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Statement of

Linda J. Blumberg, Ph.D.*

Senior Fellow

The Urban Institute

Health Policy Center

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Subcommittee on Health Care, Benefits, and Administrative Rules

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

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

2100 M Street NW
Washington DC 20037

urban.org

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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Health Affairs Blog

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

Linda Blumberg and John Holahan

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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

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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%

Notes: Premium prices displayed are for a 40-year-old nonsmoking indiviudal 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%	5.2$	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 increases, ≥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
1	2 insurers competing in 2015	15.1%
	8 insurers competing in 2015	3.8%
	Difference	11.3%
2	No change in number of insurers in a rating region	9.4%
	1 insurer exits the region in 2016	12.3%
	Difference	2.9%
3	2015 lowest-cost silver premium at the national average	10.7%
	2015 lowest-cost silver premium 10 percent above the national average	7.8%
	Difference	-2.8%
4	Medicaid insurer competes in rating area	5.4%
	No medicaid insurer competes in rating area	12.8%
	Difference	-7.3%
5	Co-op insurer competes in rating area	6.9%
	No co-op insurer competes in rating area	11.4%
	Difference	-4.5%
6	Regional insurer competes in rating area	15.2%
	No regional insurer competes in rating area	8.1%
	Difference	7.1%
7	Blue Cross Blue Shield-affiliated insurer competes in rating area	11.1%
	No Blue Cross Blue Shield-affiliated insurer competes in rating area	5.2%
	Difference	5.9%
8*	National insurer competes in rating area	10.4%
	No national insurer competes in rating area	11.2%
	Difference	-0.8%
9*	Provider-sponsored insurer competes in rating area	9.6
	No provider-sponsored insurer competes in rating area	11.3%
	Difference	-1.7%
10	Rating area in state of average population size	10.7%
	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*	*25.8%*	*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]				***5.0%***
Percentage change in lowest-cost premium state average[b]				***1.2%***

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]				***-4.5%***
Percentage change in lowest-cost premium state average[b]				***-1.1%***

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]				***21.8%***
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	Insurer 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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Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Linda Blumberg, PhD

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2012. Include the source and amount of each grant or contract.

Please see attached.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

I am not representing or speaking on behalf of any organization. I am a salaried employee of the Urban Institute. As such, when requested to provide testimony to a Congressional committee on a matter within my area of expertise, I am paid for time I spend preparing and delivering such testimony, on the condition that I make clear that the observations and suggestions I present be identified as my own and not necessarily those of the Urban Institute, its officers, or its Board of Trustees. Senior Urban Institute researchers are encouraged to accept invitations to provide testimony to Congressional committees and other government agencies as a mechanism for disseminating the results of both government-sponsored and foundation-sponsored research projects carried out at the Institute.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2012, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

Please see attached.

I certify that the above information is true and correct.

