Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Honorable Steve Mnuchin
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Georgia 1332 Waiver Application - Reinsurance

Dear Secretary Azar and Secretary Mnuchin:

Thank you for the opportunity to submit comments on Georgia's 1332 waiver application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting state health insurance marketplaces and the patients that they serve. We urge the Departments to make the best use of the recommendations, knowledge and experience our organizations offer here.

Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost enrollees, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care

Act and reduced premiums by an estimated 10 to 14 percent in its first year.[1] A recent analysis by Avalere of seven states that have already created their own reinsurance programs through Section 1332 waivers found that these states reduced individual market premiums by an average of 19.9 percent in their first year.[2]

Georgia's proposal will create a reinsurance program starting for the 2021 plan year and continuing for five years. Based on the initial analysis commissioned by the state, this program is projected to reduce premiums by 10.0 percent in 2020 and increase the number of individuals obtaining health insurance through the individual market. This would help patients with pre-existing conditions obtain affordable, comprehensive coverage.

Our organizations urge you to approve Georgia's reinsurance application. We also appreciate your decision to separate Georgia's reinsurance application from the state's problematic "Pathways to Coverage" application, consideration of which is paused pending additional information and analysis from the state. Under that proposal, the state would leave Healthcare.gov and instead shift to a state-administered subsidy program that has inadequate funding, drives people to enroll in less comprehensive coverage, and relies on private entities for enrollment that may not help patients choose the best plan for their health needs. The waiver would put the healthcare coverage of the 450,000 Georgians who currently get their insurance through the state's marketplace at risk while only attempting to expand coverage for a small fraction (35,000 individuals) of the more than 1.4 million uninsured individuals in Georgia.[3] Our organizations remain extremely concerned about those proposals and, if resubmitted, urge you to carefully review the additional information to ensure adherence to the four guardrails. We believe close scrutiny will require the Departments to deny those requests and protect quality and affordable healthcare coverage for patients with pre-existing conditions.

Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen

[1] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

[2] Avalere. *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average.* March 2019. Retrieved from https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average.

[3] American Community Survey Tables for Health Insurance Coverage, *Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2018*. Available at: https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.

References

JANUARY 2017

AN EVALUATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET AND IMPLICATIONS OF POTENTIAL CHANGES

American Academy of Actuaries
Individual and Small Group Markets
Committee

Members of the Individual and Small Group Markets Committee include:

Karen Bender, MAAA, ASA, FCA
chairperson

Barbara Klever, MAAA, FSA
vice chairperson

Eric Best, MAAA, FSA
Philip Bieluch, MAAA, FSA, FCA
Joyce Bohl, MAAA, ASA
Frederick Busch, MAAA, FSA
April Choi, MAAA, FSA
Sarkis Daghlian, MAAA, FSA
Richard Diamond, MAAA, FSA
James Drennan, MAAA, FSA, FCA
Scott Fitzpatrick, MAAA, FSA
Beth Fritchen, MAAA
Rebecca Gorodetsky, MAAA, ASA
Audrey Halvorson, MAAA, FSA
David Hayes, MAAA, FSA
Juan Herrera, MAAA, FSA
Shiraz Jetha, MAAA, CERA, FCIA, FSA
Raymond Len, MAAA, FCA, FSA
Rachel Killian, MAAA, FSA
Kuanhui Lee, MAAA, ASA
Timothy Luedtke, MAAA, FSA
Scott Mack, MAAA, ASA
Barbara Niehus, MAAA, FSA
Donna Novak, MAAA, ASA, FCA
Jason Nowakowski, MAAA, FSA
James O'Connor, MAAA, FSA
Bernard Rabinowitz, MAAA, FSA, FIA, FCIA, CERA
David Shea, MAAA, FSA
Steele Stewart, MAAA, FSA
Martha Stubbs, MAAA, ASA
Karin Swenson-Moore, MAAA, FSA
David Tuomala, MAAA, FSA, FCA
Rod Turner, MAAA, FSA
Cori Uccello, MAAA, FSA, FCA
Dianna Welch, MAAA, FSA, FCA
Tom Wildsmith, MAAA, FSA

Table of Contents

Executive Summary

In this issue paper, the American Academy of Actuaries' Individual and Small Group Markets Committee examines experience in the Affordable Care Act (ACA) individual market. It outlines the conditions necessary for a sustainable individual health insurance market, examines whether these conditions are currently being met, and discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

What is necessary for a sustainable individual health insurance market?

