ITUP
Insure the Uninsured Project

MAPPING THE FUTURE

INDIVIDUAL HEALTH INSURANCE

What's next?

MARCH 2019

The federal Affordable Care Act (ACA) imposes sweeping changes in the rules governing private health insurance and expands eligibility for Medicaid (Medi-Cal) among other provisions. The ACA changed the health care landscape in California and significantly reduced the number of uninsured Californians under age 65 to nearly three million in 2017.[1]

For individuals who do not have employer coverage, and are not eligible for public coverage programs, the individual market is the last available option to secure health coverage.

California fully embraced the ACA and became the first state to create a state-based ACA exchange that organizes the individual and small employer markets.[2] Covered California is now the largest state-based exchange in the nation.

Shifting federal policies threaten to undermine the success of Covered California and the viability of the individual market. In the next few years, California policymakers will need to examine state options that can help to stabilize the market and improve the affordability of coverage for individuals who have no other coverage option.

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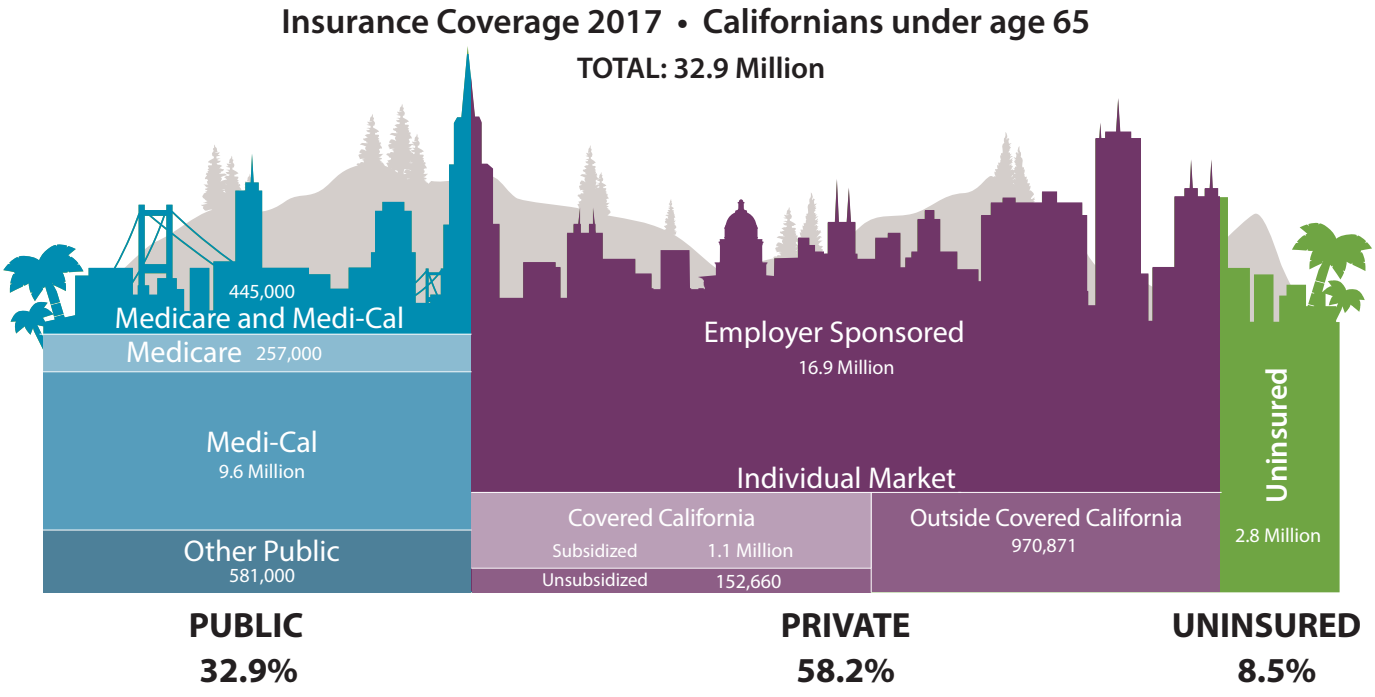
Purpose of this Report

This publication and the companion publication, *Mapping the Future of Medi-Cal*, examine pressing issues related to these coverage options for Californians without employer-sponsored coverage or Medicare. For a basic overview of Covered California and the Individual Market, see the just released edition of ITUP Essentials.

The discussion of each topic includes the relevant federal and state context with a brief analysis.



Sources: Estimates from California Health Interview Survey 2017 data, Covered California, Active Member Profiles, December 2017 and Katherine Wilson, "State Release Data on California 2017 Health Insurance Enrollment," California Health Care Foundation, August 2018, companion Excel file.

DEFINITIONS

ACA Premium Tax Credit is a federal, refundable tax credit that reduces exchange monthly premiums for eligible individuals and families at or below 400 percent of the Federal Poverty Level (FPL) ($48,560 in annual income for one person in 2019) who are not eligible for Medi-Cal.

Actuarial Value (AV) is the average percent of benefit costs covered by a health plan product compared to the out-of-pocket costs paid by the covered person. A 70% AV plan covers 70% of benefit costs and the enrollee pays 30%. The ACA assigns metal labels to specific actuarial values: bronze (60%), silver (70%), gold (80%) and platinum (90%).

Cost Sharing Reductions (CSRs) are federal payments to qualified health plans that reduce out-of-pocket costs for individuals between 138 and 250 percent FPL (between $16,753 and $30,350 in household income for one person in 2019) purchasing a silver level plan in the exchange.

Essential Health Benefits (EHBs) are ten categories of health services that must be covered in individual and small employer health plans under the ACA.

Out-of-Pocket Cost is the amount an enrollee pays for covered services at the point of care, also known as cost-sharing. Out-of-pocket costs typically come in the form of coinsurance, copayments, and deductibles.

Qualified Health Plan (QHP) is a health plan that meets state and federal ACA marketplace requirements and is certified by Covered California to offer health coverage through the exchange.

I. The Basics

The ACA establishes a federal floor that ensures individuals in every state have basic protections in common with respect to the availability, affordability, comparability and transparency of health coverage. A central theme of the ACA is to organize markets and products in ways that both protect consumers and make it easier for them to compare and choose among their coverage options.

A cornerstone of the ACA is the establishment of state-level health insurance exchanges that serve as marketplaces to support individuals and small employers in comparing coverage options and to administer federal financial assistance that helps low-income individuals and families purchase coverage.

Pre-ACA Individual Market

Prior to the ACA, individual coverage was expensive, often with very limited benefits and high out-of-pocket costs. Health plans selling individual policies routinely denied coverage or hiked premiums based on an applicant's health status or medical history and imposed coverage exclusions for pre-existing health conditions.

Health plans in California and most other states had total discretion to collect and use medical and health information to evaluate individual applicants (known as medical underwriting); no two health plans had identical criteria for making coverage and rating decisions. Common conditions triggering a denial of coverage included cancer, diabetes and mental health disorders, but also less obvious conditions such as asthma, acne and obesity.

Coverage in the individual market often included annual and lifetime dollar limits on benefits, fixed limits on coverage (e.g., maximum 60 days of hospital coverage) and typically no limits on consumer out-of-pocket costs. Some policies excluded coverage for basic primary and preventive care and focused primarily on high-cost services like hospitalization.

