FROM PREMIUM INCREASES TO FAILING CO–OPS: AN OBAMACARE CHECKUP

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, BENEFITS AND ADMINISTRATIVE RULES

OF THE

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FROM PREMIUM INCREASES TO FAILING CO–OPS: AN OBAMACARE CHECKUP

Wednesday, July 13, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, BENEFITS AND ADMINISTRATIVE RULES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 3:00 p.m., in Room 2247, Rayburn House Office Building, Hon. Jim Jordan [chairman of the subcommittee] presiding.

Present: Representatives Jordan, Walberg, DesJarlais, Meadows, Walker, Hice, Carter, Cartwright, DeSaulnier, and Lujan Grisham.

Mr. JORDAN. The Subcommittee on Oversight and Government Reform on Health Care, Benefits, and Administrative Rules will come to order.

Without objection, the chair is authorized to declare a recess at any time.

Welcome, Mr. Cartwright, and welcome to our witnesses. We will get to you in just a moment. You know how this works. You've done this many times, opening statements, and then we'll get your testimony, and then we'll get right to our witnesses.

Just about everything stated about ObamaCare when it was passed has turned out to be false. You like your doctor; you can keep your doctor. False. You like your plan; you can keep your plan. That turned out to be false. Premiums are going to go down, we were told. That turned out to be false. Premiums are going to go down an average of $2,500. Of course, that turned out to be false. The Web site will work, we were told. That turned out to be false. The Web site is secure. That was false too at the time. Deductibles will decrease. We found out that wasn't accurate either. And, of course, we were told 21 million people would get insurance under the exchange. Now that's been revised down to almost half, 11 million Americans. And, of course, we were told the CO–OPs were going to work. Just yesterday, Illinois' CO–OP folded. That's the fourth one since May. That's 16 now out of 23. That's after the administration spent $2.4 billion setting up nearly two dozen CO–OPs. Over $1.6 billion in Federal loans have gone to the failed CO–OPs, money that probably will never be recovered. More closures are expected. My guess is every single one of these, every single one, all 23, are ultimately going to fail. And that's why we're having this hearing today, to just underscore the simple fact that it's not only just CO–OPs. It's not only some of the things—it's just this law has been a complete failure. And the American people

know it. Business owners know it. I think insurance companies know it. And we're looking forward to hearing from our witnesses today on the CO–OP issue and other issues related to ObamaCare or, as some call it, the Affordable Care Act.

So I want to thank our witnesses for being here, and with that, I would now recognize the ranking member, Mr. Cartwright, for an opening statement if he has one.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

And I'd like to thank our witnesses for taking the time to be with us today. I hope the committee uses this hearing as an opportunity to have a meaningful, productive discussion about the ACA, what aspects of the law are working, areas still in need of improvement. But I've been on this committee long enough and this subcommittee long enough to know that this hearing was called to give my colleagues in the majority an occasion again to attack the law. In fact, just the one-sided title of today's hearing says it all, "From Premium Increases to Failing CO–OPs." A fair approach might be titled "From Improved Access to Health Care to Historically Low Uninsured Rates" or "From Reducing Medical Debt to Slowing National Health Expenditures." But, of course, my Republican colleagues don't want to highlight the ACA's successes, only its flaws. That's the kind of partisan political hearing they believe serves their interests in an election year, but another partisan hearing doesn't serve the public interests because there are some accomplishments of the ACA that the Republicans' partisanship ignores.

Because of the ACA, 20 million people who used to be without insurance now have access to quality, affordable healthcare coverage. And what that means at home on Main Street is that your hospitals, your local hospitals, are much less likely to fold because they are not doling out as much uninsured care as they used to have to do. That's true in my district. We had two hospitals that failed after 2010 and before the implementation of the ACA.

But here's another accomplishment. The uninsured rate in this country is at a historic low. That means there are fewer people in this country than ever before that have to worry about what happens if they get sick, they can't afford to go to the doctor, or can't afford to pay for for their medications out of pocket.

And here are some more accomplishments. Because of the ACA, people with preexisting medical conditions can no longer be denied access to coverage because of their health. Hospitals and States that expanded Medicaid have seen their rates of uncompensated care decline, as I just mentioned. Those States have also seen a decline of medical debt. So many of the people that declare bankruptcy in this country had to do so because medical debt put them under water.

But even with all these accomplishments of the ACA, my Republican friends have chosen to hold more than 60 votes attempting to repeal or undermine this law. And we all know there are aspects of the ACA that still need a lot of work. For example, CO–OPs have faced daunting challenges, just as any startup businesses would. We have to remember the reason that CO–OPs were created: to inject much-needed competition into the insurance market so that rates can stay low for consumers. Instead of taking steps to help support the CO–OPs, however, the Republican-led House,

has voted multiple times to slash that program's funding. There are certainly other aspects of the law that could be improved. I'm looking forward to hearing from our witnesses about how we can make the ACA better, how we can make it stronger and work for all Americans.

But I'd like to close by focusing on why we passed this law in the first place. In June 2015, Brent Brown of Wisconsin wrote the President a letter thanking him for enacting health reform. Mr. Brown who has, quote, "voted Republican for the entirety of his life," unquote, but who also had a preexisting medical condition that made it impossible for him to get health insurance before the ACA, he wrote, quote, "I would not be alive without access to care I received due to your law," unquote. Mr. Brown's letter is a reminder to all that the ACA is about helping real people live better, healthier lives, and it is working, unlike the harmful proposals recently put forward under the Speaker's Better Way plan, which would roll back healthcare protections for women, raise medical costs for seniors, and cut long-term Medicaid funding to the detriment of patients and medical providers.

After 6 years, Republicans still have not proposed a viable legislative alternative to the Affordable Care Act. I would urge my colleagues to keep this perspective in mind during today's hearing.

Mr. Chairman, I yield back.

Mr. JORDAN. I thank the gentleman.

We'll hold the record open for 5 legislative days for any members who would like to submit a written statement, and we'll now recognize our witnesses.

I'm pleased to welcome Mr. Kevin Counihan, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services; and Ms. Linda Blumberg, Ph.D., senior fellow at the Urban Institute.

Welcome, again, to both of you.

And pursuant to committee rules, all witnesses will be sworn in before they testify. Please raise your right hand, if you would stand and raise your right hand, excuse me.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

Let the record show that both witnesses answered in the affirmative. We will now start with—we'll just go right across, Mr. Counihan and then Ms. Blumberg.

WITNESS STATEMENTS

STATEMENT OF KEVIN COUNIHAN

Mr. COUNIHAN. Good afternoon, Chairman Jordan, Ranking Member Cartwright, and members of the subcommittee. Thank you for the opportunity to provide an update on the Affordable Care Act.

I joined CMS nearly 2 years ago after over 30 years serving various roles in the health insurance industry. At CMS, my focus is on the day-to-day operation and management of the Marketplace and other programs that help consumers gain access to affordable,

high-quality healthcare coverage. Thanks to the Affordable Care Act, millions of Americans who were previously uninsured now have access to affordable, high-quality health care. An estimated 20 million more people now have coverage because of the law, and at 9.1 percent, the uninsured rate in America is the lowest it has been on record. Preexisting conditions no longer preclude individuals from gaining health insurance, and lifetime and annual dollar limits are now a thing of the past. Tens of millions of Americans have new access to preventive services with no cost sharing, and consumers now have the comfort of knowing that if their employment changes or if they lose coverage for any reason, they can purchase affordable coverage through the Marketplace.

The Affordable Care Act has also resulted in cost savings for both consumers and taxpayers. The law requires health insurers to provide consumers with rebates if they spend too much of a consumer's premium on advertising and marketing instead of health benefits and quality care. Since this requirement has been put in place in 2011, almost $2.9 billion in total refunds have been paid to millions of consumers. And before the Affordable Care Act, insurance companies in many States were able to raise rates without explaining their actions. The law brought unprecedented transparency into health insurance pricing through the rate review process, and in 2015, rate review led to an estimated $1.5 in savings for consumers.

Since the Affordable Care Act became law, healthcare prices have risen at the lowest level in 50 years. The Congressional Budget Office has estimated that the law will generate substantial deficit savings that grow over time, translating to a total savings of more than $3 trillion over the next two decades.

One critical provision of the Affordable Care Act is the creation of the Health Insurance Marketplace. The Marketplace was designed to foster competition, facilitate comparison shopping, and ensure affordability. Three years in, the Health Insurance Marketplace is a competitive, growing, and dynamic platform, a transparent Marketplace where issuers compete on price and quality, and people across the country are finding health plans that meet their needs as well as their budgets. Every year, we encourage consumers to return to the marketplace and shop for the plan that is best for them and their family. For 2016, marketplace coverage, approximately 67 percent of marketplace consumers selected a new plan and saved an average of $42 a month, or $500 a year, in premium costs.

In addition to providing consumers with a simple way to compare and find the plan that's right for them, the Affordable Care Act also includes tax credits to help make that coverage more affordable. Roughly 85 percent of marketplace consumers receive these tax credits, and for 2016 coverage, their average monthly premium increased by only 4 percent or just $4. After taking these tax credits into account, nearly 70 percent of healthcare.gov consumers had a coverage option for $75 a month or less, and 74 percent had an option for $100 a month or less. Importantly, consumers say they can now afford primary care, prescription drugs they could not afford before the Affordable Care Act, and a majority are satisfied with their coverage.

While we are encouraged by the progress we have made, we know that implementation of the Affordable Care Act is a multiyear process. As CMS, our efforts to improve all of our programs, including the marketplace, are an ongoing commitment.

This year among numerous other efforts, we are taking steps to enhance our outreach to young adults who are more likely to remain uninsured. We have also strengthened requirements for enrollment through special enrollment periods, ensuring that this tool is available for consumers when they need it, while preventing misuse and abuse.

And we aren't the only ones that are learning. Since the Affordable Care Act became law, I've seen an unprecedented amount of innovation in the private sector. The marketplace is increasingly serving as a laboratory for strategies that are helping improve care and control costs. For example, one issuer is creating plans based on the different needs of unique geographic communities, bringing together interdisciplinary teams focused on improving care for high-risk populations in particular communities.

We look forward to continuing to work with Congress and other key stakeholders on ways to strengthen our operations to ensure the American people have access to affordable coverage and high-quality health services. Using the tools created by the Affordable Care Act, we are all working toward a healthcare delivery system that works better for everyone, where care is improved through better coordination and integration, where we spend our healthcare dollars in smarter ways, and where our system is person-centered and Americans are healthier.

I know you have a number of questions, and I am happy to answer them to the best of my ability.

[Prepared statement of Mr. Counihan follows:]

STATEMENT OF

KEVIN COUNIHAN
CHIEF EXECUTIVE OFFICER OF THE MARKETPLACE AND
DEPUTY ADMINISTRATOR AND DIRECTOR AT THE CENTER FOR CONSUMER
INFORMATION & INSURANCE OVERSIGHT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

AN AFFORDABLE CARE ACT CHECK UP

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON HEALTH CARE, BENEFITS, AND ADMINISTRATIVE RULES

JULY 13, 2016

U.S. House Committee on Oversight & Government Reform
Subcommittee on Health Care, Benefits, and Administrative Rules
Hearing on
An Affordable Care Act Check Up
July 13, 2016

Chairman Jordan, Ranking Member Cartwright, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS') continuing work to implement the Affordable Care Act and provide consumers with affordable access to high quality health coverage.

Thanks to the Affordable Care Act, millions of Americans who were previously uninsured now have access to affordable, high-quality health care. An estimated 20 million more people now have coverage because law,[1] and at 9.1 percent, the uninsured rate for Americans is the lowest it has been on record.[2] Pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history.

The vast majority of Americans get their health insurance at work, and that has not changed. However, because of the Affordable Care Act, that coverage is stronger and more secure. Lifetime and annual dollar limits are now a thing of the past, and an estimated 105 million Americans had lifetime caps on their coverage lifted. Tens of millions of people have new access to preventive services with no cost-sharing. And consumers have new tools to appeal decisions made by their insurance companies.

The Affordable Care Act has resulted in cost savings for both consumers and taxpayers. The law requires health insurers to provide consumers with rebates if the amount they spend on health

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[1] https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf
[2] https://aspe.hhs.gov/sites/default/files/pdf/204986/ACARuralbrief.pdf

benefits and quality of care, as opposed to advertising and marketing, is too low. Last year, 5.5 million consumers received nearly $470 million in rebates. Since this requirement was put in place in 2011 through 2014, more than $2.4 billion in total refunds will have been paid to consumers. The law also eliminates out-of-pocket costs for certain preventive services, and women can no longer be charged more than men for the same coverage. In addition, the Affordable Care Act phases out the "donut hole" coverage gap for nearly 10.7 million Medicare prescription drug beneficiaries, who have saved an average of $1,945 per beneficiary.[3] Furthermore, the law has provided new transparency in how health insurance plans disclose reasons for premium increases and requires simple, standardized summaries so over 170 million Americans can better understand their coverage information and compare plans. These consumer protections did not exist six years ago.[4]

Since the Affordable Care Act became law, health care prices have risen at the slowest rate in 50 years. The Affordable Care Act's reforms to Medicare payment rates, along with likely "spillover" effects on prices in the private sector, have been major contributors to this recent slow price growth. The Congressional Budget Office (CBO) recently announced that compared with their and the Joint Committee on Taxation's 2010 projection, the current estimate of the net cost of the insurance coverage provisions over the 2016-2019 period is lower by $157 billion, or 25 percent.[5] In addition, CBO has estimated that the law will generate substantial deficit savings that grow over time, implying total savings of more than $3 trillion over the next two decades. Lower long-term deficits boost national saving, thereby increasing capital accumulation and reducing foreign borrowing, which raises wages and overall national income over time.

These cost savings have been coupled with a focus on improving the quality of care provided. The law created the Hospital Readmissions Reduction Program, which adjusts payments for hospitals with higher than expected 30-day readmission rates for targeted clinical conditions such as heart attacks, heart failure, and pneumonia. CMS has also undertaken several major quality improvement initiatives, such as the Partnership for Patients, all targeted at improving the quality

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[3] https://www.whitehouse.gov/the-press-office/2016/03/22/fact-sheet-health-care-accomplishments
[4] https://www.whitehouse.gov/the-press-office/2016/03/02/fact-sheet-affordable-care-act-healthy-communities-six-years-later
[5] https://www.cbo.gov/publication/51385#section3

of care for individuals as they move from one health care setting to another and reducing unnecessary hospitalizations.

We are already seeing national trends in health care improvements that are promising and likely a combined result of our efforts and tools provided by the Affordable Care Act. Since 2010, the rate of patient harm in U.S. hospitals has fallen by 17 percent. Cumulatively since 2010, this translates into 2.1 million avoided patient harms, like infections and medication errors, and an estimated 87,000 avoided deaths,[6] resulting in $20 billion in cost savings.[7] In addition, the hospital readmission rate for Medicare patients has fallen sharply in recent years. If the readmission rate had remained at its level before the Affordable Care Act's passage, a cumulative 565,000 additional readmissions would have occurred through May 2015. That's 565,000 times that a patient didn't have to experience an extra hospital stay.[8] The Affordable Care Act incentivizes hospitals to provide high-quality care and makes investments that help hospitals learn from each other how to keep patients safe. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible.

The Marketplace is Strong

The Marketplace was designed to foster issuer competition, facilitate consumers' comparison shopping, and ensure affordability through financial assistance, and research shows we are well on our way to accomplishing these goals. Three years in, the Health Insurance Marketplace is a competitive, growing and dynamic platform -- a transparent market where issuers compete on price and quality, and people across the country are finding health plans that meet their needs, and their budgets. And, increasingly, the Marketplace is also serving as a laboratory for innovations and strategies that are helping us build a better health care system. For example, one issuer is creating plans based on the different needs of unique geographic communities, involving activities such as bringing together interdisciplinary teams focused on improving care for high-risk populations in particular communities.

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[6] https://www.whitehouse.gov/sites/default/files/page/files/20160322_aca_six_year_anniversary_slides.pdf
[7] http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html
[8] https://www.whitehouse.gov/sites/default/files/page/files/20160322_aca_six_year_anniversary_slides.pdf

Competition has worked to create more affordable choices for consumers. The average number of issuers remained stable between 2015 and 2016. On average, consumers were able to choose from 5 issuers for 2016 coverage, just as they could for 2015, and 88 percent of returning consumers were be able to choose from 3 or more issuers, translating into 50 plan options.[9]

Research also shows that consumers took advantage of these options, shopping for the coverage that best fit their and their families' needs. Approximately 67 percent of HealthCare.gov consumers selected a new plan in 2016, including all new consumers and 43 percent of returning consumers. Consumers who switched plans saved an average of $42 per month in premium costs, equivalent to over $500 in annual savings. The increase in the average premium, taking shopping into account, was 8 percent between 2015 and 2016; among the roughly 85 percent of HealthCare.gov consumers with premium tax credits, the average monthly net premium increased by 4 percent, or just $4. The average monthly tax credit amount in 2016 is around $290 and reduces a consumer's premium by 73 percent. After taking into account tax credits, nearly 7 in 10 HealthCare.gov consumers had the option of coverage for $75 or less in monthly premiums for 2016 coverage, and 74 percent had an option for $100 or less.[10] These tax credits, as of March 2016, have helped nearly 9.4 million Americans purchase health coverage through the Health Insurance Marketplaces.[11]

In addition to shopping for plans based on price, many consumers shopped for their plans based on health care providers and services. For the third Open Enrollment, for the first time, the Federally-Facilitated Marketplace (FFM) began to offer consumers the option of selecting plans by searching for plans that offered a specific hospital, physician, or prescription. In its pilot year, consumers chose this path 3.6 million times in just the 38 FFM states.[12]

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9 https://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf

10 https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf

11 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html

12 https://blog.cms.gov/2016/06/09/remarks-of-cms-acting-administrator-andy-slavitt-at-the-marketplace-innovation-conference/

As of March 31, 2016, about 11.1 million consumers had paid their premiums and had an active policy, or "effectuated" their coverage for the 2016 benefit year, [13] compared to 10.2 million individuals as of March 31, 2015, nearly a 9 percent increase.[14] Importantly, consumers are getting value for their money. Research shows that consumers say they can now afford primary care and prescription drugs they could not afford before the Affordable Care Act, and a majority are satisfied with their coverage.[15] J.D. Power found that consumers who bought coverage through the Marketplace were generally more satisfied than those with other types of insurance, including employer coverage.[16] Employer-sponsored coverage has not been disrupted, and employees now have options to move jobs without fear of their families being unable to afford and obtain coverage.

In February of this year, we issued the annual Notice of Benefit and Payment Parameters for the 2017 coverage year, along with related guidance documents. The rule finalizes provisions to: help consumers with surprise out-of-network costs at in-network facilities, provide consumers with notifications when a provider network changes, give insurance companies the option to offer plans with standardized cost-sharing structures, provide a rating on HealthCare.gov of each Qualified Health Plan's relative network breadth (for example, "basic," "standard," and "broad") to support more informed consumer decision-making, and improve the risk adjustment formula.

Enhancing Outreach to Young Adults

Since the ACA was enacted, the overall uninsured rate has fallen by more than 40 percent, and the uninsured rate among young adults has fallen by more than 50 percent. But younger and healthier adults are still more likely than average to remain uninsured.[17] In 2015, almost half of all uninsured individuals eligible for Marketplace coverage were between the ages of 18 and

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[13] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html
[14] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html
[15] http://www.commonwealthfund.org/acaTrackingSurvey/about.html
[16] http://www.jdpower.com/press-releases/2015-health-insurance-marketplace-exchange-shopper-and-re-enrollment-hix-study
[17] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-21.html

34.[18] Insuring these groups lets them invest in their health, protects them against catastrophic costs from serious illness, and helps young adults continue their education. It also contributes to a more balanced Marketplace risk pool and lower costs. CMS recently announced a series of actions to step up Marketplace outreach, especially to young adults, for the 2017 Open Enrollment.

Research during the 2016 Open Enrollment showed that young adults are almost twice as likely as older consumers to enroll because they receive an email about Marketplace coverage. During the upcoming Open Enrollment, we will draw on lessons learned this year about the messages, timing, and tactics that make email outreach more effective.

Also, new since the 2016 Open Enrollment, this year we will be able to email consumers with important proactive reminders in near-to-real time if they open an account to start an application, finish an application to select a plan, and when they select a plan pay to their first premium as the last step to gaining coverage. We've learned that sending an email, with the right information, at just the right time, can make a significant difference in whether someone gets covered, and those are lessons we'll act on this year.

In addition, we are making it easier for issuers to conduct outreach to young adults turning age 26 and moving off their parent's plans. Specifically, new guidance from the Department of Labor makes clear that the sponsors of employer plans can – and are encouraged to – provide additional information that will help young adults understand their options and enroll in Marketplace coverage as appropriate. Along with issuing new policy guidance, we are strongly encouraging insurers to contact these consumers with targeted information about Marketplace options. Additionally, on June 13, we provided states and outreach organizations with $32 million in additional funding to help with Medicaid and Children's Health Insurance Program (CHIP) outreach. In conjunction with that funding announcement, we reminded them of their obligation to help children aging out of Medicaid and CHIP transition to Marketplace or other coverage.

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[18] https://aspe.hhs.gov/basic-report/health-insurance-marketplace-uninsured-populations-eligible-enroll-2016

Finally, HHS has created a network of diverse outreach partners. While we will keep building that network until the start of the 2017 Open Enrollment and beyond, we are excited to announce that this year's partnerships will include Lyft, the American Hospital Association, and coordinated young adult campaigns that include more than 75 partnering organizations. To help focus these efforts, the White House will host a National Millennial Health Summit on September 27, 2016.

Working with States to Benefit Consumers through Medicaid Expansion

Throughout its 50-year history, Medicaid has served as an adaptable program, adjusting to national and state-specific needs and meeting the health care needs of children, adults, pregnant women, seniors, and people with disabilities. For these low-income Americans, Medicaid has provided health insurance coverage that is affordable, accessible, and has served as the Nation's major source of long-term care coverage. CMS is committed to working with states to expand Medicaid in ways that work for them, while protecting the integrity of the program and those it serves.

As a result of the Affordable Care Act, states have the opportunity to expand Medicaid eligibility to individuals 19-64 years of age with incomes up to 133 percent of the Federal poverty level (FPL). For the first time, states can provide Medicaid coverage for low-income adults without dependent children without the need for a demonstration waiver. The Affordable Care Act provides full Federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent FPL through Calendar Year 2016, and then phases down in subsequent years to cover 90 percent of costs in Calendar Year 2020 and thereafter. This increased Federal support has enabled 31 states and the District of Columbia to expand Medicaid coverage to more low-income adults. The Administration has proposed in its FY17 Budget to make full federal funding available for the first three years a state takes up expansion. Primarily as a result of the expansion of coverage to low-income adults and the eligibility and enrollment simplifications CMS and states have made, since the beginning of the Affordable Care Act's first Open Enrollment Period, Medicaid/CHIP enrollment has grown by 15.0 million individuals, and

among Medicaid expansion states, the uninsured rate for non-elderly adults declined by 49.5 percent, compared to 33.8 percent in non-expansion states[19]

States that have expanded their Medicaid programs are documenting significant reductions in uncompensated care and the uninsured rate. Hospitals provided over $50 billion in uncompensated care in 2013; in 2014, there was a $7.4 billion reduction in uncompensated care costs, with 68 percent of the reduction coming from states expanding Medicaid.[20] And of the 12 states with the greatest reductions in uninsured rates from 2013 to 2015, 11 had expanded Medicaid eligibility.[21]

Importantly, beneficiaries are satisfied with their plans. According to a recent report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), 93 percent of new Medicaid enrollees report being satisfied with their health plans and 92 percent report being satisfied with their doctors. In addition, 78 percent of new Medicaid enrollees indicated that they would not have been able to access or afford their care prior to Medicaid expansion and enrollment. Unmet health care needs among low-income adults declined 10.5 percentage points after expansion, and the percentage of low-income adults reporting problems paying medical bills also declined by 10.5 percentage points.[22] Further, compared with non-expansion states, enrollees in expansion states saw a 41 percent increase in preventive service visits in community health centers; access to Medicaid prescription drug refills increased 25.4 percent in states that expanded coverage, compared to only 2.8 percent in states that did not expand coverage; and cost-related barriers to dental care fell from 30 percent in 2013 prior to Medicaid expansion to 25 percent in 2014 post Medicaid expansion.

Ongoing Efforts to Expand Upon Affordable Care Act Successes

Part of our job at CMS in overseeing ongoing development of the Affordable Care Act is to create a predictable and level playing field for consumers, providers, issuers, and other

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[19] https://aspe.hhs.gov/sites/default/files/pdf/205141/medicaidexpansion.pdf
[20] http://aspe.hhs.gov/health/reports/2015/medicaidexpansion/ib_uncompensatedcare.pdf
[21] http://www.gallup.com/poll/189023/arkansas-kentucky-set-pace-reducing-uninsured-rate.aspx
[22] https://aspe.hhs.gov/sites/default/files/pdf/205141/medicaidexpansion.pdf

stakeholders, and to facilitate stability during these early years. Over the past several months, CMS has taken a set of actions which strengthen the risk pool, limit upward pressure on rates, and provide a strong foundation for the Marketplace for the long-term. This process is a continual ongoing commitment, and we have made meaningful progress.

