about a diverse range of coverage options under the American Rescue Plan Act—including marketplace coverage, subsidized COBRA coverage, and Medicaid.

Consumer assistance remains important even beyond the marketplaces, as millions need help with health insurance enrollment, questions, and problems. A separate provision of the ACA created statewide ombudsman, or consumer assistance programs, and appropriated initial seed funding of $30 million. This led to the establishment of nearly 40 consumer assistance programs that were required to assist consumers in all types of coverage and help answer insurance questions, resolve disputes, and file appeals for denied claims. Since then, however, no additional funding has been made available, leading some of the initial programs to close or scale back services. With adequate resources, consumer assistance programs could offer renewed help with enrollment, appeals, and consumer education. These programs could also be partners in monitoring compliance with new federal laws, including the No Surprises Act.

Protecting Consumers From Non-Comprehensive Coverage Options

There is an urgent need to ensure that consumers are enrolled in insurance products that will cover the care they need and to protect consumers from misleading marketing practices. This is always true but is heightened during the pandemic when access to affordable care and coverage has never been more critical.

One of the most prominent non-comprehensive options is short-term limited duration insurance (STLDI), a product that discriminates against people with preexisting medical conditions and does not have to comply with the ACA or other federal consumer protections.[33] The media has

[31] Pollitz & Tolbert, *supra* note 29.

[32] Pollitz et al., *supra* note 20.

[33] While this testimony focuses on STLDI, it is worth emphasizing that this is not the only non-comprehensive coverage option that has proliferated in recent years and that similar concerns are raised by limited benefit plans, excepted benefits, health care sharing ministries, farm bureau plans, and association health plans, among others. *See, e.g.*, Christen Linke Young & Kathleen Hannick, Fixed Indemnity Health Coverage is a Problematic Form of "Junk Insurance," Brookings (Aug. 2020). The U.S. Government Accountability Office, for instance, issued a report revealing deceptive marketing practices where sales representatives for STLDI and these other products misrepresented the terms of coverage or included misinformation. U.S. Government Accountability Office, Private Health Coverage: Results of Covert Testing for Selected Offerings, GAO-20-634R (Aug. 2020). A comprehensive approach is likely needed to address the range of products that fail to offer comprehensive financial and health protections to consumers. *See* Christen Linke Young, Taking a Broader View of "Junk Insurance," Brookings (Jul. 2020).

reported many stories of consumers who enrolled in STLDI only to learn that their health costs are not covered, and their coverage is inadequate.[34]

STLDI is inadequate across multiple fronts. Recent analyses show that STLDI products exclude entire categories of benefits (such as prescription drugs, maternity care, or mental health);[35] deny coverage or benefits to those with preexisting conditions;[36] discriminate against women;[37] engage in medical underwriting;[38] require much higher cost-sharing than ACA products;[39] and lead to significant out-of-pocket costs for those who become ill.[40] Some STLDI does not cover even routine preventive care or injuries,[41] and many do not cover treatment for COVID-19[42] or have a provider network, putting enrollees at risk of significant balance bills.[43] As a result, those who purchase these plans risk, often unknowingly, catastrophic medical bills that can lead to financial instability for enrollees and uncompensated care for hospitals and other providers. These and other gaps were documented in an extensive investigation of STLDI by the Democratic staff of the U.S. House of Representatives Energy and Commerce Committee.[44]

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[34] *See, e.g.*, Michelle Andrews, "Think Your Health Care Costs Are Covered? Beware the 'Junk' Insurance Plan," *NPR* (Dec. 3, 2020); Stephanie Armour, "Shorter-Term Health Plans Force Many to Pay for Lifesaving Treatments, Report Finds," *Wall Street Journal* (Jun. 25, 2020); Ben Conarck, "A Miami Man Who Flew to China Worried He Might Have Coronavirus. He May Owe Thousands," *Miami Herald* (Feb. 24, 2020); Jenny Deam, "A Doctor's Scribbled Note Leads to Patient Losing Health Insurance," *Houston Chronicle* (Nov. 27, 2019); Donna Rosato, "Short-Term Health Insurance Isn't As Cheap As You Think," *Consumer Reports* (Oct. 2, 2018); Zeke Faux et al., "Health Insurance That Doesn't Cover the Bills Has Flooded the Market Under Trump," *Bloomberg* (Sep. 17, 2019); Reed Abelson, "Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans," *New York Times* (Nov. 30, 2017); Erik Larson & Zachary Tracer, "The Health Plans Trump Backs Have a Long History of Disputes," *Bloomberg* (Oct. 16, 2017).

[35] Karen Pollitz et al., Understanding Short-Term Limited Duration Health Insurance, Kaiser Family Foundation (Apr. 2018).

[36] *See* American Cancer Society Cancer Action Network, Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans (May 2019); Sarah Lueck, Key Flaws of Short-Term Health Plans Pose Risks to Consumers, Center for Budget and Policy Priorities (Sep. 2018).

[37] *See, e.g.*, JoAnn Volk et al., Trump Administration Promotes Coverage That Fails to Adequately Cover Women's Key Health Care Needs, The Commonwealth Fund (Oct. 2020).

[38] Pollitz et al., *supra* note 35; American Cancer Society Cancer Action Network, *supra* note 36.

[39] Dania Palanker et al., New Executive Order: Expanding Access to Short-Term Health Plans is Bad for Consumers and the Individual Market, The Commonwealth Fund (Oct. 2017).

[40] Dane Hansen & Gabriela Diguez, The Impact of Short-Term Limited Duration Policy Expansion on Patients and the ACA Individual Market, Milliman (Feb. 2020).