- Individual enrollment at sufficient levels and a balanced risk pool;
- A stable regulatory environment that facilitates fair competition;
- Sufficient health insurer participation and plan offerings to provide consumer choice; and
- Slow spending growth and high quality of care.

How does the ACA individual market measure up to these conditions?

- Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected.
- For the most part, competing plans face the same rules; however, some rules might disadvantage insurers participating on the ACA marketplaces (or exchanges) compared to off the marketplaces.
- The uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.
- In recent years, health care spending has been growing relatively slowly compared with historical averages, but there are signs that growth rates are increasing.

What options have been proposed to improve the sustainability of the individual market?

Many options have been put forward to improve the sustainability of the individual market under the ACA. In addition, ACA replacement approaches have been proposed. The impact of any option or set of options depends on the specific details. This paper makes no recommendations and instead assesses the positive and negative implications of various options, including:

- **Stronger incentives to purchase coverage.** Strengthening the incentives to purchase coverage, through increased penalties for non-enrollment, increased premium subsidies, or a permanent reinsurance program, could help increase enrollment and improve the risk pool. Reducing the 90-day grace period and tightening special enrollment period (SEP) eligibility also have the potential to improve the risk pool by decreasing the potential for abuse of these protections.
- **Greater variation in premiums by age.** Widening premium variations by age could increase participation by young adults, but could result in higher uninsured rates among older adults and increased federal costs for premium subsidies, due to higher premiums for older adults.
- **Restructured premium subsidies.** Current premium subsidies are based on premium levels relative to income. The impact on enrollment, net premiums, and federal spending of basing premium subsidies instead on age or other factors depends on the amount of the subsidies relative to premiums.
- **Reduced regulatory uncertainty.** Releasing rules in a timely fashion would help reduce uncertainty for insurers. In addition, applying rules consistently among insurers is important to maintain a level playing field.
- **Allow insurance sales across state lines.** Allowing insurers to sell coverage across state lines, which states already have the ability to permit, could create an unlevel playing field and threaten the viability of insurance markets in states with more restrictive rules. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.
- **Enhanced state flexibility.** States could pursue approaches tailored to their specific situations through Section 1332 State Innovation Waivers or through other enhancements to state flexibility. Such efforts could include the pursuit of different enrollment incentives, subsidy structures, benefit coverage requirements, premium rating rules, etc.

An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes

Now that the individual market under the Affordable Care Act (ACA) is entering its fourth year of operation, experience is available from 2014–2016 that can be used to help assess the sustainability of the market over the longer term. In this paper, the American Academy of Actuaries' Individual and Small Group Markets Committee outlines the conditions necessary for the individual health insurance market to be sustainable over the long term and examines whether these conditions are currently being met. The paper then discusses the implications of potential changes to improve the ACA market rules or replace the ACA with an alternative approach.

SECTION 1

What Is Necessary for a Sustainable Individual Health Insurance Market?

This section outlines the conditions necessary for the sustainability of the individual health insurance market. In general, a financial security program is sustainable if it can be reasonably expected to be maintained over time without requiring significant curtailment or restructuring.[1] This determination involves considering whether all significant stakeholders accept the balance of benefits and costs and whether the program will achieve its goals over its time horizon. The ACA's goals include increasing access to affordable health insurance coverage, enhancing the quality of care, and addressing health spending growth.

With respect to the individual market, the conditions necessary for a sustainable market include achieving enrollment that is sufficient and balanced, a regulatory environment that is stable and facilitates fair competition, participation by health plans that is sufficient for market competition and consumer choice, and slow spending growth and high quality of care. These factors will affect premium affordability; in turn, premium affordability will affect enrollment numbers and risk pools. Subsequent sections of this paper will examine the extent to which the ACA individual market meets these conditions, including the feedback between enrollment and premiums.

Individual enrollment at sufficient levels and a balanced risk pool

Sufficient enrollment levels.

