

without health insurance in 2013 to a historic low of 8.6% in 2015.⁴ In California, the uninsured rate dropped across all racial and ethnic groups. Significantly, the greatest gains in health insurance coverage were seen among Latinos; the number of uninsured among non-senior California Latinos fell by 1.5 million, representing a decrease in the uninsured rate from 23% to 12%.⁵

Health insurance coverage saves lives. Because of the Affordable Care Act, significantly fewer Californians cite cost as a reason to forego health care.⁶ Repeal of the ACA would expose Californians, including those who receive health insurance coverage through their employer, to the specter of medical bankruptcy, as annual and lifetime limits would again be imposed on their insurance coverage. Californians with employer-based and individual market coverage would lose access to free preventative health care, which has helped so many people stay healthy. Access to preventative care would be undermined by the imposition of significant deductibles and other out-of-pocket costs. Without the Affordable Care Act, insurers can increase profits and administrative costs, reducing the premium dollars spent on actual medical care. With repeal, children would no longer be able to stay on their parents' insurance policies until the age of 26.

Health care should be a right. The repeal of the ACA would return Californians and our country to a disgraceful past, where people who need health insurance the most, people with preexisting conditions, would be denied coverage, or charged unaffordable premiums, simply because of their health history. Allowing health insurers to deny coverage to people with preexisting conditions abandons these Californians who need health care the most. Further, quarantining those with preexisting conditions into high-risk pools doesn't work: experience with high-risk pools shows that persons trapped in such pools are quickly subject to waiting lists, limited coverage, high premiums, and benefit caps. Repeal of the Affordable Care Act and permitting exclusion or sequestration of those with a history of illness, also has an adverse effect on the economy, as persons with preexisting conditions suffer "job lock," where they are reluctant to leave their existing jobs, or to strike out on their own and start a new company, because of fear that new coverage will be denied in the new job because of their health history. Similarly, with repeal of the ACA, parents of young adults with preexisting conditions would again face the fear that their children would be unable to obtain health insurance once they are too old to be covered under their parent's insurance policy.

Californians and all Americans must not be forced back to a time before the ACA when health insurance could be denied based on preexisting conditions, policies were rescinded when people fell ill, benefit packages failed to cover many essential health benefits, and there were annual and lifetime limits on coverage. Before the Affordable Care Act, health insurers could prevent people from having coverage when they needed it most. Repeal of the ACA is the return to a time when the shadow of financial catastrophe loomed over every family.

"Repeal and replace" will undo the tremendous progress we have made in reducing the number of uninsured by half, both nationally and in California. For the 20 million Americans who gained health insurance coverage thanks to the Affordable Care Act and for all Americans whose health insurance was strengthened by the consumer protections of the ACA, "repeal and replace" means death or despair.⁷

With "repeal and replace" there is no soft landing. Even "repeal and delay" creates market uncertainty that would likely result in market collapse.⁸ California went all-in with implementing the ACA to insure the maximum number of people possible. However, without ongoing federal financial assistance as provided under the Affordable Care Act, for Medicaid and other existing health programs, California lacks the financial capacity to backfill cuts to these programs.

In order to answer the questions from your letter, I am providing the following information about actions California has taken to implement the ACA, actions the Congress could take to further ACA goals of quality and affordable coverage for all, and actions the Congress should not take because they would harm Americans or the stability of the health insurance market.

The Expansion of Medi-Cal Benefitted California Workers and Their Families

Because of the expansion of Medi-Cal (California's Medicaid program) authorized by the Affordable Care Act, 3.7 million more newly eligible Californians have coverage and enrollment of previously eligible Californians has grown.⁹

Medi-Cal provides vital health coverage throughout California, but particularly to people in rural areas. For instance, 55% of the residents of Tulare County rely on Medi-Cal; 45.1% of the residents of Kern County depend on Medi-Cal.¹⁰ From San Joaquin to Kern Counties, approximately 400,000 individuals enrolled in Medi-Cal after its expansion through the Affordable Care Act.¹¹ Expanded Medi-Cal provides vital support to hard working Californians: for instance in the San Joaquin Valley, 19.4% of full-time and 15.5% of part-time workers rely upon Medi-Cal for coverage.¹² Repealing the ACA will ultimately mean the loss of the Medi-Cal coverage these Californians rely upon to keep their families healthy.

Today, more than 13 million Californians are enrolled in the Medi-Cal program.¹³ One in three Californians, including a majority of our children and 2/3 of nursing home residents are covered by Medi-Cal.^{14 15 16} The Medicaid expansion in the Affordable Care Act is responsible for much of the reduction in the uninsured population nationally and in California. Anything the Congress does to remove the existing Medicaid funding guarantee, through caps, block granting, reduction in federal share of cost, elimination of expanded eligibility or any other means, threatens the health insurance coverage of more than 13 million Californians and nearly 73 million Americans.¹⁷

California's Health Benefit Exchange Made Coverage More Affordable and Accessible for Over One Million Californians

California's Health Benefit Exchange, Covered California, has been a marketplace for vital coverage and financial assistance for Californians who obtain their health insurance coverage in the individual market. Generally the individuals acquiring coverage through Covered California are those whose income makes them ineligible to receive Medi-Cal, but whose incomes are not high enough to afford health insurance coverage without financial assistance.

As of March of 2016 Covered California had 1,415,428 individuals enrolled in coverage, with 1,239,893 (88%) of those individuals receiving premium assistance.¹⁸ In addition, 707,671 (50%) of those individuals received cost-sharing reductions.¹⁹ The percentage of individuals receiving premium assistance is even higher in certain parts of the state. For instance, in 2014, 18,083 Kern County residents obtained health insurance through Covered California; over 90% of these residents (16,385) received premium assistance through the Affordable Care Act.²⁰ Similarly, in Tulare County, 96% of residents receiving coverage through Covered California receive premium subsidies.²¹ Replacing the premium subsidy with a tax credit that many of these families won't qualify for, while others receive less financial support than they do today, will put health insurance out of reach for most of the 1.2 million people currently receiving the premium subsidy. Repealing the ACA will make health insurance unaffordable for these individuals. And if the more than 1.2 million people receiving premium subsidies can no longer afford coverage due to repeal of the ACA, insurers may respond to the dramatic shrinking of the individual market by refusing to sell in the individual market at all.

California's Implementation of the ACA Market Reforms

Californians with private health insurance coverage, whether through Covered California, the individual market, or their employer, benefit from a myriad of consumer protections implemented by the ACA. California has adopted most of the reforms provided to California's consumers by the ACA into state law. Upon repeal of the ACA, Californians will lose many protections they now rely upon. Many ACA reforms in state law are directly dependent on the federal individual mandate. The following reforms all work hand in hand, and they will be lost if the mandate for coverage is repealed:

Guaranteed availability of coverage: If the individual mandate is repealed, insurers in California in the individual market will be able to deny coverage based upon the health status of an individual. This was a concern for people before the adoption of the ACA, and a reality for many Californians.²² Based upon a conservative estimate, 24% of California's non-elderly adult population has a preexisting condition that would have been a basis to decline coverage prior to the adoption of the ACA.²³ However, under current law insurers are required to fairly and affirmatively market and sell all health insurance plans to all individuals and dependents seeking coverage. Repealing the mandate will mean that insurers can pick and choose who receives coverage, denying coverage to the sickest individuals. This will be a major step backwards for Californians.

Prohibition against health status underwriting and rating reforms: If the individual mandate is repealed, insurers in the individual market in California will be able to revert to pre-ACA practices, which include allowing insurers to underwrite based upon the health status of an individual. Insurers will be able to use this information to deny coverage, or charge a higher premium.

Preexisting condition exclusions: Before the adoption of the ACA insurers in the individual market could exclude coverage for an individual's preexisting condition, if that person did not

have continuous coverage during the previous 18 months. California law allowed insurers to have preexisting condition exclusions of up to one year. During this time period, insurers were allowed to avoid covering the condition for which insurance was sought, forcing sick people to pay for all costs for their condition out-of-pocket. If the individual mandate is repealed, insurers will be permitted to reinstitute this egregious practice.