ACA Individual Market

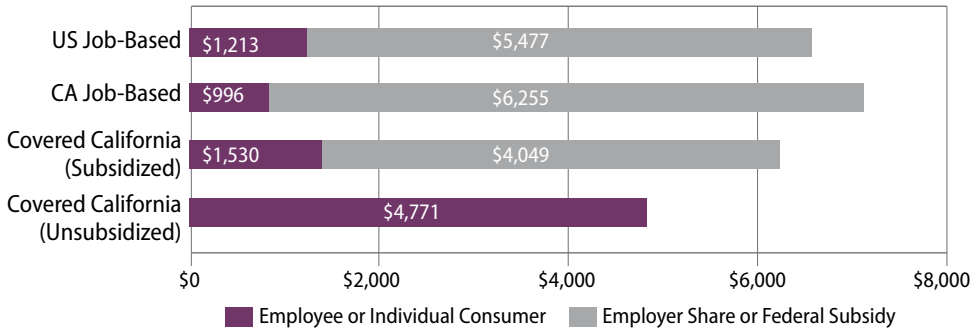
Before the ACA, states assumed the primary role in setting market rules and regulating most aspects of private health insurance. Under the ACA, states continue to have the lead in oversight but now also enforce ACA federal standards affecting virtually all aspects of health insurance—including eligibility for coverage, benefits, premium rates, market conduct, quality and transparency—with the most sweeping changes affecting coverage in the individual and small group markets.

The ACA changed the individual market by removing barriers to coverage, setting minimum standards for coverage, and funding federal premium and cost-sharing subsidies. New ACA market rules include:

- Insurers can no longer deny coverage based on health status, medical history or pre-existing conditions and must offer and renew coverage to all eligible applicants (known as guaranteed issue and renewal);
- No coverage or benefit limits can be imposed because of pre-existing health conditions;
- No annual or lifetime dollar limits on benefits;

- Children can stay on a parent's health insurance plan as dependents until age 26;
- Premiums must be based solely on age and geography (using state developed regions);
- Premiums cannot vary by more than a three-to-one ratio from the youngest enrollee to the oldest;
- Health plans must cover all ten essential health benefits, including mental health and substance use treatment;
- Health plans must meet federally defined minimum values and disclose the actuarial value of products; and
- Consumer cost sharing is limited to a maximum out-of-pocket amount set annually by federal formula.[4]

Figure 1. Comparison of Consumer Share of Premiums, Employer-Sponsored and Individual Coverage



Source: California Health Care Foundation, California Employer Health Benefits: Workers Shoulder More Costs, June 26, 2018. Covered California, June 2017 Membership Profile. Chart prepared by Insure the Uninsured Project.

Coverage under the ACA

The ACA defines four "metal tiers" of coverage based on a product's actuarial value (AV), as shown below.[5] The AV is the average portion of total health care costs covered by the health plan versus what consumers pay out-of-pocket, excluding premiums.

- ***Bronze Tier*** (60% AV)
- ***Silver Tier*** (70% AV)
- ***Gold Tier*** (80% AV)
- ***Platinum Tier*** (90% AV)

In addition, the ACA establishes a minimum coverage plan, or Catastrophic Plan, with lower monthly premiums and a high deductible ($7,900 in 2019).[6] To purchase a Catastrophic Plan, an individual must be under age 30 or qualify for a hardship or affordability exemption. The "minimum coverage" plan includes three doctor or urgent care visits with no out-of-pocket costs and offers free preventive benefits.[7]

ACA Federal Financial Assistance

The ACA establishes federal subsidies to help low- and moderate-income individuals afford exchange coverage in the form of premium tax credits for individuals with incomes at or below 400 percent FPL. In 2018, nearly 90 percent of Covered California enrollees received premium assistance.[8]

FAST FACTS

2.2 Million

Californians purchase individual coverage

1.3 Million

Californians on average are enrolled in Covered California

90%

of Covered California consumers receive federal subsidies

2 in 5

Covered California enrollees report difficulty paying monthly premiums[3]

The ACA also establishes cost sharing reduction subsidies to reduce out-of-pocket costs for consumers with incomes at or below 250 percent FPL. The federal government makes CSR payments to health plans who then reduce consumer cost sharing. In 2017, the President eliminated CSR payments. Regardless of the federal contribution, plans are still required to reduce cost sharing for low-income enrollees under the ACA. (Note: Covered California worked to ensure the premium impacts were added only-to silver tier plans, a practice known as "silver loading," so that the extra costs would be covered by increased federal subsidies rather than increasing premiums for consumers.)

The California Individual Market

California fully embraced the ACA reforms of individual and small employer (group) coverage. The state had nearly 30 years of experience with guaranteed issue and renewal in the small group market and made necessary conforming changes while preserving state standards and consumer protections that exceeded the ACA.

California also passed conforming legislation for individual coverage and included numerous provisions that exceed ACA requirements to ensure a stable and healthy state exchange and market. Examples of California provisions that exceed federal requirements:

- Requires Covered California to choose health plans through a competitive process (selectively contract) and "provide health care choices that offer the optimal combination of choice, value, quality and service."[9]
- Federal law requires exchange health plans to offer at least one silver and one gold option.[10] California requires exchange health plans to offer coverage at all five levels, including the minimum coverage option.[11]
- Limits health plans only selling non-grandfathered individual coverage outside the exchange (off-exchange) to product offerings in the four metal tiers and prohibits them from offering catastrophic coverage. Requires off-exchange plans to offer coverage in all metal tiers.[12]

Covered California as an Active Purchaser

California made the decision early on to set up the state exchange as an "active purchaser," meaning that it selectively contracts with insurers, negotiates rates, standardizes benefits and requires programs that promote delivery system improvement. Covered California is required to select participating health plans through a competitive process. For each coverage year, Covered California actively negotiates with potential plans on premiums, networks, geographic coverage and quality performance. In addition, Covered California health plan contracts impose contract requirements adopted by the independent Covered California Board related to quality, performance and public reporting.

As one indicator of the impact of an active purchaser exchange, for Covered California enrollees, weighted average premiums increased by 7.7 percent in the first five years of operation, 2014-2019, compared to 13.1 percent in the Federally Facilitated Marketplace that organizes coverage for states without an exchange.[13]

Standard Benefit Designs

As permitted in federal law and authorized in California law, Covered California requires contracted QHPs to offer standard benefits at each coverage level defined by specified coverage and consumer cost sharing requirements. Standardized benefit designs support consumer decision making by simplifying the choice between health plans, allowing for an "apples to apples" comparison of the premium price and other features.

Covered California worked with stakeholders to develop what it calls "Patient-Centered Designs" that encourage access to primary and preventive care services. For example, in bronze-tier coverage, three basic primary and preventive care services are covered before the consumer has to meet the annual deductible. In the other metal tiers, a broader set of primary and preventive care services are not subject to the deductible.

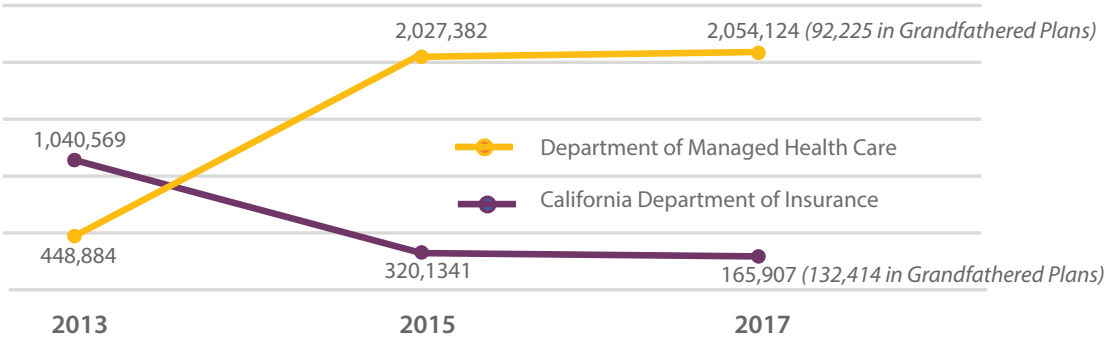
Under California law, the standard benefit designs also affect coverage offerings in the outside market. Health plans not in the exchange also have to offer standard benefit designs in each metal tier.[14] Exchange standardized products offered outside the exchange are sometimes referred to as "mirror" products.