At the overall market level, enrollment must be high enough to reduce random fluctuations in claims from year to year. In states that fund health insurance marketplace operations through user fees, market-wide enrollment must be sufficient to generate adequate user fee revenues. At the insurer level, enrollment must be high enough to achieve stability and predictability of claims and to benefit from economies of scale, so that per-enrollee administrative costs are low relative to average claims.

A balanced risk pool.

Because the ACA prohibits health plans from denying coverage or charging higher premiums based on pre-existing health conditions, having affordable premiums depends on enrolling enough healthy individuals over which the costs of the less-healthy individuals can be spread. Enrollment of only individuals with high health care needs, typically referred to as adverse selection, can produce unsustainable upward premium spirals. Attracting healthier individuals (e.g., through the ACA individual mandate and premiums subsidies) is needed to keep premiums more affordable and stable.

A stable regulatory environment that facilitates fair and sufficient insurer competition

Consistent rules and regulations applied to competing health plans.

Health plans competing to enroll the same participants must operate under the same rules. If one set of plans operates under rules that are more advantageous to healthy individuals, then those individuals will migrate to those plans; less-healthy individuals will migrate to the plans more advantageous to them. In other words, plans that have rules more amenable to higher-risk individuals will suffer from adverse selection. In the absence of an effective risk adjustment program that includes all plans, upward premium spirals could result, threatening the viability of the plans more advantageous to higher-risk individuals.

Stable effective regulatory environment.

The rules and regulations governing the health insurance market need to be announced with sufficient lead time, relatively stable over time, and not overly burdensome in terms of costs or restrictions on innovation.

Reasonable expectation of earning a fair return.

Insurers operating in the ACA-compliant individual market rely on premium payments from enrollees, federal funding for premium tax credits and cost-sharing reduction subsidies, and risk-mitigation transfers. In total, these revenues must be adequate to cover claims and administrative costs. They must also provide a reasonable margin for contribution to reserves and surplus in order to meet solvency requirements and support ongoing business activities.

Sufficient health insurer participation and plan offerings

Sufficient number of participating health insurers.

Health insurance market competition can provide incentives for health plans to improve the efficiency of health care delivery, lower administrative costs, and provide products that are attractive to consumers. The optimal number of insurers likely differs by area and local market conditions (e.g., the number of eligible enrollees, the degree of provider concentration). Rural areas can support fewer insurers, for instance, due to low potential enrollment numbers and the presence of sole community providers.

Sufficient plan offerings.

The number and range of plan offerings must be sufficient to provide appropriate choice to consumers with respect to plan design features including a variety of out-of-pocket costs, provider networks, and plan type. This does not preclude requiring standardized plan designs. Offerings should not be so numerous that they impose an overwhelming burden on consumers that results in less-than-optimal choices.

Slow health spending growth and high quality of care

Reasonable health care costs and moderate health spending growth.

Long-term sustainability of the individual market requires containing the growth in health spending.

High quality of care.

There must be a focus not only on containing the growth in health care spending but also on improving health care quality, measured for instance based on health care outcomes.

SECTION 2

Assessment of Progress to Date

This section addresses each of the conditions for sustainability identified in Section 1 and assesses progress that has been made as well as challenges that remain to be addressed. Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected. For the most part, competing plans face the same rules. However, the uncertain and changing regulatory environment—including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments—contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and declined further in 2017.

Individual enrollment at sufficient levels and a balanced risk profile

Sufficient enrollment levels.

The number of individuals selecting marketplace plans during the annual open enrollment periods increased from 8.0 million in 2014 to 11.6 million in 2015, and to 12.7 million in 2016.[2] Enrollment numbers decline during the year, as individuals shift to other coverage sources (or to being uninsured) and insurers cancel coverage for consumers who don't pay their premiums. Offsetting part of this decline is enrollment during special enrollment periods (SEPs) for individuals who experience a qualifying event, such as a loss of coverage through a job. At the end of 2015, 8.8 million individuals had marketplace coverage, down from 11.6 million during the open enrollment period.[3]