Facilitating States' Improvement of the Rate Review Process

The Affordable Care Act brought unprecedented transparency into health insurance pricing. Before the Affordable Care Act, insurance companies in many states were able to raise rates without explaining their actions to regulators or the public. Today, the rate review process improves insurer accountability and transparency. It ensures that experts evaluate whether the proposed rate increases are based on reasonable cost assumptions and solid evidence and gives consumers the chance to comment on proposed increases. In 2015, rate review led to an estimated $1.5 billion in savings for consumers.[23] Most recently, CMS announced the availability of additional funding to state insurance regulators to use for issuer compliance with Affordable Care Act key consumer protections. This award opportunity enables states to seek funding for activities related to planning and implementing select federal market reforms and consumer protections including: essential health benefits, preventive services, parity in mental health and substance use disorder benefits, appeals processes, and bringing down the cost of health care coverage (also known as medical loss ratio provision).

Strengthening Special Enrollment Period Requirements

Over the last several months, the Marketplace has taken a number of steps to ensure that Special Enrollment Periods (SEPs) are there for consumers when they need them, while avoiding misuse or abuse. We've strengthened our rules and clarified our processes for SEPs, so that the people who need to can still easily get coverage, while making it hard for anyone thinking about taking advantage of them. We also eliminated 7 SEPs, including the SEP for individuals who owed the tax penalty for not having health insurance, contributing to an almost 30 percent year-over-year drop in the number of SEP enrollments during the three months after Open Enrollment.

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[23] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf

Continuing that work, in February we announced that we would begin verifying certain consumers' eligibility for enrollments made since April through five common Special Enrollment Periods. In addition, starting June 18 all individuals who qualify for these five Special Enrollment Periods are now asked to provide documents to prove their eligibility for that Special Enrollment Period at the time that they qualify. On our website, we have posted models of these eligibility notices that include lists of examples of acceptable documents people can submit to prove their eligibility for their Special Enrollment Period, as well as articles to help answer questions and assist consumers through this process. Consumers who qualify for and enroll in coverage through one of these five Special Enrollment Periods should provide the appropriate documents by the deadline listed in their notice to confirm eligibility for that Special Enrollment Period to avoid any disruptions to their coverage.

Refining Risk Adjustment Models

By reducing incentives for issuers to try to design products that attract a disproportionately healthy risk pool, risk adjustment lets them design products that meet the needs of all consumers, protecting consumers' access to a range of robust options. Earlier this year, CMS made a number of changes to improve the stability, predictability, and accuracy of the risk adjustment program for issuers. These changes include better modeling of costs for preventive services, changes to the data update schedule, and earlier reporting of preliminary risk adjustment data where available. We also published a Risk Adjustment White Paper and hosted a conference on March 31, 2016 to solicit feedback from issuers, consumers, and other stakeholders on additional areas for improvement.

Building off the Risk Adjustment White Paper and stakeholder feedback, we recently announced two additional important changes to risk adjustment that we intend to propose in future rulemaking. First, we intend to propose that, beginning for the 2017 benefit year, the risk adjustment model include an adjustment factor for partial-year enrollees. By accounting for the costs of short term enrollees in ACA-compliant risk pool, this change will support the Marketplace's important role as a source of coverage for people who are between jobs, experiencing life transitions, or otherwise need coverage for part of the year. Second, we intend

to propose that, beginning for the 2018 benefit year, prescription drug utilization data be incorporated in risk adjustment, as a source of information about individuals' health status and the severity of their conditions. We are also considering proposing additional changes to the model for 2018 and beyond.

Furthering Data Matching Accuracy

CMS takes very seriously its obligation to ensure that access to coverage and financial assistance are limited to those individuals who are indeed eligible. The Marketplace verifies eligibility for most consumers through electronic trusted data sources, but if consumers' data cannot be matched electronically we generate a data matching issue to request additional information from enrollees. Consumers who do not provide the necessary information will have their coverage or financial assistance ended or modified.

Unfortunately, eligible individuals sometimes lose coverage or financial assistance through the Marketplace during the year because they have trouble finding documents or navigating the data matching process. In addition to the direct impact on consumers, avoidable terminations due to data-matching issues also negatively impact the risk pool, since younger, healthier individuals appear to be less likely to persevere through the data matching process. In fact, in 2015, younger open enrollment consumers who experienced a data matching issue were about a quarter less likely to resolve their problem than older consumers.

This year, CMS made a range of improvements to the data matching process, such as updating our online application and improving systems functionality, to help consumers avoid generating data matching issues in the first place and to help them resolve these issues once generated. More recently, we have also intensified our outreach, and partnered with issuers so that they are reaching out to consumers about data-matching issues as well. These efforts are beginning to pay off, with a sharp reduction in total data-matching issues generated and an almost 40 percent year-over-year increase in the number of documents consumers have submitted to resolve these issues. Continued progress in this area should benefit both directly affected consumers and other consumers who will benefit from a stronger risk pool.

Moving Forward

Since the passage of the Affordable Care Act, millions of Americans now have access to high quality, affordable health care coverage, and we are controlling the growth of health care costs. From the outset, we knew that implementation of the Affordable Care Act would be a multi-year process, and we learn daily how to improve our operations and enhance the consumer experience by making the purchasing of health insurance easier and simpler for our customers. We look forward to continuing to benefit from suggestions from customers, assisters, brokers, issuers, and other key stakeholders on ways to improve our operations to ensure the American people gain the peace of mind of health insurance coverage. Using the tools created by the Affordable Care Act, we are working toward a health care delivery system that works better for everyone—where care is improved through better coordination and integration, where we spend our health dollars in smarter ways, and where our system is person-centered and healthier.

Mr. JORDAN. Thank you, Mr. Counihan.
Ms. Blumberg, you are now recognized.

STATEMENT OF LINDA J. BLUMBERG, PH.D.

Ms. BLUMBERG. Mr. Chairman, Ranking Member Cartwright, and members of the committee, thank you for the opportunity to testify before you today. The views that I express are my own and should not be attributed to the Urban Institute, its funders, or its trustees.

The Affordable Care Act can claim substantial successes, including health insurance coverage for 20 million additional people through Medicaid and private nongroup health insurance and the elimination of discrimination related to health status in small employer and nongroup markets. The law also has contributed to the slowdown in national health expenditure growth and has created significant price competition in many nongroup health insurance markets. At the same time employer coverage rates have remained steady, and there have been no adverse employment affects.

No one should expect one piece of legislation to address all problems in the Nation's complex healthcare system, nor should one expect the full promise of the legislation to be met in the first few years of reform. Now is the appropriate time to assess remaining issues and to work seriously to improve upon these without sacrificing the many gains already achieved. I am going to address two areas where public policies could make further strides toward ensuring access to adequate affordable health care regardless of health status or income.

First, some geographic areas have had less success engendering strong price competition in their nongroup insurance markets. Second, while the ACA has improved affordability for many families, some still face high healthcare expenses relative to income given premiums and out-of-pocket costs. In many larger States, the ACA has led to strong insurer participation in nongroup insurance markets and true price competition for the first time, replacing the previously rampant insurer competition for the best healthcare risks. Our research shows that areas with low premiums and low premium growth tend to have more insurers competing, larger State populations, and competition from provider-sponsored and formerly Medicaid-only insurers.

Nationally, 48 percent of the population lives in rating areas where the lowest cost silver premium in the marketplace either decreased or increased by less than 5 percent in 2016. However, 36 percent of the population lives in areas that experienced increases of 10 percent or more. Thus the dynamics at play are uneven both across the country and across areas within individual states.

We need to design approaches that improve competition where it is missing without disrupting competition where it has been successful. Competition could be strengthened by reducing insurer and/or provider market power, adverse selection into the nongroup insurance market, and insurance policies not compliant with ACA standards. Strategies, such as continuing the reinsurance program or introducing a Medicare-based qualified health plan, can be useful to address these problems, but markets vary considerably, as will the appropriate types of intervention. The attraction of the

ACA's private sector focus was its potential to create real economic competition, yet that approach also allows for instances of continued local variability.

Next, healthcare affordability remains an issue for some. While the share of families reporting difficulty paying for medical bills or having unmet medical need due to cost has decreased significantly since 2013, not all families have enjoyed similar gains. Poor adults in 19 States are ineligible for Medicaid because their State governments did not choose to expand eligibility despite the strong State budgetary advantages of doing so. Further incentives or other strategies may be required to bring all States into the expanded program. Financial assistance through marketplace tax credits and cost-sharing reductions are generous for those with incomes below 200 percent of the Federal poverty level, but assistance decreases markedly above that level, leaving adequate coverage for some still out of financial reach.

Healthcare costs have grown much less than originally anticipated when the ACA was implemented. Using just a portion of the systemwide savings that have resulted from that lower growth, we could improve upon the ACA subsidies to ameliorate the remaining affordability gaps and further reduce the number of uninsured Americans.

In contrast, repealing the ACA would by 2021 increase the number of uninsured people by 24 million, reduce private insurance coverage by over 9 million people, increase State government spending, and substantially reduce the amount of medical care delivered to low and modest income families.

The House Republicans' plan combines repeal of the ACA with the introduction of policies that would substantially reduce assistance to low- and middle-income individuals and would undermine the ACA's many advances in improving access to care for people with health problems. The ACA's underlying framework increases the sharing of healthcare costs between the healthy and the sick. The House Republicans' proposed strategies, such as continuous coverage requirements, elimination of benefit standards, sale of insurance across State lines, and individual health pools, would place much higher financial burdens on those with current or past health problems. And while such strategies can create savings for those who are healthy at a given time, they discount the fact that we tend to develop more health problems as we age and that even a 20-something who appears perfectly healthy one day can wake up the next to find his luck has changed horribly. Focusing on how someone benefits financially by being insured in any given year is to misunderstand the inherent nature and purpose of insurance and seriously underestimates the value of continuous access to adequate affordable coverage regardless of circumstances.

With that, I'm happy to answer any questions you may have.

[Prepared statement of Ms. Blumberg follows:]

URBAN INSTITUTE · ELEVATE · THE · DEBATE

Statement of
Linda J. Blumberg, Ph.D.*
Senior Fellow
The Urban Institute
Health Policy Center

Hearing of the

United States House of Representatives

Committee on Oversight and Government Reform

Subcommittee on Health Care, Benefits, and Administrative Rules

"From Premium Increases to Failing Co-Ops: An Obamacare Checkup"

Wednesday, July 13, 2016

*The views expressed are my own and should not be attributed to the Urban Institute, its trustees or its funders

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Mr. Chairman, Ranking Member Cartwright, and members of the committee, I appreciate the opportunity to testify before you on the status of the Affordable Care Act. The views that I express are my own and should not be attributed to the Urban Institute, its trustees, or its funders. My testimony, submitted for the record, includes my oral remarks and two recent papers written with Urban Institute colleagues.

The Affordable Care Act can claim substantial successes, including health insurance coverage for 20 million additional people through Medicaid and private nongroup health insurance[1] and the elimination of discrimination related to health status in small employer and nongroup markets. The law also has contributed to the slowdown in national health expenditure growth[2] and has created significant price competition in many nongroup health insurance markets.[3] At the same time, employer coverage rates have remained steady,[4] and there have been no adverse employment effects.[5]

No one should expect one piece of legislation to address all problems in the nation's complex health care system, nor should one expect the full promise of the legislation to be met in the first few years of reform. Now is the appropriate time to assess remaining issues and to work seriously to improve upon these without sacrificing the many gains already achieved.

I'm going to address two areas where public policies could make further strides toward ensuring access to adequate, affordable health care, regardless of health status or income. First, some geographic areas have had less success engendering strong price competition in their nongroup insurance markets. Second, while the ACA has improved affordability for many families, some still face high health care expenses relative to income, given premiums and out-of-pocket costs.

In many larger states, the ACA has led to strong insurer participation in the nongroup insurance markets and true price competition for the first time, replacing the previously rampant insurer competition for only the best health care risks. Our research shows that areas with low premiums and low premium growth tend to have more insurers competing, larger state populations, and competition from provider-sponsored and formerly Medicaid-only insurers.[6] Nationally, 48 percent of the population lives in rating areas where the lowest cost silver premium in the marketplace either decreased or increased by less than 5 percent in 2016. However, 36 percent of the population lives in areas that experienced increases of 10 percent or more. Thus, the dynamics at play are uneven both across the country and across areas within individual states.

We need to design approaches that improve competition where it is missing without disrupting competition where it has been successful. Competition could be strengthened by reducing insurer and/or provider market power, adverse selection into the nongroup insurance market, and insurance policies not compliant with ACA standards. Strategies such as continuing the reinsurance program or introducing a Medicare-based qualified health plan can be useful to address these problems, but markets vary considerably, as will the appropriate types of intervention. The attraction of the ACA's private-sector focus was its potential to create real economic competition, yet that approach also allows for instances of continued local variability.

Next, health care affordability remains an issue for some. While the share of families reporting difficulty paying for medical bills or having unmet medical need due to cost has decreased significantly since 2013,[7] not all families have enjoyed similar gains. Poor adults in 19 states are ineligible for Medicaid because their state governments did not choose to expand eligibility, despite the strong state budgetary advantages of doing so.[8] Further incentives or other strategies may be required to bring all states into the expanded program.

Financial assistance through marketplace tax credits and cost-sharing reductions are generous for those with incomes below 200 percent of the federal poverty level, but assistance decreases markedly above that level, leaving adequate coverage for some still out of financial reach.[9] Health care costs have grown much less than originally anticipated when the ACA was implemented.[10] Using just a portion of the systemwide savings that have resulted from that lower growth, we could improve upon the ACA's subsidies to ameliorate the remaining affordability gaps and further reduce the number of uninsured Americans.[11] In contrast, repealing the ACA would, by 2021, increase the number of uninsured people by 24 million, reduce private insurance coverage by over 9 million people, increase state government spending, and substantially reduce the amount of medical care delivered to low- and modest-income families.[12]

The House Republicans' plan[13] combines repeal of the ACA with the introduction of policies that would substantially reduce assistance to low- and middle-income individuals and would undermine the ACA's many advances in improving access to care for people with health problems. The ACA's underlying framework increases the sharing of health care costs between the healthy and the sick.[14] The House Republicans' proposed strategies, such as continuous coverage requirements, elimination of benefit standards, sale of insurance across state lines, and individual health pools, would place much higher financial burdens on those with current or past health problems.[15] And while such strategies can create savings for those who are healthy at any given time, they discount the facts that we tend to develop more health problems as we age and that even a 20-something who appears perfectly healthy one day can wake up the next to find his luck has changed horribly. Focusing on how someone benefits financially by being insured in any given year is to misunderstand the inherent nature and purpose of insurance and seriously underestimates the value of continuous access to adequate, affordable coverage, regardless of circumstances.

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HealthAffairsBlog

Don't Let The Talking Points Fool You: It's All About The Risk Pool

Linda Blumberg and John Holahan

March 15, 2016

Most people are healthy most of the time, and as a consequence, health care expenditures are heavily concentrated in a small share of the population: about 50 percent of the health care spending in a given year by those below age 65 is attributable to just 5 percent of the nonelderly population. The lowest spending half of the population accounts for only about 3.5 percent of health care spending in a year.

Deciding how much of total health care expenditures should be shared across the population and how to share it is the fundamental conundrum of health care policy. There is more risk pooling the larger the share of health expenditures included in the insurance as covered expenses (i.e., the fewer benefits excluded and the lower the out-of-pocket cost requirements), the larger the number of both the healthy and the sick insured, and the lower the variation in premiums across different enrollees. Sharing the costs of the sick across the broader population (a.k.a., risk pooling) increases costs for the healthy to the benefit of those with health problems; this creates more financial losers than winners at a point in time, since there are many more healthy people than sick in a given year. Segmenting risk pools has the opposite effect, savings for the currently healthy while increasing costs for those with health problems.

The health policies of the two political parties and their presidential candidates differentiate themselves clearly along the lines of pooling philosophies: the Democrats generally advocate broad-based pooling of health care risk and the Republicans generally advocate more individual responsibility and are willing to accept much greater segmentation of health care risk. These positions have dramatically different implications for individuals when they experience significant health problems, and they

also have very different implications for low- and middle-income populations as compared to those with high incomes. As a consequence, each health care policy proposal should be evaluated as to its ramifications for risk pooling.

Left unchecked, people who perceive themselves healthy will tend, if they are pursuing their own near-term financial self-interests, to separate themselves from sick people—either by avoiding health insurance entirely, purchasing insurance products sold predominantly to other healthy people, or purchasing insurance products offering limited benefits that likely are not attractive to those requiring significant medical care. Those supporting public policies that allow or encourage this type of separating of health care risks often argue that they are placing greater personal responsibility on each individual, who will in turn make better decisions about the use of medical services. However, the burden of that increased responsibility falls most heavily on those with health problems, since it places larger financial costs on those with medical care needs at the time those needs arise, reducing costs for individuals while they are healthy.

Depending upon the extent of the risk segmentation created, these policies can effectively deny care to those that need it. Those who are well off financially can finance a considerable amount of necessary care out-of-pocket; a low- or middle-income individual experiencing a health crisis cannot. Thus, policies that separate risks will not only harm the sick, they will decrease access to care most heavily for the non-wealthy with health problems. Therefore, the amount of risk pooling versus risk segmentation is a fundamental choice.

The Risk Pooling Continuum

Policies That Promote Greater Pooling Of Risk

The degree of risk sharing under current law varies by the insurance market. ***Public insurance*** (e.g., Medicare, Medicaid) represents the most pooling of risk. All beneficiaries are eligible for the same health insurance benefits, and the cost of providing those benefits is largely financed by broad-based revenue sources (e.g., income or payroll taxes), completely separating enrollee health status from financing of the programs' benefits. Public programs that include deductibles, co-insurance, or co-payments or limit covered benefits reduce the sharing of risk to some extent, as these provisions increase financial burdens directly with medical care use.

Employer based insurance, still the primary source of insurance for the non-elderly, promotes natural pooling of risk, since individuals generally choose employers for reasons unrelated to their health status, and participation in employer-offered plans

tends to be high. Trends that are increasing cost-sharing requirements in employer-based coverage are, however, reducing risk pooling to some extent in these plans over time.

Prior to 2014 when the Affordable Care Act's main coverage provisions were implemented, the***nongroup and small employer insurance markets*** were characterized by very little risk pooling, with risk segmentation being the greatest for nongroup insurance. Individual purchasers could be denied coverage outright in the vast majority of states due to health care risk, they could be offered policies that permanently excluded care associated with particular health problems, they could be offered policies with higher cost-sharing requirements (deductibles, coinsurance) because of their health profile, and many policies excluded or severely limited benefits such as maternity care, prescription drugs, and mental health services. In both the small group and nongroup markets, minimum benefit standards were rare, higher premiums could be charged depending on the health care profiles of enrollees, and substantial pre-existing condition exclusion periods often applied.

An array of policies included in the Affordable Care Act increased risk pooling significantly in these markets, but by no means does the law pool all risk. Key risk pooling provisions include guaranteed issue, modified community rating, minimum benefit and cost-sharing standards, prohibitions on pre-existing condition exclusion periods, the individual mandate, and income-related financial assistance for the purchase of nongroup insurance coverage. By requiring insurers to "take all comers" regardless of their health status or health history (***guaranteed issue and renewal***) and once they are covered to reimburse them for expenses related to health conditions that began prior to purchasing insurance (***prohibitions on pre-existing condition exclusions***), the ACA ensures that all insured individuals share in each other's health care costs, yielding a more diverse pool than would otherwise exist.
Minimum benefit and cost-sharing standards increase the share of total health expenditures that are financed through premiums, spreading health care costs more broadly and reducing the financial exposure for those with greater health care needs. Limiting variance in premiums due to the individual characteristics of the insured (***modified community rating***) increases pooling substantially compared to unregulated markets featuring different premiums for purchasers based upon their health status, health history, gender, and industry of employment, as well as much broader premium variation by age and other factors. Modified community rating is also critical to ensuring the effectiveness of guaranteed issue and guaranteed renewal; otherwise, insurers

could charge unhealthy enrollees much higher premiums than their healthy counterparts, counteracting the intended effects of those rules.

By requiring all or most individuals to enroll in health insurance coverage, *individual mandates* increase the number of healthy and sick individuals in insurance pools by providing incentives for them to enroll in and retain insurance; such mandates have the largest behavioral effect on those with lower health care costs who would be less likely to enroll otherwise. The more people subject to the mandate and the stronger the enforcement mechanisms, the greater its effect in spreading health care risk. Importantly, without the individual mandate, the other consumer protections (rating rules, guaranteed issue, benefit standards, etc.) would allow individuals to remain uninsured until a health problem arose, leading to a costly and unstable insurance pool.

Significant income-related financial assistance for the purchase of private insurance coveragenot only improves affordability for the sick, it also brings in low-income healthy individuals who otherwise could not enroll. This yields greater diversity in insurance pools and lowers the average health care costs of those enrolled; the greater the financial assistance provided, the broader the sharing of risk.

The ACA does not pool all risk even in the small group and nongroup markets; some enrollees have large cost-sharing requirements and certain benefits are not included in the essential benefit requirements, for example. Moreover, policy decisions that allowed for grandfathered and grandmothered plans in the small employer and nongroup insurance markets reduced risk pooling in the short-run, keeping the health care risk of people insured through those plans (who tended to be healthier on average) separate from the rest of those markets.

Policies That Decrease Risk Pooling, Separating The Risks

While the Affordable Care Act increased risk pooling, conservative members of Congress, presidential candidates, and policy analysts have proposed a number of health policies, many of which would work in combination to reverse that change. They would tend to isolate much larger shares of the health care costs of the sick from those that are healthy. This would reduce costs for the healthy and increase them for the sick. And because there are more healthy people than sick at a point in time, the savings

engendered for each healthy person would be smaller than the increased costs created for each unhealthy person. These policies include:

Various Forms Of Experience Rating Of Insurance Premiums

Experience rating of premiums includes, e.g., health status/health history rating, gender rating, age rating, tobacco use rating, industry rating, and rating based on genetic information. Allowing insurers to vary health insurance premiums according to the characteristics of insured individuals and groups increasingly segments the healthy from the sick. Each factor on which premiums can vary allows insurers to effectively create separate health insurance pools—pools in which only the health care costs of those with similar characteristics are averaged together. Those not in "healthy" pools would have high average expected costs and could be charged enough that most or all of them simply cannot afford insurance coverage.

Incentives To Increase Use Of Health Savings Accounts

Health Savings Accounts (HSAs) are investment accounts that allow individuals to deposit funds pre-tax and accrue tax free earnings on those funds; by current law, the accounts must be used in conjunction with high-deductible health plans, although some have proposed eliminating that requirement. Funds in the accounts can be used for medical purposes without incurring taxes or penalties and can be used for any purpose without penalty after age 65.

HSAs allow individuals to pull health care dollars that would otherwise be devoted to more comprehensive coverage out of the insurance pool and place them into accounts for the individual's own use. As a result, they have very different implications for those who are healthy and those who are sick. With an HSA, those with low expected use of medical care can limit their sharing of risk with a high-deductible insurance plan and receive significant tax benefits from deposits into the HSA; the tax benefits are greatest for those in the highest tax brackets. If they do not need much medical care, they benefit from the equivalent of an additional IRA.

People with health problems and people without the financial resources to fund the individual accounts do not receive the tax benefits associated with the accounts' growth and must face the financial burden of funding substantial portions of their care independently. Proposals designed to increase the numbers of people using HSAs by eliminating current restrictions on them will tend to decrease the number of healthy people enrolled in comprehensive insurance, reducing the sharing of their risk with those more likely to use medical care. (HSAs can be funded by employers, but a large percentage who offer HSA qualified high-deductible plans to their employees do not

contribute to them; among those that do, the average contribution is small relative to the potential out-of-pocket liability faced by the worker.)

Allowing Unrestricted Sales Of Insurance Across State Lines

Often mentioned by advocates as a way to increase competition across insurers, unrestricted sales of insurance across state lines would directly undermine state policies designed to broadly pool health care risk. Advocates for this policy consistently combine it with the elimination of the policies currently in place that encourage risk sharing in the private, individually purchased insurance market.

As a result, insurers domiciled in states with much more limited insurance market regulations (e.g., without guaranteed issue of insurance, as well as those permitting use of pre-existing condition exclusions, premium rating based on health status, and limited benefit plans) could sell low-cost coverage to healthy individuals living in a state with policies designed to share health care risk. These insurers could pull healthier consumers out of the insurance pools in their home states while leaving their sicker neighbors behind in higher-cost pools. Left with only those with health problems to enroll, insurance pools could not survive in those states attempting to share risk more broadly, ultimately leaving many of the sick with no insurance options at all.[1]

Allowing Coverage Denials, Benefit Exclusions, Cost-Sharing Variations With Health Status

Allowing private insurers to deny coverage to those at risk for higher-than-average medical expenses, to offer plans that exclude particular benefits consumers are expected to use based on their health histories, and to offer only coverage with high-cost sharing requirements to those with higher expected use of medical services are all strategies that place greater financial burdens for health care on those who most need to use it. These approaches separate all or significant portions of the expenses of high-need consumers from the insurance risk pool. For example, excluding mental health services from a plan requires a person with mental health care needs to bear the cost of those services themselves. Advocates for eliminating guaranteed issue, the current minimum benefit requirements, and/or actuarial value standards in the individually purchased and small-group insurance markets would re-instate strategies used to segment health care risk prior to implementation of the Affordable Care Act.