State Oversight of Health Insurance in California

For more than 50 years, California has maintained a bifurcated system for regulation of health insurance. The Department of Managed Health Care (DMHC) regulates Health Maintenance Organizations (HMOs) and some Preferred Provider Organizations (PPOs) under the Knox-Keene Health Care Service Plan Act of 1973 (Knox-Keene). The California Department of Insurance (CDI) regulates some PPOs and traditional indemnity insurance subject to the California Insurance Code.

State regulators control market entry, evaluate initial and ongoing compliance with statutory and regulatory standards, and enforce standards through legal remedies including fines, penalties, court injunctions, suspension or revocation. Once the ACA reduced the differences between products, health plans moved products to DMHC which now regulates 75 percent of the individual market. (See Figure 2.) Although similar rules and standards now apply, legacy differences remain and parallel statutes have not always resulted in parallel regulations or enforcement.

Figure 2. Individual Market Enrollment by Regulator Pre- and Post ACA, 2013-2017



Source: Katherine Wilson "State Releases Data on California 2017 Health Insurance Enrollment," California Health Care Foundation, August 1, 2018, Document Downloads, "California Health Insurance Enrollment Data, 2017 (zip)."

Key Characteristics of California's Individual Health Insurance Market

- ***Individual Coverage Differs from Job-Based or Public Coverage.*** Individual health insurance is often the only coverage option for individuals without job-based coverage or eligibility for public coverage programs such as Medi-Cal or Medicare. Because individuals must pay the full premium and cost sharing for their coverage, unlike job-based coverage where employers contribute to the premiums, financial assistance, affordability and the need for outreach that encourages individuals to sign-up are especially important in the individual market.

  Given the potential for consumers to bear significant premiums and out-of-pocket costs, those who have existing health care needs or worries are more likely to seek out coverage than healthier individuals. Given the relatively small number who purchase individual coverage (2.2 million), compared with the larger employer market (16.9 million), the associated "risk profile" of individuals purchasing individual coverage has a significant impact on costs and premiums for everyone.

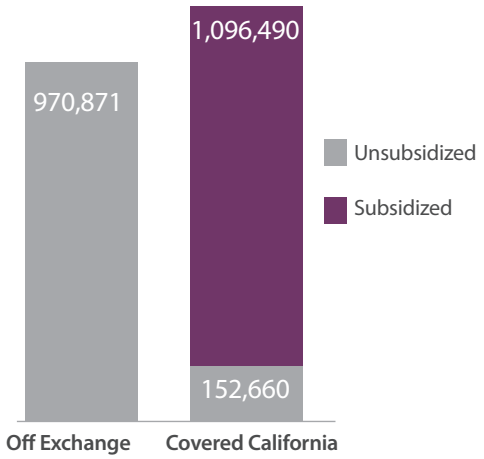
- ***Coverage Split Between Exchange and Off-Exchange.*** About 2.2 million Californians purchased individual coverage in 2017, 56 percent through Covered California and 44 percent "off-exchange" purchased directly from health plans.[15] (See Figure 3.) Product choices outside Covered California include those that meet ACA standards (ACA-compliant) and products identical to products sold in Covered California ("mirror" products). In addition, a small number of "grandfathered plans" (approximately 225,000 enrolled in 2017), which are described below, remain in the individual market.

  Grandfathered Plans. Under the ACA, individual and small group health plans that existed on March 23, 2010 – the day the ACA was enacted –are subject to only certain provisions of the law. For example, grandfathered health plans are limited to individuals (and small employers) enrolled prior to passage of the ACA, the offering health plans can charge more based on pre-existing conditions and they do not have to meet all of the ACA's essential benefits requirements. Grandfathered health plans can lose this status if certain significant changes are made to the coverage that reduce benefits or increase consumer costs.

- ***Covered California is Strong Despite Enrollment "Churn."*** California has successfully implemented a strong and resilient state-based exchange. Resources dedicated to outreach, marketing, and application assistance, and state policies that exceed ACA requirements, have helped to maintain steady enrollment in the nation's largest state-based marketplace. Despite more turnover or churn in Covered California than in the large employer market, Covered California has maintained relatively consistent total enrollment numbers over the past five years. Each year, approximately 40 percent of Covered California enrollees leave the marketplace, with most (84 percent) transitioning to other coverage.[16] This phenomenon, often referred to as "churn," also characterized the individual market pre-ACA. The level of churn underscores that individual coverage is a fallback option as people move back and forth to job-based coverage, or as incomes fluctuate between eligibility for Medi-Cal versus federal subsidies available in the exchange.

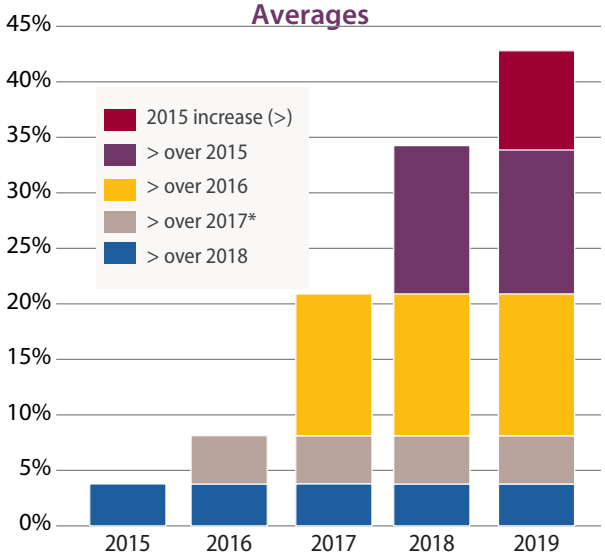
- ***Federal Financial Assistance is Essential but Affordability Concerns Remain.*** Covered California administers the federal premium tax credits that reduce premiums for individuals under 400 percent FPL.

Figure 3. Profile Of California's Individual Market, 2017



Source: Katherine Wilson, "State Releases Data on California 2017 Health Insurance Enrollment" California Health Care Foundation, August 2018, companion Excel file.

Figure 4. Covered California Premium Rate Increases, Year-Over-Year, Statewide Weighted Averages



Source: Covered California Rate for 2015, 2016, 2017, 2018, 2019. * The Cost sharing reduction surcharge imposed on silver tier plans is not included in these rates.

Federal ACA subsidies are critical to the success of Covered California and to preserving California's coverage gains. In 2018, nearly 90 percent of Covered California enrollees were eligible for and received federal subsidies.[17] Individuals can choose to purchase coverage through Covered California or directly from a health plan outside the state marketplace, but premium subsidies and CSRs based on family income are only available through Covered California. Although federal subsidies have been a game-changer in bringing many low- and moderate-income individuals into coverage, affordability challenges remain as discussed below.