It is unfathomable that Congress would vote to allow insurers to restore these practices, but that will be the impact of a repeal. In addition, the following important benefits afforded to individuals by the ACA will be lost to Californians if the ACA is repealed:

Preventative Care without cost-sharing: As stated previously, preventative care without patient cost sharing increases the likelihood that these services will be used. Preventative services are intended to either prevent disease in the future, or detect diseases early on when they are easier and less costly to treat.

One example of the critical importance of the ACA's requirement that preventative care be provided without cost sharing is in the area of prenatal care. Access to routine prenatal care, the leading contributor to healthy pregnancies and healthy newborns, has dramatically expanded under the ACA. The ACA classifies routine prenatal care as preventative care that must be provided with no cost sharing for the patient. Prior to the ACA, the average total cost for prenatal care throughout a typical pregnancy was about \$2,000.²⁴ This figure includes about 12 doctors' visits at \$100 to \$200 each, as well as routine blood tests, urinalysis and at least one ultrasound.²⁵ Before the adoption of the ACA expectant mothers may not have had the monetary resources necessary to pay for both prenatal care, and the cost of delivery and newborn care, which can reach an additional \$12,000.²⁶ The ACA spared expectant mothers from having to make the hard choice of avoiding prenatal care. However, repeal of the requirement that insurers provide preventative care at no cost will mean that low-income expectant mothers may be forced to choose which preventative services they receive based upon the cost of those services. The impact on the health of the mother, and her child, may be grave, and may increase later costs for serious complications which could have been preventative.

In addition, preventative services such as screening pregnant women for gestational diabetes are cost-effective. Screening for gestational diabetes permits identification and treatment, and helps improve the health of mothers and babies. Controlling and monitoring gestational diabetes is important for the mother and child. Women with gestational diabetes have an increased risk of type 2 diabetes²⁷ and due to increased child size, a higher risk of caesarian delivery.²⁸ After birth, the baby is at higher risk for child obesity.²⁹ By testing for gestational diabetes early in pregnancy and focusing on treating that condition, the long term costlier risks can be minimized or eliminated.

Essential Health Benefits (EHB): In the individual and small group markets the ACA requires insurers to provide essential health benefits in health insurance policies. Should the EHB requirement under federal law be repealed, California's law will become inoperative. The essential health benefits provisions of the ACA include many important protections. However, if

the federal EHB statute is repealed, California's insurers will no longer be required to cover essential benefits, such as prescription drugs or habilitative services, nor adhere to mental health parity requirements, to name a few.

Many Californians rely upon prescription drug coverage on a daily basis. People with hemophilia or those who have had organ transplants need prescription drugs to survive. People with chronic conditions like HIV and autoimmune diseases need medication to keep their disease at bay. At the same time prescription drug costs are one of the biggest drivers of rate increases across the country. If insurers are not required to cover prescription drugs, they may simply choose to stop providing this benefit, forcing individuals to pay for coverage out-of-pocket. However, without coverage, individuals will likely forego adhering to their treatment regime due to the high cost of prescription drugs, ultimately leading to costlier medical issues down the road.

Another benefit that will be lost if the essential health benefits provision of the ACA is repealed is the requirement that insurers cover habilitative services at the same level as rehabilitative services. While rehabilitative services are intended for individuals who have lost a skill, habilitative services are necessary for those who never acquired those skills, such as children who suffer a catastrophic brain injury at birth.

Before the ACA many insurers covered a service if it was considered rehabilitative, but would not cover the same service if it was considered to be habilitative. For example, prior to the ACA an insurer could offer rehabilitative services to restore speech to someone who had lost the ability to speak, but could deny the same service to a disabled child who had never learned to speak. The ACA imposed requirements forbidding insurers from discriminating against these children. Further, prior to the ACA there was no requirement that insurers cover therapy for children with developmental delays or teach a child with a chronic condition how to walk.³⁰ The addition of habilitative services as an ACA-required essential health benefit ensured that children had access to these services.

Mental Health Parity: Parity of coverage and cost sharing for mental health care services was expanded to the individual and small group markets by the essential health benefits requirements of the ACA. These same ACA requirements also mandated coverage of outpatient and inpatient mental health care services for the small group markets. Prior to the ACA, the Mental Health Parity and Addiction Equity Act only applied to the large group market. Even then, it only required parity with medical and surgical service *if* a plan covered mental health or substance use disorder services. It did not mandate coverage of mental health services: only the ACA did that. Congress recently reaffirmed its commitment to mental health care by passing the 21st Century Cures Act with bipartisan support. Repeal of the ACA and its essential health benefits requirements would leave millions of vulnerable Americans without access to mental health and substance use disorder services, putting their lives and the lives of others at immediate risk. Further, the ACA rules relating to coverage of mental health and substance abuse disorders has been touted as a major step to help curb gun violence in this country.³¹ Congress cannot turn its back on the steps made towards curbing this epidemic.

Annual and Lifetime Limits: The prohibition on annual and lifetime limits ensures that insurance is there when someone faces a catastrophic health care need and protects families from medical bankruptcy, which was a common cause of bankruptcy prior to the passage of the ACA. If the prohibition against annual and lifetime limits is repealed, insurers will be able to impose these limits upon Californians. Repeal of the ACA will hurt those that need medical coverage the most: those with chronic conditions, those with terminal illnesses, and those who need life-saving surgeries.³²

Medical Loss Ratio (MLR): The MLR requirement requires insurers to spend at least 80% of premium on health coverages. Without this ACA requirement insurers will be able to spend less premium dollars on actual health coverage, and more on administrative costs.

In addition, many ACA protections found in state law are so intertwined with the federal requirements or rely so heavily upon federal regulations, that a repeal of those federal requirements under the ACA would make the remaining parts of the state statute untenable. These laws range from limits on deductibles and out-of-pocket expenditures to consumer disclosure requirements. If the Affordable Care Act is shattered, as you are proposing, California won't be able to pick up the pieces.

The magnitude of the positive impact of the ACA reforms is profound. The U.S. Department of Health and Human Services determined that:

Compared to pre-ACA coverage, 12,092,000 Californians are no longer threatened by lifetime limits on their health insurance coverage.³³

An estimated 294,000 young adults have benefitted from the ability to stay on their parents' health insurance to age 26.³⁴

Expansion of preventative care has improved the health of 15,867,909 Californians, through access to flu shots, cancer screenings, mammograms, and tobacco cessation services at no cost.³⁵

The implementation of the Medical Loss Ratio (MLR), which requires insurers to spend at least 80% of their premiums on coverage, has returned \$124,910,743 in insurance refunds to Californians who receive coverage through their employers.³⁶

In addition, the impact of repeal will fall on those who need the most help. For instance, repeal of the ACA will certainly impact individuals with developmental disabilities. The UCLA Center for Health Policy Research has found that:

The ACA has greatly improved access to health services for all Californians and includes important provisions for individuals with developmental disabilities. The biggest change in benefits can be seen for individuals with developmental disabilities who do not qualify for [Regional Center] services. Behavioral health and habilitative services are included in

California's essential health benefits (EHB) benchmark plan. ... Significantly, under the ACA, insurers are no longer allowed to deny coverage or to rescind it based on preexisting conditions, an issue that significantly affected the ability of individuals with disabilities to find affordable coverage prior to passage of the ACA. Other benefits that may be particularly important for the developmentally disabled population include a ban on lifetime and annual limits and new standardized EHBs, which include rehabilitative services and devices. Furthermore, Senate Bill 946, passed in 2011, compels insurers to cover autism-specific services as outlined in the ACA's behavioral health requirements.³⁷

Working class families with children with developmental delays rely upon these reforms to provide coverage for their children. In addition, the chronically ill rely upon the ACA to ensure that they have prescription drug coverage. Thanks to the ACA people don't live in fear of annual and lifetime limits. Women rely upon the ACA for access birth control and maternity coverage and to prevent coverage from being unaffordable through gender rating that was permitted prior to the passage of the ACA. Individuals with mental health conditions rely upon the ACA for access to care. Individuals born with disabilities rely upon the ACA for habilitative services.