Because of differences in populations and other factors, such as consumer outreach and enrollment systems, marketplace enrollment varies among the states. In 2016, the number of individuals with marketplace selections ranged from about 15,000 in Hawaii to 1.7 million in Florida.[4] Hawaii had a state-based marketplace, but moved to using the federal marketplace because its low enrollment numbers were not enough to generate sufficient revenues to sustain marketplace operations.[5] Other state-based marketplaces with relatively low enrollment numbers could be at similar risk. For instance, of the 13 remaining state-based marketplaces in 2016, three had fewer than 35,000 individuals with plan selections through the marketplaces during open enrollment (District of Columbia, Rhode Island, and Vermont).[6]

The ACA requires that insurers use a single risk pool when developing premiums. ACA-compliant off-marketplace plans are included as part of this single risk pool. In other words, insurers must pool all of their individual market enrollees together when setting the prices for their products. Therefore, premiums reflect insurer expectations of medical spending for enrollees both inside and outside of the marketplace. Although there are no official off-marketplace enrollment numbers, the Department of Health and Human Services (HHS) estimates that in 2016, about 7 million individuals enrolled in individual market coverage outside of the marketplace.[7] The majority of these individuals are likely to have ACA-compliant coverage; the Kaiser Family Foundation estimates that in 2016, only 12 percent of all individual market plans are non-ACA-compliant (i.e., grandfathered and transitional plans).[8,9] This suggests a total ACA-compliant individual market enrollment in 2016 of about 17-18 million.

Enrollment, both on the marketplace and in total, was lower than initially projected by the Congressional Budget Office (CBO) and others. In its May 2013 baseline estimates, CBO projected a total individual market enrollment in 2016 of about 37 million—22 million on the marketplace and about 15 million off marketplace.[10] In updated estimates from its March 2016 baseline, CBO lowered its 2016 enrollment projection to 21 million—12 million on the marketplace and 9 million off.[11] One major reason for the downward adjustment is that more employers than projected are continuing to offer coverage, resulting in fewer individuals moving from employer coverage to coverage in the individual marketplace. Lower-than-expected enrollment also suggests that affordability remains a challenge—in 2015, 46 percent of uninsured adults said that they had tried to obtain coverage but it was too expensive.[12] In addition, the ACA's individual mandate may be too weak to provide sufficient enrollment incentives. Outreach efforts may be insufficient to raise consumer awareness of the mandate and availability of premium assistance.

Even with enrollment lower than expected, uninsured rates have declined under the ACA. For instance, the National Health Interview Survey reports that the share of individuals under age 65 who were uninsured at the time of the interview declined from 18.2 percent in 2010 to 10.4 percent during the first six months of 2016.[13]

Despite these coverage gains, about 27 million nonelderly people remain uninsured in 2016.[14] Of these, the Kaiser Family Foundation estimates that 19 percent are eligible for a premium tax credit and 24 percent are eligible for Medicaid. These individuals may be unaware of their eligibility or, in the case of those eligible for premium subsidies, they may still find premiums unaffordable. Forty-seven percent of the uninsured are ineligible for premium assistance—20 percent due to their immigration status, 17 percent because they have an employer offer of coverage that is deemed affordable, and 11 percent because they have incomes that are too high. Another 10 percent of the uninsured would have been eligible for Medicaid if their state had expanded Medicaid coverage. Affordability may also be an issue for these groups. Notably, these are national estimates; percentages will vary among and within states.

A balanced risk pool.

A sustainable market requires not only enrollment at sufficient numbers, but also a balanced risk profile. That is, enrollment should not be skewed toward those with high health care costs; sustainability requires the enrollment of healthy individuals as well. The ACA includes several provisions that aim to reduce the potential adverse selection effects of allowing guaranteed access to coverage at standard premiums regardless of pre-existing health conditions. These provisions include providing premium and cost-sharing subsidies to lower the cost of coverage and imposing a financial penalty for individuals who remain uninsured. Each encourages even healthy individuals to obtain coverage. However, affordability issues and the weakness of the individual mandate could have disproportionately suppressed enrollment among individuals with low expected health care costs.