Signature: Linda J. Blumberg

Date: 7.12.16

The Urban Institute
Project Disclosure List for Congressional Testimony

UI No.	Title	UI Source	Prime Source	P/I	Start	End	Contract Total
07112	MOBIS FEDERAL SUPPLY SCHEDULE	VARIOUS	US DHUD	M.TURNER	7/1/1998	9/30/2017	13,164,372
08322	MOBIS FEDERAL SUPPLY SCHEDULE	VARIOUS	VARIOUS	J.ROMAN	7/1/1998	9/30/2017	23,463,637
08350	PROGRAM SUPPORT CENTER IDIQ	US DHHS	US DHHS	D.KASSABIAN	8/29/2009	6/30/2016	21,466,264
08553	NORVAL MORRIS PROJECT	US DOJ	US DOJ	S.ROSSMAN	9/1/2010	9/30/2016	894,528
08555	MOBIS FEDERAL SUPPLY SCHEDULE	US DOA	US DOA	P.JOHNSON	8/31/2010	2/28/2017	1,713,851
08573	DNA COLD HITS	US DOJ	US DOJ	K.WALSH	1/1/2011	6/30/2016	351,054
08575	MEDICAID/CHLD HLTH INS PROG	US DHHS	US DHHS	W.VROMAN	9/27/2010	8/11/2018	33,031,454
08577	HOUSING DISCRIMINATION STUDIES	US DHUD	US DHUD	M.TURNER	10/1/2010	7/11/2017	23,204,683
08585	ELDER ABUSE, MISTREATMENT	US DOJ	US DOJ	J.ZWEIG	10/1/2010	12/31/2016	449,874
08586	OCOA PROVIDER CRIMINAL JUSTICE	US DOJ	US DOJ	N.LA VIGNE	10/1/2010	9/30/2016	2,851,261
08588	EMPLYMNT AND SELF-SUFFICIENCY	ABT	US DHHS	D.NIGHTINGALE	7/7/2010	9/29/2016	349,821
08592	SYSTEM AND OUTCOME EVALUATION	ABT	US DHHS	P.LOPREST	9/30/2010	9/29/2016	4,148,635
08593	CONTINUITY OF CHILDCARE IN IL	U CHICAGO	US DHHS	H.SANDSTROM	9/30/2010	9/29/2016	781,602
08594	DC PROMISE NGHBRHD INITIATIVE	VARIOUS	VARIOUS	S.POPKIN	10/1/2010	12/31/2016	771,546
08629	NATL PAROLE RESOURCE CTR	CENTER EFFECTIVE PUBLI	US DOJ	J.JANNETTA	10/1/2010	9/30/2016	140,138
08647	HOME HEALTH CASE-MIX SYSTEM	MEDPAC	MEDPAC	A.GARRETT	4/27/2011	11/15/2016	714,228
08673	FIREFIGHTER SAFETY	CFAI-RISK	DEPT OF HOMELAND SECURITY	R.SANTOS	6/25/2011	6/29/2017	461,142
08678	EVALUATION ABE TO CREDENTIALS	JOBS FOR F	JOBS FOR F	R.LERMAN	8/8/2011	9/30/2016	1,495,329
08684	EVALUATION OF MAPCP DEMO	RTI	US DHHS	S.ZUCKERMAN	8/9/2011	4/30/2017	2,131,486
08692	ASPE DALTCP IDIQ	US DHHS	US DHHS	B.SPILLMAN	9/22/2011	9/29/2017	2,711,602
08706	EVAL STATE DEMO INTEGRATE CARE	RTI	US DHHS	T.WAIDMANN	9/29/2011	9/28/2016	3,140,486
08727	FIN EDU PRGM EVAL SUPPT SVCS	CONSUMER FINANCIAL PR	CONSUMER FINANCIAL PROTEC	M.SIMMS	12/30/2011	8/8/2016	1,806,135
08774	MOBIS FEDERAL SUPPLY SCHEDULE	US DOL	US DOL	M.PERGAMIT	6/27/2012	6/19/2018	5,965,064
08785	MANAGED CARE ENROLLMENT	MEDICAID & CHIP PAYMEN	MEDICAID & CHIP PAYMENT	E.HOWELL	8/2/2012	12/15/2016	1,088,849
08800	PROGRAM SUPPORT CENTER IDIQ	US DHHS	US DHHS	S.DORN	9/4/2012	9/19/2018	14,747,393
08802	SOCIAL IMPACT BONDS IN THE US	US DOJ	US DOJ	J.ROMAN	10/1/2012	9/30/2016	749,811
08807	NATIONAL PRETRIAL REPORTING	US DOJ	US DOJ	K.KIM	10/1/2012	6/30/2016	349,969
08810	EVAL OF JUVENILE SCA	US DOJ	US DOJ	J.BUCK WILLISON	11/1/2012	10/31/2017	1,997,100
08811	EVAL JJRRI DEMO PROGRAM	US DOJ	US DOJ	J.ROMAN	10/1/2012	12/31/2016	699,623
08826	HPOG IMPLEMENTATION, SYSTEMS	ABT	US DHHS	P.LOPREST	10/10/2012	11/23/2019	1,862,780