Age-Related Tax Credits That Do Not Vary With Income

Some of those advocating a replacement of the ACA suggest eliminating income-related subsidization of health insurance, replacing it with fixed tax credits for all Americans that vary somewhat with age but which would be available in equal amounts regardless of

income. Those in favor of these policies argue that administrative costs and marginal tax rates would be lower than under the income-related assistance in current law. In principle, one could provide tax credits to all irrespective of income of sufficient size to make adequate coverage affordable for those of all ages and financial means; however, such an approach would cost a fortune in government dollars. As such, proposals for this type of substitution are consistently associated with elimination of benefit and cost-sharing standards and significant loosening of limits on premium variations in the individually purchased insurance market.

The proposed age-related-only credits are much smaller than the ACA's income-related credits for an obvious reason: spreading aggregate tax credit costs across a much larger number of people (an entire population versus the low-income) inevitably means that the size of the credit allocated to each person must be much smaller, unless much more public money is devoted to the program. With a reduction in individual financial assistance and deregulated insurance markets, insurers would offer narrower coverage or no coverage at all to those with significant expected health care needs, and the assistance available would be insufficient to make adequate coverage affordable to those with modest incomes. Considerable costs would fall upon those with health care needs themselves, and even healthy people of modest means would not be able to afford coverage that gave them effective access to necessary care.

High Risk Pools

High risk pools are insurance pools designed to cover individuals with significant expected medical needs; these are individuals who have been denied coverage in private health insurance plans or who have specified conditions that are extremely likely to lead to denials. In other words, these are mechanisms for explicitly separating the costs of those with high medical needs from others, and these pools only makes sense in a market that allows insurers to deny coverage outright based on individuals' health status. A well-financed high risk pool that provided such high-need individuals with adequate, affordable coverage is in principal conceivable but would require very hefty public expenditures. As a result, customarily, states (and the federal government as transitional assistance between 2010 and 2013 prior to full ACA implementation) have provided only limited subsidization of insurance coverage through high risk pools.

Because the average health care costs of those eligible to enroll were high by design (they all had at least one high-cost medical condition) and because subsidies were limited, the high risk pools' insurance premiums and cost-sharing requirements were large. Many such pools had pre-existing condition exclusion periods, limited benefits, and enrollment limits; all of these characteristics served to reduce the value of the

coverage, creating high financial burdens for enrollees and limiting the number of people who could access the coverage. These problems could be addressed, but only with a much higher investment of tax dollars than any candidate proposing this approach has suggested.

"De-Linking" Insurance From Employment

The tax code provides strong incentives for individuals to obtain insurance for themselves and their family members through their employers, and this encourages risk spreading. The larger the employer, the greater the pooling of risk. Policy proposals to "de-link" insurance from employment, usually by eliminating the tax preference for employer-based insurance, would tend to reduce the provision of, and the participation in, those employer plans.

If the alternative is an individually purchased private insurance market that is built around policies that broadly pool health care risk (like those in the ACA), the effect on risk sharing of such a de-linking would be limited. However, those supporting these approaches consistently advocate for the deregulation of the individual insurance market, including eliminating minimum benefit requirements, premium rating rules, and other policies that operate to ensure access to adequate coverage for those with health problems. That combination would greatly reduce the sharing of health care risk; it would lower costs for those who are healthy at any point in time, but substantially increase costs and reduce access to coverage for those with current or past health problems. The currently healthy would be at similar risk if and when they develop health problems in the future.

The Competing Philosophies: Crystallizing The Difference

While those who are healthy at a given point in time may benefit financially from policies that separate their health care costs from those with health problems, health status is not a fixed state. As many of us know too well, the good fortune of a young, healthy 20- or 30-something can turn quickly with a single diagnosis of cancer, multiple sclerosis, or pulmonary emboli, or in the event of a serious motor vehicle accident. A perfectly healthy kindergartner can fall victim to leukemia without warning; a bright, active teenager can become severely depressed and require intensive psychiatric treatment.

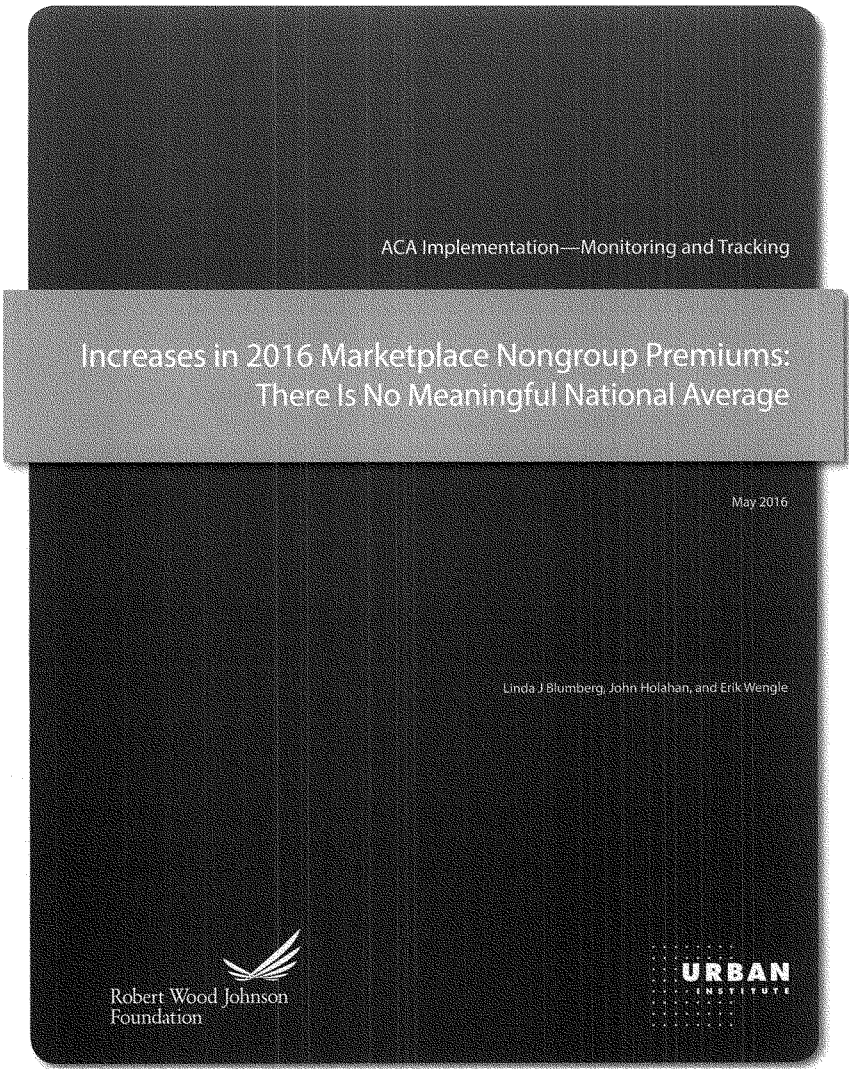
Even the most fortunate among us must face increasing health care costs as we age, although we erroneously may discount the value of our future access to adequate and affordable health insurance coverage when we are young and feeling invincible. Meanwhile, once we experience health problems, the broad sharing of health care risk that provides us with affordable access to necessary care may be invaluable.

The health care policy proposals offered by the various political players emerge from two starkly different philosophies. Those proposed by Democrats are generally consistent with broad based sharing of health care risk across the healthy and the sick. Their approaches employ deductibles, co-payments, and co-insurance and limit benefits to a degree, so some risk is borne by individuals themselves. But, in general, they are designed to spread risk broadly, increasing financial burdens on the currently healthy to the benefit of those with current health care needs.

Republican proposals generally place health care costs much more heavily on non-healthy individuals through various approaches that segment risk pools. Some proposals would pool risk for high catastrophic expenses; others would not. The risk segmenting approach has real financial benefits for those who are healthy at a given time, and those who are healthy significantly outnumber the unhealthy—hence the short term appeal. But these approaches place heavy financial burdens on those with the most health care needs, and they discount the value to the currently healthy of having affordable access to adequate care when and if they develop health problems in the future.

Risk pooling approaches promote broad access to affordable medical care regardless of income or health status, while the risk segmenting approaches do not and would in fact reduce access relative to current law. Advocates of the latter generally employ terms such as individual responsibility, skin in the game, consumer choice, and market competition, but make no mistake about it: it is all about the risk pool.

[1] Even under the ACA which provides regulatory floors below which states may not go, state regulations differ. For example, New York's nongroup and small group insurance markets comply with pure community rating; Massachusetts allows age rating in their markets to vary by a ratio of 2 to 1; and the ACA prohibits greater age variation than a ratio of 3 to 1.Therefore, unrestricted sales across state lines could undermine state decisions under the current system as well. That is why today the ACArestricts cross-state line sales of insurance to states that have mutually agreed to permit them through an interstate insurance compact.


ACA Implementation—Monitoring and Tracking
Increases in 2016 Marketplace Nongroup Premiums: There Is No Meaningful National Average
May 2016
Linda J Blumberg, John Holahan, and Erik Wengle
Robert Wood Johnson Foundation
URBAN INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

INTRODUCTION

Several reports estimate that 2016 nongroup marketplace premium increases were considerably higher than in previous years. Depending on the source and the premium measure used, premium increases have been reported as 7.5 percent, 12.6 percent, and 11 percent.[1] Earlier this year, we published a national estimate that the lowest-cost silver plan premium available in 2016 was, on average, 4.3 percent higher than the lowest-cost silver plan premium available in 2015; that estimate is based on the largest population rating areas in the first states to have their rates approved, and the estimate weights premiums by rating area population size.[2] That analysis used data on 20 states plus the District of Columbia and included large and small states from a diverse geographic distribution. Now, with data available for all states, we find that the average change in premiums for the lowest-cost silver plan across all rating areas in all states increased a weighted average of 8.3 percent between 2015 and 2016. However, further exploration reveals that the rates of increase vary tremendously across states and across rating areas within states, with statewide averages as high as 41.8 percent in Oklahoma and as low as -12.1 percent in Indiana.

We conclude that a national average rate of premium increase is a fairly meaningless statistic since different markets are having very different experiences. The focus of attention should be on understanding the wide variability by identifying the characteristics of markets that have experienced high premiums or high growth in premiums and of markets with lower premiums or lower growth in premiums. Tables 1 and 2 summarize the considerable variation in the changes in lowest-cost silver plan premiums offered between 2015 and 2016, comparing statewide and regional averages as well as detailing the variation in experiences across rating areas within each state. We find the following:

- Across 499 rating areas nationally, 29.1 percent of the population lives in rating areas with reductions between 2015 and 2016 in lowest-cost silver plan premiums. Another 19.0 percent live in rating areas with increases between 0 and 5 percent, and 16.1 percent live in areas with increases between 5 and 10 percent. Finally, 9.6 percent of the population live in rating areas with increases between 10 and 15 percent, and 26.3 percent live in areas with increases greater than 15 percent (table 2).
- There is also considerable variation in premium changes by geographic area. In 19 states (including Michigan, Florida, Texas, Virginia, California, and Ohio), solid majorities of the population reside in areas where the lowest-cost silver plan marketplace premium either decreased any amount or increased less than 5 percent.
- On the other hand, 16 states (including North Carolina, Colorado, Arizona, Oklahoma, Tennessee, Minnesota, and West Virginia) had majorities of their populations living in areas in which the lowest-cost silver plan marketplace premium increased more than 15 percent between 2015 and 2016.
- In some states (such as New York), the large population centers (such as New York City, Long Island, and Buffalo) saw decreases or small increases in lowest-cost silver plan premiums, although the rest of the state saw larger increases.

Table 1. State Average Premium Price for Lowest-Cost Silver Plan Available, 2014–2016

State	Average 2014 premium	Average 2015 premium	2014-15 relative change	Average 2016 premium	2015-16 relative change	Year-to-year average
National Average	**$256**	**$264**	**2.9%**	**$283**	**8.3%**	**5.5%**
Northeast						
Regional Average	**$284**	**$288**	**1.8%**	**$307**	**6.7%**	**4.2%**
Connecticut	$346	$348	0.6%	$351	0.8%	0.7%
Delaware	$286	$297	4.0%	$354	19.0%	11.2%
District of Columbia	$238	$239	0.3%	$229	-4.2%	-2.0%
Maine	$311	$307	-1.5%	$309	0.8%	-0.4%
Maryland	$221	$228	3.2%	$245	7.5%	5.3%
Massachusetts	$247	$243	-1.5%	$247	1.5%	0.0%
New Hampshire	$288	$238	-17.5%	$260	9.3%	-5.1%
New Jersey	$308	$315	2.2%	$325	3.3%	2.7%
New York	$340	$344	1.0%	$372	8.1%	4.6%
Pennsylvania	$207	$222	7.1%	$245	10.5%	8.8%
Rhode Island	$274	$244	-10.9%	$259	6.1%	-2.8%
Vermont	$395	$428	8.3%	$465	8.6%	8.5%
Midwest						
Regional Average	**$239**	**$248**	**3.5%**	**$261**	**6.2%**	**4.8%**
Illinois	$222	$229	3.0%	$247	8.1%	5.5%
Indiana	$313	$300	-4.3%	$264	-12.1%	-8.3%
Iowa	$219	$231	5.7%	$273	18.2%	11.8%
Kansas	$208	$201	-3.3%	$241	19.6%	7.6%
Michigan	$218	$241	10.5%	$237	-1.9%	4.1%
Minnesota	$178	$199	11.8%	$250	25.8%	18.6%
Missouri	$257	$269	4.6%	$303	12.6%	8.5%
Nebraska	$239	$254	6.3%	$320	26.2%	15.8%
North Dakota	$281	$292	3.7%	$313	7.4%	5.6%
Ohio	$244	$252	3.2%	$249	-1.1%	1.0%
South Dakota	$274	$257	-6.4%	$318	23.8%	7.6%
Wisconsin	$277	$281	1.3%	$290	3.4%	2.3%

Table 1 Continued

State	Average 2014 premium	Average 2015 premium	2014-15 relative change	Average 2016 premium	2015-16 relative change	Year-to-year average
National Average	**$256**	**$264**	**2.9%**	**$283**	**8.3%**	**5.5%**
South						
Regional Average	**$248**	**$261**	**5.4%**	**$284**	**9.5%**	**7.4%**
Alabama	$244	$255	4.8%	$288	12.7%	8.7%
Arkansas	$282	$281	-0.6%	$293	4.5%	1.9%
Florida	$244	$276	12.8%	$283	2.6%	7.6%
Georgia	$255	$260	1.8%	$279	7.5%	4.6%
Kentucky	$203	$208	2.5%	$233	11.8%	7.0%
Louisiana	$294	$297	1.1%	$327	10.2%	5.5%
Mississippi	$324	$283	-12.5%	$264	-6.8%	-9.7%
North Carolina	$289	$307	6.2%	$371	20.6%	13.2%
Oklahoma	$206	$201	-2.2%	$285	41.8%	17.8%
South Carolina	$267	$266	-0.6%	$300	13.0%	6.0%
Tennessee	$189	$199	5.0%	$275	38.6%	20.7%
Texas	$231	$248	7.1%	$251	1.2%	4.1%
Virginia	$259	$273	5.3%	$280	2.7%	4.0%
West Virginia	$266	$290	9.0%	$352	21.6%	15.1%
West						
Regional Average	**$260**	**$261**	**0.4%**	**$281**	**8.8%**	**4.5%**
Alaska	$380	$488	28.4%	$684	40.2%	34.2%
Arizona	$200	$177	-11.3%	$221	24.4%	5.1%
California	$280	$293	4.5%	$297	1.4%	2.9%
Colorado	$258	$225	-12.5%	$281	24.8%	4.5%
Hawaii	$176	$195	10.4%	$260	33.6%	21.5%
Idaho	$223	$235	5.7%	$272	15.5%	10.5%
Montana	$249	$237	-4.8%	$320	35.2%	13.4%
Nevada	$276	$270	-2.1%	$284	5.2%	1.5%
New Mexico	$225	$204	-9.2%	$195	-4.7%	-7.0%
Oregon	$204	$216	5.9%	$254	17.6%	11.6%
Utah	$196	$211	8.0%	$231	9.1%	8.6%
Washington	$269	$237	-12.0%	$255	7.8%	-2.6%
Wyoming	$396	$429	8.6%	$454	5.6%	7.1%

Note: Premium prices displayed are for a 40-year-old nonsmoking individual and are weighted by rating area population.
Colorado's data for 2014 and 2014–15 change do not include rating areas 8 and 9 because they were adjusted after the first open enrollment period.

Table 2. Distribution of Changes in Lowest-Cost Silver Plan Premium

State	Number of rating areas	Percent of population with decrease	Percent of population with <5% increase	Percent of population with 5%–9.99% increase	Percent of population with 10–14.99% increase	Percent of population with largest increases, ≥15%
National Average	**499**	**29.1%**	**19.0%**	**16.1%**	**9.6%**	**26.3%**
Northeast						
Regional Average	**46**	**23.7%**	**39.1%**	**17.2%**	**4.7%**	**15.4%**
Connecticut	8	29.6%	65.2%	5.25	0.0%	0.0%
Delaware	1	0.0%	0.0%	0.0%	0.0%	100.0%
District of Columbia	1	100.0%	0.0%	0.0%	0.0%	0.0%
Maine	4	30.1%	69.9%	0.0%	0.0%	0.0%
Maryland	4	0.0%	13.6%	75.2%	11.2%	0.0%
Massachusetts	7	48.4%	27.2%	0.0%	12.1%	12.4%
New Hampshire	1	0.0%	0.0%	100.0%	0.0%	0.0%
New Jersey	1	0.0%	100.0%	0.0%	0.0%	0.0%
New York	8	49.3%	27.2%	0.0%	0.0%	23.4%
Pennsylvania	9	0.0%	36.2%	25.4%	11.6%	26.8%
Rhode Island	1	0.0%	0.0%	100.0%	0.0%	0.0%
Vermont	1	0.0%	0.0%	100.0%	0.0%	0.0%
Midwest						
Regional Average	**124**	**41.4%**	**7.4%**	**10.1%**	**9.5%**	**31.6%**
Illinois	13	40.7%	0.0%	5.4%	10.9%	43.1%
Indiana	17	100.0%	0.0%	0.0%	0.0%	0.0%
Iowa	7	0.0%	0.0%	0.0%	29.2%	70.8%
Kansas	7	0.0%	0.0%	0.0%	0.0%	100.0%
Michigan	16	74.9%	3.6%	18.8%	0.0%	2.6%
Minnesota	9	0.0%	0.0%	0.0%	0.0%	100.0%
Missouri	10	0.0%	0.0%	51.6%	9.8%	38.6%
Nebraska	4	0.0%	0.0%	0.0%	0.0%	100.0%
North Dakota	4	0.0%	0.0%	77.5%	22.5%	0.0%
Ohio	17	62.5%	15.1%	0.0%	22.3%	0.0%
South Dakota	4	0.0%	0.0%	0.0%	0.0%	100.0%
Wisconsin	16	26.1%	50.5%	10.5%	12.9%	0.0%

Table 2 Continued

States	Number of rating areas	Percent of population with decrease	Percent of population with <5% increase	Percent of population with >5–9.99% increase	Percent of population with 10–14.99% increase	Percent of population with largest increase, ≥15%
National Average	**499**	**29.1%**	**19.0%**	**16.1%**	**9.6%**	**26.3%**
South						
Regional Average	**249**	**23.6%**	**22.1%**	**13.9%**	**11.2%**	**29.2%**
Alabama	13	4.4%	0.0%	23.3%	55.9%	16.4%
Arkansas	7	0.0%	82.9%	17.1%	0.0%	0.0%
Florida	67	44.7%	19.0%	19.8%	1.5%	15.0%
Georgia	16	6.0%	50.1%	0.0%	22.1%	21.8%
Kentucky	8	20.5%	19.1%	0.0%	11.5%	48.9%
Louisiana	8	9.4%	0.0%	24.9%	65.6%	0.0%
Mississippi	6	93.4%	6.6%	0.0%	0.0%	0.0%
North Carolina	16	0.0%	0.0%	0.0%	12.7%	87.3%
Oklahoma	5	0.0%	0.0%	0.0%	0.0%	100.0%
South Carolina	46	0.0%	0.0%	42.8%	21.1%	36.0%
Tennessee	8	0.0%	0.0%	0.0%	0.0%	100.0%
Texas	26	32.7%	44.2%	11.5%	0.9%	10.7%
Virginia	12	48.6%	9.6%	41.8%	0.0%	0.0%
West Virginia	11	0.0%	0.0%	8.5%	36.7%	54.8%
West						
Regional Average	**80**	**30.5%**	**7.7%**	**23.9%**	**11.4%**	**26.4%**
Alaska	3	0.0%	0.0%	0.0%	0.0%	100.0%
Arizona	7	0.0%	0.0%	6.7%	0.0%	93.3%
California	19	47.1%	10.4%	31.8%	10.6%	0.0%
Colorado	9	0.0%	7.9%	0.0%	0.0%	92.1%
Hawaii	1	0.0%	0.0%	0.0%	0.0%	100.0%
Idaho	7	0.0%	0.0%	30.6%	21.5%	48.0%
Montana	4	0.0%	0.0%	0.0%	0.0%	100.0%
Nevada	4	13.5%	22.3%	64.2%	0.0%	0.0%
New Mexico	5	54.8%	7.1%	38.1%	0.0%	0.0%
Oregon	7	0.0%	0.0%	0.0%	28.0%	72.0%
Utah	6	19.0%	0.0%	63.0%	0.0%	18.0%
Washington	5	37.3%	0.0%	0.0%	42.1%	20.6%
Wyoming	3	0.0%	86.1%	0.0%	13.9%	0.0%

Notes: Population is determined at the rating area level

This analysis focuses on identifying the characteristics of local markets associated with higher and lower premiums and larger and smaller changes in premiums between 2015 and 2016. We estimate regression models as a way to summarize these associations. We find the following:

- There is some regression to the mean; rating areas that had high premiums in 2015 relative to the national average had lower premium growth in 2016 and vice versa.
- However, the most important factors associated with lowest-cost silver plan premiums and premium increases are those defining the contours of competition in the market. Rating areas with more competitors had significantly lower premiums and lower rates of increase than those that did not.
- Those rating areas with a Medicaid insurer competing in the marketplace also have lower premiums and lower rates of increase than those regions without a Medicaid insurer competing. The presence of a co-op insurer was associated with lower premium increases although a co-op was not significantly associated with a lower premium level in 2016.

We also provide detailed information on substate rating areas in seven states that had high statewide average increases in their 2016 lowest-cost silver plan premiums and seven states that had low statewide average increases in 2016. These examples allow us to ground the findings of the regressions in specific experiences.

DATA AND METHODS

We analyze nongroup marketplace premium and insurer participation data taken from the 2015 and 2016 Robert Wood Johnson Foundation Health Insurance Exchange Comparison (HIX Compare) datasets for every rating area in the country; we combine those data with several validity checks and edits based on Healthcare.gov and the relevant state marketplace websites. Our analyses use the premium for the lowest-cost silver plan offered in each rating area for a 40-year-old nonsmoker. We have focused on the lowest-cost silver plan as a premium measure because it represents the least expensive entry point into the most popular tier of coverage. All averages presented are weighted by rating area population. In addition to average changes in state premiums between 2015 and 2016, we also calculate changes in average state premiums between 2014 and 2015 and the average annual change between 2014 and 2016 (geometric mean) to provide a broader context for the premium changes seen thus far.

To summarize the market-level characteristics associated with higher or lower premiums and higher or lower growth in premiums, we estimate linear probability models. We estimate two regressions, each with premium rating area as the unit of observation. The first has a dependent variable equal to the lowest-cost monthly silver plan premium in the rating area in 2016, and the second has a dependent variable equal to the percentage difference between the lowest-cost silver plan premium in the rating area in 2015 and in 2016. Explanatory variables in each regression include state population; the number of insurers in the rating area in 2015; the change in the number of insurers between 2015 and 2016; and indicators for 2016 participation in the rating area for previously Medicaid-only insurers (hereafter referred to as Medicaid insurers), co-ops, national insurers, regional or local insurers (including new commercial entrants like Oscar), provider-sponsored insurers, and Blue Cross Blue Shield–affiliated insurers (including Anthem and subsidiaries such as Bridgespan).