Lower-than-expected marketplace enrollment has been accompanied by concerns that the risk profile of enrollees was worse than many insurers expected.[15] The average risk profile for a given population in a guaranteed issue environment generally can be viewed as inversely proportional to enrollment as a percentage of the eligible population. Higher individual market participation rates will tend to reflect a larger share of healthy individuals enrolling, and therefore a more balanced risk profile. In contrast, lower participation rates will tend to reflect a less-healthy risk profile, and in turn higher average costs. This is because those previously uninsured individuals with greater health care needs are more likely to enroll than those with lesser needs.

As expected, evidence from the 2014 open enrollment period suggests that less-healthy individuals were more apt to sign up first. For instance, early marketplace enrollees were more likely to be older and use more medications than later enrollees.[16] Examinations of how the risk pool has been changing over time have yielded some mixed results. A Center for Consumer Information and Insurance Oversight (CCIIO) analysis of per-enrollee costs in 2014 and 2015 suggests that slower cost growth may have resulted from a broader and healthier risk pool and that states with stronger enrollment growth had greater improvements in their enrollee risk profiles.[17] Similarly, an analysis of Covered California marketplace data found that the risk profile at the end of the open enrollment period improved from 2014 to 2015[18] and nationwide estimates suggest an improvement from 2014 to 2015 in the share of marketplace enrollees self-reporting very good or excellent health status.[19] In contrast, an analysis of the ACA risk adjustment program shows an increase in risk scores from 2014 to 2015.[20] Although this result suggests a deterioration of the risk pool, other factors could have played a role, such as increased diagnostic coding and better data submission to the Centers for Medicare & Medicaid Services (CMS). In addition, similar to the CCIIO analysis, the report finds that enrollment growth is correlated with an improvement in the risk profile when other factors such as a state's transition policy and Medicaid expansion decisions are controlled for.

The risk corridor results for 2014 and 2015 also support assertions that enrollment was sicker than insurers expected; for many insurers, 2014 and 2015 premiums were too low relative to actual claims.[21] Some of this understatement was likely due to the implementation of the transitional policy that allowed individuals to keep their prior non-ACA-compliant coverage. In states adopting the transition policy, ACA-compliant plans exhibited less favorable experience because lower-cost individuals were more likely to retain their prior policies. But even in many states that didn't allow for transition policies, insurers were more likely to receive risk corridor payments, suggesting that market average claim costs were higher than assumed in premium pricing.

Except for grandfathered plans, individuals will not be allowed to renew non-ACA-compliant plans beyond Dec. 31, 2017. In states that allowed transition policies, an influx of individuals from these plans to ACA-compliant plans could help improve the risk profile in 2018.

Risk profile concerns may have continued into 2016. The Kaiser Family Foundation estimated that during the 2016 open enrollment period, nationwide only 46 percent of the potential marketplace population selected a marketplace plan, ranging from a low of 22 percent in Iowa to a high of 74 percent in the District of Columbia.[22] However, these figures understate total ACA-compliant enrollment to the extent that individuals enrolled off marketplace (notably, the District of Columbia does not offer plans off marketplace).

The availability of SEPs for individuals who encounter certain life events—such as losing health insurance coverage, moving, or getting married—also can affect average claim costs. Eligibility requirements for SEPs in the marketplaces have not been stringently enforced, thereby creating opportunities for individuals to delay enrollment until health care services are needed. On average, SEP enrollees have had higher claim costs and higher lapse rates than individuals enrolling during the open enrollment period.[23] The worse experience exhibited by SEP enrollees could be resulting from a combination of higher enrollment among SEP-eligible higher-cost individuals, lower enrollment among SEP-eligible low-cost individuals, and enrollment among higher-cost individuals who would not meet SEP eligibility criteria if validation were required. CCIIO is exploring additional verification requirements for individuals who purchase coverage on the marketplaces.

The availability of long premium payment grace periods for subsidized enrollees could also contribute to an unhealthy risk profile. Individuals who receive premium subsidies on the marketplace and have paid at least one month's premium are allowed a grace period of 90 days for future premium payments. States govern the grace period, typically 30 days, for individuals not receiving subsidies and those purchasing coverage off marketplace. Longer grace periods for on-marketplace plans can worsen the risk pool profile by allowing healthy people to pay premiums for nine months and be assured of 12 months of coverage if needed. In other words, individuals who develop health problems can retroactively pay premiums in order to maintain coverage; individuals who remain healthy can skip payments for the last three months of the year and simply enroll for the next year's coverage during the open enrollment period. The risk adjustment program does not mitigate lost revenue problems arising due to healthy people not paying a full year of premium. It's unclear the extent to which subsidized enrollees may be taking advantage of the extended grace period.