UI No.	Title	UI Source	Prime Source	P/I	Start	End	Contract Total
08833	MEDICAID EXPANSION EVALUATION	RTI	US DHHS	S.LONG	10/1/2012	6/30/2017	564,231
08846	RENT REFORM DEMONSTRATION	MDRC	US DHUD	M.ABRAVANEL	10/1/2012	9/29/2019	231,230
08868	RENTAL ASSISTANCE DEMO EVAL	ECONOMETRICA INC	US DHUD	S.POPKIN	1/15/2013	12/29/2016	737,715
08874	MOBIL SUSTAIN:THOMPSON V HUD	APPLIED REAL ESTATE AN	US DHUD	M.ABRAVANEL	9/30/2012	6/30/2017	407,486
08895	SIM EVALUATION	RTI	US DHHS	T.COUGHLIN	6/3/2013	6/2/2018	3,165,241
08902	EVAL OF FY11 SCA ADULT OFFENDR	RTI	US DOJ	J.BUCK WILLISON	6/19/2013	6/30/2017	900,788
08927	CENSUS OF CRIM LABORATORIES	US DOJ	US DOJ	K.WALSH	10/1/2013	8/31/2016	397,421
08928	RECIDIVISM OF YOUNG OFFENDERS	US DOJ	US DOJ	K.KIM	10/1/2013	3/31/2017	149,977
08929	JUVENILE SEX OFFENDERS	US DOJ	US DOJ	N.LA VIGNE	1/1/2014	12/31/2016	999,984
08930	SEXUAL ASSAULT KITS,NON-FORENI	US DOJ	US DOJ	K.KIM	1/1/2014	12/31/2018	499,956
08931	FORCED MARRIAGE, INTIMATE PART	US DOJ	US DOJ	K.KIM	1/1/2014	9/30/2017	649,776
08932	PREVALENCE OF WRONGFUL CONVICT	US DOJ	US DOJ	N.LA VIGNE	1/1/2014	10/31/2016	367,894
08933	FED JUSTICE STATISTIC ANALYTIC	US DOJ	US DOJ	K.KIM	10/1/2013	9/30/2017	999,892
08934	RETENTION INVENTORY VALIDATION	US DOJ	US DOJ	J.BUCK WILLISON	9/9/2013	9/8/2016	139,006
08936	LEGISLATIVE STRENGTHENING	CHEMONICS	US AID	C.CADWELL	11/10/2011	11/9/2016	0
08957	RETIREMENT RESEARCH CONSORTIUM	BOSTON COLLEGE	SOC SEC AD	R.JOHNSON	9/30/2013	9/30/2016	947,409
08968	COGNITIVE BEHAVIOR INTERVENTIO	US DOJ	US DOJ	K.KIM	1/1/2015	12/31/2017	569,702
08976	EVAL MEDIC ACCESS HALFWAY HOUS	US DOJ	US DOJ	K.MALLIK KANE	1/1/2015	12/31/2017	499,989
08977	PHYSICIAN FEES/HOSPITALIZATION	U ILLINOIS	US DHHS	S.ZUCKERMAN	8/15/2013	6/30/2016	413,122
08979	INVEST INNOVATION (I3) EVAL	CASA DE MARYLAND, INC.	US DOEd	M.SCOTT	1/1/2014	12/31/2016	205,000
08994	EARLY INTERVENTION SYSTEMS	JOHN F FINN INST PUBLIC S	US DOJ	K.KIM	1/1/2014	6/30/2016	100,000
08997	AGILE AND HARMONIZED ASSISTANC	RES FDN STATE UNIV OF N	US AID	C.CADWELL	1/1/2014	12/31/2018	467,538
09010	RESILIENCY IN NORTHERN GHANA	GLOBAL COMMUNITIES	US AID	B.EDWARDS	7/2/2014	12/31/2018	550,382
09013	C COLSON TASK FORCE	US DOJ	US DOJ	J.SAMUELS	6/1/2014	7/31/2016	1,750,000
09014	YOUNG PARENT DEMO IMPACT ANAL	CAPITAL RESEARCH CORP	US DOL	L.EYSTER	6/1/2014	6/26/2016	396,829
09019	NEW NSLP NUTRITION STANDARDS	US DHHS	US DHHS	T.VERICKER	8/1/2014	7/31/2016	109,191
09023	SCORECARD/ETPL STUDY	IMPAQ INTERNATIONAL	US DOL	L.EYSTER	6/27/2014	12/26/2016	18,873
09029	CFPB FIN COACHING PROJECT	ARMED FORCES SVCS COR	CONSUMER FINANCIAL PROTEC	B.THEODOS	6/9/2014	6/30/2017	538,076
09034	DMH ANALYTIC SUPPORT	L&M POLICY RESEARCH, L	US DHHS	L.DUBAY	8/20/2014	8/19/2016	386,614
09035	RETIREMENT IDIQ	US DOL	US DOL	R.JOHNSON	9/30/2014	9/29/2019	1,756,700
09036	FAMILY PLANNING ACA IMPACT	ALTARUM INSTITUTE	US DHHS	S.BENATAR	8/1/2014	6/30/2016	243,872
09037	MOBIS FEDERAL SUPPLY SCHEDULE	EQUAL EMPLOYMENT OPP	EQUAL EMPLOYMENT OPP COM	H.HATRY	9/26/2014	9/28/2016	310,370
09040	BLDG COMM & CAPACITY INTERNET	NSF	NSF	L.GIANNARELLI	9/1/2014	8/31/2016	319,116
09064	DOL EVAL YOUTH CAREER CONNECTN	ABT	US DOL	R.LERMAN	9/16/2014	6/15/2017	7,840
09073	EVALUATION OF ROUND 4 TAACCCT	ABT	US DOL	L.EYSTER	10/1/2014	9/29/2019	421,560