Additionally, in the premium regression we included indicators for states with pure community rating (New York and Vermont) because premiums in those states for a 40-year-old are significantly higher than in other states because the former states' insurers are prohibited from varying premiums by age (relative to cases in which premium variation by age is permitted, pure community rating increases premiums for younger enrollees and reduces them for older enrollees).[3] In the premium change regression we add average lowest-cost silver plan premiums in the rating area relative to the national average in 2015 to test for regression to the mean as an explanation for variation in premium increases or decreases.

We define Blue Cross Blue Shield insurers as those that are members of the Blue Cross Blue Shield Association. Co-ops were established under the Affordable Care Act (ACA), and all operating members are listed on the National Alliance of State Health Co-ops website. Medicaid insurers are those that only offered public insurance (Medicaid with or without Medicare) plans before the 2014 nongroup open enrollment period. Provider-sponsored insurers are those directly affiliated with a provider group (usually a hospital system).

A limitation of our analysis is that some insurers participating in a given rating area do not serve the full population in that rating area, only a part of it. As a result, in some portions of some rating areas, individuals likely do not have access to the lowest cost silver premium we identify. However, we are unable to analyze sub-rating area service areas at this time.

FINDINGS

Characteristics of Markets Associated with High and Low Premium Levels and Growth Rates, 2016

The weighted means of each variable used in the regressions are shown in table 3. The regressions estimated to summarize the association of market characteristics with premium levels and relative premium growth are shown in table 4. In table 4, the dependent variables are the monthly premium of the lowest-cost silver plan in each rating area in 2016 and the percentage difference between the lowest-cost silver plan premium in the rating area in 2015 and the lowest-cost silver plan premium in the rating area in 2016.

Table 4 shows that the lowest-cost silver plan premium available is lower when more insurers participate in the nongroup marketplace in a given region in 2015. Although this is likely because of the effect of competition, it could also be because markets that begin with somewhat lower premiums have more competition; causation cannot be determined here. Markets with a Medicaid insurer or a provider-sponsored plan in 2016 had lowest-cost silver plan premiums that were statistically lower than those in rating areas in which these insurer types did not compete. Premiums in rating areas with a local or regional insurer or a Blue Cross Blue Shield–affiliated insurer participating tended to be higher, signaling that such insurers may be more likely to participate in higher-priced markets, were less likely to price aggressively, or were underpriced in 2015. The presence of a co-op insurer in a rating area in 2016 is negatively correlated with the lowest-cost silver plan premium in the rating area, but the relationship is not statistically significant. The presence of a national insurer is also not statistically significant.

Table 3. Table of Means for Premium Level and Percent Change Regression Models, at the Rating Area Level

Variable	Weighted mean[a]
Dependent variables	
Percentage change in lowest-cost silver plan premium, 2015-16	0.08
2016 lowest-cost silver plan monthly premium	283.12
Independent variables	
State population	14,003,000
Number of participating insurers, 2015	5.69
Change in number of insurers, 2015-16	-0.38
Lowest-cost silver plan premium relative to the national average, 2015[b]	0.97
Medicaid insurer participating in 2016	0.48
Co-op insurer participating in 2016	0.20
National insurer participating in 2016	0.76
Regional or local insurer participating in 2016	0.52
Provider-sponsored insurer participating in 2016	0.55
Blue Cross Blue Shield insurer participating in 2016	0.95
Community rated nongroup market[c]	0.06

a. Weighted by rating region population
b. Only included in the premium percent change regression
c. Only included in the premium level regression; yes value for rating areas in New York and Vermont

Table 4 shows that rating areas with more insurers participating in the marketplace in 2015 tended to have smaller relative premium increases in 2016, and this relationship is highly significant. Each additional insurer participating in 2015 is associated with a 2016 premium increase that is 1.9 percentage points lower, all else constant. For example, a rating area that had eight marketplace insurers in 2015 had an expected premium increase of 3.8 percent in 2016; a rating area with average characteristics (including having two marketplace insurers in 2015) had an expected premium increase of 15.1 percent in 2016, measured at the mean for all other variables (table 5, scenario 1).

Whether a rating area experienced an increase or decrease in the number of marketplace insurers between 2015 and 2016 was also significantly correlated with its relative change in lowest-cost silver plan premium. Increases in the number of marketplace insurers are correlated with lower increases in the regions' lowest-cost silver plan premiums; the opposite holds true for decreases in the number of marketplace insurers. A 2016 increase (or decrease) of one in the number of insurers is associated with a 2.9 percentage point lower (or greater) increase in its lowest cost silver premium than an identical region that had the same number of insurers in each of 2015 and 2016 (table 5, scenario 2).

Rating areas with 2015 silver plan premiums that were high relative to the national average tended to have lower premium increases in 2016. For example, a rating area that was average in all other characteristics but that had a 2015 lowest-cost silver plan premium that was 10 percent above the national average had an expected premium increase in 2016 2.8 percentage points lower than an otherwise identical rating area in which the 2015 lowest-cost silver plan premium was equal to the national average (table 5, scenario 3). This finding suggests a possible regression to the mean over time; that is, markets in which early premiums were high are growing at a slower rate than markets in which early premiums were low.

Table 4. Lowest-Cost Silver Plan Monthly Premium and 2015-2016 Percentage Change Regression Models Coefficients

	2016 premium regression model	2015-16 relative change regression model
State population	-5.52E-08	-2.77E-09***
Number of participating insurers, 2015	-10.60***	-0.02***
Change in number of insurers, 2015-16	-4.50	-0.03***
Lowest-cost silver plan premium in 2015 relative to national average	N/A	-0.28***
Medicaid insurer participating in 2016	-21.07***	-0.07***
Co-op insurer participating in 2016	-10.72	-0.05***
National insurer participating in 2016	-4.59	-0.01
Regional or local insurer participating in 2016	26.13***	0.07***
Provider-sponsored insurer participating in 2016	-12.31**	-0.02
Blue Cross Blue Shield insurer participating in 2016	28.13***	0.06***
Community rated nongroup market	112.16***	N/A
Intercept	320.67	0.45
R^2	0.34	0.39
n	499	499

Source: Author's analysis of RWJF HIX Compare datasets combined with Healthcare.gov and state marketplace websites
Note: N/A = Variable not included in this regression.
* $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$.
R^2 is a representation of the share of variation in the dependent variable explained by the independent variables.

Table 5. Effect of Market Characteristics on Relative Change in Lowest-Cost Silver Plan Premiums, 2015-2016

Scenarios		Percentage point difference in estimated annual growth rates between scenarios
	2 insurers competing in 2015	15.1%
1	8 insurers competing in 2015	3.8%
	Difference	11.3%
	No change in number of insurers in a rating region	9.4%
2	1 insurer exits the region in 2016	12.3%
	Difference	2.9%
	2015 lowest-cost silver premium at the national average	10.7%
3	2015 lowest-cost silver premium 10 percent above the national average	7.8%
	Difference	-2.8%
	Medicaid insurer competes in rating area	5.4%
4	No medicaid insurer competes in rating area	12.8%
	Difference	-7.3%
	Co-op insurer competes in rating area	6.9%
5	No co-op insurer competes in rating area	11.4%
	Difference	-4.5%
	Regional insurer competes in rating area	15.2%
6	No regional insurer competes in rating area	8.1%
	Difference	7.1%
	Blue Cross Blue Shield-affiliated insurer competes in rating area	11.1%
7	No Blue Cross Blue Shield-affiliated insurer competes in rating area	5.2%
	Difference	5.9%
	National insurer competes in rating area	10.4%
8*	No national insurer competes in rating area	11.2%
	Difference	-0.8%
	Provider-sponsored insurer competes in rating area	9.6
9*	No provider-sponsored insurer competes in rating area	11.3%
	Difference	-1.7%
	Rating area in state of average population size	10.7%
10	Rating area in state of with population size 10 million above average	7.9%
	Difference	-2.8%

Note: Effects are evaluated at mean values for all other variables; unit of observation is the rating area.
* The variables indicating presence in the market of a national insurer or a provider sponsored insurer is not statistically significant in the regression (see table 4)

The regression results also indicate that a Medicaid insurer or a co-op participating in the marketplace in 2016 is associated with a significantly lower rate of increase in the lowest-cost silver plan premium in 2016. For example, competition from a Medicaid insurer in a rating area with otherwise average characteristics is associated with a relative premium increase 7.3 percentage points lower than that in an identical rating area that lacks a Medicaid insurer (table 5, scenario 4). The participation of a co-op in a rating area with otherwise average characteristics is associated with an increase in the lowest-cost silver plan premium that is 4.5 percentage points lower than that of an identical rating area that lacks a co-op (table 5, scenario 5). On the other hand, the presence of a regional insurer or a Blue Cross Blue Shield–affiliated insurer was associated with a higher rate of increase (7.1 percentage points and 5.9 percentage points, respectively; table 5, scenarios 6 and 7). The presence of a national insurer or a provider-sponsored insurer in the market did not have a statistically significant correlation with premium growth (table 5, scenarios 8 and 9).

Rating areas in states with larger populations had lower rates of premium growth than rating areas in states with smaller populations. For an otherwise average rating area, for example, being in a state with 10 million more people than average was associated with an increase in that region's lowest-cost silver plan premium that is 2.8 percentage points lower than that of an identical rating area in a state with the average population (table 5, scenario 10).

These results, which show smaller increases in lowest-cost silver plan premiums in rating areas with more marketplace participating insurers in 2015, combined with larger increases in the number of marketplace participating insurers in 2016, point to strong effects of competition in the marketplaces. That is, in markets with strong and growing competition, premium increases are held down. Markets with few insurers and those in which competition is diminishing are seeing much greater rates of increase. However, our findings also indicate that the presence of certain types of insurers in a market is associated with lower premium increases than the presence of other types. Medicaid insurers, co-ops, and to a lesser extent provider-sponsored insurers, seem to be associated with lower rates of premium growth than Blue Cross Blue Shield–affiliated insurers, regional or local insurers, and national insurers.

Examples of Market Experiences of Low Premium-Increase States, 2016

We ground the findings in the regression further by looking in detail at 2016 changes in lowest-cost silver plan premiums in seven states with low average rates of increase (California, Texas, Florida, Michigan, Virginia, Ohio, and New York) and seven states with high average rates of increase (Colorado, Minnesota, North Carolina, Arizona, Oklahoma, Tennessee, and West Virginia). Within each of these states, we analyze premium changes in the largest rating areas (including providing detail by insurer), show the average relative change in lowest-cost silver plan premiums across the state's remaining rating areas, and provide a statewide average percentage change in lowest-cost silver plan premiums. Table 6 (low average premium growth states) and table 7 (high average premium growth states) show the change in the lowest-cost silver plan premium between 2015 and 2016, the 2015 premium relative to the national average, and the number of insurers in each rating area. We also provide an average for the rest of the state and the state population. Detailed tables for each of the 14 states are provided as an appendix (tables A.1 through A.14). In each, we present additional detail on the lowest-cost silver plan premiums offered by each insurer participating in the marketplace in each rating area studied.

In general, large urban markets in larger states are experiencing lower rates of increase in their lowest-cost silver plan premiums, reflecting the higher level of competition in those markets. Smaller markets outside the large cities, even in low-growth states, are experiencing higher rates of growth. The data also show that states with higher average rates of growth have fewer competitors.

Table 6. Summary Table of Selected States with Decreases or Low Increases in Lowest-Cost Silver Plan Premium, 2015-16

State	Rating area	2015-16 relative change	Number of 2015 insurers	2015 lowest-cost silver premium relative to national average	State population
California	*State Average*	*1.4%*	*5*	*1.08*	38,333,000
	East Los Angeles	5.4%	6	0.85	
	West Los Angeles	-4.5%	6	0.91	
	San Francisco	-1.1%	5	1.31	
	San Diego	-3.3%	6	1.09	
	Rest of State	2.2%	4	1.16	
Texas	*State Average*	*1.2%*	*8*	*0.92*	26,448,000
	Dallas	-6.7%	7	1.03	
	Austin	15.7%	9	0.84	
	Houston	1.9%	9	0.92	
	San Antonio	0.3%	8	0.82	
	Rest of State	5.0%	7	0.87	
Florida	*State Average*	*2.6%*	*5*	*1.02*	19,553,000
	Miami	-5.6%	7	1.01	
	Ft Lauderdale	10.0%	8	0.89	
	Orlando	4.9%	5	1.06	
	Tampa	-10.4%	5	1.02	
	Rest of State	6.1%	5	1.02	
Michigan	*State Average*	*-1.9%*	*8*	*0.89*	9,896,000
	Detroit	-4.4%	11	0.81	
	North of Detroit	-4.4%	10	0.81	
	Grand Rapids	-5.6%	7	0.81	
	Rest of State	0.8%	6	0.99	
Virginia	*State Average*	*2.7%*	*4*	*1.01*	8,260,000
	Richmond	9.2%	5	0.89	
	DC Suburbs	-0.9%	5	1.01	
	Virginia Beach	5.4%	3	1.01	
	Rest of State	4.9%	3	1.05	

Table 6. Continued

State	Rating area	2015-16 relative change	Number of 2015 insurers	2015 lowest-cost silver premium relative to national average	State population
Ohio	*State Average*	*-1.1%*	*10*	*0.93*	11,571,000
	Cincinnati	3.2%	12	0.86	
	Columbus	10.7%	9	0.90	
	Cleveland	-4.7%	12	0.89	
	Rest of State	-4.5%	9	0.97	
New York	*State Average*	*8.1%*	*9*	*1.27*	19,651,000
	New York City	-1.5%	11	1.37	
	Long Island	0.8%	9	1.40	
	Buffalo	4.3%	6	0.97	
	Rest of State	29.4%	6	1.10	

Table 7. Summary Table of Selected States with Large Increases in Lowest-Cost Silver Plan Premium, 2015-16

State	Rating area	2015-16 relative change	Number of 2015 insurers	2015 lowest-cost silver premium relative to national average	State population
Colorado	*State Average*	*24.8%*	*8*	*0.82*	5,267,000
	Denver	29.0%	10	0.76	
	Colorado Springs	32.2%	7	0.72	
	West	0.0%	4	1.29	
	Rest of State	31.2%	6	0.84	
Minnesota	*State Average*	*26.8%*	*4*	*0.73*	5,420,000
	Rochester	16.8%	2	1.04	
	West of Minneapolis	31.8%	3	0.83	
	Minneapolis	25.5%	4	0.67	
	Rest of State	30.9%	3	0.78	
North Carolina	*State Average*	*20.6%*	*3*	*1.13*	9,848,000
	Charlotte	18.7%	3	1.19	
	Fayetteville	21.1%	3	0.99	
	Raleigh/Durham	25.5%	3	1.08	
	Rest of State	21.8%	3	1.15	
Arizona	*State Average*	*24.4%*	*10*	*0.65*	6,627,000
	Phoenix	23.1%	11	0.61	
	Tucson	20.2%	10	0.63	
	Flagstaff	26.8%	8	0.76	
	Rest of State	30.3%	8	0.79	
Oklahoma	*State Average*	*41.8%*	*3*	*0.74*	3,851,000
	Oklahoma City	40.9%	4	0.74	
	Tulsa	41.4%	4	0.75	
	Rest of State	42.8%	3	0.74	
Tennessee	*State Average*	*38.6%*	*3*	*0.73*	6,496,000
	Knoxville	49.0%	4	0.67	
	Nashville	35.4%	4	0.72	
	Memphis	47.0%	4	0.68	
	Rest of State	33.3%	2	0.80	
West Virginia	*State Average*	*20.5%*	*1*	*1.07*	1,854,000
	Charleston	21.1%	1	1.16	
	Huntington	2.8%	1	1.02	
	Rest of State	23.3%	1	1.07	

Table 6 and tables A.1 through A.7 provide data on seven states with low increases. California had an average rate of increase of 1.4 percent in its lowest-cost silver plan premiums between 2015 and 2016; this was quite low compared to the national average increase of 8.3 percent (table 6). Throughout the state, there was strong competition among Health Net (a regional insurer) Blue Shield, Anthem, and Kaiser (table A.1). A national Medicaid plan, Molina Healthcare, provided strong competition in several California markets. A large local Medicaid plan, L.A. Care, was important in the Los Angeles markets. On balance, 2015 lowest-cost silver plan premiums in California were higher than the national average, although this was not the case in the Los Angeles rating areas (table 6). The California experience is consistent with the regression analysis finding that 2015 premiums that are high relative to the national average are associated with a lower percent increase in premiums in 2016 as well as the finding that larger states tend to have lower rates of increase. The marketplace participation of multiple Medicaid insurers in several regions also likely contributed to low increases.

Texas's statewide average increase in its lowest-cost silver plan premiums was only 1.2 percent between 2015 and 2016 (table 6). All its major urban areas except Austin had very low increases or decreases. The rest of the state, which includes midsize cities and rural areas, had a premium increase of 5.0 percent on average. Texas has several insurance competitors; the average number of insurers per rating area is eight. The state has strong competition from Medicaid plans, both national plans such as Molina and local Medicaid insurers (table A.2). Texas also had active competition from Blue Cross Blue Shield, Scott & White Health Plan (a provider-sponsored insurer) and Oscar (a startup insurer that initially offered coverage only in New York and New Jersey but offers coverage in Oregon, Dallas–Fort Worth and San Antonio starting in 2016). Although most large cities and the rural rating area had small increases or decreases in the number of marketplace insurers and the price of their lowest-cost options, Austin lost three of the nine insurers participating in their 2015 marketplace and had an increase of 15.7 percent in its lowest-cost silver plan premium in 2016.

Florida had a statewide average increase in lowest-cost silver plan premiums of 2.6 percent in 2016 (table 6). The state had many insurers in 2015, particularly in large urban areas. The largest rating area in the state, Miami, had a reduction of 5.6 percent in its lowest-cost silver plan premium, and Tampa had a reduction of 10.4 percent. Coventry Health Care (part of Aetna); Florida Blue, part of the Blue Cross and Blue Shield Association and which offered an HMO product in much of the state; and United Healthcare all participated in several markets (table A.3). Ambetter and Molina, both national Medicaid chains, were also important players in Florida. The state has a large population and had average lowest-cost silver plan premiums slightly above the national average in 2015 ($276 per month versus $264 per month, table 1).

Michigan had many insurers in 2015 and an almost 2 percent decrease in its average lowest-cost silver plan premium in 2016 (table 6). Michigan has strong competition from Humana (a national insurer), a Blue Cross HMO product, Priority Health and Health Alliance Plan (both provider-sponsored insurers), and Molina, a national Medicaid chain (table A.4). Although Michigan's average 2015 lowest-cost silver plan premium was below the national average, a circumstance correlated with higher 2016 premium growth in our data, the large number of competitors in the marketplace and the presence of Medicaid and provider sponsored insurers are associated with the state's relatively low premiums and its average lowest cost silver premium decrease in 2016.

In **Virginia**, the average rate of increase in lowest-cost silver plan premiums across the state was 2.7 percent in 2016 (table 6). In 2015, there were five competitors in the major urban markets (excluding Virginia Beach, which had three) and fewer in the rest of the state. Anthem is the largest insurer in the state and offers an HMO product throughout the state, HealthKeepers, as well as a multistate plan option (table A.5). Innovation, a provider-sponsored insurer operated by the Inova Hospital System, is highly competitive in the Washington, DC, suburbs. Optima, an insurer operated by the Sentara Hospital System, is a low-cost insurer in Virginia Beach and is priced almost the same as Anthem's HealthKeepers lowest-cost silver plan there. Both Anthem HealthKeepers and Coventry are the most price-competitive insurers in Richmond. Kaiser, a provider-sponsored insurer, is very competitive in Richmond and the Washington, DC, markets. The state's premiums were roughly equivalent to the national average in 2015, a correlate of low premium increases in our model as is its relatively large population.

Ohio had a statewide average decrease in lowest-cost silver plan premium in 2016, seemingly associated with its large number of insurers; the state averaged 10 insurers per rating area (table 6). Cincinnati and Cleveland each had 12 insurers and Columbus had nine. CareSource, a regional Medicaid insurer, and national Medicaid chains Molina and Ambetter are strong price competitors in the state and were primarily responsible for keeping rates low (table A.6). Anthem, Aetna, and Humana also competed but are not among the lowest-cost insurers. Premier Health Plan, a provider-sponsored insurer, is price competitive in Cincinnati in 2016.

New York had a statewide average increase of 8.1 percent in its lowest-cost silver plan premiums between 2015 and 2016 (table 6). But the interesting feature of New York is that New York City experienced a drop in its lowest cost silver option (-1.5 percent), there was almost no change in Long Island (0.8 percent), and there was a small increase in Buffalo (4.3 percent), all rating areas where there are a large number of competitors. The participating insurers include several Medicaid insurers in both New York City and Long Island as well as one in Buffalo. Many of those Medicaid insurers had lower rates of premium increase than their competitors (table A.7). New York also has participation by Empire Blue Cross Blue Shield and several national and regional insurers, but those are generally not among the lowest-cost insurers. Northshore LIJ, a provider-sponsored insurer, became the lowest-cost silver plan for 2016 in New York City and Long Island. Oscar, a startup commercial insurer, was also reasonably price competitive in both years in the same rating areas. Outside of the New York City, Long Island, and Buffalo regions, there were fewer insurers (including fewer Medicaid insurer participants), and lowest-cost silver plan premium increases were substantially higher at 29.4 percent on average. Competition from Fidelis, a Medicaid plan, was still associated with modest premium increases in some markets. Health Republic, the state's co-op, had premiums in 2015 priced significantly below the remainder of the market. The subsequent exit of Health Republic significantly contributed to these large increases.

Examples of Market Experiences in High Premium Increase States, 2016

Table 7 provides data on seven states with larger relative premium increases in their lowest-cost silver plans between 2015 and 2016, averaging across rating areas. Some had low 2015 premiums relative to the national average, some lost a low-cost insurer from 2015, and others simply had little competition. All of these market characteristics are associated with higher relative premium increases in our summary regression.

Colorado had a 24.8 percent statewide average increase in its lowest-cost silver plan premiums in 2016 (table 7). Before 2016, Colorado had significant marketplace competition and participation among insurers, with an average of eight insurers participating in the state's marketplace and 10 insurers offering coverage in Denver. However, several insurers left the marketplace for 2016, including the co-op, which left Colorado in its entirety and was the lowest-premium insurer in Denver and Colorado Springs in 2015 (table A.8). In 2016, eight of the state's nine rating areas saw a reduction in the number of insurers offering marketplace nongroup coverage. Plus, in 2015, the average lowest-cost silver plan premiums on the state's marketplace were significantly below the national average (0.82 relative to the national average), with the exception of the western counties (1.29 relative to the national average). The large increases can likely be attributed to the exit of its lowest-cost insurer, the co-op, and possibly to premium re-adjustments to account for setting premium rates too low in the first two years of reform.

Minnesota had a statewide average increase of 25.8 percent from 2015 to 2016 for its lowest-cost silver plan premiums (table 7). In 2014, Minnesota had the lowest premiums in the country, attributable to incredibly low premiums set by PreferredOne, a provider-sponsored insurer (data not shown). After taking substantial losses because of inadequate premiums, PreferredOne left the market in 2015, immediately increasing the lowest-cost silver plan premium for 2015. But Minnesota premiums were still very low in 2015, reflected by the 0.73 index relative to the national average. Blue Cross Blue Shield increased its lowest-cost silver plan premium more than 50 percent, possibly because of disproportionate enrollment of high-risk individuals for which they were not compensated adequately (table A.9). Despite double-digit rate increases themselves, local Medicaid insurers Ucare and Medica have become the lowest-cost insurers in the state's largest markets.

North Carolina had a 2015–16 statewide average increase in the lowest-cost silver plan premium available of 20.6 percent (table 7). North Carolina's marketplace has been a relatively stable insurance market with little change in the number of insurers offering marketplace coverage in the state. However, the number of participating insurers is low compared to states with lower premium growth. North Carolina has no Medicaid insurers participating, nor do they have a co-op or a provider-sponsored insurer (table A.10). The state's Blue Cross Blue Shield plan had relatively high premiums in both 2015 and 2016 compared with the national average, and its lowest-cost silver plan premiums increased over 30 percent in 2016. Its lowest-cost insurers are national carriers (Aetna or United, depending upon the rating area), and they are typically not aggressive marketplace competitors.

Arizona has had an experience somewhat similar to Colorado's in terms of 2015 insurer participation. Of the focal states with high premium growth, Arizona had the largest number of insurers participating in the marketplace in 2015 (table 7). Arizona also had an average lowest-cost silver plan premium substantially below the 2015 national average, 0.65 relative to the national average. These below-average premium prices were present in all the rating areas studied here: Phoenix, Tucson, Flagstaff, and the rest of the state (0.61, 0.63, 0.76, and 0.79 relative to the national average, respectively). Many of the 2015 insurers left the Arizona marketplace in 2016, however, with an average of five insurers leaving the marketplace across

the states' seven rating areas (table A.11). Meritus Health, the state's co-op, was the lowest-cost insurer in much of the state in 2015 and left the state altogether in 2016. The exit of so many insurers combined with the substantially below-average 2015 premiums likely led to the high rate of premium growth in the state from 2015 to 2016.