Repealing the ACA will mean that these and other consumer protections provided by the ACA will be lost to tens of millions of Californians. The Affordable Care Act has unquestionably improved access to care for Californians. This improved access to care results in better health outcomes.

Moreover, in addition to these health benefits for Californians, the Affordable Care Act has improved California's economy. The University of California has projected that repeal of the Affordable Care Act will result in net economic losses to California that include 209,000 lost jobs, \$20.3 billion in lost state GDP, and \$1.5 billion in lost state and local tax revenue.³⁸

Potential Congressional Action: Market Disruption, Loss of Coverage, Loss of Jobs, Loss of Hope

Before I address in further detail the potential legislative action by Congress, I must first comment on what the House of Representatives should do now as a litigant regarding the Affordable Care Act. I urge the House leadership to maintain stability in the market by withdrawing its pending lawsuit in *House v. Burwell*.³⁹ Continuing to utilize litigation to address the issues of executive and Congressional power pertaining to budget allocation of cost sharing reduction payments could needlessly expose Californians and all Americans to immediate withdrawal of the financial support on which they depend to access needed medical care.

A court decision in *House v. Burwell* in favor of House leadership could result in immediate cessation of care and bankruptcy for Californians, destabilization of the health insurance market, and withdrawal of insurers from California's market. I urge the House leadership to maintain stability in the market by withdrawing this lawsuit. If the House were to prevail in this lawsuit, immediately destroying the cost-sharing reduction that many Californians now depend upon, marketplace chaos will result; the individual health insurance market would likely collapse.⁴⁰

While health insurers may temporarily have no choice but to provide the cost-sharing reductions that would be suddenly unfunded as a result of the House leadership's litigation, such unanticipated losses could drive some insurers into insolvency or near insolvency, unless they withdraw from the market, depriving Californians of choice and coverage.⁴¹ For those insurers who remained solvent and remained in the market, premiums would spike in 2018 due to these losses, and because of increased utilization as desperate customers accelerate care before they must drop coverage made suddenly unaffordable due to the House's litigation. Those health insurers that remain solvent could also simply withdraw from the individual market, leaving individuals without any coverage.

An attempt to vindicate the position of the leadership of the House of Representatives regarding executive power should not be pursued at the expense of the health and financial security of Californians and all Americans. The issue in *House v. Burwell* is whether the Congress appropriated funds for the cost-sharing reductions authorized by the Affordable Care Act. Millions of Americans now rely on these funds to make health coverage affordable. The immediate stability of the insurance market also relies on these funds. If you believe the President acted beyond his authority, then appropriate the funds necessary for the cost-sharing reduction payments and move on.

Proposals That are Detrimental to the California Health Insurance Market: Selling Across State Lines

A number of other policy proposals would be detrimental to the health insurance market and to the Californians who rely on that market for their health coverage. President-Elect Trump and others have proposed allowing insurers to sell across state lines. In fact, insurers can already sell across state lines. They just have to comply with the rules of the states they sell in, which is consistent with the principle of "state's rights," where each state prescribes laws that best meet the needs of that state as decided by the state legislature and governor.

What is now being proposed is that insurers be allowed to sell across state lines without having to comply with the laws of the state in which they sell. Instead, it is proposed that the insurer would only have to comply with the laws of the state in which it is incorporated or "domiciled." This change in the long standing existing state based regulatory approach would be very harmful to consumers and ought to be rejected. This proposal infringes upon states' rights and undermines state regulatory authority, stranding consumers with only illusory coverage, without recourse to effective consumer protection and assistance from their state legislature and state insurance department. The non-partisan National Association of Insurance Commissioners (NAIC) has expressed strong objections to proposals to allow the sales of insurance across state lines without complying with state laws in the state in which insurance is sold. The NAIC appropriately noted that one of the major causes of the recent financial crisis was due to the ability of banks to choose their regulator, and that "interstate sales of insurance will allow insurers to choose their regulator, the very dynamic that led to the financial collapse."⁴²

Each state has different consumer protections and benefits in place, which have been enacted by the state's legislature and Governor to protect the consumers in that state. If cross-border sales are permitted without complying with state laws, it would promote a "race to the bottom," where insurers choose to incorporate in the state with the weakest laws and requirements providing the fewest benefits and skimpiest consumer protections, and then selling those products to consumers in other states regardless of those state's laws.

Cross-border sales without meeting state consumer protections create undisclosed risks for consumers. Were an insurer licensed only in another state able to sell in California without complying with California law, such an insurer could operate without complying with California's solvency laws, which ensure that insurers are fiscally sound. That insurer would not participate in California's guarantee association, which provides coverage of claims for policyholders in the event of an insurer insolvency. This would expose Californians to the risk of the insolvency of these out-of-state insurers, leaving them without access to medical treatment and without recourse for payment of medical bills. Furthermore, California would be unable to enforce its requirements that health insurers have adequate medical provider networks to give individuals meaningful health insurance coverage. California's health coverage regulators would be unable to help consumers with claims disputes, as out-of-state insurers would be outside their jurisdiction. Instead, California consumers would be forced to look to a distant state with weak protections, and with little incentive to assist Californians. Competitors who can flout California's laws would erode compliance. Cross-border sales of insurance would leave all Californians, including your constituents, without the protections that they pay taxes for, rely on, and which they deserve.

In addition, allowing insurers to sell across state lines without complying with state laws will lead to adverse selection and rate increases. Healthier individuals will acquire the cheaper, but flimsier, coverage from insurers incorporated in states with less coverage, leaving the individuals with greater health needs to seek coverage from insurers incorporated in states with more comprehensive coverage. This will essentially convert the insurers incorporated in states that require meaningful benefits into high risk pools for the insurers incorporated in states with little or no mandated benefits: as individuals age or get sick, they would simply seek coverage from insurers incorporated in a state with more comprehensive benefits. This will lead to rate spikes, and, ultimately market failure, for insurers incorporated in the states with more comprehensive benefits, and it is likely to lead to less competition within those states. Insurers will choose to no longer incorporate in states that require a more comprehensive benefit package, since they will not be on a level playing field. Further, and significantly, Californians will be unable to keep their current insurance if cross-border sales without state law compliance are permitted, as California insurers will be placed at a competitive disadvantage against policies that can avoid providing comprehensive benefits, while providing shoddy service essentially free of regulatory oversight. As California's market collapses, and insurers withdraw, Californians will be deprived of the quality insurance they have come to expect, and upon which they rely.

Ongoing Stability Needed in the Individual, Small Group, and Large Group Health Insurance Markets, Not Repeal

Maintaining and improving the ACA would be the best way for Congress and the incoming administration to stabilize the health insurance markets in California. Repeal would be irresponsible. The ACA works because all the components work together as an integrated, mutually-supporting whole: the less popular provisions, such as the individual mandate, make possible the most important provisions, like the prohibition against denying coverage due to a preexisting condition.⁴³ In addition, by making health insurance affordable through premium subsidies, the ACA provides an incentive for healthy people to enroll in coverage who might otherwise not have been able to enroll.

Despite six years of votes by Republicans in Congress to repeal the ACA, the Congress has yet to come forward with a proposal which would result in greater benefit than harm for Americans. In fact, many current concerns regarding the ACA stem not from the law itself, but, rather, from subsequent actions of Congress to remove the transitional supports needed to stabilize premiums and make the ACA a success. Congress withheld billions of dollars of funding for the risk corridor program.⁴⁴ Similarly, the transitional reinsurance program currently faces issues regarding potential underfunding related to the actual risk experience.⁴⁵ Full funding of the 2016 transitional reinsurance commitment is necessary for a healthy insurance market. Failure to make full reinsurance payments will adversely impact the entire health insurance market, with the greatest impact being on smaller carriers who rely upon these funds for financial stability. Threats to their financial stability will erode their continued ability to compete. The reinsurance and risk corridor programs should be fully funded, and then extended.