UI No.	Title	UI Source	Prime Source	P/I	Start	End	Contract Total
09077	NGA PRESCRIPTION DRUG ACADEMY	NATL GOVN ASSN CTR BES	US DHHS	N.LA VIGNE	12/1/2014	6/30/2016	90,907
09088	WORKFORCE DEV TECH ASSISTANCE	ICF	US DHHS	M.SIMMS	2/1/2015	9/30/2016	97,830
09089	SOCIAL INOVATION FUND EVAL	JOBS FOR F	CNCS	E.PETERS	2/11/2015	2/10/2018	960,000
09104	HOUSING FINANCE STUDIES	US DHUD	US DHUD	L.GOODMAN	3/31/2015	11/21/2016	214,963
09129	SAMHSA CROSS-SITE EVALUATIONS	ICF	US DHHS	J.ZWEIG	5/19/2015	4/13/2017	121,847
09138	RESTORATIVE JUSTICE IN RI SCHO	CENTRAL FALLS SCHOOL D	CENTRAL FALLS SCHOOL DISTRI	A.LIBERMAN	1/1/2015	12/31/2017	761,394
09139	FEDERAL RESOURCE PROGRAM GUIDE	FDIC	FDIC	L.GOODMAN	7/2/2015	7/31/2016	345,619
09152	PROGRAM SUPPORT CENTER IDIQ	US DHHS	US DHHS	S.MCKERNAN	3/16/2015	8/17/2020	892,661
09153	PROGRAM SUPPORT CENTER IDIQ	US DHHS	US DHHS	E.PETERS	3/16/2015	8/17/2020	3,224,819
09159	EVALUATION OF PRCD	CITY OF PHILADELPHIA	US DOJ	J.BUCK WILLISON	3/1/2015	2/28/2017	140,076
09161	IMPACT REFUGEES ON HOST COMMUN	US DOState	US DOState	A.MALIK	9/1/2015	8/31/2016	199,564
09165	EVALUATION OF MTW	US DHUD	US DHUD	D.LEVY	9/2/2015	9/2/2018	2,171,076
09167	BUILDING COMM TRUST & JUSTICE	RFCUNY	US DOJ	N.LA VIGNE	10/1/2014	9/30/2017	1,090,027
09169	SURVEY OF SAGO	US DOJ	US DOJ	W.ADAMS	10/1/2015	9/30/2018	449,735
09170	TANZANIA PUBLIC SYSTEMS STNGTH	ABT	US AID	C.CADWELL	8/20/2015	5/1/2020	1,040,376
09171	FIRST MARRIAGE RATES US WOMEN	US DHHS	US DHHS	S.MARTIN	9/16/2015	8/31/2016	86,633
09172	IMMIGRANT CHILD CARE CHOICES	US DHHS	US DHHS	H.SANDSTROM	9/30/2015	2/28/2017	150,000
09173	PAYMENT RATES & CHILDCARE QUAL	US DHHS	US DHHS	T.DERRICK-MILLS	9/30/2015	2/28/2017	149,939
09174	HOMELESSNESS ANALYSIS BPA	US DHHS	US DHHS	M.PERGAMIT	9/21/2015	9/20/2020	88,531
09175	JRI OVERSIGHT & OUTCOME ASSESS	US DOJ	US DOJ	N.LA VIGNE	10/1/2015	9/30/2018	2,629,855
09176	RISK ASSESSMENT CLEARINGHOUSE	US DOJ	US DOJ	K.KIM	10/1/2015	9/30/2017	550,000
09177	PUBLIC SAFETY & HEALTH OUTCOME	US DOJ	US DOJ	J.JANNETTA	10/1/2015	9/30/2016	499,985
09178	OPTIMIZING VIDEO ANALYTICS	US DOJ	US DOJ	B.PETERSON	1/1/2016	12/31/2018	599,742
09179	CONTRABAND & INTERDICTION MORT	US DOJ	US DOJ	B.PETERSON	1/1/2016	12/31/2018	499,999
09180	USE & IMPACT VIDEO ANALYTICS	US DOJ	US DOJ	N.LA VIGNE	1/1/2016	12/31/2018	1,199,947
09181	GDT REDUCTION FIREARM VIOLENCE	US DOJ	US DOJ	N.LA VIGNE	1/1/2016	12/31/2018	622,432
09184	PERCEPTIONS JUSTICE TRAFF SURV	US DOJ	US DOJ	C.OWENS	1/1/2016	12/31/2017	573,509
09185	REGISTERED APPRENTICESHIPS	US DOL	US DOL	R.LERMAN	9/25/2015	9/24/2016	596,971
09186	ADVANCING JUVENILE JUSTICE	US DOJ	US DOJ	S.HARVELL	10/1/2015	9/30/2016	500,000
09190	PRACTICES SOCIAL MEDIA ENGAGEM	US DOJ	US DOJ	K.KIM	9/1/2015	8/31/2017	299,965
09191	TRANSFORM MARKET HIGHER EDUCA	BROOKINGS	IRS	M.CHINGOS	7/21/2015	9/29/2017	160,952
09194	SIM EVALUATION ROUND II	RTI	US DHHS	T.COUGHLIN	9/2/2015	9/1/2020	1,177,765
09196	MACPAC IDIQ	MEDICAID & CHIP PAYMEN	MEDICAID & CHIP PAYMENT	A.GARRETT	10/1/2015	10/1/2016	437,645
09199	EVALUATION MEDICAID HIP 2.0	SOCIAL & SCIENTIFIC SYS I	US DHHS	T.COUGHLIN	9/29/2015	9/28/2016	147,664
09200	MACRA PHYSICIAN PAYMENT MODEL	SOCIAL & SCIENTIFIC SYS I	US DHHS	S.ZUCKERMAN	9/30/2015	9/29/2018	239,324