Oklahoma had the highest state average increase in the lowest-cost silver plan of any state in the country in 2016, 41.8 percent. Few insurers participated in the Oklahoma marketplace in 2015, with four participating in Oklahoma City and Tulsa and only three in the rest of the state (table 7). Blue Cross Blue Shield of Oklahoma was the only insurer to offer coverage statewide. In 2016, three of the insurers, Global Health, CommunityCare, and Assurant, left the market, but United Healthcare entered statewide, though it had significantly higher premiums than Blue Cross Blue Shield (table A.12). Thus, Blue Cross Blue Shield has little price competition statewide in 2016. Similar to the other states with large premium increases, Oklahoma had 2015 lowest-cost silver plan premiums well below the national average, with a statewide average premium index of 0.73. In 2016 only a Blue Cross Blue Shield–affiliated insurer and a national insurer participate in the Oklahoma nongroup marketplace; both types of insurers are correlated with higher premium increases in our regression.

Tennessee had an experience very similar to Oklahoma's, with a statewide average increase in the lowest-cost silver plan premium of 38.6 percent in 2016 (table 7). Insurer marketplace participation was low during plan year 2015; only four insurers participated in the major cities in the state and only two participated statewide following the collapse of the state's co-op earlier in the year. Consistent with expectations based on the regression analysis, Tennessee's premium prices in 2015 were low relative to the national average, with a statewide average index value of 0.73; those low 2015 premiums may have contributed to relatively large premium increases in 2016. Community Health Alliance was the lowest-cost insurer in the state in 2015, but it left the marketplace in 2016 as did Assurant, although the latter was high priced (table A.13). Blue Cross Blue Shield of Tennessee was the second-lowest-priced insurer in 2015, and it increased the premium of its lowest-cost option by 27 to 37 percent in 2016, depending upon the rating area. United Healthcare entered the Tennessee marketplace in 2016 with fairly competitive premiums relative to Blue Cross Blue Shield and Cigna. Thus, Tennessee's marketplace, like Oklahoma's, now relies on Blue Cross Blue Shield–affiliated and national insurers.

West Virginia, unlike many of the states with large 2016 premium increases, had a statewide average lowest-cost silver plan premium slightly above the national average in 2015, with an index value of 1.07 (table 7). West Virginia had only one insurer participating in its marketplace in 2015, Highmark Blue Cross Blue Shield. As shown by the regression analysis, the number of insurers is inversely correlated with premium increases and the price of the lowest-cost option available. In addition, Blue Cross Blue Shield–affiliated insurers are associated with larger premium increases in 2016 than Medicaid insurers and co-ops. It has been difficult for other insurers to enter the state because of Highmark's dominance, and it is difficult for Highmark to negotiate rates in most of the state because of the limited number of providers. In 2016, CareSource, a regional Medicaid insurer, entered some regions in West Virginia. CareSource, although high priced compared with insurers in nearby states, is price competitive with Highmark in the regions it entered.

CONCLUSION

We find that although the national average increase in lowest-cost silver plan premiums between 2015 and 2016 was 8.3 percent, the rates of increase in premiums across the country vary tremendously. Average increases range from -12.1 percent in Indiana to 41.8 percent in Oklahoma. Across the country, about 29.1 percent of the population lives in rating areas that experienced reductions in the lowest-cost silver premium available to them; at the other extreme, 26.3 percent of the population lives in rating areas that experienced increases of more than 15 percent. In large states, such as Michigan, Ohio, Florida, Texas, Virginia, and California, a majority of people live in areas in which the lowest-cost silver plan premiums either fell or increased less than 5 percent in 2016. At the other extreme, 16 states, including North Carolina, Colorado, Arizona, Oklahoma, Tennessee, Minnesota, and West Virginia, have most of their population in areas in which the lowest-cost silver plan premiums increased more than 15 percent between 2015 and 2016.

We show that several factors are associated with these differences. Both large and small increases in lowest-cost silver plan premiums in a rating area sometimes reflect regression to the mean. Rating areas with relatively high 2015 lowest-cost silver plan premiums tended to see smaller increases on average; states with low lowest-cost silver plan premiums in 2015 tended to see larger increases. We find that one of the

most important factors associated with premium levels for the lowest cost silver plan and premium increases between 2015 and 2016 is the amount of competition in the market as measured by the number of insurers. Rating areas with more competitors tend to have lower premiums for their lowest-cost silver plans and lower premium growth; having fewer insurers competing is associated with higher premiums and premium growth. Competition from Medicaid insurers is also correlated with lower premiums and lower rates of premium increase than seen in rating areas without a Medicaid insurer competing; the same is true of co-ops. The presence of provider-sponsored insurers is correlated with lower premiums but is not significantly correlated with lower growth. However, having a national insurer (such as United Healthcare, Aetna, or Cigna) competing in a rating area is not significantly associated with premiums or premium growth. On average, the presence of insurers affiliated with Blue Cross Blue Shield in a market is associated with higher premiums and higher premium growth. In many instances, however, a Blue Cross Blue Shield insurer offers an HMO product that is price competitive.

These findings also support our earlier work indicating that United Healthcare was not driving price competition in most marketplaces, and that therefore the insurers' announcement that it intends to leave several marketplace nongroup markets should not cause substantial disruption.[4] United Healthcare does participate in some markets in which there are few other insurers, and its departure from these markets could be problematic.

The results of this analysis indicate that, where markets are competitive, premium levels and premium increases tend to be lower. This most often occurs in large states and in urban markets. Such markets typically have several insurers, and they also often have intense competition from insurers that provided coverage only through Medicaid (or Medicaid and Medicare) before 2014, Blue Cross Blue Shield–affiliated insurers offering health maintenance organization products, or provider-sponsored insurers. One consequence of this successful price competition is the growth in insurers using more-limited provider networks. Limited networks could create barriers to access to needed care, particularly for specialists, and the adequacy of these networks bear monitoring and evaluation.

But many markets in the nation are not seeing significant insurer competition, and premium increases are higher in those areas. Such areas have too few insurers or new insurers who have entered the area are having a difficult time competing with an established insurer, such as one affiliated with Blue Cross Blue Shield, that dominates the market. In some markets, even dominant insurers have a difficult time negotiating rates with a limited supply of providers. Thus, the managed competition approach, an essential feature of the ACA, is having success in many but not all markets. If the degree of insurer competition does not increase naturally or if provider consolidation or limited supply means insurers have little ability to negotiate payment rates, other options can be considered to control premium increases. These could include the adoption of a public option in less-competitive markets or public regulation of both insurer and provider payment rates. However, such interventions could focus on the rating areas where premium levels and premium growth rates are problematic; the many areas where the ACA's design has already engendered market price competition can be left alone.

Meanwhile, as has happened in the first three open enrollment periods, some have begun to predict widespread, large premium increases for marketplace plans in 2017.[5] These predictions are being fed by insurer reports of adverse selection into the nongroup insurance market, concerns that the current risk-adjustment methodology may be inadequate, and the planned end of the federal reinsurance and risk corridor programs. Insurers that are still priced too low in 2016 may increase premiums in 2017 to avoid losses. However, several factors will soon arise that should contribute to improved risk pools and hence lower premium increases. First, the size of the individual mandate penalties increased to their permanent and highest level for 2016, and the penalty's full effect will be felt by those remaining uninsured in early 2017 when they file their 2016 tax returns. This could increase marketplace enrollment with individuals who are healthier on average and who have been more resistant to purchasing coverage in the early years of reform. Second, "grandmothered" and "grandfathered" plans, which have kept some healthier nongroup insurance enrollees out of ACA-compliant markets and risk pools in some areas, will continue to decrease in size, and the grandmothered plans will be eliminated by the end of 2017.[6] Many enrollees currently in these plans will enroll in ACA-compliant coverage once their current coverage options are gone, a shift that should improve the average health care risk of those in the ACA-compliant plans. Finally, as the first few years of the reforms have demonstrated, the incentives for insurers to offer lower-cost plans in the marketplaces are strong, and large premium increases will tend to decrease enrollment in a given plan as many consumers are willing to change plans to save money. These competitive pressures, present in many markets and for large swaths of the population, tend to keep premium increases in check. So although increases will undoubtedly be substantial in some areas with weaker competition, the experience will vary considerably across the country with no overall average able to meaningfully describe the dynamics of marketplace premiums.

APPENDIX

Table A.1: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], California

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015–16
Rating Area 15: East Los Angeles				
Anthem	Blue	$257	$274	6.5%
Blue Shield	Blue	$270	$245	-9.3%
Health Net	Regional	$230	$243	5.4%
Kaiser Permanente	Provider	$287	$298	3.9%
L.A. Care	Regional	$265	$254	-4.3%
Molina Healthcare	Medicaid	$259	$253	-2.3%
Percentage change in region's lowest-premium option				**5.4%**
Rating Area 16: West Los Angeles				
Anthem	Blue	$270	$278	2.9%
Blue Shield	Blue	$308	$318	3.4%
Health Net	Regional	$247	$255	3.4%
Kaiser Permanente	Provider	$300	$312	3.9%
L.A. Care	Regional	$278	$266	-4.3%
Molina Healthcare	Medicaid	$259	$236	-9.2%
Oscar	Regional	N/A	$298	N/A
Percentage change in region's lowest-premium option				**-4.5%**
Rating Area 4: San Francisco				
Anthem	Blue	$414	$455	9.9%
Blue Shield	Blue	$401	$388	-3.2%
CCHP	Regional	$356	$352	-1.1%
Health Net	Regional	$449	$438	-2.4%
Kaiser Permanente	Provider	$393	$413	5.0%
Percentage change in region's lowest-premium option				**-1.1%**

Table A.1: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 19: San Diego				
Anthem	Blue	$333	$361	8.5%
Blue Shield	Blue	$343	$342	-0.2%
Health Net	Regional	$295	$296	0.2%
Kaiser Permanente	Provider	$314	$329	4.8%
Sharp	Provider	$329	$344	4.7%
Molina Healthcare	Medicaid	$314	$286	-9.1%
Percentage change in region's lowest-premium option				**-3.3%**
Percentage change in lowest-cost premium, rest-of-state average[b]				2.2%
Percentage change in lowest-cost premium state average[b]				1.4%

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.2: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Texas

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 8: Dallas/Fortworth				
Molina Healthcare of Texas	Medicaid	$280	$260	-7.1%
Oscar Insurance Company of Texas	Regional	N/A	$320	N/A
Blue Cross Blue Shield of Texas	Blue	$279	$334	19.6%
Insurance Company of Scott & White	Provider	$292	$340	16.4%
Aetna Life Insurance Company	National	$361	$362	0.1%
Cigna Health and Life Insurance Company	National	$364	$368	1.1%
Assurant Health	National	$475	N/A	N/A
United Healthcare	National	$290	N/A	N/A
Percentage change in region's lowest-premium option				**-6.7%**
Rating Area 3: Austin				
Humana Health Plan of Texas, Inc.	National	$229	$280	22.4%
Ambetter	Medicaid	$260	$264	N/A
Assurant Health	National	$388	N/A	N/A
Cigna HealthCare of Texas, Inc.	National	$338	N/A	N/A
Insurance Company of Scott & White	Provider	$250	$290	16.1%
Blue Cross Blue Shield of Texas	Blue	$261	$309	18.3%
Sendero Health Plans	Medicaid	$241	N/A	N/A
United Healthcare	National	$258	$291	12.7%
Aetna Life Insurance Company	National	$296	$338	14.0%
Percentage change in region's lowest-premium option				**15.7%**
Rating Area 10: Houston				
Molina Healthcare of Texas	Medicaid	$268	$253	-5.6%
Community Health Choice, Inc.	Medicaid	$248	$261	5.1%
Insurance Company of Scott & White	Provider	$250	$290	16.1%
Blue Cross Blue Shield of Texas	Blue	$250	$292	16.8%
Cigna HealthCare of Texas, Inc.	National	$339	$311	-8.3%
Aetna Life Insurance Company	National	$327	$328	0.1%
Assurant Health	National	$432	N/A	N/A
United Healthcare	National	$264	N/A	N/A
Humana Health Plan of Texas, Inc.	National	$294	$375	27.6%
Percentage change in region's lowest-premium option				**1.9%**

Table A.2: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 19: San Antonio				
Oscar Insurance Company of Texas	Regional	N/A	$224	N/A
Celtic Insurance Company	Medicaid	$233	$236	1.6%
Community First Health Plans, Inc.	Medicaid	$239	$245	2.5%
All Savers Insurance Company	National	$244	$260	6.5%
Humana Health Plan of Texas, Inc.	National	$223	$280	25.3%
Allegian Insurance Company	Regional	$271	$281	3.7%
Blue Cross Blue Shield of Texas	Blue	$254	$301	18.2%
Assurant Health	National	$307	N/A	N/A
Aetna Life Insurance Company	National	$273	$316	16.0%
Percentage change in region's lowest-premium option				**0.3%**
Percentage change in lowest-cost premium, rest-of-state average[b]				6.0%
Percentage change in lowest-cost premium state average[b]				4.2%

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.3: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Florida

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 43: Miami				
Ambetter	Medicaid	$274	$258	-5.6%
Coventry	National	$309	$301	-2.6%
Florida Blue (BCBS of Florida)	Blue	$362	$347	-4.1%
Florida Blue HMO	Blue	$430	$307	-28.6%
Humana	National	$301	$362	20.3%
Molina	Medicaid	$274	$274	0.0%
United Healthcare Assurant	National	N/A	$366	N/A
	National	$397	N/A	N/A
Cigna	National	$419	N/A	N/A
Percentage change in region's lowest-premium option				**-5.6%**
Rating Area 6: Ft. Lauderdale				
Coventry	National	$241	$265	10.0%
Ambetter	Medicaid	$293	$277	-5.5%
Florida Blue	Blue	$363	$342	-5.8%
Florida Blue HMO	Blue	$388	$279	-28.1%
Molina	Medicaid	$287	$288	0.3%
Humana	National	$272	$299	9.9%
Assurant	National	$397	N/A	N/A
Cigna	National	$377	N/A	N/A
United Healthcare	National	$308	$338	9.7%
Percentage change in region's lowest-premium option				**10.0%**
Rating Area 48: Orlando				
Florida Blue (BCBS of Florida)	Blue	$312	$312	0.0%
Florida Blue HMO	Blue	$374	$302	-19.3%
Humana	National	$288	$336	16.7%
Cigna	National	$374	N/A	N/A
Assurant	National	$348	N/A	N/A
United Healthcare	National	$298	$355	19.1%
Percentage change in region's lowest-premium option				**4.9%**

Table A.3: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 28: Tampa				
Ambetter	Medicaid	N/A	$247	N/A
Florida Blue (BCBS of Florida)	Blue	$275	$275	0.0%
Florida Blue HMO	Blue	$345	$287	-16.8%
Humana	National	$275	$306	11.1%
Assurant	National	$327	N/A	N/A
United Healthcare	National	$292	$348	19.2%
Cigna	National	$369	N/A	N/A
Percentage change in region's lowest-premium option				**-10.4%**
Percentage change in lowest-cost premium, rest-of-state average[b]				6.1%
Percentage change in lowest-cost premium state average[b]				2.6%

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.4: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Michigan

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 1: Detroit				
Humana Medical Plan of Michigan, Inc.	National	$219	$209	-4.4%
Total Health Care USA, Inc.	Regional	$243	$250	2.8%
Blue Care Network of Michigan	Blue	$234	$236	0.6%
McLaren Health Plan, Inc.	Provider	$309	$324	4.9%
Health Alliance Plan (HAP)	Provider	$266	$260	-2.3%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$301	$332	10.2%
Priority Health	Provider	$285	$246	-13.8%
Molina	Medicaid	$252	$229	-8.8%
Alliance Health and Life	Provider	$338	$335	-0.9%
Consumers Mutual Insurance of Michigan	Co-op	$348	N/A	N/A
Assurant	National	$334	N/A	N/A
UnitedHealthcare	National	$230	$262	14.1%
Percentage change in region's lowest-premium option				**-4.4%**
Rating Area 2: North of Detroit				
Blue Care Network of Michigan	Blue	$244	$236	-3.3%
McLaren Health Plan, Inc.	Provider	$309	$324	4.9%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$301	$331	10.1%
Priority Health	Provider	$286	$246	-14.0%
Alliance Life and Health	Provider	N/A	$334	N/A
Health Alliance Plan	Provider	$264	$258	-2.3%
Humana Insurance Company	National	$221	$211	-4.4%
Molina	Medicaid	$252	$229	-8.8%
Total Health Care	Regional	$243	$250	2.8%
United Health Care	National	$248	$253	1.7%
Assurant	National	$347	N/A	N/A
Consumers Mutual Insurance of Michigan	Co-op	$348	N/A	N/A
Percentage change in region's lowest-premium option				**-4.4%**

Table A.4: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 12: Grand Rapids				
Blue Care Network of Michigan	Blue	$219	$226	3.6%
McLaren Health Plan, Inc.	Provider	$274	$287	4.9%
Priority Health	Provider	$273	$235	-14.0%
Blue Cross Blue Shield of Michigan (MSP)	Blue	$326	$378	15.9%
Consumers Mutual Insurance of Michigan	Co-op	$274	N/A	N/A
Humana Insurance Company	National	$232	$206	-10.9%
Assurant	National	$328	N/A	N/A
Physician's Health Plan	Provider	$356	$348	-2.3%
Percentage change in region's lowest-premium option				**-5.6**
Percentage change in lowest-cost premium, rest-of-state average[b]				0.8%
Percentage change in lowest-cost premium state average[b]				-1.9%

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.5: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Virginia

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 7: Richmond				
Aetna	National	$312	$335	7.4%
Anthem (MSP)	Blue	$280	$295	5.4%
Anthem HealthKeepers	Blue	$264	$276	4.7%
CoventryOne	National	$241	$264	9.2%
Kaiser Permanente	Provider	$273	$384	3.9%
Optima Health	Provider	$372	$382	2.5%
United Healthcare	National	N/A	$280	N/A
Piedmont Community Health Care	Provider	$324	$305	-5.6%
Percentage change in region's lowest-premium option				**9.2%**
Rating Area 10: Washington D.C. suburbs				
Anthem (MSP)	Blue	$309	$323	4.4%
Anthem HealthKeepers	Blue	$292	$303	3.8%
CareFirst BlueChoice, Inc.	Blue	$323	$356	10.1%
CareFirst (MSP)	Blue	N/A	$413	N/A
Innovation Health Insurance Company	Provider	$282	$270	-4.1%
Kaiser Permanente	Provider	$273	$284	3.9%
United Healthcare	National	N/A	$288	N/A
Optima Health	Provider	$355	$389	9.4%
Percentage change in region's lowest-premium option				**-0.9%**
Rating Area 9: Virginia Beach, Norfolk				
Aetna	National	$305	$333	9.3%
Anthem (MSP)	Blue	$304	$321	5.4%
Anthem Health Keepers	Blue	$287	$301	4.8%
Optima Health	Provider	$285	$308	7.9%
Percentage change in region's lowest-premium option				**5.4%**
Percentage change in lowest-cost premium, rest-of-state average[b]				4.9%
Percentage change in lowest-cost premium state average[b]				2.7%

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.6: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Ohio

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 4: Cincinnati				
CareSource	Medicaid	$232	$243	4.6%
Ambetter from Buckeye Health Plan	Medicaid	$236	$240	1.5%
Humana, Inc.	National	$253	$295	16.9%
Premier Health Plan	Provider	$257	$247	-3.6%
HealthSpan	Regional	$268	$343	28.0%
Molina Marketplace	Medicaid	$281	$244	-12.9%
Aetna	National	$298	$340	14.0%
InHealth Mutual	Co-op	$300	$344	14.4%
Anthem Blue Cross and Blue Shield	Blue	$319	$304	-4.7%
UnitedHealthcare	National	$326	$330	1.1%
MedMutual	Regional	$353	$367	4.1%
Assurant Health	National	$478	N/A	N/A
Percentage change in region's lowest-premium option				**3.2%**
Rating Area 9: Columbus				
CareSource	Medicaid	$244	$270	10.7%
Molina Marketplace	Medicaid	$281	$274	-2.3%
Paramount Insurance Company	Medicaid	$282	$312	10.7%
Aetna	National	$303	$337	11.0%
InHealth Mutual	Co-op	$307	$351	14.4%
Anthem Blue Cross and Blue Shield	Blue	$342	$317	-7.3%
MedMutual	Regional	$352	$396	12.6%
UnitedHealthcare	National	$366	$304	-17.1%
Assurant Health	National	$435	N/A	N/A
HealthSpan	Regional	N/A	$421	N/A
Percentage change in region's lowest-premium option				**10.7%**

Table A.6: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 11: Cleveland				
Ambetter from Buckeye Health Plan	Medicaid	$242	$230	-4.7%
CareSource	Medicaid	$252	$252	-0.2%
HealthSpan Integrated Care	Regional	$268	$319	19.4%
Molina Marketplace	Medicaid	$278	$265	-4.7%
Aetna	National	$283	$333	17.9%
MedMutual	Regional	$301	$339	12.6%
Paramount Insurance Company	Medicaid	$302	$334	10.7%
UnitedHealthcare	National	$322	$314	-2.5%
InHealth Mutual	Co-op	$326	$372	14.3%
Anthem Blue Cross and Blue Shield	Blue	$346	$317	-8.2%
SummaCare Inc	Provider	$373	$372	-0.3%
Assurant Health	National	$488	N/A	N/A
Humana, Inc.	National	N/A	$315	N/A
Percentage change in region's lowest-premium option				**-4.7%**
Percentage change in lowest-cost premium, rest-of-state average[b]				-4.6%
Percentage change in lowest-cost premium state average[b]				-7.1%

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.7: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], New York

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015–16
Rating Area 4: New York City				
Metro Plus	Medicaid	$383	$422	10.3%
Health Republic Insurance	Co-op	$380	N/A	N/A
Oscar	Regional	$394	$430	9.0%
Emblem	Regional	$407	$463	13.7%
New York Fidelis	Medicaid	$384	$408	6.4%
Empire BCBS	Blue	$448	$513	14.5%
Northshore LIJ	Provider	$394	$366	-7.1%
Healthfirst	Medicaid	$387	$435	12.3%
Affinity - All Standard Benefits	Medicaid	$372	$395	6.3%
United Healthcare of NY	National	$545	$667	22.4%
Wellcare HMO	Medicaid	$472	$486	3.0%
Percentage change in region's lowest-premium option				**-1.5%**
Rating Area 8: Long Island				
Health Republic Insurance	Co-op	$380	N/A	N/A
Affinity	Medicaid	$380	$403	6.1%
Emblem HIP	Regional	$407	$527	29.4%
Empire HMO	Blue	$448	$472	5.3%
Fidelis	Medicaid	$384	$395	3.0%
Health First	Medicaid	$387	$435	12.3%
North Shore LIJ	Provider	$394	$383	-2.8%
Oscar	Regional	$394	$430	9.0%
United Healthcare of NY	National	$545	$667	22.4%
Percentage change in region's lowest-premium option				**0.8%**
Rating Area 2: Buffalo				
New York Fidelis	Medicaid	$337	$353	4.7%
Univera (An Excellus Company)	Blue	$474	$514	8.3%
Health Republic Insurance	Co-op	$342	N/A	N/A
IHBC	Provider	$428	$374	-12.7%
MVP Health	Regional	$365	$389	6.5%
Blue Cross Blue Shield of Western NY	Blue	$342	$352	2.9%
Percentage change in region's lowest-premium option				**4.3%**
Percentage change in lowest-cost premium, rest-of-state average[b]				29.4%
Percentage change in lowest-cost premium state average[b]				8.1%

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.8: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Colorado

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 3: Denver				
Kaiser Permanente	Provider	$240	$266	17.8%
Humana	National	$244	$278	13.7%
Colorado Health OP	Co-op	$207	N/A	N/A
Denver Health Medical Plan	Provider	$318	$363	13.8%
Colorado Choice Health Plan	Regional	$308	$287	-6.8%
Rocky Mountain Health Plans	Regional	$345	$459	33.2%
Cigna	National	$339	$296	-12.4%
HMO Colorado (Anthem)	Blue	$316	$402	27.0%
All Savers	National	$349	$331	-5.1%
New Health Ventures (Access Health Colorado)	Regional	$274	N/A	N/A
United Healthcare of CO	National	N/A	$319	N/A
Percentage change in region's lowest-premium option				**29.0%**
Rating Area 2: Colorado Springs				
Humana	National	$233	$267	15.0%
Colorado Choice Health Plan	Regional	$276	$257	-7.0%
Kaiser Permanente	Provider	$257	$259	1.0%
Rocky Mountain Health Plans	Regional	$312	$451	45.0%
HMO Colorado (Anthem)	Blue	$296	$320	8.0%
Colorado Health Op	Co-op	$194	N/A	N/A
New Health Ventures (Access Health Colorado)	Regional	$251	N/A	N/A
Percentage change in region's lowest-premium option				**32.2%**
Rating Area 9: Western Counties				
HMO Colorado (Anthem)	Blue	N/A	$446	N/A
United Healthcare of CO	National	N/A	$529	N/A
Rocky Mountain Health Plans	Regional	N/A	$452	N/A
Cigna	National	N/A	$446	N/A
Kaiser Permanente	Provider	N/A	$346	N/A
Percentage change in region's lowest-premium option				**0.0%**
Percentage change in lowest-cost premium, rest-of-state average[b]				**31.2%**
Percentage change in lowest-cost premium state average[b]				**24.8%**