Problems related to premiums in ACA policies relate in part to the failure of government to keep its commitment to stabilize the individual market through reinsurance. I strongly urge Congress to take into consideration the full implications of repeal of the ACA before acting, including the specific concerns posed by the American Academy of Actuaries in its December 7, 2016 Letter to Speaker Ryan and Leader Pelosi.⁴⁶

Attempts to repeal and replace the ACA are likely to destabilize the individual insurance market. Congressional action can result in adverse selection or premium death spirals, or create such a level of market uncertainty that insurers will withdraw from the individual market. This will at best lead to premium increases, and, at worst, to market collapse. Further, consumers who fear that they may lose their health insurance coverage may seek to receive treatments while they still have coverage. This will generate higher loss ratios for those plans in 2017 than otherwise anticipated by the actuaries at the insurance companies. This is already occurring for some benefits provided under the preventative care mandate. For instance, compared to the month before the election, Planned Parenthood noted that online appointments for birth control surged by 900% in the weeks following the election.⁴⁷ Similar increased demand for other services based upon fear of Congressional actions that could damage the health insurance market will result in insurers proposing to increase rates in 2018 due to a spike in demand caused by uncertainty about Congressional action, destabilizing the market.

Preserving the ACA is the best way to maintain market stability. Repeal of the ACA not only threatens that stability, but also would remove important protections against discrimination. For example, regulations implementing the ACA's essential health benefits requirements forbids health insurers from creating or implementing a health insurance policy in a manner that discriminates based upon based upon an race, color, national origin, disability, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.⁴⁸ These requirements are necessary to protect Americans. Before the ACA individual market policies frequently excluded maternity coverage. In addition, without the protections of the ACA, insurers could create coverage that would not cover chronic conditions. The Affordable Care Act protects Californians and all Americans from discrimination.

Proposals to merely provide "universal access" ignore the need to have access to affordable health insurance. "Universal access" means nothing if people cannot afford health care services. While some might frame the treatment decisions arising from increased deductibles as merely a decision to delay care from emergency care the night your child breaks his arm to an office visit the next day,⁴⁹ the more common reality is much starker. Those with limited means do not have the luxury of choosing to go to the emergency room or waiting a day to see the doctor. Instead, their choices are much more basic: paying for their medication or feeding their children. This is especially troubling for the chronically ill, who need to take medications for disease management. If a disease is not being managed properly this increases the risk of a serious complication, which ultimately leads to higher costs. The reality on the ground is that, in order for working Californians to have meaningful access to care, monthly premium subsidies must be maintained.

California's Medicaid Program

As previously mentioned, the expansion of Medicaid under the Affordable Care Act has enabled California to insure 3.7 million more Californians and has enabled 15.5 million additional Americans nationwide to obtain insurance.^{50 51}

Proposals to block grant, reduce or cap federal funding for, or eliminate the Affordable Care Act's eligibility expansion for Medicaid would deprive millions of Californians and tens of millions of Americans from health insurance coverage.⁵² I oppose proposals to block grant, reduce or cap federal funding for, or eliminate the Affordable Care Act's expansion of eligibility criteria as any of these actions would wreak havoc in the lives of millions of Californians and deprive them of health care.⁵³ Fewer people will continue to have coverage if you shift or increase costs to the states.

I defer to California Governor Jerry Brown for additional specific comments regarding Medi-Cal, California's Medicaid program, which is under his Administration not mine. However, as Insurance Commissioner I will address the impact on the private insurance market that would result from inadequate funding of Medicaid and Medicare, and how increasing the number of uninsured leads to premium increases in the private markets.

Reductions in Funding for Medicaid and Medicare

Reduction in the federal funding for Medicaid, through block granting, caps, direct reductions or narrowing of eligibility criteria, will lead to premium increases for private insurance. The same holds true for Medicare. If Medicaid or Medicare funding is reduced, medical providers will shift costs no longer adequately reimbursed by public health insurance to private commercial health insurance. The cost shifting by medical providers from public programs to private health insurance payers would significantly increase commercial health insurance premiums. Prior to the adoption of the ACA, a study of 1992-2001 data from a private hospital in California indicated that "cost shifting from Medicare and Medicaid to private payers accounted for 12.3% of the total increase in private health insurance payers' prices from 1997 to 2001."⁵⁴

The Uninsured and the "Hidden Tax"

Reductions in funding for or eligibility for Medicaid will result in a significant increase in the number of uninsured Californians and Americans.

Uninsured individuals use health care. However, many individuals who are uninsured cannot pay for some or even all of their medical bills. According to the Kaiser Family Foundation:

Though the uninsured are typically billed for medical services they use, when they cannot pay these bills, the costs may become bad debt or uncompensated care for providers. State, federal, and private funds defray some but not all of these costs.⁵⁵

Hospitals and providers charge health insurers higher rates for their services in order to help pay for the uninsured:

In 2008, the uninsured "received about \$116 billion in care." Of that amount, they paid 37% out-of-pocket, and "government programs and charities paid for another 26 percent." The remaining \$42.7 billion was "passed on to the insured in the form of higher prices for their care," the study found. The "so-called 'hidden health tax'" has increased from 2005, ... [when], families paid an extra \$922 in premiums and individuals an extra \$341 (5/28).⁵⁶

That same study found that by 2009 the average insured family paid about \$1,017 extra in premiums to cover these costs.⁵⁷ Repeal of the Affordable Care Act would certainly increase the number of uninsured. The ACA currently funds health coverage for millions of Californians, either through Covered California, or through Medi-Cal.⁵⁸ As these Californians are at or below 400% of the federal poverty level, they simply cannot afford health insurance coverage without government assistance. Failure to fund these programs will certainly lead California's uninsured rate to spike, resulting in a concomitant spike in uncompensated care and emergency room use, a burden that the health care system will shift onto private insureds. The resulting premium increases would fall on the shoulders of California's working people.

Employer Sponsored Coverage

In order to preserve the employer-sponsored market, Congress should try to strengthen the group health insurance markets, rather than undermining the markets through repeal of the Affordable Care Act. Congress has made great strides towards creating stability in the small employer health insurance market. Before the ACA, due to experience rating, a small employer's rates could spike if one employee developed a high cost health condition. However, moving to community rating and imposing requirements wherein all small employers are in the same risk pool, has helped to stabilize rates for small employers. In addition, providing tax credits for small employers enables them to offer their employees coverage where they might not have been able to in the past.

Repealing the prohibition against annual and lifetime limits will harm businesses and employees

Repealing the ACA will harm businesses and employees, since it would reinstate the ability for insurers to impose annual and lifetime limits on coverage. Reinstating those provisions through ACA repeal would be particularly insidious. Annual and lifetime limits discriminate against the sickest, those who need coverage the most.

Before the prohibition against annual and lifetime limits was enacted in the Affordable Care Act, Californians and Americans generally lived in fear that significant medical conditions would no longer be covered if they met the limits found in their policy and they would be forced to pay for coverage out of pocket. For example, such limits discriminate against the chronically ill, and against young children born with complex, life threatening conditions who need years of complex surgeries at California's most expensive university medical centers in order to have a chance at survival. I heard directly from constituents who had run up against an annual or a lifetime limit in their policies and no longer had insurance coverage for their medically necessary life-saving medical treatment. For these Californians, the ACA elimination of lifetime and annual limits was life-saving.

Prior to the adoption of the ACA, Department of Insurance staff learned of the family of one such child, whose father had to change jobs because he had exhausted the lifetime limit on his employer-provided coverage. California's economy suffers when parents have to change jobs solely to continue to provide a sick child with needed care. Concerns about reinstatement of annual and lifetime limits have been raised across the country.⁵⁹ Annual and lifetime limits places the families of seriously ill children, cancer patients, and adults requiring a lifetime of expensive medications at risk of the loss of the coverage needed to sustain their ability to work, and to preserve their very life, against the onslaught of life-threatening disease. For some of your constituents, repeal of the ACA provides the stark reality of bankruptcy, destitution, and the abandonment of both vital medical treatment and any hope of survival.