UI No.	Title	UI Source	Prime Source	P/I	Start	End	Contract Total
09201	HPOG2 IMPACT STUDY	ABT	US DHHS	P.LOPREST	10/1/2015	9/30/2016	280,684
09209	ALLEGHENY CNTY SMART PROBATION	PENN COMMONWEALTH	PENN COMMONWEALTH	J.BUCK WILLISON	1/1/2015	9/30/2018	249,728
09211	ENHANCING ANTIHMN TRAFFICK TF		US DOJ	C.OWENS	10/1/2015	9/30/2018	100,000
09218	OCC WEBSITE/HOTLINE MEMBERSHIP	ICF	US DHHS	T.DERRICK-MILLS	11/9/2015	6/29/2016	23,111
09226	NEW PATHWAYS FATHERS & FAMILY		US DHHS	J.FONTAINE	10/1/2015	9/30/2020	186,916
09230	MILWAUKEE SMART POLICING		US DOJ	N.LA VIGNE	10/1/2015	9/30/2018	0
09232	JUSTICE DATABASE	THE REGENTS OF UCLA	OPEN SOCIETY FOUNDATIONS	T.LLOYD	9/14/2015	6/30/2016	0
09233	CAPTURING TRAFFICKING VICTIMIZ	NE UNIV	US DOJ	M.DANK	1/1/2016	12/31/2017	180,966
09234	THRIVING FAMILIES	J BELL ASO	HEISING-SIMONS FOUNDATION	J.ISAACS	11/20/2015	11/30/2017	350,595
09243	ALTGELD-MURRAY HOME VISIT PILT	CHICAGO HOUSING AUTHO	CHICAGO HOUSING AUTHORITY	M.MCDANIEL	12/1/2015	3/30/2017	0
09253	RURAL DEVELOPMENT CO-OP	US DOA	US DOA	R.PENDALL	3/22/2016	6/30/2016	74,730
09280	FISCAL REFORM & PUB FIN MGMNT	DEL&TOUCHE	US AID	C.CADWELL	6/1/2016	6/1/2020	0