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.
N/A: Data not Available

Table A.9: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Minnesota

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 1: Rochester				
Medica	Medicaid	$282	$329	16.8%
BCBS Minnesota	Blue	$283	$445	57.5%
BCBS Minnesota (MSP)	Blue	$351	$502	42.9%
Blue Plus	Blue	N/A	$422	N/A
Percentage change in region's lowest-premium option				**16.8%**
Rating Area 8: Minneapolis, St. Paul, Bloomington				
HealthPartners	Regional	$181	$235	29.8%
BCBS Minnesota	Blue	$201	$321	59.8%
Ucare	Medicaid	$183	$228	24.4%
Medica	Medicaid	$222	$254	14.2%
BCBS Minnesota (MSP)	Blue	$249	$361	45.1%
Blue Plus	Blue	$205	$300	46.4%
Percentage change in region's lowest-premium option				**25.5%**
Rating Area 7: West of Minneapolis				
HealthPartners	Regional	N/A	$260	N/A
BCBS Minnesota	Blue	N/A	$358	N/A
Ucare	Medicaid	N/A	$252	N/A
Medica	Medicaid	N/A	$270	N/A
BCBS Minnesota (MSP)	Blue	N/A	$403	N/A
Blue Plus	Blue	N/A	$286	N/A
Percentage change in region's lowest-premium option				**31.8%**
Percentage change in lowest-cost premium, rest-of-state average[b]				30.9%
Percentage change in lowest-cost premium state average[b]				25.8%

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.
N/A: Data not Available

Table A.10: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], North Carolina

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 4: Charlotte				
Aetna Health Inc.	National	$317	$376	18.7%
Blue Cross and Blue Shield of NC	Blue	$328	$452	37.7%
UnitedHealthcare of North Carolina, Inc	National	$340	$409	20.3%
Percentage change in region's lowest-premium option				**18.7%**
Rating Area 9: Fayetteville				
Aetna Health Inc.	National	$339	$446	31.7%
Blue Cross and Blue Shield of NC	Blue	$362	$472	30.4%
UnitedHealthcare of North Carolina, Inc	National	$267	$324	21.1%
Percentage change in region's lowest-premium option				**21.1%**
Rating Area 13: Raleigh/Durham				
Aetna Health Inc.	National	$282	$358	27.0%
Blue Cross and Blue Shield of NC	Blue	$293	$392	33.9%
UnitedHealthcare of North Carolina, Inc	National	$305	$354	15.8%
Percentage change in region's lowest-premium option				**25.5%**
Percentage change in lowest-cost premium, rest-of-state average[b]				**27.8%**
Percentage change in lowest-cost premium state average[b]				**20.6%**

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.11: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Arizona

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 4: Phoenix				
Aetna	National	$257	$277	7.6%
All Savers	National	$262	$249	-5.0%
Blue Cross Blue Shield of Arizona, Inc.	Blue	$240	$269	11.8%
Health Choice Insurance Co.	Medicaid	$195	$207	6.2%
Health Net of Arizona, Inc.	Regional	$222	$276	24.3%
Humana Health Plan, Inc.	National	$265	$269	1.4%
Cigna	National	$350	$259	-25.9%
Meritus	Co-op	$166	N/A	N/A
University of Arizona	Provider	$202	N/A	N/A
Assurant	National	$314	N/A	N/A
Phoenix Health Plans, Inc.	Medicaid	$252	$204	-19.0%
Percentage change in region's lowest-premium option				**23.1%**
Rating Area 6: Tucson				
All Savers	National	$217	$208	-4.1%
Blue Cross Blue Shield of Arizona, Inc.	Blue	$200	$229	14.6%
Meritus	Co-op	$170	$204	20.2%
University of Arizona	Provider	$189	N/A	N/A
Aetna	National	$221	N/A	N/A
Health Choice Insurance Co.	Medicaid	$232	$256	10.5%
Health Net of Arizona, Inc.	Regional	$191	$237	24.3%
Cigna	National	$290	N/A	N/A
Assurant	National	$313	N/A	N/A
Humana Health Plan, Inc.	National	$238	$247	3.7%
Percentage change in region's lowest-premium option				**20.2%**

Table A.11: Continued

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 1: Flagstaff				
All Savers Insurance Company	National	$424	$409	-3.4%
Blue Cross Blue Shield of Arizona, Inc.	Blue	$334	$380	14.0%
Health Choice Insurance Co.	Medicaid	$309	$325	5.2%
Meritus	Co-op	$206	$262	26.8%
Health Net of Arizona, Inc.	Regional	$295	N/A	N/A
Assurant	National	$399	N/A	N/A
Cigna	National	$470	N/A	N/A
Aetna	National	$355	N/A	N/A
Percentage change in region's lowest-premium option				**26.8%**
Percentage change in lowest-cost premium, rest-of-state average[b]				30.3%
Percentage change in lowest-cost premium state average[b]				24.4%

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.12: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Oklahoma

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 3: Oklahoma City				
Blue Cross Blue Shield of Oklahoma	Blue	$201	$283	40.9%
UntiedHealthcare of Oklahoma, Inc.	National	N/A	$334	N/A
GobalHealth	Regional	$270	N/A	N/A
Assurant	National	$276	N/A	N/A
ComunityCare	Regional	$269	N/A	N/A
Percentage change in region's lowest-premium option				**40.9%**
Rating Area 4: Tulsa				
Blue Cross Blue Shield of Oklahoma	Blue	$204	$289	41.4%
UnitedHealthcare of Oklahoma, Inc.	National	N/A	$334	N/A
GlobalHealth	Regional	$265	N/A	N/A
Assurant	National	$340	N/A	N/A
ComunityCare	Regional	$269	N/A	N/A
Percentage change in region's lowest-premium option				**41.4%**
Percentage change in lowest-cost premium, rest-of-state average[b]				42.8%
Percentage change in lowest-cost premium state average[b]				41.8%

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.13: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], Tennessee

Insurer name	Insurer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 2: Knoxville				
Blue Cross Blue Shield of Tennessee	Blue	$210	$288	37.3%
Humana Insurance Company	National	$241	$292	21.2%
Assurant Health	National	$355	N/A	N/A
Community Health Alliance	Co-op	$181	N/A	N/A
United	National	N/A	$270	N/A
Percentage change in region's lowest-premium option				**49.0%**
Rating Area 4: Nashville, Clarksville				
Blue Cross Blue Shield of Tennessee	Blue	$220	$288	30.7%
Humana Insurance Company	National	$292	$350	20.2%
Cigna Health and Life Insurance Company	National	$301	$262	-12.9%
Community Health Alliance	Co-op	$194	N/A	N/A
United	National	N/A	$303	N/A
Percentage change in region's lowest-premium option				**35.4%**
Rating Area 6: Memphis				
Blue Cross Blue Shield of Tennessee	Blue	$214	$271	26.8%
Humana Insurance Company	National	$240	$288	20.2%
Cigna Health and Life Insurance Company	National	$298	$324	8.8%
Community Health Alliance	Co-op	$184	N/A	N/A
United	National	N/A	$291	N/A
Percentage change in region's lowest-premium option				**47.0%**
Percentage change in lowest-cost premium, rest-of-state average[b]				**33.3%**
Percentage change in lowest-cost premium state average[b]				**38.6%**

a. Monthly Premium prices displayed are for a non-smoking individual

b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

Table A.14: Lowest-Cost Silver Plan Premiums for a 40-Year-Old, by Insurer, Selected Rating Areas, 2015 and 2016[a], West Virginia

Insurer name	Issuer type	2015 lowest-cost silver plan premium	2016 lowest-cost silver plan premium	Percentage change 2015-16
Rating Area 2: Charleston				
Highmark Blue Cross Blue Shield (MSP)[2]	Blue	$314	N/A	N/A
Highmakr Blue Cross Blue Shield West Virginia	Blue	$314	$388	23.5%
CareSource	Medicaid	N/A	$381	N/A
Percentage change in region's lowest-premium option				**21.1%**
Rating Area 5: Huntington				
Highmark Blue Cross Blue Shield (MSP)[2]	Blue	$277	N/A	N/A
Highmakr Blue Cross Blue Shield West Virginia	Blue	$277	$342	23.5%
CareSource	Medicaid	N/A	$284	N?A
Percentage change in region's lowest-premium option				**2.8%**
Percentage change in lowest-cost premium, rest-of-state average[b]				23.3%
Percentage change in lowest-cost premium state average[b]				20.5%

a. Monthly Premium prices displayed are for a non-smoking individual
b. State and rest-of-state average are weighted by rating region population. These averages are only for the lowest-cost silver plan available in the region.

ENDNOTES

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Mr. JORDAN. Thank you, Ms. Blumberg.

The chair recognizes the gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman, and thank you, panel, for being here.

Mr. Counihan, let's start with the CO–OPs. How many CO–OPs were initially created under the Affordable Care Act?

Mr. COUNIHAN. Initially, we had granted 24. One never started, so in all practice, 23.

Mr. DESJARLAIS. And how many are still active today?

Mr. COUNIHAN. Seven.

Mr. DESJARLAIS. Seven. Okay. And we had a hearing in February, and at the time, I think there were 11, so there has been 4 more that have failed since February?

Mr. COUNIHAN. Yes.

Mr. DESJARLAIS. About how many individuals have been impacted by the CO–OP closures?

Mr. COUNIHAN. I'm going to have to get back to you on that.

Mr. DESJARLAIS. I have 870,000. Does that sound right?

Mr. COUNIHAN. I need to confirm that one.

Mr. DESJARLAIS. Okay. If you and your family were going to buy insurance through one of the remaining CO–OPs, would you think that maybe you should be warned that two-thirds of these CO–OPs have closed in the past year or so?

Mr. COUNIHAN. Yeah. I do not, and I'll tell you why. The CO–OPs are like any other insurance company that are certified by a State division of insurance. They have to have the same actuarial standards, the same capital standards. They have to meet a solvency requirement. They have to meet a variety of certain circumstances. If the State certifies those issuers, if the State certifies that CO–OP, that feels to me that they should be on a level playing field with any other issuer.

Mr. DESJARLAIS. Okay. Well, President Obama said if you like your plan, you can keep it. But, apparently, if you get a CO–OP, that's not necessarily the case. You got a two-out-of-three chance that you're going to lose your insurance. So you're saying you would still recommend people and their families to go to the CO–OPs to obtain insurance?

Mr. COUNIHAN. I would say that, if they are certified and licensed by the State, which they are, that they should be judged on the same basis as any other, and I think it would be unfair not to.

Mr. DESJARLAIS. The two-thirds that have failed, they weren't certified and licensed by the State?

Mr. COUNIHAN. As you know, sir, this is a challenging business. The CO–OPs are not the first issuers to have felt the challenge of that or to have closed.

Mr. DESJARLAIS. Well, you painted a pretty rosy picture of the successes of the healthcare law. Our chairman tended to disagree. Mr. Cartwright said that we're enjoying a historically low uninsured rate. What is the historical low, and what year was that noted or documented?

Mr. COUNIHAN. Well, as of 2015, the uninsured rate is 9.1 percent. That was a drop from 16 percent before the Affordable Care Act.

Mr. DESJARLAIS. And what's the historical low? Do we know? I'd asked this question before dating back to 1950, and no one knew, and they were supposed to get back to me, but they never did.

Mr. COUNIHAN. I will need to do the same, sir.

Mr. DESJARLAIS. Okay. So how many people are uninsured now in America? What percentage?

Mr. COUNIHAN. 9.1 percent.

Mr. DESJARLAIS. Is that taking into account the people who have lost their insurance because they couldn't afford premiums? Has there been any study? I guess I would like to know where we got this data. The chairman mentioned that 11 million had insurance. You're saying 20 million. What did President Obama say was uninsured when we needed this law?

Mr. COUNIHAN. Well, I think the difference there between what the chairman had quoted and what I had quoted was the difference is Medicaid expansion. So the 20 million that I quoted, for example, includes marketplace enrollment plus expanded Medicaid enrollment.

Mr. DESJARLAIS. So the average person has not really been helped then by the healthcare law that has to pay for it with the increased deductibles and increased premiums. We don't really have a study showing how many are just opting to pay the tax that the Supreme Court ruled was not a penalty but a tax. Do we have any studies indicating how many people have just opted out of the insurance and chosen to pay the tax?

Mr. COUNIHAN. Well, I think it's actually the opposite. I think what we're finding is that the average American has completely benefitted from this law, and I'll tell you how. A is through the elimination of preexisting conditions. B is through the elimination of lifetime caps. C is there are no gender premium differentials that there were. There is expanded coverage. It's more affordable than before.

Mr. DESJARLAIS. I get the talking points. You're in a parallel universe with what I'm hearing. We hear different things back home, but I appreciate and respect your right to have an opinion. I just don't know that those can be backed on facts.

Now, we had $1.6 billion in loan money that was given out. Dr. Mandy Cohen was here before, and she said that we're going to recoup this. I asked, why didn't they just call them grants, because I don't think we have any real chance of getting them back? Now she said that they were very much loans, and we expect to get these taxpayer dollars back from these failed CO–OPs. And at the time, she had just started. Can you give us an update of how successful the recoupment efforts have been?

Mr. COUNIHAN. So the Department of Justice is engaged in the recoupment efforts. I cannot speak for them with respect to their progress. Happy to have somebody from DOJ come to report.

Mr. DESJARLAIS. A half year later, we still have no update on how we're going to recoup the $1.6 billion to these failed CO–OPs. This is taxpayer money, and they have a right to know.

Mr. COUNIHAN. As I said, the way taxpayer, these moneys can be received, how they can be recovered, is typically when administrative expenses are paid and runout claims are fully satisfied. For

most of these wind-downs, that has not occurred yet, so it's really premature to be able to speculate.

Mr. DESJARLAIS. So I'm just about of time, but I guess I tend to agree with the chairman. We have seen 24 turn to 23 to 11. Now we have seven, and you're telling people they should still go use these CO–OPs with confidence that their family can get insurance, and they're not going to lose it, and then you're also trying to tell them that we're going to recoup the money from all these failed businesses. I have an idea we'll probably be having this hearing again in a few months, and I anticipate, unfortunately, the chairman's predictions will come true, but we'll see where we're at. I would like to get the data on the numbers where you're saying 20 million are now uninsured, and I'd like to see how many people have lost their insurance because that's what I tend to hear back home, not the successes that the both of you have laid out for us today.

I yield back.

Mr. JORDAN. I thank the gentleman, and I now recognize Mr. Cartwright for 5 minutes.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

In the 6 years since the ACA was enacted, as I mentioned, Republicans have held over 60 votes to repeal or undermine the law, but they still haven't proposed a viable legislative alternative. Now, the Speaker recently unveiled his, "Better Way" plan for health care. The title of this plan is something of a misnomer because it is the wrong way, not a better way. A Better Way plan is short on specifics but contains many ideas that really would be harmful to working Americans.

And, Dr. Blumberg, I'd like to ask you, are you familiar with Speaker Ryan's Better Way plan?

Ms. BLUMBERG. Yes, I did read the materials that they released.

Mr. CARTWRIGHT. And you commented on this in your testimony. Do you think it's a viable alternative to the ACA?

Ms. BLUMBERG. Well, it is not an alternative to the ACA in terms of an equivalent way to expand coverage and to reduce costs for individuals—regardless of their health status, to make that coverage adequately accessible.

Mr. CARTWRIGHT. One element of the Speaker's plan is to encourage the use of these health savings accounts combined with high-deductible health plans, and according to the plan, this is supposed to help patients understand the true cost of care.

Dr. Blumberg, isn't it true that this change could increase the out-of-pocket costs for middle class Americans?

Ms. BLUMBERG. Well, it certainly increases out-of-pocket costs when individuals move into a health savings account combined with a high-deductible health plan. They are designed to be, at this point anyway, to be combined with a high-deductible plan. Individuals then have larger cost-sharing requirements, but they have certain tax advantages which tend to accrue most greatly to those who are high income, so they are—the health savings account itself can act, if not used for health purposes, as an additional IRA, which is beneficial for the high income. The problem comes in for those individuals who don't get the tax advantages and don't have the extra money to put into the HSAs. They are certainly disadvan-

taged, and it tends to pull healthy people out of the insurance market where they would otherwise be sharing healthcare costs with those with healthcare problems.

Mr. CARTWRIGHT. Okay. So it's the Better Way plan for higher-income people, is it?

Ms. BLUMBERG. Well, a lot of components of the Better Way approach would be most advantageous to those with higher incomes and those very much in particular who are healthy at a given point in time.

Mr. CARTWRIGHT. Well, do you think the people who couldn't afford health insurance before the ACA was enacted really need help understanding the true costs of their medical care?

Ms. BLUMBERG. Well, for the lowest income population, those that are assisted through the Medicaid expansion under the Affordable Care Act and those who receive the most generous assistance under the marketplaces really are in situations where having higher out-of-pocket costs are going to very much reduce the amount of care that they receive. And contrary to popular belief, individuals are not very good at discriminating between care that is necessary and care that is unnecessary. So what happens is, when you increase their out-of-pocket costs, particularly for the modest income, they use much less care, and a lot of it is necessary care.

Mr. CARTWRIGHT. The Speaker's plan would also irreparably harm Medicaid. First of all, it would prevent any more States from expanding Medicaid as provided by the ACA. It would also force States to choose between receiving Medicaid payments as a per capita allotment or a block grant.

Now, Dr. Blumberg, what would these changes mean for people who rely on Medicaid for their health coverage?

Ms. BLUMBERG. Well, in both cases, regardless of what the States chose, the amount of Federal dollars going to States for the Medicaid population would be reduced over time. There would be both initial reductions because of changes in matching rates. There would also be—the intent is to lower the rate of growth in Federal dollars going to States. The biggest concern, while there's danger for sure with the per capita caps, the block grant, as I read it in the materials that were released, suggests that the only mandatory populations that would continue to be required that States provide Medicaid coverage for under the block grant approach would be the elderly and the disabled.

Mr. CARTWRIGHT. Okay. Now, the Speaker's plan would once again allow insurance companies to discriminate by charging higher premiums based on health status, sex, and age, and it would eliminate caps on out-of-pocket expenses.

Mr. Counihan, aren't these the types of abusive insurance practices that the ACA protects against?

Mr. COUNIHAN. Those are good examples of dramatic improvements that the Affordable Care Act brought.

Mr. CARTWRIGHT. The Speaker's plan would also harm seniors by raising the Medicare eligibility age to age 67. Now, the Center on Budget and Policy Priorities said this about the Speaker's plan, "Overall, the plan would represent an enormous step backward for our country, reversing historic progress in expanding health coverage under the Affordable Care Act."

Dr. Blumberg, do you agree with that statement?

Ms. BLUMBERG. I do.

Mr. CARTWRIGHT. I don't know why anybody would want to go back to the bad old days before the ACA, and that's apparently exactly what the Republicans are trying to do with this misguided plan.

I yield back, Mr. Chairman.

Mr. JORDAN. I thank the gentleman.

I now recognize the gentleman from Georgia, Mr. Hice, for his questions.

Mr. HICE. Thank you, Mr. Chairman.

I respect my colleague, but I thought we were here to discuss the Affordable Care Act and ObamaCare, and I have anything to say about it other than the false belief that somehow it has ushered us into the good old days. This has been nothing but a disaster and continues to be a disaster. Premiums and deductibles are raising. I hear it every time I go home. People can't afford it. Insurers are reducing plan offerings. CO–OPs, as we have already discussed, are imploding. We have administrative requirements that are ballooning to the tune of $273 billion in administrative expenses attributable to ObamaCare, which amounts to hundreds and thousands of hours of paperwork to try to keep up with the requirements. The enrollment is skewed, going down. I don't see how in the world this has ushered us into the good old days. It is absolutely a disaster every way I can possibly look at it.

Mr. Counihan, you mentioned today that, because of the Affordable Care Act, that a lot of people have insurance because of ObamaCare. But what you did not mention, in all honesty, is that these folks are older; they're sicker; they're more expensive to insure even than the administration ever anticipated. As a result, we now have insurers who are rising the premiums because it is so expensive to insure these folks. Kaiser predicts that premium increases this year are going to be steeper than they have seen so far. And it has already just gone up and up and up since the beginning. The former CMS Administrator recently predicted the same thing.

We have high deductibles that, quite frankly, are just making insurance coverage less affordable and less accessible to the people. This is anything but an Affordable Care Act. People can't afford it. I hear it constantly, not only from people in my district but from small rural hospitals: 17 percent of the people have a deductible over $5,000. They can't afford the deductible. They go to the hospitals, and hospitals end up never getting paid, and they are going under.

We have already mentioned ObamaCare promised to keep the doctors, keep your health plan, and we, of course, all know that that simply has not been the case. Insurers have limited their provider networks trying to cover the cost of this thing. Brian Webb of the National Association of Insurance Commissioners recently said that the individual market is a mess. I mean, how in the world can we look at this in any other possible honest way but to say, "This is a disaster"? And I really, Mr. Chairman, I really don't have any questions. I'm just flabbergasted that we are still in any way trying to defend this and trying to continue to push it on the

American people, rather than face the reality. We have fewer plans. We have fewer doctors. We have reduced choice. And I guess my only question, is this the legacy of ObamaCare? I don't see any other way out of it.

Mr. Chairman, I thank you for holding this hearing.

And I yield back.

Mr. JORDAN. I thank the gentleman.

I couldn't agree more with his sentiments on the disaster that this legislation has turned out to be.

Mr. Counihan, is the CO–OP program in ObamaCare a complete failure?

Mr. COUNIHAN. No, not in my view, and I'll tell you why.

Mr. JORDAN. Okay. Tell me why or define to me what would be a complete failure if the facts—let me just recite the facts again. Twenty-three programs were given money just 2 years ago, and 16 of them have already failed. The seven that haven't failed yet, four are on corrective action plans. Isn't that accurate?

Mr. COUNIHAN. No. Six are on corrective action plans.

Mr. JORDAN. So the six that haven't failed—six of them are on—of the seven that haven't failed, six of them are on corrective action plans?

Mr. COUNIHAN. Correct.

Mr. JORDAN. Oh, wow, so it's worse than I thought. Because of the last four that failed, all those were on corrective action plans, and they all failed here, one in Ohio just a few months ago. So 23 started. Sixteen have failed. Of the remaining seven, six are on corrective action plans. Every other CO–OP that was put on a corrective action plan did, in fact, actually then later fail. $2.4 million allocated—$2.4 billion allocated; $1.5 given out and now lost. And yet you don't think that defines a complete failure?

Mr. COUNIHAN. Let me just if I can, Mr. Chairman——

Mr. JORDAN. Tell me what would be a complete failure. Let me ask this way, if all 23 actually fail, would that be a complete failure, because that's where this is headed——

Mr. COUNIHAN. I think we're seeing with the CO–OP program, as we are with other parts——

Mr. JORDAN. No. Answer that question. If all 23 fail, would that be a complete failure?

Mr. COUNIHAN. I think if all 23 fail, it underscores how challenging the health insurance business is.

Mr. JORDAN. That's not what I asked you. Would it be a complete failure if every single CO–OP that you guys authorized just 2 years ago failed? Would that be a complete failure? Because we all know that's where it's headed. Sixteen have already failed. Of the seven left, six are on corrective action plans, and they're going to fail too. So when all 23 fail, would that be a complete failure of the CO–OP program under ObamaCare?

Mr. COUNIHAN. As I said, I think it underscores how tough this business is. I think it underscores how challenging it is it being a small business——

Mr. JORDAN. Mr. Counihan, you're a witness here today, and I'm asking you to answer one question. If they all fail, if they all fall apart, like we know they're going to, is that a complete failure? Just give me a yes or no to that one. That's all I'm asking you.

Mr. COUNIHAN. I'm just, Mr. Chairman, it underscores again that this is a very tough business.

Mr. JORDAN. Is it a no? Is it a yes?

Mr. COUNIHAN. And, Mr. Chairman, I've worked for an insurance firm that was about the size of one of the larger CO–OPs. We became successful, but I understand very, very specifically——

Mr. JORDAN. Are you saying some of these 16 are going to come back to life? They're not dead forever. They're going to miraculously revive and resurrect themselves? Is that what you're saying?

Mr. COUNIHAN. What I'm trying to say is the following.

Mr. JORDAN. Let me ask you this. Are you sitting here today and saying you're going to assure me that the seven left, that they're not going to fail? Those seven are going to keep working? They're going to be fine. Will you tell me that? Would you tell me that? Are they going to continue to be in operation? The seven that haven't failed yet, are they going to still be good when you come back here in a few months and we have this same kind of hearing?