Preventative Care

According to the Centers for Disease Prevention and Control (CDC), free preventative care increases the likelihood that these services will be used.⁶⁰ This is important to note in the context

of the workplace. The Centers for Disease Control and Prevention note that “Health problems are a major drain on the economy, resulting in 69 million workers reporting missed days due to illness each year, and reducing economic output by \$260 billion per year. Increasing the use of proven preventative services can encourage greater workplace productivity.”⁶¹ Congress should not derail the advances made by the ACA in health promotion. Health promotion and disease prevention leads to healthier lives, and a more productive workforce, resulting in increased productivity, lower absenteeism, and improvements in talent acquisition and retention.⁶²

High deductible health plans

Proposals to substitute Health Savings Accounts (HSAs) tied to High Deductible Health Plans (HDHPs) instead of the Affordable Care Act's requirement that employers provide affordable and comprehensive health insurance, will leave many employees without real health insurance coverage and increase personal bankruptcies related to medical bills. Although the idea that if people have more money at stake, they will make smarter health choices may sound good in theory, it oftentimes does not work in practice. First, many employees are paid such low wages and salaries that they are unable to make contributions to a Health Savings Account nor will their employers contributions be sufficient to cover their medical needs. The practical failure of HSA's coupled with High Deductible Plans is particularly acute for those who become or are chronically ill. The chronically ill need to access care and to remain on a treatment regimen, and yet may be less able to fund a Health Savings Account tied to a High-Deductible plan. Moreover, since High-Deductible plans withhold coverage until the high deductible is met, studies suggest that people avoid care, because of the high deductible, until their health problems become serious, costing more in the long run.⁶³ In addition to adverse health consequences, this detrimentally impacts the workforce, since more serious problems require a longer healing process, leading to missed work and increased insurance rates.

What Key Long-term Reforms Would Improve Affordability for Patients?

Instead of focusing on repealing the ACA, Congress should try to address what is driving up the cost of health insurance. “Universal access” means nothing, because many Americans cannot afford their coverage without the Affordable Care Act.

Prescription Drug Costs

To meaningfully enhance the ability of Americans to afford health coverage, Congress is best positioned to address some of the underlying causes that are driving up the cost of health insurance. For instance, when my Department reviews rates, a consistent trend across insurers has been increased prescription drug prices. Congress could begin to address these costs by allowing federal negotiation of drug costs under the Medicare Part D program, an important national price benchmark. This would both directly save tax dollars in the Part D program, and also bolster efforts in the commercial insurance market to effectively negotiate drug prices.

High-risk Pools

High-risk pools are not a substitute for the Affordable Care Act and do not return more choice, control or access to consumers. High risk pools have failed to provide coverage for Californians and Americans generally. High risk pools are doomed to failure because they take the sickest persons --those with the highest risk -- and concentrate them in a risk pool so that the costs associated with covering these people are high. States are then unable to cover the costs of subsidizing the high premiums needed to cover the medical costs of these individuals, and as a consequence few people can afford coverage.

Instead of concentrating the sickest in a single high risk pool, the Affordable Care Act creates a larger risk pool of all individuals, using the basic principles of risk spreading inherent in insurance coverage, and thereby spreads risk and costs in a way that makes individual premiums more affordable. In contrast, a high risk pool concentrates risk, guaranteeing only that premiums will be unaffordable for most of the Californians relegated to that high risk pool.

The ACA prohibits insurers from utilizing tools to make coverage unavailable or unaffordable for those with preexisting health conditions. Before the ACA insurers were able to utilize medical underwriting to deny coverage. The Kaiser Family Foundation estimates that approximately 5.8 million (24%) of California's non-elderly adult population has a preexisting condition that would have been a basis to decline coverage prior to the adoption of the ACA.⁶⁴ Further, the study acknowledges that this is a conservative estimate, and that the number of people with preexisting conditions is likely even higher.⁶⁵

Before the ACA, if these individuals did not have health insurance coverage, they would have to forego health insurance or, if they could afford it, acquire coverage through a high-risk pool. Before the ACA, California had a high risk pool, the Major Risk Medical Insurance Program (MRMIP). However, MRMIP was paid for through a tobacco tax, which resulted in an enrollment cap due to limited funding.⁶⁶ MRMIP only covered a small percentage of the individuals who needed coverage, an amount dwarfed by the substantial expansion of coverage made possible by the ACA. In 2009 MRMIP only covered about 7,000 Californians.⁶⁷ By 2011 MRMIP's coverage had dropped to 6,334 individuals.⁶⁸ Part of the reason for the drop in enrollment was that the premiums were unaffordable. The Commonwealth Fund found that:

By concentrating risk, high-risk pools also concentrate costs, resulting in greater expenses to administrators and consumers and driving plans to impose severe coverage limits that often serve to negate the benefit of having insurance. Indeed, pronounced adverse selection is common in high-risk pools, because only the very sickest and most expensive individuals are willing to pay the high premiums for coverage, increasing administrative costs even more.⁶⁹

The premiums for MRMIP were substantial. In 2009 the premiums for MRMIP were between 25-37.5% higher than the rates found in the outside market.⁷⁰ MRMIP had no subsidies for low income individuals.⁷¹ Therefore, many individuals who have coverage now would not be able to utilize a program such as MRMIP, since it would be unaffordable.

In addition, MRMIP had a preexisting condition exclusion period of up to three months.⁷² Essentially, individuals would suffer for three months before they could obtain coverage for the condition which had relegated them to MRMIP in the first place. Also, MRMIP had an annual limit of \$75,000 and a lifetime limit of \$750,000.⁷³ For individuals with serious chronic conditions MRMIP's annual and lifetime limits were quickly exhausted. For instance, in 2012 the national average annual cost to for coronary artery disease was around \$75,000 and end stage renal disease on average \$173,000,⁷⁴ while the national *average* cost to treat a newborn in a neonatal intensive care unit was \$101,000.⁷⁵ Significantly, these were just averages, and the actual costs could be much higher in individual cases, quickly depleting the available coverage in a high risk pool.

Once those limits were met, individuals had to pay for coverage out-of-pocket, increasing their risk of medical bankruptcy and financial ruin, and forcing them forgo treatment. Therefore, even MRMIP, the last stop for coverage for individuals, did not provide coverage they could rely upon when they suffered from a medical condition that was costly to treat. Simply put, some individuals could not rely on high risk pools for coverage when they needed it the most. In addition, MRMIP was losing money despite the high premiums and coverage limitations. In 2011 MRMIP received \$47.6 million in premiums, but had \$70.3 million in expenses, resulting in a \$22.7 million loss.⁷⁶ Reinstating this program would be a major step backward for California's consumers, would be fiscally irresponsible, would harm health, and inflict hopelessness.

Timing Issues for the Insurance Market and States?

California has implemented by statute and regulations most of the reforms contained in the ACA. This took years of work after the passage of the ACA and years to fully implement. The insurance industry and medical providers have taken years to revise products and procedures to conform to the Affordable Care Act. Neither state legislatures nor state insurance markets can quickly shift course if the ACA is repealed. An immediate repeal of the ACA will have devastating consequences for health insurers and plans and medical providers and consumers. Any changes should be delayed for at least four years, much as it took four years to implement the ACA and open the new exchange markets, from passage of the ACA in 2010.

Conclusion

The protections afforded by the ACA are important to all Californians. If the ACA is repealed, 20 million Americans will lose health coverage: of which over 5 million will be Californians. Repeal of the ACA will harm Californians, including the majority of your constituents.

The ACA allows the poor and unemployed to have access to coverage based upon the Medicaid expansion and subsidies. This is particularly important in your district, which includes parts of Kern and Tulare Counties. According to a recent news report "Unemployment in Kern and Tulare counties runs between 9 percent and nearly 11 percent, twice as high as the state average.