A recognition by insurers of worse-than-expected risk pool profiles in 2015 was likely a factor that contributed to 2017 premium increases. Insurers have more information now than they did last year regarding the risk profile of the enrollee population and used that information to adjust their 2017 assumptions accordingly.[24]

A stable regulatory environment facilitating fair competition

Consistent rules and regulations applied to competing health plans.

A stable marketplace requires that rules be consistently applied to all competitors in order to prevent particular insurers from being inappropriately advantaged or disadvantaged. Inconsistent regulations distort the market, reducing competition and limiting consumer choices. Fair competition also requires rules to prevent insurers from gaming the system. These conditions are generally met under the ACA, but not completely.

The same issue and rating requirements apply to all individual market insurers in a state, regardless of whether coverage is offered on or off the state marketplace. However, many states decided to take up the federal option of allowing individuals to keep non-ACA-compliant coverage, which put ACA-compliant plans at a disadvantage with respect to enrolling healthier individuals. This transition policy expires at the end of 2017; beginning in 2018, individuals in these plans will need to purchase ACA-compliant coverage.

ACA-compliant plans on and off the marketplaces participate in the risk adjustment program. By transferring funds between insurers based on the relative risk of their plan participants, the risk adjustment program aims to reduce incentives for insurers to avoid enrolling people at risk of high health spending. An Academy analysis found that for the 2014 plan year, the risk adjustment program compressed the loss ratio differences among health plans—risk adjustment transfers increased average loss ratios among health plans with low loss ratios and reduced loss ratios for health plans with high loss ratios, indicating that the program generally worked as intended for the individual market.[25] Nevertheless, risk adjustment payments can be affected by diagnostic coding and operational issues, and risk adjustment transfers as a percent of premium are much more variable among smaller insurers, which can produce unexpected results.

Non-ACA-compliant plans are not part of the risk adjustment program. Therefore, the program cannot mitigate the differences in enrollment patterns between non-ACA-compliant plans, which are more attractive to healthy individuals, and ACA-compliant plans.

One example of rules that apply differently on and off marketplace is the length of the premium grace period. As noted above, a 90-day grace period is available for individuals receiving premium subsidies, whereas the grace period is typically 30 days for other enrollees, including those purchasing coverage off the marketplaces. This can create a minor advantage for insurers selling off marketplace only.

There are also some differences in how fees are levied among insurers. Marketplace user fees are collected to support marketplace operations. The fee is charged only on marketplace business, but insurers must spread the fee across its marketplace and off-marketplace business. Insurers that operate only off marketplace do not need to reflect the fee in their premiums.

Stable effective regulatory environment.

Uncertainty in the regulatory environment can impact premium adequacy and stability, and ultimately insurer solvency. ACA regulations put into place standardized and effective processes for premium rate development, actuarial value determinations, and rate review processes that contribute to relative stability in the year-by-year rate filing processes. However, certain regulatory and legislative changes have seriously undermined this stability, negatively affecting the risk pool profiles, premium adequacy, and insurer financial results. In addition, delays in the release of important information can negatively affect stability.

- **Allowing individuals to retain pre-ACA coverage.** The decision to allow individuals to retain pre-ACA coverage was not made until 2014 premiums were finalized. In states that allowed pre-ACA plans to be renewed, this decision resulted in the risk pool profiles of ACA-compliant coverage being worse than expected and contributed to premiums being low relative to actual claims.