Mr. COUNIHAN. Nobody could make that kind of prediction, sir, but let me tell you one of the reasons why. It's because there are so many variables that could impact the success of a business like that, most fundamentally claim costs. So, for example, if an issuer like a CO–OP has a very tough year——

Mr. JORDAN. We just heard from you, Dr. Blumberg, and the ranking member that ObamaCare is the greatest thing since sliced bread. We just heard that. And yet we have this phenomena in front of us. Sixteen of 23 have completely failed. And we know the other seven are going to fail. And yet you just all told us ObamaCare is the greatest thing in the world. And I'm just asking you, can we at least just focus on the CO–OP and say, if all 23 of those fail, that part of ObamaCare, at least that has to be a complete failure, right?

Mr. COUNIHAN. Yeah. As I've said, I've worked for a company that's one of the sizes of the larger CO–OPs. What can impact the business of a CO–OP——

Mr. JORDAN. I'm not looking for excuses. I'm just looking for an answer to that question. If they all fail, is it a complete failure?

Mr. COUNIHAN. What I'm trying to tell you, number one, is that the CO–OP program is not the whole Affordable Care Act. Number two is that it's a very, very tough low margin business. Number three is it deals with a lot of——

Mr. JORDAN. Do you know what the COOP program is, Mr. Counihan? It's one more thing that was promised when ObamaCare was first enacted that was going to be just so special, just like you all just had said earlier—well, one of the other things that was promised: ObamaCare passes, there will be no one without insurance. We know that's not the case because you even said it. There are still several million people that don't have insurance. One of the things we were promised when ObamaCare passed is 20 million people will use the exchange. We know that's not true because you all had to change the definition. You now say, well, it is 20 million, but it's the exchange plus Medicaid expansion. You totally changed the definition to meet that number.

So, not to mention all the other—if you like your plan, keep it; like your doctor, keep it; premiums are going to go down—all those

other things have turned out to be false as well. And all I'm asking you is one program, the CO–OP program, and you won't answer my question. It seems, by definition, if 23 out of 23 fail, then you should be able to say that, of course, by definition is a complete failure.

Mr. COUNIHAN. Yeah. So let me tell you, sir, what the CO–OP program has done. The CO–OP program has provided more choice. It's provided more competition. It's helped consumers in a variety of different States, giving them opportunities that they may not have had before. If I may, sir, tell you something else. It's also given the opportunity to innovate. Several of these CO–OPs have introduced new types of care management programs that have been new in their markets and new in their States.

Mr. JORDAN. So new and so great; that is laughable. So new and so great that they actually went out of business. I find that to be laughable on its face.

Mr. COUNIHAN. But the others, sir, are replicating. So the health insurance business and the healthcare business, as you well know, is highly dynamic. It changes. There are a lot of variables to it. The CO–OP program has provided a lot of choice to people, and that's a key part of what it was for.

Mr. JORDAN. Are you willing to tell this committee today, Mr. Counihan, that when you come back later this fall and we have another hearing on the CO–OPs, that the seven that are still in business are still going to be in business then?

Mr. COUNIHAN. Sir, I would, number one, be very happy to come back at any time. Number two is I could not predict the future of any issuer.

Mr. JORDAN. You were here a couple months ago, and it was 11, and we asked you then, and you wouldn't commit. We said we think they're all going to fail, and here we are a couple months later and four more are gone, and the other six or the other seven are on corrective action plans. Let me ask you this. Have you done anything to recover the $1.5 billion that's out the door?

Mr. COUNIHAN. Yes, sir.

Mr. JORDAN. What have you done?

Mr. COUNIHAN. So the Department of Justice is in the process of working with several of the CO–OPs——

Mr. JORDAN. I didn't say that. I said "you." Not the—you're CMS. You don't work for the DOJ, do you?

Mr. COUNIHAN. No.

Mr. JORDAN. Okay. So I'm asking CMS. You have the ability to terminate the loan agreements, don't you?

Mr. COUNIHAN. Well, what I was trying to do——

Mr. JORDAN. Is DOJ a signatory on the loan?

Mr. COUNIHAN. What I was trying to say, sir, is that these are Federal loans. Once those Federal loans become in recovery, that moves over to the DOJ.

Mr. JORDAN. What are you doing? You're the one who gave out the—you're the one who decided who got the money. You allocated the money. You gave it out. What is CMS doing to recover the $1.5 billion of taxpayer money?

Mr. COUNIHAN. The process of how this works, sir, is when a Federal loan goes into recovery of that sort, it moves to DOJ for

that process, and I am very happy to have someone from DOJ come here to give you an update.

Mr. JORDAN. You can't terminate yourself?

Mr. COUNIHAN. Well, I'm talking about loan recovery. I thought your question was about recovery of the loan. The process of recovering a Federal loan is that DOJ takes over that process.

Mr. JORDAN. But what have you done? Have you terminated a loan so that DOJ, in fact, can do that?

Mr. COUNIHAN. Sir, it very much depends on the situation of the CO–OPs. I think what's important for everyone to remember——

Mr. JORDAN. We know the situation, Mr. Counihan. Sixteen of them have completely failed. What are you doing to get the money back?

Mr. COUNIHAN. And these are independent, licensed issuers by States. They compete just like any other health insurance company in that State.

Mr. JORDAN. Okay. I went a couple minutes over. I apologize.

So we will now turn to the right fine gentleman from North Carolina, Mr. Meadows, for his questioning.

Mr. MEADOWS. Thank you, Mr. Chairman.

Good to see you both. Kevin, good to see you. Let me do a little housekeeping if I could on one particular issue, Mr. Counihan. You are aware I guess that Ways and Means and Energy and Commerce has issued subpoenas as it relates to I guess the cost-sharing reduction program. Is that correct?

Mr. COUNIHAN. Yes.

Mr. MEADOWS. And so have you been instructed to collect materials that are responsive to that subpoena?

Mr. COUNIHAN. No.

Mr. MEADOWS. You haven't?

Mr. COUNIHAN. No.

Mr. MEADOWS. So no one has reached out to you? Because that's a real problem.

Mr. COUNIHAN. My job——

Mr. MEADOWS. Again, if that's your sworn testimony—so what you're saying is no one has asked you to collect any documents responsive to a congressional subpoena regarding that program?

Mr. COUNIHAN. Yeah. We have a staff of people that I work with that are responsible for collecting documents of that sort, and they're responsible for doing it. That's not in my role.

Mr. MEADOWS. But you haven't been instructed? So have you instructed anyone to collect those documents?

Mr. COUNIHAN. No.

Mr. MEADOWS. So are you aware of anyone who has been instructed to collect those documents?

Mr. COUNIHAN. You know, as I said, sir, we have a whole staff of people that are responsive to that.

Mr. MEADOWS. But you know the point I'm trying to get to. Is somebody collecting those documents or not, Kevin?

Mr. COUNIHAN. Congressman, to that very issue that you are speaking to, we have tried to be as responsive as we possibly can because I know the issue about document retrieval is very important to the committee——

Mr. MEADOWS. So when will we get them—or when will they get them?

Mr. COUNIHAN. I'll need to get back to you.

Mr. MEADOWS. But you're saying no one's asked you, and you've instructed no one. Wouldn't you know if someone were instructed? Because you're the head of the—we have had a number of conversations about responses and the lack thereof.

Mr. COUNIHAN. That's right.

Mr. MEADOWS. And I guess my question is—you've got a staff behind you.

Mr. COUNIHAN. Yes.

Mr. MEADOWS. Are they aware of anybody collecting the documents?

Mr. COUNIHAN. Sir, I want to be responsive to you. Let me get back to you, please.

Mr. MEADOWS. And you can get back to me by when?

Mr. COUNIHAN. I'll have to circle that back with you.

Mr. MEADOWS. I mean, it's not a hard question. You got a subpoena. I'm sure when the subpoena came in, somebody said, "Oh, my gosh, we got a subpoena," because we don't issue subpoenas just willy-nilly. We only issue subpoenas after you don't respond.

Mr. COUNIHAN. Yeah. And Congressman——

Mr. MEADOWS. So have you been asked for the documents personally?

Mr. COUNIHAN. Congressman, we want to be responsive. I know we have already provided——

Mr. MEADOWS. Let me tell you the last person who told me that. The last person who told me that was not responsive, Kevin. I apologize. I shouldn't be calling you Kevin, Mr. Counihan. The last person who told me that was actually part of a rulemaking process who they had been working on it for a year, and we came to find out they hadn't been working on it. So I guess my question is, when can Ways and Means and when can Energy and Commerce expect a production of the documents according to the subpoena that you acknowledge you're aware of?

Mr. COUNIHAN. Sir, what I would like to say is I need to get back to you with that timing.

Mr. MEADOWS. Actually, it would be appropriate for you to get back to this committee but also to Chairman Brady and Chairman Upton with regards to a timeframe, and so can we expect a response by the close of business on Friday in terms of a timeframe?

Mr. COUNIHAN. We'll get back to you.

Mr. MEADOWS. Yes or no, is that not reasonable?

Mr. COUNIHAN. Sir, I need to get back to you.

Mr. MEADOWS. Mr. Counihan, you do not have the option of not giving me a timeframe, because in doing that, you're thereby forcing the same issue, and it would be a contempt of Congress to continue to stonewall. So is that what you're saying is, is that you're not willing to give me any kind of a timeframe?

Mr. COUNIHAN. Sir, what I'm telling you is the following: I want to be as responsive to you as possible. I want to give you an accurate timeframe. What I'm asking from you is to give me the time to be able to be responsive.

Mr. MEADOWS. What's a reasonable amount of time?

Mr. COUNIHAN. As I said, sir, I need to go back with my folks, understand it, and get back to you then.

Mr. MEADOWS. Let me, by Friday, the close of business, I either want a response on why you can't respond by then, why you haven't been able to find it, or some kind of legitimate response in terms of a timeframe, okay?

Mr. COUNIHAN. That's fair.

Mr. MEADOWS. And so, as we start to see this—and I apologize, Mr. Chairman, if you'll indulge me just a few moments. Let me say one of my concerns, and you know, philosophically, we probably have a big difference. I don't want to get into the philosophical differences. Let me tell you where I am troubled, is for all the stories of people who now have coverage, I continue to get a disproportionate number of people who are saying their premiums are going up or their companies are going out of business. And so today we're talking about really a CO–OP program. And I've had some of the major insurers in the country come to me saying that not only are they losing money, but they're hemorrhaging a loss of money because they can't get either this on a profitable point of view or costs continue to go up. Are you hearing some of the same concerns from insurance companies?

Mr. COUNIHAN. You know, let me tell you what I'm hearing, and I talk to a lot of CEOs. And in this past open enrollment, I was in 13 States talking to people. What I'm hearing is that looking at the traditional way of managing care, contracting with the providers, servicing this new population is less effective than it is by designing newer, more customized approaches that often exist within Medicaid plans. So issuers——

Mr. MEADOWS. So let me make sure I'm understanding that. So, in your 13–State tour and talking to CEOs, they're suggesting that we go to a Medicaid?

Mr. COUNIHAN. No.

Mr. MEADOWS. Because I thought that's what you were saying.

Mr. COUNIHAN. I apologize. I was not clear. What I meant to say was that if you look at issuers that have a strong Medicaid background, that have served the Medicaid population, that work to design and customize care management tools that are more specific to this new type of population, they're finding themselves being more effective than those that have just traditionally served, say, the small group insurance market or the large group market.

Mr. MEADOWS. But you and I both know that I'm a numbers guy.

Mr. COUNIHAN. Yes.

Mr. MEADOWS. In a Medicaid patient, the amount of money spent per Medicaid patient is higher than the other patients typically. I know it is in North Carolina, exponentially higher. So what you're saying is, is that we need to go to a model where we spend more per patient?

Mr. COUNIHAN. No. I'm actually saying the opposite. What I'm actually saying is that one of the interesting things I'm seeing in talking to CEOs is that they are retooling their provider contracting to match a number of issuers that have been successful in this business from the beginning. And what we're finding, Congressman, is that there's a clear opportunity for issuers that have thought of this market more strategically, that have used a lot of

data to understand the specifics of their market, understand the uninsured in their State, design products that meet them, tier networks, if appropriate, and provide new cost-management tools. That's what I'm saying.

Mr. MEADOWS. So let me go to one of the biggest ones, Blue Cross Blue Shield, in my State, obviously the largest provider. They have gone up 30 percent, 34 percent, and anticipated 20-plus percent this year in terms of the insurance rates. We're hoping that it's lower. I talked to them just 2 weeks ago. So, when you look at that, you know, you aggregate all of that together.

Mr. COUNIHAN. Yeah.

Mr. MEADOWS. That is not affordable health care, and certainly my rates are not anywhere close to what they used to be 3 years ago. Fortunately, I can afford to pay it. Many cannot. They are just barely scraping by. What they shared with me is that emergency room visits are not really down. Is that correct? Because that was the whole premise: we would get this group of uninsured from going to use the emergency room as their primary healthcare provider. And, actually, they're saying that that went up, and it continues to stay at an elevated rate. Are you finding that?

Mr. COUNIHAN. A couple things that you've raised. First of all is that, if you look at cost increases, cost increases are at the lowest level during the ACA than they've been historically over the past 50 years——

Mr. MEADOWS. Lowest level against what? What are we comparing it to? Mr. Counihan, how can you say lowest level? I'm 57 years old. I've been paying insurance premiums for over 35 years. So 35 percent, 30 percent, and 18 to 20 percent is not the lowest level of increases that I've faced. That is just factually incorrect.

Mr. COUNIHAN. But if you've looked at the average in the markets, so, for example, if you looked at the cost increases on average nationally——

Mr. MEADOWS. Let's look at North Carolina. You knew I was going to be here, and you know my numbers, so let's look at North Carolina. Is it better in North Carolina over the last 3 years than it was in the previous 10 years, in terms of rate of increase?

Mr. COUNIHAN. Yeah. And, unfortunately, Congressman, I don't have the benefit of the insight of North Carolina——

Mr. MEADOWS. Well, you can get back to me.

Mr. COUNIHAN. But I can speak to nationally, and I can tell you that from 2000 to 2010, the average rate increase was 8 percent. From 2010 to 2015, it was lowered to 5 percent. So I'm talking nationally.

Mr. MEADOWS. So what you're saying is we're an anomaly in North Carolina? Is that your sworn testimony? Because we went 30, 35, 34 percent, now 18, and we are astronomically more than anybody else?

Mr. COUNIHAN. Sir, what I am saying is that there's not any monolithic or consistent level of rate increases nationally. If you look at rate actions, they vary by urban areas versus rural, as you and I have discussed?

Mr. MEADOWS. They vary by Medicaid and Medicare more so than anything else.

And I will yield back.

Mr. COUNIHAN. Well, okay. All right.

Mr. JORDAN. I thank the gentleman. I now recognize the gentleman from Tennessee for an additional round of questions.

Mr. DESJARLAIS. I guess I'm going to kind of follow up where Representative Meadows was on numbers. You are saying that 20 million people now have insurance. What percentage of that is Medicaid expansion?

Mr. COUNIHAN. Roughly half, about 9 million.

Mr. DESJARLAIS. Okay. So what did President Obama claim we had in terms of the number of uninsured when he was proposing his healthcare law?

Mr. COUNIHAN. I can't remember, Congressman, exactly. You want to use your percentage? You said 16 percent?

Mr. COUNIHAN. Oh, excuse me. The percentage of uninsured? Excuse me, 16 percent.

Mr. DESJARLAIS. Okay. And we have 300 and some odd million people in the country, so 40, 45 million people.

Mr. COUNIHAN. Yeah, 43 or so, yeah.

Mr. DESJARLAIS. So what we have done is we have doubled the number of people on Medicaid, and of the other 10 million that now have insurance, how many of those have significant subsidies?

Mr. COUNIHAN. About 85 percent of our population have subsidies apply, tax credits apply.

Mr. DESJARLAIS. I can see where the cash flow problem might be coming from then, because only just a million and a half then are actually paying for their health care or a small number, small percent?

Mr. COUNIHAN. I guess I believe, Congressman, that everybody is paying for their health care. It's just that these individuals, based on their income, are getting tax credits to help them make it more affordable, but everyone's paying.

Mr. DESJARLAIS. Did we ever figure out how many people—there are people that are living here illegally that are getting health care, correct?

Mr. COUNIHAN. I'm not familiar about the number of people, illegals, that are getting health care in this country.

Mr. DESJARLAIS. It seemed like there was an estimate of—I don't remember—10, 15 million people possibly that were getting that, but you don't know?

Mr. COUNIHAN. No.

Mr. DESJARLAIS. We're talking about the cost of deductibles. Even President Obamaacknowledged that too many Americans are straining to pay other physicians for their deductibles and costs. And I think somewhere that you said the deductibles have decreased $850. We have heard numbers thrown around here upward of $5,000 is the deductible cost. Why the discrepancy? That's a big difference.

Mr. COUNIHAN. The median deductible in our plans actually was lower this year by about 5 percent from the year before, to about $850.

Mr. DESJARLAIS. That's the median. And that's for the people who are being subsidized, the 10 million who are not getting Medicaid expansion?

Mr. COUNIHAN. Yeah. That's correct. That's in that number of the 11 million. That's right.

Mr. DESJARLAIS. So, basically, healthcare costs have gone up for about 90 percent, maybe even 95 percent, of Americans because of ObamaCare?

Mr. COUNIHAN. I think it's actually the opposite, sir.

Mr. DESJARLAIS. You're saying that healthcare costs have gone down?

Mr. COUNIHAN. What I'm saying is that healthcare costs have been made more affordable than ever because of the Affordable Care Act. If you look at last year, just as an example, the average individual out-of-pocket increase went up by $4, 4 percent. So we're making costs more affordable. We're making coverage more accessible.

Mr. DESJARLAIS. And the CO–OPs are going broke, and there's been money that's come out. The Court ruled that the Obama administration was using funds to subsidize insurance companies that it wasn't authorized to do. That's probably a topic for another hearing.

Ms. Blumberg, you're talking about access to care. I practiced medicine for 20 years. I know if you're on Medicaid, you essentially have no deductible. You can go to the ER. You can go to a clinic, but if you have private insurance, if you go to the ER, your deductible might be $300, $400 or more. So, even if you have an emergency, you can't afford to go to the ER, so you might wait to the next day to come see the doctor. I know I've seen that happen. Now people have deductibles up to $5,000. Middle class folks are not going to the doctor, and they're not seeking to get care, so their quality of care is actually going down. We have helped some people. We have helped some people. As you've said, we've helped people get Medicaid, and we have helped subsidize people, but there's a whole lot of other people hurting because they can't afford to go to the doctor, or they won't go to the doctor, and they let problems fester because of that high deductible. What would you say to them?

Ms. BLUMBERG. Well, I think, with regard to the emergency room care, according to the rules under the Affordable Care Act, if it's emergent care that you're receiving through the emergency room, you don't face those deductibles. So it may be, yes, if you're going in to get nonemergent care through the emergency room and you've got a private insurance plan——

Mr. DESJARLAIS. Are you talking Medicaid or private insurance?

Ms. BLUMBERG. But if you're getting nonemergent care, then out-of-pocket cost is going to be significant if you go use the emergency room because the intent is to give financial incentives to get alternative sources of care for nonemergent care. And what we have found in our survey work is that, indeed, the number of—the percentage of adults reporting a usual source of care outside the emergency room has increased significantly since 2013, and those not obtaining necessary care due to cost has gone down substantially since then.

Mr. DESJARLAIS. I'd like to see those numbers.

Ms. BLUMBERG. Certainly.

Mr. DESJARLAIS. Mr. Counihan, quickly, how many people now—ObamaCare has been around for a while. How many people have

paid the penalty on their IRS taxes rather than getting health care? In other words, how many people had health care that have dropped their health care and opted to pay the taxes?

Mr. COUNIHAN. Yeah. So I—sir, I can't remember the exact number of people that have paid that penalty. I'm, again, happy to get back to you with that figure.

Mr. DESJARLAIS. Can you ballpark? Can you guess?

Mr. COUNIHAN. You know, I really wouldn't——

Mr. DESJARLAIS. Okay. We still have 10 percent uninsured by your number.

Mr. COUNIHAN. Nine percent, yeah.

Mr. DESJARLAIS. Nine percent. Okay. So that is roughly 30 million people. Who are they?

Mr. COUNIHAN. Excuse me?

Mr. DESJARLAIS. Who are the 30 million people that don't have insurance? If 10 percent are still uninsured and we have all of these other people that now have insurance, who are the ones that don't have it?

Mr. COUNIHAN. Yeah. So it's in a couple of different segments. So one would be Medicaid expansion States, States that have an expanded Medicaid; a significant component there. Number two would be young people. I mentioned earlier about the importance of enrolling younger folks and the outreach efforts that we are making to that. That's another cohort that's critical for that.

Mr. DESJARLAIS. Yeah. It's really expensive for young people. I know that by talking to them. But I think what we've done is shifted health care. Some people that didn't have health care where now they get subsidized, but a large group of people that had health care can't afford it now, so they are paying taxes to the IRS and going without insurance. And the ones that do have high deductibles and they can't get health care because they are afraid they have to spend their deductible. But somehow you both seem to think this is a success; not at all what we are hearing back home.

Mr. COUNIHAN. Yeah. To your point, sir, around young people and affordability, the vast bulk of them would be eligible for subsidies, for tax credits, and I think that would make that coverage much more affordable for them.

Mr. DESJARLAIS. But that's going to make the overall program—any time you give cash subsidies to somebody, it makes it way more expensive somewhere else. Right?

Mr. COUNIHAN. As I said, sir, our job is to enroll people into affordable care. I think we've made good progress. We've got more to do, as you say.

Mr. DESJARLAIS. Sounds like socialized medicine. Thank you.

Mr. JORDAN. I thank the gentleman.

I will now recognize the gentleman from Pennsylvania.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

So I'm going to throw this one open to both witnesses. It's a toss-up question. Mr. Hice of Georgia just said that because of the ACA, we have fewer doctors. Is there any substance to that? Do we have fewer doctors in this country since the enactment of the ACA?

Ms. BLUMBERG. I don't know that we have any evidence of that whatsoever.

Mr. CARTWRIGHT. That would have been a shock to me. And of course, my friend, Mr. Meadows of North Carolina, was lamenting the premium increases and he was talking about his advanced age, and I'm a bit long in the tooth myself. And I was a business owner for many years and year after year, we would have premium increases. This was long before the Affordable Care Act, you know, 20 percent and 30 percent and 35 percent in a single year. And that was tough to take. It's still tough to take. But how about either of you, can you put your finger on the ACA as the reason for annual premium increases as opposed to what went on in the world before ACA?

Mr. COUNIHAN. Yeah. If I could just answer that, Congressman?

Mr. CARTWRIGHT. Sure.

Mr. COUNIHAN. I understand exactly what you're referring to, and I actually think that the ACA has had the exact opposite effect. It's moderating increases. And I will just give you an example. In the mid-1980s, mid to late 1980s, annual trend, inflationary trend in health insurance was in the mid 20s, 24, 25, 26 percent. That's beyond the impact of any utilization expense. That was pure inflationary trend. That's been dramatically, dramatically cut back. So I think that helps prove your point.

Mr. CARTWRIGHT. Do you want to weigh in on that, Dr. Blumberg?

Ms. BLUMBERG. Sure. There definitely has been a long history of variability in premiums from year to year. What we are finding in terms of the increases in the nongroup marketplace plans, which I think is the focus of some of the concern here, is that there is huge variation by geographic area. We have seen that in the areas that tend to have the biggest increases, we're talking about the smallest population centers. We're also talking about seeing larger increases coming where the premiums had been in the prior years quite low relative to the national average.

And so we think some of this is a regression to the mean over time, that some of these insurers came in too low and they're correcting now, but it's not necessarily that they're all going very high, relative to what you're seeing in other parts of the country, but they made some errors in judgment originally and they're correcting for them. So some of these large percentage increases are on a much smaller premium basis. And so the——

Mr. CARTWRIGHT. Like a market correction.

Ms. BLUMBERG. Exactly.

Mr. CARTWRIGHT. All right. And I don't mean to cut you off. You have long interesting answers, but we're on the clock here.

Ms. BLUMBERG. Sorry.

Mr. CARTWRIGHT. So we're very—we have to have short, couple of sentence answers. Not paragraph answers.

Ms. BLUMBERG. Understood.

Mr. CARTWRIGHT. Your research found, and I quote, "Rates of increase vary tremendously across States and across rating areas within States."

The question is: Why do premium rates vary in this way?

Ms. BLUMBERG. They vary depending upon the market conditions that were there prior to the Affordable Care Act to some extent, how many insurers are competing, and that is related to the histor-

ical situation, what types of insurers are competing and the types of insurers that have come in or have exited from the market.

Mr. CARTWRIGHT. Okay. And here's my question. The Affordable Care Act, has it helped facilitate increased competition that is needed to drive down the rates?

Ms. BLUMBERG. Definitely. Because in the nongroup insurance market, in particular prior to the ACA, we didn't really have price competition in these areas. But what the insurers were doing was competing for healthcare risks. Now there is transparency, there is equivalency of the plans. And so for the first time, we're seeing price competition where we didn't see it before in this market.

Mr. CARTWRIGHT. Now, Mr. Counihan, I want to get your answer on that as well.