About a quarter of residents live in poverty, according to U.S. Census data.”⁷⁷ Without the benefits under the ACA residents in your district that are struggling to get by will simply be unable to afford health coverage.

I am greatly concerned with the major negative consequences for Californians and all Americans that will result if the ACA is repealed. Before you vote to repeal the ACA, every American has the right to know exactly what, if anything, you intend to replace it with. A vote to repeal the ACA, without a specific replacement, would create crippling uncertainty, causing instability in the insurance market which could bring about the collapse of our health care system.

As California’s elected Insurance Commissioner, I represent the millions of Californians who have benefited from the ACA, as you represent them in Congress. I ask that we make common cause to assure that none of our constituents lose the quality health insurance coverage and the federal financial assistance necessary for it to remain affordable that the ACA has provided. If you would like to talk to me or my staff about my concerns, please feel free to call me or Janice Rocco, Deputy Commissioner, Health Policy and Reform at (916) 492-3500, or email her at Janice.Rocco@insurance.ca.gov.

Sincerely,



DAVE JONES
Insurance Commissioner

cc: The Honorable Kevin Brady, Chairman, House Committee on Ways & Means
The Honorable Fred Upton, Chairman, House Committee on Energy & Commerce
The Honorable John Kline, House Committee on Education and the Workforce
The Honorable Greg Walden, Chair-Elect, House Committee on Energy & Commerce
The Honorable Virginia Foxx, House Committee on Education & the Workforce
California Congressional Delegation

- ¹ *Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose* (Nov. 2016) California HealthCare Foundation <<http://www.chcf.org/publications/2016/11/facts-figures-aca-ca>> [as of Jan. 12, 2017].
- ² *Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose* (Nov. 2016) California HealthCare Foundation <<http://www.chcf.org/publications/2016/11/facts-figures-aca-ca>> [as of Dec. 30, 2016].
- ³ *Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose* (Nov. 2016) California HealthCare Foundation <<http://www.chcf.org/publications/2016/11/facts-figures-aca-ca>> [as of Dec. 30, 2016].
- ⁴ Barnett & Vornovitsky (Sept. 2016) *Health Insurance Coverage in the United States: 2015*, table A-1, *Population Without Health Insurance Coverage by State: 2013-2015*. U.S. Census Bureau. <<https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>> [as of Jan. 12, 2017]
- ⁵ *Uninsured Rates for the Nonelderly by Race/Ethnicity*. Kaiser Family Foundation. <<http://kff.org/uninsured/state-indicator/rate-by-raceethnicity/?dataView=0&activeTab=graph¤tTimeframe=0&startTimeframe=2&selectedDistributions=hispanic&selectedRows=%7B%22nested%22:%7B%22california%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D%7D>> [as of Jan. 12, 2017].
- ⁶ Adams, *Two Years After ACA Implementation: Coverage Gains Continued and Fewer Affordability Concerns Cited* (Dec. 15, 2016) California HealthCare Foundation <http://www.chcf.org/aca-411/insights/two-years-coverage-gains?_cldee=a2xld2lzQHnkY21zLm9yZw> [as of Dec. 30, 2016].
- ⁷ *Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose* (Nov. 2016) California HealthCare Foundation <<http://www.chcf.org/publications/2016/11/facts-figures-aca-ca>> [as of Dec. 30, 2016].
- ⁸ Antos & Capretta, *The Problems with 'Repeal and Delay'* (Jan. 3, 2017) Health Affairs Blog <<http://healthaffairs.org/blog/2017/01/03/the-problems-with-repeal-and-delay>> [as of Jan. 12, 2017]
- ⁹ Dietz, et. al., *ACA Repeal in California: Who Stands to Lose?* (Dec. 2016) UC Berkeley Center for Labor Research and Education UCLA Center for Health Policy Research <<http://laborcenter.berkeley.edu/pdf/2016/ACA-Repeal-in-California.pdf>> [as of Jan. 5, 2017]. See also Anderson, *If Obamacare is repealed, millions could lose Medi-Cal coverage* (Dec. 10, 2016) The Fresno Bee <<http://www.fresnobee.com/news/local/article119968148.html>> [as of Dec. 30, 2016].
- ¹⁰ Anderson, *If Obamacare is repealed, millions could lose Medi-Cal coverage* (Dec. 10, 2016) The Fresno Bee <<http://www.fresnobee.com/news/local/article119968148.html>> [as of Dec. 30, 2016].
- ¹¹ Anderson, *If Obamacare is repealed, millions could lose Medi-Cal coverage* (Dec. 10, 2016) The Fresno Bee <<http://www.fresnobee.com/news/local/article119968148.html>> [as of Dec. 30, 2016]. See also Mathematica Policy Research Fresno: *As Uninsured Rate Falls, Capacity Constraints Grow* (Apr. 2016) California Health Care Foundation. <<http://www.chcf.org/publications/2016/04/regional-market-fresno>> [as of Dec. 30, 2016].
- ¹² Weinberg, Kallerman, & Mena, *Mainstreaming Medi-Cal Investing in Patient Access, Improving Economic Productivity* (June 2016) The Bay Area Council Economic Institute <<http://www.bayareaeconomy.org/report/mainstreaming-medi-cal/>> [as of Dec. 30, 2016].
- ¹³ *Facts and Figures on the ACA in California: What We've Gained and What We Stand to Lose* (Nov. 2016) California HealthCare Foundation <<http://www.chcf.org/publications/2016/11/facts-figures-aca-ca>> [as of Dec. 30, 2016].
- ¹⁴ *Medi-Cal Certified Eligibles – Recent Trends* (August 2016) California Department of Health Care Services <<http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx>> [as of Jan. 12, 2017].
- ¹⁵ Ostrov, *Half of California's Children Now Covered by Medi-Cal* (Jan. 29, 2015) KQED News <<https://www2.kqed.org/stateofhealth/2015/01/29/half-of-californias-children-now-covered-by-medi-cal/>> [as of Jan. 12, 2017]
- ¹⁶ *Medi-Cal Facts and Figures: A Program Transforms* (May, 2013) California Health Care Foundation. <<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalFactsAndFigures2013.pdf>> [as of Jan. 12, 2017].
- ¹⁷ *Medi-Cal Monthly Enrollment Fast Facts* (August 2016) California Department of Health Care Services <http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_August_2016_ADA.pdf> [as of Jan. 12, 2017].