- ***Premium Prices Matter.*** Cost is the primary reason Californians report for remaining uninsured.[18] Since individuals bear the full premium costs for individual coverage, absent financial assistance, the decision to purchase coverage is heavily impacted by premium rates. Premium costs also influence coverage selection. In 2018, a majority of Covered California enrollees selected products with lower premiums even though the products cover a lower proportion of anticipated expenses – 29 percent selected a bronze plan (lowest premiums) and 56 percent chose a silver plan; less than 15 percent enrolled in a gold or platinum plan (highest premiums) which cover a higher proportion of anticipated expenses.[19] Among subsidized enrollees, the majority selected a silver plan (60 percent) where CSRs are available to lower-income individuals. By contrast, higher proportions of unsubsidized enrollees chose bronze (47 percent) compared to relatively low numbers choosing gold (18 percent) or platinum (8 percent) plans.[20]

- ***Premiums Vary by Region.*** Insurers wanting to participate in the exchange propose regions and partial regions they wish to serve, and region-specific rates, which are then negotiated with Covered California. Wide variation in average premiums have occurred across the state in each of the past five years. For example, comparing San Francisco and Los Angeles, premiums can be as much as 24 percent higher in San Francisco.[21] Premium rates are also subject to rate review by DMHC and CDI. The regulators determine the reasonableness of the rates but cannot approve or disapprove the final rates. Annual rate increases have generally not impacted total Covered California enrollment and in most regions consumers can shop for a lower cost product in the same tier. For Covered California enrollees receiving premium assistance, subsidies increase as premiums increase, insulating consumers from the cost increases. (See Figure 4.)

- ***Number of Health Plans Varies by Region.*** Consistent with federal law, California divides the state into 19 pricing or rating regions for individual and small employer coverage. The number and type of health plan options varies by region. In the last three years, the same eleven health plans participated in Covered California but many cover only a few regions of the state. For some rating regions, and in some zip codes, consumers have only one or two health plan choices in the exchange, often contributing to premiums much higher than other areas of the state. Approximately four percent of Covered California enrollees in 2019 had only one health plan choice. Ninety-six percent had at least two plans and 80 percent had three.[22]

II. Federal Threats to the ACA

In 2017, there were more than 50 Republican-led attempts to repeal or modify the ACA. Major Congressional efforts to repeal and replace the ACA in 2017 included the American Health Care Act, the Better Care Reconciliation Act, and the Graham-Cassidy-Heller-Johnson Proposal. All of these bills failed. (See Figure 5 below.)

Figure 5. Federal ACA Repeal and Replace Legislation

Repeal and Replace Bill	Overview of Individual Market Provisions
American Health Care Act	▪ Eliminates the ACA requirement for individuals and employers to purchase coverage (individual and employer mandates) and the penalties associated with failure to comply. ▪ Replaces the individual mandate with a late enrollment penalty. ▪ Maintains the requirement that health plans cover EHBs unless the state secures a waiver. ▪ Eliminates ACA actuarial value standards. ▪ Replaces ACA tax credits with new age-adjusted tax credits that do not vary by geographic region, income or premium levels. ▪ Repeals the CSR subsidies. ▪ Allows states to change the ratio for health care premiums between the youngest and oldest adults to 5:1 instead of the 3:1 ratio in the ACA.
Better Care Reconciliation Act	▪ Retroactively, eliminates the ACA penalties for individuals and employers who do not comply with the individual mandate. ▪ Replaces the individual mandate with a late enrollment penalty. ▪ Reduces the value and amount of premium tax credits by linking the credit to coverage with an actuarial value of 58 percent instead of the ACA benchmark of the second lowest cost silver plan, a 70 percent actuarial value plan. ▪ Reduces the income eligibility for premium tax credits from 400 percent to 350 percent FPL. ▪ Allows premium tax credits to be used to purchase catastrophic plans. ▪ Repeals the CSR subsidies.
Graham-Cassidy-Heller-Johnson Proposal	▪ Eliminates penalties for individuals and employers that do not comply with the ACA coverage mandates and allows states to waive many of the consumer protections of the ACA. ▪ Establishes a new state block grant program consolidating ACA funding for coverage expansion (premium tax credits, cost sharing reductions and Medicaid expansion), reducing the funding and implementing complex funding formulas for determining individual state grants. ▪ Ends refundable tax credits and CSR subsidies.

While no major repeal effort succeeded in Congress, over the last two years, Congress and the federal administration have adopted other strategies that weaken the ACA, including repealing the penalty for not having health insurance, and adopting regulations and administrative guidance that rollback key provisions and protections built in to the ACA. In addition, legal challenges initiated at the state level also pose a significant threat to the coverage gains and market improvements California has made under the ACA.

***FEDERAL THREAT ISSUE 1**: Elimination of the Individual Mandate Tax Penalty*

Overview

The ACA requires individuals to maintain minimum coverage unless exempted, or pay a tax penalty. The basic rationale behind an individual coverage requirement is that if everyone is required to have insurance—including young and healthy people—the "risk pools" will be broad enough to lower premiums for everyone, even those with expensive medical conditions. Health insurers "pool," or combine, the medical costs of specific groups to calculate premiums. Pooling risks together allows the higher costs of the less healthy covered individuals to be offset by the relatively lower costs of healthier individuals. In general, the larger the risk pool, the more predictable and stable the premiums will be. For this reason, the individual health insurance market, a relatively small market compared to employer coverage and large public programs, has always been susceptible to significant premium changes based on the relative number and risk profile of the individuals covered.

Federal Context

In December 2017, Congress passed the Tax Cuts and Jobs Act, which eliminated the financial penalty for not having health insurance effective January 1, 2019. At the time, the Congressional Budget Office estimated that four million fewer people would be covered in 2019 because of the elimination of the individual mandate penalty, increasing to 12-13 million from 2021-2027, while premiums in the individual market would increase by about 10 percent most years between 2019-2027.[23]

At the state level, several states adopted state coverage requirements (See Figure 6 below) and other states have considered legislation to adopt state-specific individual mandates, including Connecticut and Maryland. The legislation did not advance in these two states.

As just one illustration of the impact of a state-based individual mandate, in Massachusetts, enrollment doubled following the full implementation of the state individual mandate which imposed a different penalty structure than that of the ACA. As a result, enrollment growth was greater among those without, compared to those with, a chronic illness, and the average enrollee age also dropped.[24]

Figure 6. State-Specific Individual Mandates and Penalties

State	State-Specific Individual Mandate and Penalty
Massachusetts	▪ Enacted pre-ACA in 2006. ▪ Requires all adults to have a minimum level of affordable coverage except for people with sincerely held religious beliefs or with certain financial hardships. ▪ The tax penalty for not complying equals up to 50 percent of the lowest cost plan available to the individual in the state's marketplace. Exemptions from the penalty include individuals under 150 percent FPL and those with a short gap in coverage.
New Jersey	▪ Recently enacted and in effect in 2019 with rules closely resembling the federal rules, but the maximum penalty is tied to state-specific bronze plan premium. ▪ Requires uninsured taxpayers to receive a notice informing them about coverage options. ▪ Penalty revenue to be used for state-operated reinsurance program.
Vermont	▪ Recently enacted and in effect in 2020. ▪ No enforcement mechanism or penalty, a workgroup is charged with developing recommendations. ▪ Requires outreach to inform consumers about coverage options and the new state-specific individual mandate.
District of Columbia (DC)	▪ Recently enacted and in effect in 2019 with rules closely resembling the federal rules, but the maximum penalty is tied to DC-specific bronze plan premium. ▪ Requires uninsured taxpayers to receive a notice informing them about coverage options. ▪ Penalty revenue is to be used for outreach, education, and increasing availability or affordability of insurance.