Mr. COUNIHAN. I just wanted to say, in addition to that, we have significantly enhanced the quality of the coverage that the individual market now gets access to. Both the substance of that coverage and also the elimination of the ability to discriminate in that coverage. So just the elimination of preexisting conditions alone is a significant and a huge improvement. The fact, again, that there is no annual lifetime maximums, there is no caps on specific types of procedures. All of these types of things are significantly enhancing.

Mr. CARTWRIGHT. No penalty for being a woman.

Mr. COUNIHAN. That is exactly right. In my old State, women were typically priced twice as high as men for the same type of coverage. We have also seen that the number of bankruptcies due to medical costs have dramatically reduced since the introduction of the ACA. So, again,you know, significant movement and progress.

Mr. CARTWRIGHT. Now, it's also important to remember that the premium rates insurers have filed for next year, 2017, are not necessarily the rates that will be approved by State departments of insurance. Am I correct in that?

Mr. COUNIHAN. Correct.

Mr. CARTWRIGHT. All right. And in fact, ACA created a rate review program to help State departments of insurance strengthen their rate review process. Is that right?

Mr. COUNIHAN. That's correct.

Mr. CARTWRIGHT. According to a 2015 HHS report, rate review reduced total premiums in individual small group markets by $1.5 billion.

Mr. COUNIHAN. That's right.

Mr. CARTWRIGHT. Rate review process. Mr. Counihan, what other tools did the ACA provide to help consumers mitigate the effects of the premium increases?

Mr. COUNIHAN. Well, number one, we talked about the tax credits. We talked about other ways to make things affordable. You've mentioned already the ability of States to take a more aggressive, transparent view for the creation of rates. We've created more competition. We've created more choice.

Just to give you a quick example, last year the average enrollee had an option of looking at three health plans—three issuers, and 50 health plans to choose from. So there's a variety of different ways that we're using the marketplace to help dampen prices and give people more options.

Mr. CARTWRIGHT. You know, I was just complaining about, you know, as a business owner, what it was like to go through these every year, double-digit premium increases. I just saw a figure that premiums increased by 58 percent during the last 6 years of the Bush administration.

Have you seen that number?

Mr. COUNIHAN. I hadn't.

Ms. BLUMBERG. I haven't.

Mr. COUNIHAN. My colleagues in the majority have also brought up the fact that UnitedHealth and a small number of other issuers have decided not to participate in the ACA marketplaces in 2017 as evidence that the ACA is not working.

Dr. Blumberg, what do you make of that argument?

Ms. BLUMBERG. We looked pretty seriously at the United situation and they came in very—mostly in the second year. They really didn't participate much at all the first year and where they came in, they ended up coming in really high. In a few areas they were the low-cost insurer, but in general, they priced very high relative to the others. As a consequence, it is a very price-sensitive population. They really didn't get much enrollment.

Mr. CARTWRIGHT. Is that evidence that the ACA is not working?

Ms. BLUMBERG. No. It's evidence that United strategically was not paying enough attention to how this market was working.

Mr. CARTWRIGHT. Okay.

Mr. COUNIHAN. And Congressman——

Mr. CARTWRIGHT. Yes.

Mr. COUNIHAN. —that is not uncommon in business of any sort or in the health insurance business. People's strategies change, their strategic direction can evolve. So we see more of that. But the——

Mr. CARTWRIGHT. Not only that, startup businesses in general fail for a whole spectrum of reasons. Right?

Mr. COUNIHAN. That's correct. And particularly health insurance. It's a low margin, very, very challenging industry.

Mr. CARTWRIGHT. Now, a recent article in JAMA, the Journal of the American Medical Association, it's titled "Reports of ObamaCare's Demise Are Greatly Exaggerated." It notes other large insurers like Anthem and CIGNA have, quote, "expressed more confidence in the ACA's marketplaces as a business opportunity." In fact, CIGNA is even planning to expand its presence in the marketplaces.

Mr. COUNIHAN. Yeah.

Mr. CARTWRIGHT. Mr. Counihan, what do you make of the fact that some insurers are deciding not to participate in ACA marketplaces in 2017?

Mr. COUNIHAN. I think it's a couple of things. I think, A, this is an example as strategies evolve. Two, I think an example so that people look at opportunities. You used the example of CIGNA. That's a good example. There are other examples of big national publicly-traded firms that are expanding into new markets.

I think the other thing that it's showing is that with any new market—and this is a new market and there hasn't been a new market like this in a long, long time—it takes a combination, whether looking at it from an underwriting perspective, an actu-

arial perspective, a risk management perspective, a care management perspective, a provider contract perspective, all these are different. And what we're finding is that those that are using the same kind of pattern that they used for their commercial business are being less successful and are in the process of retooling, versus those that have looked at this market and this enrollment more uniquely.

Mr. CARTWRIGHT. All right. Last question, and this is the $64,000 question, Dr. Blumberg. If my Republican friends get their way and we repeal the ACA, what do you think will happen to health insurance premiums in this country?

Ms. BLUMBERG. Well, I think health insurance premiums would go up extraordinarily for those who have past health problems or current health problems. And that's really the key is, are we going to leave those who are most vulnerable at their time of most need with inadequate access to care or are we going to pool them together with people who are currently healthy?

Mr. CARTWRIGHT. Well, thank you.

I yield back, Mr. Chairman.

Mr. JORDAN. I thank the gentleman.

Dr. Blumberg, Mr. Counihan wouldn't answer the question, probably can't answer the question. He is in the administration. When I asked him the fact that 16 of 23 CO–OPs have already failed and the other 7 are going to, he wouldn't answer the question whether that's a complete failure. But you don't work for the government. You work for the Urban Institute. Is that right?

Ms. BLUMBERG. That's right.

Mr. JORDAN. You are here on your own capacity today.

Ms. BLUMBERG. Correct.

Mr. JORDAN. All right. So you're not part of the administration. Right?

Ms. BLUMBERG. I am not.

Mr. JORDAN. So when you have a program where 23 CO–OPs are created in this CO–OP program in ObamaCare, 16 have already failed and 7 are going to, would you describe that as a complete failure?

Ms. BLUMBERG. I'd say it's a—you know, you can't say that's a success when all of those plans fail. But I also think that there's—the important thing is for us to look at why those plans failed. I think it was a combination of issues related to they had a big hill to climb as new insurers to begin with. But I also think that the problem with the redefinition of what the risk corridors were going to be and making those, forcing those to be budget neutral, which they were not intended to be, had bad implications for those CO–OPs as well. And that was something that came after the Affordable Care Act.

I also think that it's an indication that we have some improvements to make in the risk adjustment system that I think are some in progress, additional ones that could be done. And I think that, you know, the timing of those support payments from the risk adjustment reinsurance and risk corridors were important there.

Mr. JORDAN. Mr. Counihan, we've asked certain individuals to be scheduled for transcribed interviews, including yourself, Mr.

Cleary, Ms. McNeill, and—I guess just three. When are we going to get that scheduled?

Mr. COUNIHAN. Sir, I need to get back to you on that. I don't do that type of scheduling and I'm happy to respond to you fast.

Mr. JORDAN. Yeah, but you're the boss there at CMS and so we've been trying to do this. Can you make a commitment that you're going to get it done here? We want to get it done this month.

Mr. COUNIHAN. You're absolutely right, sir, that I am the boss. But the CO–OP program, for example, has its own director, it's own team of people that are dedicated to it. I need to circle back with you.

Mr. JORDAN. But they answer to you. Right?

Mr. COUNIHAN. Correct.

Mr. JORDAN. Okay. Well, that's why I'm asking you. You're the guy here on the witness stand. You're the boss at CMS.

Mr. COUNIHAN. Yeah.

Mr. JORDAN. So we want to get you and two other people in for an interview.

Mr. COUNIHAN. Yeah.

Mr. JORDAN. We're just asking you, can we make that happen in 2 weeks?

Mr. COUNIHAN. Yeah. And, sir, I want to comply with that. As I said, I'm just looking——

Mr. JORDAN. Okay. We've also requested——

Mr. COUNIHAN. —for a time to be able to get back to you.

Mr. JORDAN. We've also requested documents from you. When are you going to give those to us?

Mr. COUNIHAN. So, sir, we have already given you, as you're probably very, very much aware, thousands of pages of documents to be responsive.

Mr. JORDAN. We want them all. We want the ones—we want the ones that we need, the ones we've asked for, not some—you know, we hear this every time in congressional committees. We've given you thousands of—I don't care if you have given us a bazillion. If they're not the ones that matter——

Mr. COUNIHAN. Yeah.

Mr. JORDAN. —who cares? I want the ones that matter. When are you going to give those to us?

Mr. COUNIHAN. Well, and the ones that—and I'm not sure how you're defining the ones that matter, but the one that have——

Mr. JORDAN. The ones that matter are the ones we asked for.

Mr. COUNIHAN. Well, the ones that have business risk to those businesses, those CO–OPs, have been available in camera. They continue to be available in camera to your staff. We're not hiding anything from you. But——

Mr. JORDAN. Sure sounds like you are when you're saying in camera. Give them to us. We want them. We don't want to have to come over there with a special thing in a special room, look at them, can't take notes and all this. We've been through this before in other committees as well.

Mr. COUNIHAN. Yeah.

Mr. JORDAN. It's just ridiculous. It's a congressional investigation, congressional inquiry. We want the information. Give it to us.

Mr. COUNIHAN. Yeah. And we want to give you the information, but we can't have the information leak out for businesses. As I told you, I worked for a small business——

Mr. JORDAN. Now, that is, again, almost laughable. They're all going to fail. Anyone with a brain can see that, and now you are telling us, oh, we got to be X—we're going to be confidential with the information. But to say you have to see them in camera because, oh, by the way, some of these things might fail, we already know that. Anyone with a brain knows it because every one of these are going to fail. So that's sort of a lame excuse, frankly, Mr. Counihan. Just let us have the documents. Will you?

Mr. COUNIHAN. Well, sir, I respectfully have a different perspective on your comment about them all going to fail. What I would tell you is that we have an obligation, a fiduciary obligation, to make sure that no confidential information about their businesses gets leaked out and can be used against them. And I'm sure you can appreciate that.

Mr. JORDAN. I certainly can, and we can certainly keep confidential information confidential.

Mr. COUNIHAN. Yeah.

Mr. JORDAN. How about the materials relating to the CO–OP risk committee? When are we going to get those materials?

Mr. COUNIHAN. Yeah. So I will have to check on the status of your request for information related to that. That's not an area that I personally get engaged with, so I will follow up with you on that.

Mr. JORDAN. What about the notes from the weekly calls you have with the CO–OPs? When are we going to get that information?

Mr. COUNIHAN. Yeah. Sir, as I said, I'm not responsible for responding for those types of document requests. And we'll be happy to get back to you with details.

Mr. JORDAN. The gentlelady from New Mexico is recognized for 5 minutes.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman, and thanks to the witnesses.

So I know that Mr. Counihan is very familiar with New Mexico and our woes. And to be fair, given what I've heard in your answers today and in reading your prepared testimony—and I agree with my colleague Mr. Cartwright, that there were plenty of significant difficult issues pre-ACA. And the reality is, is that a private insurance, private healthcare market has significant challenges for a sick population in this country that's not very homogeneous and we are effectively, as a result, have been very poor healthcare consumers.

I believe in the fundamental consumer protections unequivocally in the ACA, but between my colleagues asking questions, I find myself in a very interesting position where I may disagree with you about the ACA and its impact and about whether or not we've really been proactive in dealing with the issues that we were clear or we wouldn't have had a risk corridor, we wouldn't have worked on a CO–OP model. We knew there were going to be some very interesting competitive issues. We were also a bit nervous about premiums and premium stability, which is why were alerted to the

fact, but I think in many States, particularly mine, very surprised by the out-of-pocket costs and the very high deductibles which, quite frankly, has just pushed people into emergency rooms. And we just cost shift somewhere else.

And as you're well aware, New Mexico has never had competition in the marketplace. And now, in my district, this minute, I only have one. Now, Secretary Burwell, and I know that you're aware, have known that these issues—so to the credit of my colleagues behind me, you have seen them coming. I've alerted the White House. I've alerted HHS. I've alerted CMS on multiple occasions. Our superintendent of insurance is, you know, feeling really confident that he can manage this. I would say I don't share his confidence. We've got another 10,000 enrollees, 80 percent of whom need those and get those subsidies. They are going to find themselves maybe in a precarious position.

The rates that are published that are not yet agreed to is an 80 percent increase by Blue Cross Blue Shield. That was with Presbyterian in. If they're out, I don't know what that means, and given that nationally they've been another one like United that's given us great pause about what they can and should and are willing to do.

So given that, that New Mexico doesn't fit any of the things that you've described as successes, what are we going to do? And that CO–OP is in the most precarious position. What strategies have you specifically thought about, given that rural and frontier States and poor States, higher risks to begin with—it's not like we didn't know that.

Mr. COUNIHAN. Yeah.

Ms. LUJAN GRISHAM. I've seen nothing that's been targeted or strategic for those States, and I've seen very little, quite frankly, from the administration about dealing with these issues, except telling me that the marketplace is incredibly competitive and people have great choices and it's all going to work itself out. So I want to know, and I haven't given you very much time, but what specifically have you done in the 7 years given these serious issues? I know that you weren't there for the whole 7——

Mr. COUNIHAN. Yeah.

Ms. LUJAN GRISHAM. —but you are at the top now.

Mr. COUNIHAN. Yeah.

Ms. LUJAN GRISHAM. —about New Mexico, and what are you going to do to help us make sure that consumers really are, in fact, protected as is the vision in the ACA? Because I'm not seeing it.

Mr. COUNIHAN. Okay. First of all, thank you for the question. I happen to be fairly familiar with New Mexico and with the competitive environment there.

Ms. LUJAN GRISHAM. Or the lack thereof, you mean.

Mr. COUNIHAN. I'm aware too—I have a valued relationship with the DOI superintendent, and actually just spoke with him about 10 days ago about the competitive environment, also rate actions by Blue Cross. So I had that review. So we had a good——

Ms. LUJAN GRISHAM. Did he actually tell you that Presbyterian was going to pull out yesterday?

Mr. COUNIHAN. No, he did not.

Ms. LUJAN GRISHAM. I would say that your relationship with our superintendent needs to be reevaluated.

Mr. COUNIHAN. Well, I value the relationship that we have. And I will tell you that he and I have discussed a variety of things about different issuers. One of the things that we both understood is some of the complexity about urban versus rural counties.

Ms. LUJAN GRISHAM. In fact, the rural counties, Mr. Counihan, have higher competition, given the regional plans that are on the marketplace. It's the urban area that is the most at risk currently today with both the CO–OP and now Presbyterian, all the large insurance carriers are pulling off the marketplace in the largest city and the most urban area in the State. It's contrary to what you just said, in fact.

Mr. COUNIHAN. Yeah. Well, one of the things that we've talked about is I think that the CO–OP is a good example of new choice, of more competition, of innovation.

Ms. LUJAN GRISHAM. Right. But that hasn't translated. And I'm out of time. But the reality is, I'm going to ask you to give me in writing—and hope that the chairman will continue to let me have a few more seconds. I need those specific strategies, given that we have asked for them from this administration on multiple occasions. I believe you have an obligation to hold us accountable, to work on strategies that are going to protect those consumers, because so far, that has not translated and I think we can get it right. We have significant challenges. That is not occurring currently, and I don't think that the administration has really been thoughtful about that.

In addition, which is not really in your wheelhouse, but I'd like you to take back to the administration that I think that they should be—look very seriously at the 6 percent Medicaid cuts that are going to drive even more providers out of New Mexico. So you have a very precarious situation there that I'm not sure is getting the attention that it really deserves and needs.

Thank you. I yield back.

Mr. CARTER. [Presiding.] The gentlelady yields.

I now recognize myself for 5 minutes.

Mr. Counihan, to date, we know that 16 of 23 ObamaCare CO–OPs have collapsed and it's impacted 870,000 enrollees. That's including the Land of Lincoln, Co-Op of Illinois, which announced just yesterday, just yesterday, that it will close after only 3 years of operation, leaving 50,000 enrollees without insurance.

What's more troubling than that, perhaps, is that CMS loaned nearly $1.5 billion to these failed CO–OPs, despite the administration's projection that the program would lose a significant amount of taxpayers' dollars, over 40 percent predicted to never be repaid. That's a lot of taxpayer dollars. I think you would agree with that. A lot of taxpayers' dollars casually thrown away to prop up yet another failed facet of ObamaCare.

Mr. Counihan, I'm concerned that despite the previous oversight hearings that we've had and on the failing CO–OPs and the staggering amount of taxpayer dollars that are at risk, that CMS still has yet to come up with a plan or a process for recouping the loans lost by these CO–OPs.

Mr. COUNIHAN. Yeah. So——

Mr. CARTER. Am I right? I mean, tell me I'm wrong.

Mr. COUNIHAN. Yeah.

Mr. CARTER. Do you have a plan to recoup the money?

Mr. COUNIHAN. We have a specific process for recoupment of moneys. I explained some of it just before you were able to arrive, and if you don't mind, I'd like to explain it again.

Mr. CARTER. Very briefly.

Mr. COUNIHAN. Yeah. So fundamentally, this is a matter of make sure that claim runouts are finally resolved and paid and administrative expenses to vendors are paid. Moneys left over from that are typically the best ways for us to recover money. The Department of Justice is in the process right now of doing just that with a couple of these CO–OPs.

Mr. CARTER. So you're trying to do it through payment offsets or what?

Mr. COUNIHAN. No, I'm trying to do it through recovery of Federal loans. And recovery——

Mr. CARTER. And are you doing witness all of the CO–OPs that have failed?

Mr. COUNIHAN. As appropriate as in at the appropriate time.

Mr. CARTER. When is the appropriate time? I mean, after they fail, they failed, and there's no money left. Right?

Mr. COUNIHAN. But—no, not necessarily. And as I mentioned, the vast majority of these CO–OPs still are in runout, which means that their claims, their incurred but unreported claims still need to be paid.

Mr. CARTER. Okay. So let's go back here. It's my understanding that now we have got seven remaining CO–OPs. Is that correct?

Mr. COUNIHAN. Correct.

Mr. CARTER. How are they doing? From my understanding, they're not doing well at all. They're in very similar situations and they're set to fail.

Mr. COUNIHAN. Sir, these are small businesses. They're small businesses in the health insurance business. This can very much depend on a month-by-month basis. So——

Mr. CARTER. Well, let me ask you something. You know, I was always taught that you don't want to throw good money after bad. While they still have got some good money, why don't we just go back and get it and recoup it and just call it a day? Obviously, if 16 out of 23 have failed, why should we think that the remaining seven are going to make it?

Mr. COUNIHAN. The moneys that have been—that we have have been obligated already to those businesses. Those businesses right now are in the process of succeeding like any other business or any other insurance company does in the State where they do business. This is a tough industry, as you very well know. It's very tough to be a small business and it's tough to be a small health insurance company. I used to work for one, so I can tell you that.

But we're doing everything that we can to collaborate with the State divisions of insurance, and with the CO–OPs to make them successful.

Mr. CARTER. But it's not working. It's failed 16 out of 23. Another one failed yesterday. The remaining seven are in bad shape and you know it.

Mr. COUNIHAN. So, sir, if you look at the history of new entrants in health insurance, typically, at least half of them or so have a hard time making it. So this is not inconsistent with the industry.

Mr. CARTER. Okay. Well, let me ask you something, Mr. Counihan. Out of the seven that are still currently operating——

Mr. COUNIHAN. Yeah.

Mr. CARTER. —how many of them are profitable?

Mr. COUNIHAN. So profitability very much can depend on the month.

Mr. CARTER. That's yes or no.

Mr. COUNIHAN. It depends on the month, sir.

Mr. CARTER. It depends on the month?

Mr. COUNIHAN. Yes.

Mr. CARTER. This month, how many of them are profitable?

Mr. COUNIHAN. I can't tell you that.

Mr. CARTER. Last month?

Mr. COUNIHAN. The claims data that we have right now——

Mr. CARTER. Can you tell me last month?

Mr. COUNIHAN. —it's typically through May. You know, we've got actuarially certified data through the second quarter. You know, we're trying—actually, we get that in August. We're trying to do our best to keep up, as we are with the State divisions of insurance, but when you're a small carrier like this, it very much depends on the claims you get for that month.

Mr. CARTER. Mr. Counihan, this looks like a total failure. I mean, not only are we throwing good money after bad, losing money, but now we got all these enrollees who don't have any insurance coverage.

Mr. COUNIHAN. Well, so, can I give you another perspective on that?

Mr. CARTER. Please.

Mr. COUNIHAN. So another perspective on that is that because of these CO–OPs, we've been able to give people more choice. Because of the CO–OPs we've been able to enhance competition in these States. Because of these CO–OPs we have been able to innovate. Many of these new CO–OPs have come up with new care management models that are being replicated by some of their larger competitors. So there's been all sorts of dynamics.

Mr. CARTER. If I were one of their larger competitors, I would not—I wouldn't copy anything they've done. They've failed.

Mr. COUNIHAN. But, sir, there's a variety of different reasons that lead to the expenses in a health insurance company. Care management models are things that can help migrate between sizes of firms and profitability of firms. So I'm giving you three examples of where they've added specific value.

Mr. CARTER. Okay. Okay. Okay. If there is a silver lining, perhaps you just—you've just described it. I fail to believe that. Nevertheless, let's shift gears for one second. Okay? Let's talk about—we know the CO–OPs are not the only entities that are struggling under ObamaCare. UnitedHealth has pulled out of a number of markets, abandoned a number of exchanges due to profit concerns. If the Nation's largest insurers can't assume the risks and burdens of ObamaCare, why should we believe that anyone can?

Mr. COUNIHAN. Well, could I—if I could just give you some examples for that, because——

Mr. CARTER. Please very quickly.

Mr. COUNIHAN. Okay. I've got a deep history in this industry. Often, insurers that came into this market were making some assumptions about the utilization and the morbidity of the new enrollees. What we're finding is some of those assumptions and old care management tools have been less appropriate to this new population than those that innovated and created new ones. And so many right now, issuers, are retooling based on looking at new models.

Mr. CARTER. Okay. All right. I need to finish up. I'm sorry, Mr. Counihan. Out of all due respect, sir, they're failing. They're losing money. The patients aren't being covered. Their premiums are going up. It looks to me like it's a total failure.

Mr. COUNIHAN. Sir——

Mr. CARTER. I've got a closing statement I want to make. Okay. In a July 11, 2016, article in Healthcare Reform, President Obama acknowledged that too many Americans still strain to pay for their physician visits and prescriptions, cover their deductibles, or pay for their monthly insurance bills. That's directly from the President. Even the President can't avoid the fact that after 6 years, his signature healthcare reform bill has completely failed. Completely failed. Healthcare costs are higher than ever. Families have seen their premiums double and deductibles increase and the average American cannot afford health insurance.

This is why we've come out with Speaker Ryan's A Better Way policy agenda, and I hope that we will look at that. We all want healthcare coverage here in America. Republicans, Democrat, we want it. And we feel like we have a better way. Obviously, to anyone who's looking at this, this is not working. It is failing.

Finally, there's some documents that we've asked you to produce. On November 20, December 23, and May 18, we sent letters, and on February 17 we sent a subpoena to Secretary Burwell. Are you familiar with this?

Mr. COUNIHAN. I am familiar with the request, yes.

Mr. CARTER. Have you been asked to collect any of the material?

Mr. COUNIHAN. Sir, a couple of things. One is, I know that we've already sent thousands of pages in response. Number two is, to the extent that there are requested documents that are confidential that could put any of these businesses at risk—and again, I used to work for one.

Mr. CARTER. I thought it was a subpoena we sent.

Mr. COUNIHAN. We have made those available in camera. They remain that way, but we can't have those divulged publicly or those businesses——

Mr. CARTER. Mr. Counihan, if we agree on anything in this committee, Democrats, Republicans, Independents, whoever, it is that y'all need to pay attention, and when we ask you something we expect for you to get it to us. I don't think you will find anyone who disagrees with that.

Mr. COUNIHAN. That's understood. But we have a fiduciary responsibility to these firms, as I'm sure you can appreciate.

Mr. CARTER. I can appreciate that, but you have an even greater responsibility to this committee and to answering to the people who have been elected to represent the American citizens. All right. That's all.

Mr. CARTWRIGHT. Mr. Chairman, I have a unanimous consent request.

The witness was questioned about profitability and was not able to answer questions on second quarter because they won't be out until—and audited until August.

Mr. COUNIHAN. Yeah.

Mr. CARTWRIGHT. I request unanimous consent to put into the record a Financial Press article noting that for the first quarter, at least three ACA created CO–OPs turned Q–1 profits in Maryland, New Mexico, and Massachusetts.

Mr. CARTER. Without objection.

Mr. CARTWRIGHT. Thank you.

Mr. CARTER. Mr. Counihan, Ms. Blumberg, I want to thank both of you, and thank you for taking time out to appear before us today.

Is that it? Did you have anything else? We're all done.

If there's no further business, without objection the subcommittee stands adjourned.

[Whereupon, at 4:30 p.m., the subcommittee was adjourned.]

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