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Linda J. Blumberg, Ph.D. is an economist and senior fellow at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. She has been at the Urban Institute since 1992 and currently co-directs a large multi-year quantitative and qualitative analytic effort monitoring and evaluating the effects of the ACA. Her recent work includes a variety of projects related to the analysis of health reform as well the provision of technical assistance to states in their efforts to implement the Affordable Care Act. Examples are: analyses of the implications of the *King v. Burwell* and *House v. Burwell* Supreme Court cases (her analysis of the former was cited in the Chief Justice's majority opinion); an array of studies of competition in nongroup insurance marketplaces; estimation of the coverage effects of the ACA; delineation of the characteristics of the remaining uninsured and potential strategies for reaching them; directing a 22-state case study of stakeholder perspectives on ACA implementation; a number of analyses of the implications of the ACA for employers of different sizes; comparison of the implications of the ACA's employer and individual mandates; explanation of incentives structures under the ACA and how they interact with employer decisions to offer coverage to their employees; and analysis of the distributional effects of age-rating. She directed the quantitative analyses that supported building a roadmap to universal coverage in the state of Massachusetts. She serves as a senior advisor for the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

From August 1993 through October 1994 she served as health policy advisor to the Clinton Administration during its initial health care reform effort. First at the Department of Health and Human Services and then at the Office of Management and Budget, she was a coordinator of the quantitative modeling effort through the final stages of development of the Health Security Act, and then through the development of alternative policies with Congress. She worked pro-actively with White House officials, members of Congress and their staffs. Blumberg was a 2006 Ian Axford Fellow and received the 2016 Health Services Research Impact Award. She received her Ph.D. in economics from the University of Michigan, Ann Arbor.