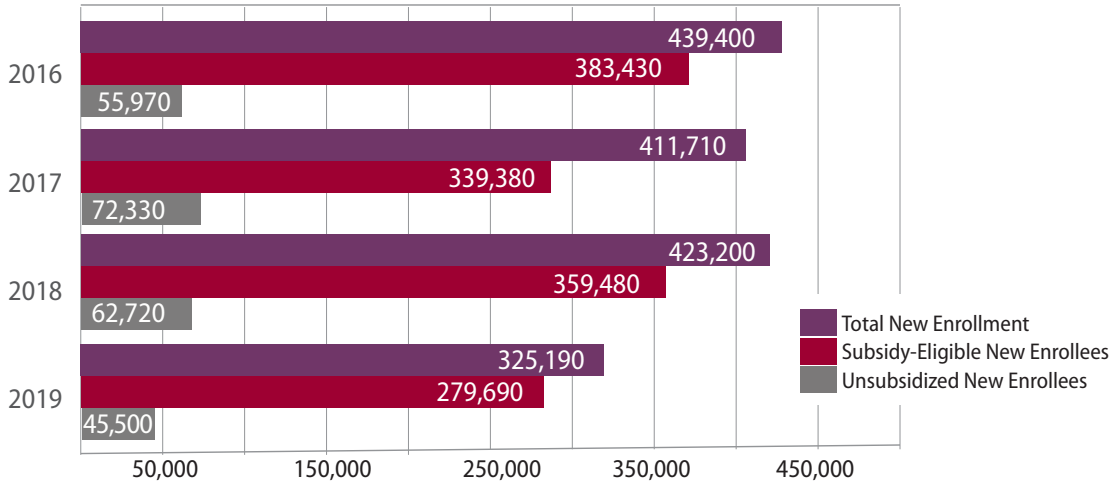
Source: Office of Legislative Research, "Federal and State Individual Mandate Penalties," November 2018 and Dania Palanker, Rachel Schwab, and Justin Giovannelli, "State Efforts to Pass Individual Mandate Requirements Aim to Stabilize Markets and Protect Consumers," June 14, 2018.

State Context

Covered California estimated that the elimination of the individual mandate penalty would increase premiums by 6 percent and reduce enrollment by approximately 12 percent in 2019.[25] A study published in Health Affairs estimated that the elimination of the penalty would negatively impact the recent coverage gains by a substantial margin (about 19 percent of respondents said they would not have purchased coverage in 2017 if there had been no penalty), particularly for those who have historically been less likely to be insured (e.g., those with lower income, lower education, Latinos, younger and healthier people).[26]

Covered California health plans anticipated the impact of eliminating the penalty and submitted higher premiums for 2019; rate increases ranged from 2.5-6 percent, with an average increase of 3.5 percent.[27] Results of the 2019 Covered California open enrollment period suggest that the drop in new enrollment associated with the elimination of the individual mandate tax penalty may be substantially higher than anticipated. According to preliminary data from the 2019 open enrollment, new enrollments dropped 23.7 percent, with new enrollment of subsidy-eligible consumers dropping 22.2 percent (from 359,480 individuals in 2018 to 279,690 in 2017) and unsubsidized new enrollment dropping 28.6 percent (from 63,720 individuals in 2018 to 45,500 in 2017.)[28] (See Figure 7 below.)

Figure 7. Preliminary New Enrollment in Covered California, Open Enrollment Period, 2016-2019



Source: Sources: Covered California, "Covered California 2019 Open Enrollment Early Observations and Analysis," January 30, 2019, see Appendix. Covered California, 2016, 2017 and 2018 Open Enrollment plan selection profile. Chart prepared by Insure the Uninsured Project.

Analysis

UCLA and UC Berkeley researchers estimate that the rate of uninsured Californians will increase without state action to counteract the elimination of the tax penalty.[29] The study projects that between 150,000 and 450,000 more Californians will be uninsured in 2020, growing to between 490,000 and 790,000 more uninsured in 2023, compared to the projected number if the ACA penalty had been maintained. Researchers found that the most substantial enrollment changes will occur in the individual market, where they project enrollment will decline by 10.1 percent in 2020 and 14.4 percent in 2023.

To ensure stability of insurance markets, particularly the individual market, policymakers are considering options to address the enrollment and cost impacts. Options under discussion include:

- Financial incentives for individuals to retain coverage, such as adding state-funded premium assistance for individuals above 400 percent FPL and increased assistance for subsidy-eligible individuals;
- State-specific individual mandate, an approach that is being implemented by Massachusetts, New Jersey, Vermont and the District of Columbia, and being considered by several other states;
- Increased resources for outreach and enrollment; and
- Reinsurance as a cost containment tool. A reinsurance program would provide state funds to protect insurers from high cost claims by covering costs above a certain amount.

In the 2019-20 budget, the Governor proposes a state individual coverage requirement with a financial penalty modeled after the federal tax penalty. The Governor proposes to use the revenues from the tax penalty to fund increased premium assistance in Covered California, as described in more detail in the Affordability section below. The Governor's budget estimates the penalty would raise approximately $500 million in additional state revenues. Pending legislation (Assembly Bill (AB) 414 (Bonta) and Senate Bill (SB) 175 (Pan)) require California residents and their dependents to maintain minimum essential health coverage, as defined, and impose a financial penalty for failure to do so. These bills also require Covered California to determine the penalty and any exemptions from the minimum coverage requirement.

FEDERAL THREAT ISSUE #2:
Litigation to Invalidate the ACA

Overview

There are multiple ACA-related lawsuits that challenge key provisions of the ACA. One of the most high-profile cases is *Texas v. U.S.(Azar)* initiated by the Texas Attorney General (AG) on behalf of 18 Republican AGs and two governors. The case argues that the entire ACA should be overturned since the individual mandate tax penalty is no longer being enforced because of elimination of the tax penalty. This lawsuit relies in part on the 2012 Supreme Court decision to uphold the ACA based on finding that the "individual mandate must be construed as imposing a tax on those who do not have health insurance."[30] In that ruling, The Supreme Court declared the individual mandate penalty a tax and in upholding the individual mandate, reaffirmed Congressional authority to impose taxes including those intended to encourage the purchase of health insurance.

In the lawsuit, the plaintiff AGs and governors are urging the court to overturn the entire health care law now that the individual mandate is no longer being enforced. They argue that when Congress set the penalty for going without coverage at $0 in 2019, Congress rendered the mandate unconstitutional, in light of the 2012 Supreme Court ruling. Finally, if the Court allows the law to stand, Texas still wants the court to rule that guaranteed issue (the requirement that insurers must sell to all regardless of health status) and community rating (which prohibits individual market insurers from pricing policies based on health status) must end because those provisions are linked to the individual mandate and tax penalty.

Federal Context

Although the federal government typically defends existing federal laws, the federal Department of Health and Human Services and the U.S. Department of Justice partially sided with the plaintiffs in *Texas v. U.S. (Azar)*, arguing that guaranteed issue and community rating could not be sustained absent the mandate penalty.

States stepped in. California's AG, Xavier Becerra, is leading a group of 17 Democratic AGs to defend the ACA. On December 14, 2018, the lower court judge hearing the case ruled in favor of the plaintiffs that the ACA is unconstitutional. On January 3, 2019, 16 states and the District of Columbia, led by California's AG, filed a notice of appeal of the December ruling in the U.S. Court of Appeals 5th Circuit in New Orleans; this is the first formal step in advancing a legal challenge to the lower court decision.

In the meantime, a series of ongoing lawsuits are challenging the Trump administration's regulatory initiatives. These have included regulations that encourage the marketing of association health plans that do not comply with ACA individual and small-group requirements, and of short-term limited duration plans that can last nearly a year and be renewed for up to 36 months, but are completely exempt from all ACA consumer protections. Proposed regulations would also allow employers to help finance coverage for their employees in the individual market through health reimbursement arrangements.[31] These provisions, along with lawsuits to reinstate CSR payments to health plans, are pending in federal court.