- ¹⁸ *Total Marketplace Enrollment and Financial Assistance Timeframe: March 31, 2016* (2016) The Henry J. Kaiser Family Foundation <<http://kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0>>[as of Dec. 30, 2016].
- ¹⁹ *Total Marketplace Enrollment and Financial Assistance Timeframe: March 31, 2016* (2016) The Henry J. Kaiser Family Foundation <<http://kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0>>[as of Dec. 30, 2016].
- ²⁰ *Individuals Enrolled from Oct. 1, 2013, Through March 31, 2014, with Subsidy Status, Across Region* (2014) Covered California and The California Department of Health Care Services. <http://www.coveredca.com/news/PDFs/regional-stats-march/March_RegionalEnrollmentTables_forWeb_ss.pdf>[as of Dec. 30, 2016].
- ²¹ Hiltzick, *On Obamacare repeal, GOP ideology is colliding with reality* (December 7, 2016) The Los Angeles Times <<http://www.latimes.com/business/hiltzik/la-fi-hiltzik-obamacare-repeal-20161205-story.html>>[as of December 30, 2016].
- ²² Galewitz, *Millions Previously Denied Insurance Coverage Because Of Health Problems Look To Online Marketplaces* (Sep. 30, 2013) Kaiser Health News <<http://khn.org/news/preexisting-condition-consumers-insurance-obamacare-marketplaces/>>[as of Dec. 30, 2016]. See also Seipel, *Obamacare enrollees in California frightened about the future* (Nov. 14, 2016) The Mercury News <<http://www.mercurynews.com/2016/11/14/obamacare-enrollees-worried-about-future/>>[as of Dec. 30, 2016] & Seipel, *Californians with preexisting conditions worried about health care future* (Dec. 17, 2016) The Mercury News <<http://www.mercurynews.com/2016/12/17/californians-with-preexisting-conditions-worried-about-health-care-future/>>[as of Dec. 30, 2016].
- ²³ Claxton, et al., *Preexisting Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA* (Dec. 12, 2016) The Henry J. Kaiser Family Foundation <<http://kff.org/health-reform/issue-brief/preexisting-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>>[as of Dec. 30, 2016].
- ²⁴ *How Much Does Prenatal Care Cost?* Costhelper <<http://children.costhelper.com/prenatal-care.html>>[as of Jan. 5, 2017].
- ²⁵ *How Much Does Prenatal Care Cost?* Costhelper <<http://children.costhelper.com/prenatal-care.html>>[as of Jan. 5, 2017]. <<http://content.healthaffairs.org/content/34/7/1212.abstract>>[as of Dec. 30, 2016].
- ²⁶ Xu, et al., *Wide Variation Found In Hospital Facility Costs For Maternity Stays Involving Low-Risk Childbirth* (July 2015) Health Affairs July 2015 vol. 34 no. 7 1212-1219. <<http://content.healthaffairs.org/content/34/7/1212.abstract>>[as of Dec. 30, 2016].
- ²⁷ *Gestational Diabetes Screening: Questions for the doctor* (Sep. 26, 2016) U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion <<https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/gestational-diabetes-screening-questions-for-the-doctor>>[as of Dec. 30, 2016].
- ²⁸ *Gestational Diabetes Screening: Questions for the doctor* (Sep. 26, 2016) U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion <<https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/gestational-diabetes-screening-questions-for-the-doctor>>[as of Dec. 30, 2016].
- ²⁹ *Gestational Diabetes Screening: Questions for the doctor* (Sep. 26, 2016) U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion <<https://healthfinder.gov/HealthTopics/Category/doctor-visits/talking-with-the-doctor/gestational-diabetes-screening-questions-for-the-doctor>>[as of Dec. 30, 2016].
- ³⁰ Whitney, *People with Disabilities Face Complex Choices under Obamacare* (Aug. 13, 2013) KQED News <<http://www.kqed.org/stateofhealth/2013/08/13/people-with-disabilities-who-need-habilitative-services-face-complex-choices-under-obamacare/>>[as of Dec. 30, 2016].
- ³¹ Pugh, *Regulation requires parity from insurers for mental illness coverage* (Nov. 8, 2013) McClatchy DC <<http://www.mcclatchydc.com/news/nation-world/national/article24758749.html>>[as of Dec. 30, 2016].
- ³² Associated Press, *Health Insurance Caps Leave Patients Stranded* (July 13, 2008) NBC News <http://www.nbcnews.com/id/25644309/ns/health-health_care/t/health-insurance-caps-leave-patients-stranded/#.WGRAWMrJ0w>[as of Dec. 30, 2016]. See also Volk, *Affordable Care Act's Ban on Lifetime Limits Has Ended Martin Addie's Coverage Circus* (Nov. 14, 2012) Georgetown University Health Policy Institute Center for Children and Families <<http://ccf.georgetown.edu/2012/11/14/affordable-care-acts-ban-on-lifetime-limits-has-ended-martin-addies-coverage-circus/>>[as of Dec. 30, 2016] & Chen, *Economic Costs of Hemophilia and the Impact of Prophylactic Treatment on Patient Management* (Apr. 2016) American Journal of Managed Care <<http://www.unipartners.net/files/Costs%20of%20Hemophilia.pdf>>[as of Dec. 30, 2016].

- ³³ *Impact of the Affordable Care Act in California* (Dec. 13, 2016) United States Department of Health and Human Services <<https://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-california/index.html>>[as of Dec.30, 2016].
- ³⁴ *Impact of the Affordable Care Act in California* (Dec. 13, 2016) United States Department of Health and Human Services <<https://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-california/index.html>>[as of Dec.30, 2016].
- ³⁵ *Impact of the Affordable Care Act in California* (Dec. 13, 2016) United States Department of Health and Human Services <<https://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-california/index.html>>[as of Dec.30, 2016].
- ³⁶ *Impact of the Affordable Care Act in California* (Dec. 13, 2016) United States Department of Health and Human Services <<https://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-california/index.html>>[as of Dec.30, 2016].
- ³⁷ Mager-Mardeusz, *More Than 400,000 Californians with Developmental Disabilities Remain Outside the State Safety Net* (Nov. 2016) UCLA Center for Health Policy Research. <<http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/DisabilityPN-nov2016.pdf>>[as of Dec. 30, 2016].
- ³⁸ Lucia & Jacobs, *Data Brief: California Projected Economic Losses Under ACA Repeal* (Dec. 2016) UC Berkeley Center for Labor Research and Education <<http://laborcenter.berkeley.edu/pdf/2016/Californias-Projected-Economic-Losses-under-ACA-Repeal.pdf>>[as of Dec. 30, 2016].
- ³⁹ *United States House of Representatives v. Sylvia M. Burwell, et al.* USDC, DC Circuit case no. 1:14-cv-01967, US Court of Appeals, DC Circuit no. 16-5202.
- ⁴⁰ Jost, *House Seeks Pause In Cost-Sharing Reduction Litigation (Updated)* (Nov. 22, 2016) Health Affairs Blog <<http://healthaffairs.org/blog/2016/11/22/house-seeks-pause-in-cost-sharing-reduction-litigation/>>[as of Dec. 30, 2016].
- ⁴¹ Jost, *House Seeks Pause In Cost-Sharing Reduction Litigation (Updated)* (Nov. 22, 2016) Health Affairs Blog <<http://healthaffairs.org/blog/2016/11/22/house-seeks-pause-in-cost-sharing-reduction-litigation/>>[as of Dec. 30, 2016].
- ⁴² National Association of Insurance Commissioners, *Interstate Health Insurance Sales: Myth vs. Reality*, <http://www.naic.org/documents/topics_interstate_sales_myths.pdf > [As of January 3, 2017].
- ⁴³ Sanger-Katz, *Why Keeping Only the Popular Parts of Obamacare Won't Work* (Nov. 15, 2016) The New York Times <<http://www.nytimes.com/2016/11/15/upshot/why-keeping-only-the-popular-parts-of-obamacare-wont-work.html>>[as of Dec. 30, 2016].
- ⁴⁴ Pear, *Marco Rubio Quietly Undermines Affordable Care Act* (Dec. 9, 2015) New York Times <https://www.nytimes.com/2015/12/10/us/politics/marco-rubio-obamacare-affordable-care-act.html?_r=0> [as of Jan. 12, 2017].
- ⁴⁵ Hiltzik, *What Ails the Obamacare Insurance Exchanges? (It's Not What You Think)* (Aug. 5, 2016) Los Angeles Times <<http://www.latimes.com/business/hiltzik/la-fi-hiltzik-obamacare-exchanges-20160805-snap-story.html>> [as of Jan. 12, 2017].
- ⁴⁶ Westerfield, *Letter to Speaker Paul Ryan and Leader Nancy Pelosi, Re: Consequences of Repealing ACA Provisions or Ending Cost-Sharing Reduction Reimbursements* (Dec. 7, 2016) American Academy of Actuaries <http://actuary.org/files/publications/HPC_letter_ACA_CSR_120716.pdf>[as of Dec. 30, 2016].
- ⁴⁷ Green, *Health care providers report surge in IUD requests following Trump victory* (Nov. 15, 2016) Decode DC <<http://www.decodedc.com/health-care-providers-report-surge-iud-requests-following-trump-victory/>>[as of Dec. 30, 2016].
- ⁴⁸ 45 Code of Federal Regulations sections 156.125 & 156.200(e).
- ⁴⁹ Martinez, *Son's broken arm: Bill Huizenga says people must be responsible for own health care costs* (Dec. 19, 2016) Michigan Live <http://www.mlive.com/news/grand-rapids/index.ssf/2016/12/sons_broken_arm_bill_huizenga.html>[as of Dec. 30, 2016].
- ⁵⁰ Dietz, et al., *ACA Repeal in California: Who Stands to Lose?* (Dec. 2016) UC Berkeley Center for Labor Research and Education UCLA Center for Health Policy Research <<http://laborcenter.berkeley.edu/pdf/2016/ACA-Repeal-in-California.pdf>>[as of Jan. 5, 2017].
- ⁵¹ Gates, et al., *Two Year Trends in Medicaid and CHIP Enrollment Data: Findings from the CMS Performance Indicator Project* (Jun. 2016) The Henry J. Kaiser Family Foundation <<http://files.kff.org/attachment/Issue-Brief-Two-Year-Trends-in-Medicaid-and-CHIP-Enrollment-Data>>[as of Jan. 5, 2017].
- ⁵² Park, *Medicaid Block Grant Would Slash Federal Funding, Shift Costs to States, and Leave Millions More Uninsured* (Nov. 30, 2016), Center on Budget and Policy Priorities <