[41] Cheryl Fish-Parcham, Seven Reasons the Trump Administration's Short-Term Health Plans Are Harmful to Families, Families USA (Aug. 2018), (finding STLDI exclusions for sports injuries and tonsillectomies); Jackson Williams, "Short-term Health Insurance Coverage is Almost Worthless," *Philadelphia Inquirer* (Jul. 2018) (noting that some STLDI policies limit hospitalization coverage to $1,000 per day, even though the average U.S. cost of hospitalization is more than $5,000 per day).

[42] *See* Emily Curran et al., In the Age of COVID-19, Short-Term Plans Fall Short for Consumers, The Commonwealth Fund (May 2020).

[43] Dania Palanker & Kevin Lucia, Opportunities to Better Protect Consumers and Markets from the Negative Impact of Short-Term Plans, The Commonwealth Fund (Jan. 2021).

[44] U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Subcommittee on Oversight and Investigations, Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk (Jun. 2020), [hereinafter *Shortchanged*].

These benefit gaps persist despite predictions that STLDI would evolve to offer more comprehensive benefits under a Trump administration rule that allowed these products to be sold for up to 364 days and renewed for up to three years. One review of more than 400 policies concluded that 12-month STLDI continued to deny coverage based on health status, exclude coverage for preexisting conditions, exclude major benefit categories, and impose low dollar limits on care.[45] These gaps, researchers concluded, show that the STLDI market "continues to place enrollees at huge risk."[46]

These gaps are especially pernicious given the aggressive and misleading marketing tactics used by some STLDI insurers and sales representatives. Investigations and studies have shown that STLDI insurers and sales representatives misrepresent coverage to consumers, urge consumers to purchase plans over the phone without written information, or fail to disclose major coverage limitations.[47] Some have deliberately designed and sold STLDI plans to mimic ACA-compliant plans, or targeted consumers searching for comprehensive coverage, promising coverage for specific medical conditions without disclosing exclusions.[48] The sale of STLDI through out-of-state associations has also increased significantly as insurers presumably use these associations to circumvent state restrictions.[49]

STLDI and other non-comprehensive products leave consumers exposed to devastating financial costs and no coverage. The ACA—as bolstered by the American Rescue Plan Act—extends financial help for comprehensive coverage to those who need it. In a reformed market with comprehensive subsidies at all income levels, there is little, if any, need for non-comprehensive options such as STLDI.

Helping States Expand Access to Comprehensive Coverage

Additional federal funds are key to enabling state-based initiatives that expand access to affordable, comprehensive coverage under the ACA. Federal funding could help states lower out-of-pocket costs, prioritize health equity, and experiment with auto-enrollment or other ways to maximize enrollment and reduce churn.

States are already leading in many of these areas, but federal funding would bolster these efforts and spur additional action by more states. Nevada, New Jersey, and Pennsylvania recently

[45] Dania Palanker et al., Limitations of Short-Term Health Plans Persist Despite Predictions That They'd Evolve, The Commonwealth Fund (Jul. 2020).

[46] *Id*.

[47] *See, e.g.*, *Shortchanged* at 29-41; Christen Linke Young & Kathleen Hannick, Misleading Marketing of Short-Term Health Plans Amid COVID-19, Brookings Institution (Mar. 2020); Sabrina Corlette et al., The Marketing of Short-Term Health Plans, Robert Wood Johnson Foundation (Jan. 2019); Office of Senator Bob Casey, Health Care Sabotage Online: A Warning to Consumers (Oct. 2019).

[48] *Shortchanged* at 29-41.

[49] *See* Emily Curran et al., Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections, The Commonwealth Fund (Jan. 2019); *Shortchanged* at 25.

transitioned from HealthCare.gov to their own full state-based marketplaces, with other states expected to soon do the same.[50] States interested in transitioning to their own marketplace cite greater control over decisionmaking and cost savings,[51] and additional federal funding to establish state-based marketplaces would spur more states to take advantage of this flexibility under the ACA. Fifteen states have already received state innovation waivers to operate state-based reinsurance programs; the average premium reduction for the 12 states with programs in effect for 2020 was 17.7%.[52] States are experimenting with other initiatives as well. California, Massachusetts, New Jersey, and Vermont provide additional premium subsidies to consumers to improve affordability.[53] And several states have adopted their own individual coverage mandates[54] or experimented with "easy enrollment" options.[55]

Federal funding for these and similar efforts could lead to coverage gains, improved health care access, and strong models for future federal policy. Federal funds are especially important given the budgetary challenges that many states face due to the pandemic.

Conclusion

The ACA has resulted in historic coverage gains and played a crucial role in the nation's pandemic response. The American Rescue Plan Act will further cement these gains by dramatically improving the affordability of marketplace coverage. Congress should make those changes permanent and continue to expand upon the ACA in the ways discussed above.

[50] Louise Norris, Health Insurance Marketplaces by State, Healthinsurance.org (Feb. 2021).

[51] Sabrina Corlette et al., States Seek Greater Control, Cost-Savings by Converting to State-Based Marketplaces, Robert Wood Johnson Foundation (Oct. 2019); Rachel Schwab & JoAnn Volk, States Looking to Run Their Own Health Insurance Marketplace See Opportunity for Funding, Flexibility, The Commonwealth Fund (Jun. 2019).

[52] Centers for Medicare and Medicaid Services, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, CCIIO Data Brief Series (Jun. 2020).

[53] Justin Giovannelli et al., States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership, The Commonwealth Fund (Jan. 2020).

[54] *Id*.

[55] Stan Dorn, Maryland's Easy Enrollment Health Insurance Program: An Innovative Approach to Covering the Eligible Uninsured, Health Affairs Blog (May 2019).