State Context

As noted above, California's AG is leading states in defending the ACA and led the group appealing the December 2018 district court decision in *Texas v. U.S. (Azar)*. As outlined in the next section, California has also taken steps to respond to many of the regulatory initiatives that are the subject of the federal lawsuits summarized above, with the goal of preventing or reducing the impacts in the state.

The Texas district court judge announced his decision invalidating the ACA in *Texas v. U.S. (Azar)* on the final day of the federal marketplace 2019 open enrollment and during open enrollment for Covered California. Concerned that news accounts of the federal court ruling could confuse or discourage Californians from enrolling, Covered California extended the enrollment deadline for coverage beginning on January 1, 2019, and issued public statements to clarify that the ruling has no effect on ACA coverage at this stage.

Analysis

Many legal scholars, including opponents of the ACA, have concluded that the judge's initial ruling in *Texas v. U.S. (Azar)* will ultimately be overturned.[32] Should the judge's ruling be upheld on appeal , legal scholars believe there is a reasonable chance that the courts would sever (separate) the mandate from the rest of the law.

To date, California leaders have been united in their efforts to actively respond to federal challenges to the ACA and California remains a leader in defending the ACA in court. California is likely to remain in the forefront of the legal challenges to the ACA. Stay tuned.

FEDERAL THREAT ISSUE #3:
Federal Administrative Actions to Undermine the ACA

Overview

The Trump administration has implemented numerous executive and regulatory actions that many observers view as challenges and rollbacks to key ACA consumer protections. There is widespread concern that many of the new rules and proposed changes could undermine the ACA success in dramatically reducing the number of uninsured, both nationally and in California.

A key to sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules.[33] Federal policies that encourage individuals to enroll in coverage not subject to ACA market rules, allow some health plans to potentially attract healthier and younger individuals. For example, short-term policies typically cover fewer benefits and may be a viable option for individuals who consider themselves at low risk of needing health services.

With that backdrop, California has responded swiftly to federal administrative actions by evaluating the impacts for California and, when necessary, enacting state policies or procedures aimed at preserving the coverage gains the state has made under the ACA.

Federal Context

A key to sustainability of health insurance markets is that health plans competing to enroll the same participants must operate under the same rules.[34]

Following passage of the ACA, federal agencies adopted numerous regulations and guidance to define, refine and interpret provisions of the ACA. The ACA regulations and guidance include a significant body of federal administrative rules affecting individual coverage, state exchanges and administration of the federal premium subsidies.

Examples of federal ACA implementation rules include: authorizing states to further define essential health benefits and setting forth the options for states to choose a benchmark plan; defining and clarifying annual and special enrollment periods, guaranteed issue exceptions, the rating factors and methods health plans must use to pool risks, establishing the process and the standards for state exchanges to certify qualified health plans to participate in the exchange, and setting the terms for exchanges to determine eligibility for federal subsidies.

Over the last two years, the federal Administration has reviewed, revised and reinterpreted some existing ACA rules and developed additional policies affecting the individual market, such as efforts to expand short-term policies and association health plans.

Experts are concerned that the combination of policies, including elimination of the federal mandate penalty, will weaken the individual market and state exchanges by encouraging healthier individuals to drop out of ACA coverage, and the associated risk pools, in favor of lower benefit, non-ACA compliant plans. Younger and healthier individuals might also choose to remain uninsured. To the extent that younger and healthier individuals leave coverage, premiums can be expected to rise for those that remain.

State Context

California has responded to federal changes by evaluating the impacts for California and when necessary, enacting state policies or procedures aimed at preserving the coverage gains the state has made under the ACA. Figure 8 highlights specific federal actions and California's response.

Figure 8. California Response to Federal Changes to the ACA

Federal policy	Description	California Response
Curtailing federal marketing and outreach efforts	Federal funds for outreach/advertising and enrollment assistance for the Federally Facilitated Marketplace (FFM) (healthcare.gov) was substantially reduced and the open enrollment period cut in half to 45 days in 2017.[35] The shortened open enrollment period and reduced funds for outreach continued in 2018 and 2019.	Although not directly impacted by changes in the FFM, Covered California increased funding for outreach/ advertising and enrollment assistance following the federal reductions. California also requires combined open and special enrollment periods for the period October 31-January 15. Pending legislation, AB 1309 (Bauer-Kahan) establishes a combined open and special enrollment period of October 15-January 31 starting in 2020.
Eliminating federal funding for CSRs	The ACA requires the federal government to reimburse health plans for the cost of reductions to consumer cost sharing (CSRs). Regardless of the federal contribution, plans are still required to reduce cost sharing for low-income enrollees under the ACA. The President cancelled the payments in October 2017. As a result, health plans increased premiums to cover the costs of the CSRs.	Covered California worked with qualified health plans to impose the CSR "surcharge" on 2018 premiums for silver plans only – the average increase was 12.4 percent and ranged from 8 to 27 percent.[36] This strategy protected individuals enrolling in silver plans who receive a subsidy, since their subsidies increased in parallel with the premiums. Individuals not receiving subsidies could purchase coverage directly from the health plans outside the exchange to avoid paying the CSR surcharge.
Expanding the use of short-term policies and association health plans	The federal government recently expanded the timeframe for which short-term health insurance policies can be offered from 3 to 12 months and authorized renewals, and also issued rules that encourage more association health plans. Short-term policies and association health plans are not required to meet ACA guaranteed issue rules or meet benefit and value standards.	In response to the federal guidance expanding access to these policies, Governor Brown signed Senate Bill (SB) 910 (Hernandez, Chapter 687, Statutes of 2018) that prohibits the sale of short-term policies in California. SB 1375 (Hernandez, Chapter 700, Statutes of 2018) clarifies existing California law that ACA market rules apply even if individuals or small employers join together in an association.
Easing requirements for ACA Section 1332 Waivers	Section 1332 of the ACA authorizes states to waive certain ACA provisions so long as the waiver meets specific criteria, or 'guardrails,' including guarantee that people retain access to coverage that is at least as comprehensive and affordable as without the waiver, covers as many individuals and is deficit neutral to the federal government.[37] In October 2018, the federal Centers for Medicare & Medicaid Services (CMS) issued guidance easing requirements, including guardrail protections, for states interested in Section 1332 waivers.	The recent federal guidance expanding the ability of states to secure Section 1332 waivers can be used by states seeking to roll back coverage requirements of the ACA. Pending California legislation, AB 1063 (Petrie-Norris) would hold Covered California to the higher Section 1332 waiver standards outlined in the ACA should the state seek a 1332 waiver in the future.

The Chilling Effect of Public Charge. In addition to federal health reform changes, proposed changes to federal immigration policy may also be having an impact on Covered California enrollment. The federal policy related to "public charge" is one of several factors affecting an individual's application to become a legal permanent resident. A new proposed federal rule would broaden the definition of public charge. (See ITUP public comments on the proposed rule for more information.)

Recent research estimates that the proposed rule is likely to increase the number of uninsured, as immigrants shy away from public programs even if they are eligible under federal law. For example, even though the health programs proposed to be added in a public charge determination do not include receiving financial help for marketplace coverage under the ACA, the federal changes may be having a chilling effect on Covered California's new enrollment.

According to the recently published Covered California Analysis, the most significant decline in new sign-ups for 2019 was in Korean, Spanish and Mandarin speakers, the largest limited English-speaking groups in Covered California. Compared to the 21.7 percent drop in 2019 new enrollments among English-speakers, Mandarin speakers dropped by 28 percent, Spanish speakers by 29 percent and Korean speakers by 46 percent.[38] Therefore, it is possible that some individuals who are legally eligible for coverage, including subsidies, are hesitant to engage with public programs out of fear, confusion or concerns related to other family members who might be seeking or will seek a change in legal status.