<http://www.cbpp.org/research/health/medicaid-block-grant-would-slash-federal-funding-shift-costs-to-states-and-leave>> [as of Jan. 12, 2017].

⁵³ Dietz, Lucia, Kominski, & Jacobs, *ACA Repeal in California: Who Stands to Lose?* (Dec. 2016) UC Berkeley Center for Labor Research and Education/UCLA Center for Health Policy Research <<http://laborcenter.berkeley.edu/pdf/2016/ACA-Repeal-in-California.pdf>> [as of Jan. 12, 2017].

⁵⁴ Zwanzinger & Bamezai, *Evidence Of Cost Shifting In California Hospitals* (Jan 2006) Health Affairs <<http://content.healthaffairs.org/content/25/1/197.long>> [as of Dec. 30, 2016].

⁵⁵ *Key Facts about the Uninsured Population* (Sep. 29, 2016) The Henry J. Kaiser Family Foundation <<http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>> [as of Dec. 30, 2016].

⁵⁶ *Study: Insured Paying Higher 'Hidden Tax' For Uninsured Health Care* (May 28, 2009) The Henry J. Kaiser Family Foundation <<http://khn.org/morning-breakout/hidden-tax/>> [as of Dec. 30, 2016].

⁵⁷ *Study: Insured Paying Higher 'Hidden Tax' For Uninsured Health Care* (May 28, 2009) The Henry J. Kaiser Family Foundation <<http://khn.org/morning-breakout/hidden-tax/>> [as of Dec. 30, 2016].

⁵⁸ Karlamangla, *If Obamacare is repealed, California has the most to lose — putting the insured on edge* (Nov. 13, 2016) <<http://www.latimes.com/local/california/la-me-obamacare-trump-california-20161110-story.html>> [as of Dec. 30, 2016].

⁵⁹ Schenckner, *If you have employer health insurance, an Obamacare repeal will affect you too* (Dec. 17, 2016) The Chicago Tribune <chicagotribune.com/business/ct-obamacare-repeal-worries-employees-1218-biz-20161214-story.html> [as of Dec. 30, 2016].

⁶⁰ *Preventative Health Care* (June 12, 2013) Centers for Disease Control and Prevention <<https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/preventativehealth.html>> [as of Dec. 30, 2016].

⁶¹ *Preventative Health Care* (June 12, 2013) Centers for Disease Control and Prevention <<https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/preventativehealth.html>> [as of Dec. 30, 2016].

⁶² Orchard, *The Business Benefits of a Healthy Workforce* (June 1, 2015) Harvard T.H. Chan School of Public Health <<https://www.hsph.harvard.edu/ecpe/the-business-benefits-of-a-healthy-workforce/>> [as of Dec. 30, 2016].

⁶³ Islam, *Trouble Ahead For High Deductible Health Plans?* (Oct. 7, 2015) Health Affairs Blog <<http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans/>> [as of Dec. 30, 2016].

⁶⁴ Claxton, *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA* (Dec. 12, 2016) The Henry J. Kaiser Family Foundation <<http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>> [as of Dec. 30, 2016].

⁶⁵ Claxton, *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA* (Dec. 12, 2016) The Henry J. Kaiser Family Foundation <<http://kff.org/health-reform/issue-brief/preexisting-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>> [as of Dec. 30, 2016].

⁶⁶ *MRMIP Frequently Asked Questions (FAQs)* (Apr. 10, 2015) California Department of Health Care Services <http://www.dhcs.ca.gov/services/Documents/MCQMD/MRMIP_FAQs.pdf> [as of Dec. 30, 2016].

⁶⁷ *Individual Health Insurance in California* (July 2009) California HealthCare Foundation <<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20FactsFindingsIndividualHealthIns.pdf>> [as of Dec. 30, 2016].

⁶⁸ *MRMIP Subscriber and Health Plan Data: December 2011 Summary* (Jan. 18, 2012) The California Managed Risk Medical Insurance Board <http://www.mrmib.ca.gov/mrmib/Agenda_Minutes_011812/Agenda_Item_10.a_MRMIP_Board_Report_Summary_for_June_2011.pdf> [as of Jan. 5, 2017].

⁶⁹ Hall, *Why High Risk Pools (Still) Won't Work* (Feb. 13, 2015) The Commonwealth Fund <<http://www.commonwealthfund.org/publications/blog/2015/feb/why-high-risk-pools-still-will-not-work>> [as of Dec. 30, 2016].

⁷⁰ *Individual Health Insurance in California* (July 2009) California HealthCare Foundation <<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20FactsFindingsIndividualHealthIns.pdf>> [as of Dec. 30, 2016].

⁷¹ Pollitz, *High-Risk Pools For Uninsurable Individuals* ((Aug. 1, 2016) Appendix 3) The Henry J. Kaiser Family Foundation <<http://kff.org/report-section/high-risk-pools-for-uninsurable-individuals-appendix-tables/>> [as of Dec. 30, 2016].

⁷² *MRMIP Frequently Asked Questions (FAQs)* (Apr. 10, 2015) California Department of Health Care Services <http://www.dhcs.ca.gov/services/Documents/MCQMD/MRMIP_FAQs.pdf> [as of Dec. 30, 2016].

⁷³*MRMIP Frequently Asked Questions (FAQs)* (Apr. 10, 2015) California Department of Health Care Services <http://www.dhcs.ca.gov/services/Documents/MCQMD/MRMIP_FAQs.pdf>[as of Dec. 30, 2016].

⁷⁴Whelan, *The 10 Most Expensive Common Medical Conditions* (Feb. 25, 2012) Forbes <<http://www.forbes.com/sites/davidwhelan/2012/02/25/the-10-most-expensive-common-medical-conditions/#530559735a1d>>[as of Dec. 30, 2016].

⁷⁵Whelan, *The 10 Most Expensive Common Medical Conditions* (Feb. 25, 2012) Forbes <<http://www.forbes.com/sites/davidwhelan/2012/02/25/the-10-most-expensive-common-medical-conditions/#530559735a1d>>[as of Dec. 30, 2016].

⁷⁶Pollitz, *High-Risk Pools For Uninsurable Individuals* (Aug. 1, 2016) The Henry J. Kaiser Family Foundation <<http://kff.org/report-section/high-risk-pools-for-uninsurable-individuals-appendix-tables/>>[as of Dec. 30, 2016].

⁷⁷Bartolone & Bazar, *In House Majority Leader's Home District, Many Depend On Health Law He Wants To Scrap* (Dec. 4, 2016) National Public Radio <<http://www.npr.org/sections/health-shots/2016/12/04/504172801/in-house-majority-leaders-home-district-many-depend-on-health-law-he-wants-to-sc>>[as of Dec. 30, 2016].