Figure 9. Primary Language of Covered California Enrollees

Open Enrollment, 2016 - 2019				
	2016	2017	2018	2019
Korean	5,330	3,790	4,320	2,320
Mandarin	7,780	8,280	11,690	8,450
Spanish	48,930	41,350	41,360	29,280
English	333,770	317,350	349,590	273,900

Source: Covered California, Covered California 2019 Open Enrollment Early Observations and Analysis, January 2019. Covered California, 2016, 2017 and 2018 Open Enrollment Plan Selection Profile, February 2016, 2017 and 2018. Table prepared by Insure the Uninsured Project.

Analysis

State policymakers will need to continue to track and respond to federal administrative actions and evaluate the potential impacts on health coverage and care in the state. California solutions will likely require a combination of executive, legislative, and administrative branch efforts, similar to the California response to date.

III. Affordability of Individual Coverage

The affordability of premiums in the individual market and any resulting impacts on enrollment are ongoing concerns. The average unsubsidized premium in Covered California for 2019 is estimated to be over $6,500 and many pay more, especially older enrollees and those in high cost areas. The impacts on individual premiums from various federal strategies to alter the ACA are beginning to materialize, but the full extent of the impact is unknown. Health plans often respond to uncertainty in the marketplace by increasing rates, which would exacerbate concerns about affordability.

Before Congress reduced the federal individual mandate penalty to $0 starting in 2019, taxpayers could avoid the penalty for being uninsured if the only coverage available to them was unaffordable, defined for this purpose as more than 8.16 percent of the taxpayer's income. UC Berkeley Labor Center estimates that in 2017 hundreds of thousands of Californians over the 400 percent FPL, and therefore ineligible for federal subsidies, spent more than 8.16 percent of their income on premiums for coverage in the individual market.[39]

AFFORDABILITY ISSUE #1: *Limitations of ACA Subsidies*

Overview

Affordability is the main reason subsidy-eligible and unsubsidized Californians do not participate in the individual market.[40] According to 2017 California Health Interview Survey data, 37.3 percent of individual market consumers found it "very difficult" to find an affordable plan through Covered California and an additional 23.8 percent found it "somewhat difficult" to find an affordable plan.[41] Outside the exchange, 46.5 percent of individual market consumers found it "very difficult" to find an affordable plan.[42]

As of September 2018, 62 percent of Covered California enrollees qualified for CSRs based on income, and of these individuals 71 percent enrolled in a silver plan with CSRs.[43] In that month, 88 percent of Covered California enrollees were eligible for premium assistance and the remaining enrollees (156,330 individuals) paid the full cost of coverage.[44] Most unsubsidized individual market enrollees (almost 1 million in 2017) secure coverage outside the exchange.

Federal Context

As described above, ACA marketplace subsidies include premium tax credits and CSRs, depending on family income relative to the FPL. ACA premium assistance works by capping the amount of a household's income an individual or family must spend on marketplace plan premiums for coverage under the state's "benchmark" plan. The benchmark plan used for calculating subsidy levels is the second lowest cost silver tier plan available to the consumer in their region. (See Figure 10.)

Figure 10. Premium Contribution Cap by Income in 2019

Income: % Poverty	2019 Premium Contribution Cap Max % of income for 2nd lowest silver plan in the region
Under 100% FPL	No Cap
100% - 133% FPL	2.08% of household income
133% - 150% FPL	3.11 – 4.15% of household income
150% - 200% FPL	4.15 – 6.54% of household income
200% - 250% FPL	6.54 – 8.36% of household income
250% - 300% FPL	8.36 – 9.86% of household income
300% - 400% FPL	9.86% of household income
Over 400% FPL	No Cap

Source: Kaiser Family Foundation, "Explaining Health Care Reform: Questions about Health Insurance Subsidies," November 2018.

Although premium assistance will adjust based on the benchmark plan in any given region, premium assistance does not adjust for other geographic differences, such as the costs of non-health related living expenses. This means that ACA premium assistance has a greater impact for individuals living in lower cost communities and helps them to afford coverage. For individuals living in higher cost communities, ACA subsidies are often inadequate to make health coverage affordable, given the other high costs they experience, such as housing.

State Context

California's high cost of living limits the effectiveness of subsidies in supporting individual market consumers afford coverage. Using the California Poverty Measure, an unofficial measure that accounts for cost of living and a range of family needs, the UC Berkeley Labor Center found the upper eligibility limit for ACA premium subsidies, 400 percent FPL, is equivalent to approximately 500 percent FPL statewide in California, and still higher in high-cost regions like San Francisco.[45] In 2018, with the exception of those living in Hawaii, in general, Californians spent more on living expenses when compared the rest of the nation.[46] The amount of disposable income Californians have to afford individual market coverage is impacted by California's high cost of living.

California is considering various policy options to address affordability concerns and in one of the highest cost counties in the state, county leadership has already adopted an affordability strategy. SF Covered Medical Reimbursement Account (SFCovered MRA) offers premium subsidies to certain San Francisco workers with incomes under 500 percent FPL who purchase coverage through Covered California. Enrollees in the program pay 40 percent of the Covered California premiums, with the remainder subsidized by the program.[47]

In 2018, several bills were introduced to address affordability in Covered California but failed passage. The Legislature also considered, but did not adopt, a budget augmentation of $150 million General Fund in 2018-19 and $300 million ongoing for state premium assistance in Covered California. The SFY 2018-19 budget trailer bill (AB 1810, Chapter 34, Statutes of 2018) does direct Covered California to form a workgroup and submit a report on options to address affordability.

Covered California Affordability Workgroup. The 2018-19 budget trailer bill directs Covered California to develop options for administering financial assistance for low- and middle-income Californians to help them access affordable coverage. Legislative language tasks Covered California with exploring assistance options for low-income individuals spending significant amounts of their household income on coverage, even with federal financial assistance, and for individuals with incomes up to 600 percent FPL ineligible for federal assistance. Covered California provided the report to the Legislature and the Governor on February 1, 2019.

The report considered the following policy options to address the cost burdens faced by individual market consumers:

- Premium subsidies: These options reduce the ACA's income-based premium contribution cap for individuals currently eligible for federal premium tax credits up to 400 percent FPL or extend the contribution cap to higher income levels, or both.
- Cost-sharing subsidies: These options enhance the value of cost-sharing subsidies for currently eligible individuals up to 250 percent FPL or extend eligibility for cost-sharing subsidies to individuals up to 400 percent FPL, or both.
- Individual mandate penalty: This option models the impact of a reinstatement of an individual mandate penalty.
- Reinsurance: This option models the impact of a reinsurance program. A reinsurance program would provide state funds to protect insurers from high cost claims by covering costs above a certain amount.

According to the modeling for the Covered California study, implementation of one or more of these policy options would add between 27,000 and up to 478,000 consumers to the individual market at a cost of $215 million to more than $1 billion. Some of the policy options would generate hundreds of millions in revenue, which could offset costs. For example, the reinstatement of the individual mandate penalty would generate an estimated $482 million in penalty revenue.

2019-20 Legislative Session and the Proposed State Fiscal Year (SFY) 2019-20 Budget. Legislation has been introduced in the current legislative session to provide additional financial assistance for low- and moderate-income Californians to afford health insurance in Covered California. See SB 65 (Pan) and AB 174 (Wood). The proposed SFY 2019-20 budget builds on and expands the ACA premium subsidies for individual coverage in Covered California. In presenting the proposed budget, Governor Newsom said the state-specific individual mandate penalty, discussed above, would raise approximately $500 million in additional state revenues. The budget proposes using the new revenues to expand premium subsidies for those between 250-400 percent FPL and for new state subsidies for individuals between 400-600 percent FPL (up to $72,840 for individuals and $150,600 for a family of four).

Analysis

California's high cost of living limits the effectiveness of subsidies and makes affordability challenging for many individual market consumers even with federal financial assistance. The challenge is still greater for individuals who must bear the entire cost of premiums and cost sharing without the assistance of subsidies.

The ACA recognized the need for financial assistance but also included exemptions from the individual mandate penalty if affordable coverage is unavailable. California took every opportunity available in the ACA and in many instances, went beyond what is required, making coverage possible for millions of Californians. However, in 2020, an estimated 1.2 million Californians eligible for individual coverage will instead be uninsured unless California does more to support affordability.[48]

The individual market, and coverage through Covered California, are not isolated from the overall high costs of health care and coverage. In addition to specific proposals to increase financial assistance, policymakers are considering strategies to address the underlying costs of health care. These efforts are an essential component of improving affordability.

AFFORDABILITY ISSUE #2: *Plan Choice in the Individual Market*

Overview

The number of health plans available to an individual market consumer impacts affordability by reducing competition. In general, regions with a higher number of plans competing for consumers have more affordable plan options when compared to regions with limited plan choice.

Federal Context

Since implementation of the ACA, the number of health plan options available (plan choice) decreased significantly for consumers participating in the FFM. From 2016 to 2019, the number of insurers in the FFM dropped by a third and the percent of consumers with only one plan to choose from increased from 2 in 100 in 2016 to 20 in 100 consumers by 2019. In 2016, Wyoming was the only state with just one insurer statewide. In subsequent years, four to seven additional states offered only one insurer. Nationally, off-exchange-only plans decreased by half from 2017 to 2018.[49]

Figure 11. Plan Choice in HealthCare.gov

Year	Insurers in HealthCare.gov	Other States with Only 1 Insurer Statewide	% of Consumers Limited to 1 Plan Choice
2016	232	Wyoming	2%
2017	167	Alaska, Alabama, Oklahoma, South Carolina, Wyoming	20%
2018	132	Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming	29%
2019	155	Alaska, Delaware, Mississippi, Nebraska, and Wyoming	20%

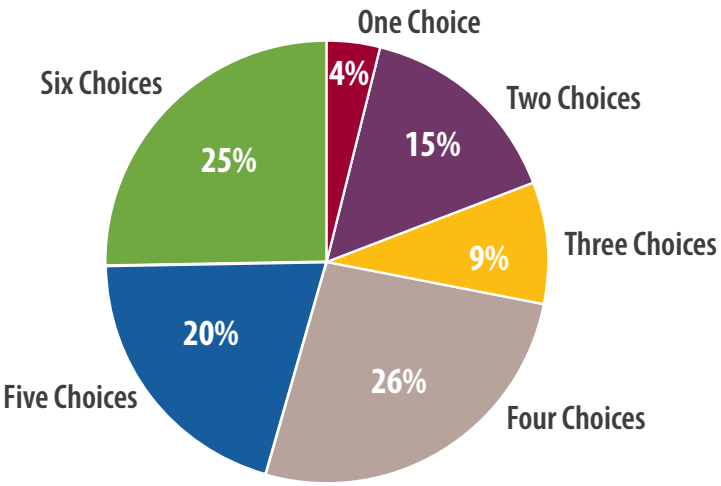
Source: Office of the Assistant Secretary for Planning and Evaluation, "2016, 2017, 2018 and 2019 Health Plan Choice and Premiums in the Federal Health Insurance Exchange," U.S. Department of Health & Human Services, obtained in February 2019.

State Context

In the last three years, the same 11 insurers have participated in Covered California but many offer coverage in just a few regions of the state. Covered California reported that for plan year 2019, 96 percent of consumers had the choice of at least two health plans.[50] A recent analysis by the California Health Care Foundation showed that, for 2019, there was only one health plan choice for about 63,250 enrollees in several counties (the majority in Monterey, Santa Barbara and San Luis Obispo Counties) representing 4 percent of total enrollment, and another 219,270 enrollees who had two health plan choices, representing 15 percent of total enrollment . (See Figure 12.)

In California, the number of plans off-exchange decreased in most counties from 2017 to 2018.[51] In 2018, the number of plans stayed the same in six counties (Merced, Placer, Sacramento, Sutter, Tulare and Yolo) and increased in only two Central Valley counties (San Joaquin and Stanislaus) when compared to the prior year.[52]

Figure 12. Covered California Enrollees - Number of Health Plan Choices Available in 2019



Source: Katherine Wilson, *Plan Choice for Covered California Consumers, 2017 - 2019*, California Health Care Foundation, February 27, 2019.

Analysis

Although the majority of Californians have a choice of two or more health plans in Covered California and the outside market, policymakers continue to be concerned about regions where there is limited plan choice. From the early days of ACA implementation, California recognized the importance of choice, empowering and requiring Covered California to develop a competitive health plan selection process that would provide health care choices that offer the optimal combination of choice, value, quality and service.

Multiple factors likely lead to limited plan choice. Health professional shortages, sparsely populated communities and historical health care markets have resulted in limited health plan and provider coverage in areas of the state for decades. Some experts argue that there are regions that will never be able to support more than one or a very few plans operating at an efficient scale, typically characterized by small populations, large geographic areas and a limited number of providers.[53] Since competition and the number of health plan choices can impact both affordability and quality, it is important to develop a deeper understanding of the factors at play in the specific areas of concern in the state. Additional research and analysis would be helpful to determine the causes and to identify potential policy solutions.

Another option that policymakers and stakeholders are exploring is whether the state can (or should) adopt a form of public option, similar to proposals Congress rejected in the lead up to the ACA. Advocates for public plan choice promote it as a publicly insured plan that would be offered in direct competition with other options for private health insurance coverage, with the hope that the features of a publicly sponsored option, and the competition it would bring to markets, will drive down both premiums and underlying health care costs. For an analysis of public plan options in California, see the ITUP Issue Brief, Exploring Public Options in California.

IV. The Future of the Individual Market

Individual coverage is for most people a last resort. Absent financial assistance, they must pay the full premium and cost sharing for their coverage, unlike job-based coverage where employers contribute to the payment of premiums. For this reason, affordability and strategies that encourage individuals to sign-up are especially critical in the individual market.

Prior to the ACA, individual coverage was expensive, often with very limited benefits and high out-of-pocket costs. Health plans selling individual policies routinely denied coverage or hiked premiums based on an applicant's health status or medical history or imposed coverage exclusions for pre-existing health conditions.

The ACA fundamentally changed the individual market by removing barriers to coverage, setting minimum standards for coverage and funding federal subsidies for the purchase of individual coverage through state-based exchanges.

California enacted legislation to conform with the ACA and in many instances enacted policies that exceed ACA requirements. California became the first state to create a state-based ACA exchange, and Covered California is now the largest state-based exchange in the nation.

The future challenges facing the individual market include federal threats to the ACA, including many of the reforms that improved individual coverage as a viable option for those with no other source of health coverage, and ongoing concerns about affordability. Affordability continues to be a significant barrier to obtaining individual coverage for many Californians, including many who are eligible for federal subsidies.

Since the early days of ACA implementation in California, state policymakers have embraced and extended ACA reforms, including those affecting individual coverage. This issue brief highlights future issues the state will face in ensuring a viable individual market and state exchange into the future.

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About ITUP

Insure the Uninsured Project (ITUP) is a Sacramento-based nonprofit health policy institute that for more than two decades has provided expert analysis and facilitated convenings for California policymakers and decisionmakers focused on health reform.

The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of Californians, through policy-focused research and broad-based stakeholder engagement.

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