- **Constraints on risk corridor payments.** Risk corridors were included in the ACA to mitigate the pricing risk in the early years of the program. Although originally not specified to be budget neutral, subsequent legislative and regulatory actions have limited risk corridor payments to those that can be paid through risk corridor collections. If there is a shortfall, risk corridor payments are made on a pro rata basis. Due to such a shortfall for the 2014 plan year, only 12.6 percent of risk corridor payments were made.[26] The failure to pay the full amounts led to financial difficulty for many plans, in particular many Consumer Operated and Oriented Plans (CO-Ops). For instance, the Kentucky Health Cooperative specifically cited the lack of full risk corridor payments as a reason for closure.[27] HHS has indicated that no funds will be available for 2015 risk corridor payments, as any 2015 risk corridor collections will be used toward remaining 2014 risk corridor payments.[28]

- **Legal challenges to the ACA.** The steady flow of lawsuits has created additional costs and uncertainty. For instance, many states using the federal marketplace required dual premium submissions for the 2016 plan year because the Supreme Court had not yet

ruled on *King v. Burwell* (regarding the availability of premium subsidies) at the time premium filings had to be submitted for review. This required additional resources and expenses. Other cases are currently working their way through the courts. One that could have significant implications for premiums and insurer financial stability involves whether the administration has the legal authority to make cost-sharing reduction payments to health plans.[29]

- **Timing of available risk adjustment information.** Because the risk adjustment program depends on the market-wide risk profile, there is uncertainty regarding the amount that insurers expect to pay or receive under the program. Risk adjustment results in 2014 and 2015 were much different than expected for some insurers, resulting in unexpected losses. This risk adjustment "shock" is another reason cited for causing solvency problems for CO-OPs and other smaller plans.[30] Because of the lag in reporting, final risk adjustment results for a given plan year are not released until the middle of the next year, after premiums have already been filed for the year after that. In recognition of this time lag, CCIIO has begun to release interim reports that provide summary risk adjustment information. This information is not available for all states and insurers using the reports must do so with caution because the final results can differ significantly from interim estimates.

- **Timing of final rules.** The rulemaking process is understandably long and involved. Nevertheless, the earlier that rules are finalized, the easier it is for insurers to meet deadlines for product and rate filings in May. The final rules applicable to 2018 premium filings were released in December, earlier than in prior years. This earlier release will reduce rulemaking uncertainty, especially if this timeframe is continued in future years.

Reasonable expectation of earning a fair return.

Like all businesses, insurers participating in the individual market have an obligation to protect their viability and solvency, requiring that they must earn a fair return that supports ongoing business activities. Premiums net any of other payments or receipts (e.g., through the risk adjustment and reinsurance programs) must be adequate to cover claims and all administrative costs, taxes, and fees, and still provide a margin for profit or contribution to reserves and surplus.

The ACA reforms implemented in 2014 significantly changed insurance market rules and increased business risks. The most fundamental of these risks is related to projecting claim costs. Insurers had very limited data available to estimate who would enroll in plans under the new rules and what their health spending would be. It was likely that the composition of the insured population would change dramatically due to the elimination of underwriting and the introduction of premium subsidies. The risk adjustment and transitional reinsurance programs also needed to be factored in, while the temporary risk corridor program could be viewed as providing a partial safety net for premium rate development uncertainty.

Even with all the known risks, issuers were further subject to circumstances that could not reasonably have been anticipated. As noted above, these include the ability for individuals in many states to continue non-ACA-compliant transitional coverage in 2014 and beyond, as well as the federal government's failure to make risk corridor payments in full.

In an analysis of 2014 experience, McKinsey & Company found much variation in financial performance among insurers, with about 40 percent of the market covered by insurers with positive margins; the aggregate post-tax margin in 2014 was -4.8 percent.[31] The transition policy may have contributed to losses, as did insurer-specific factors, with CO-OPs and insurers offering preferred provider organization (PPO) plans and broad networks experiencing larger losses. Health maintenance organizations (HMOs), insurers with narrower networks, and Medicaid-based plans had more favorable experience, on average.

Once financial losses have been suffered, they cannot easily be recouped through future gains in the individual marketplace. Pricing margins can be limited by the rate review process and competitive pressures, which often puts downward pressure on rates, and health plans are not allowed to build in provisions to recoup past losses into premium rates.

Prior to the ACA, normal fluctuations in year-by-year margins could result in poorer-than-expected margins being offset by better-than-expected margins in subsequent years. The ACA's medical loss ratio (MLR) requirements limit the extent to which this can occur. These requirements stipulate that if claims plus quality improvement expenses fall below 80 percent of premium net of taxes and fees (in effect meaning that administrative costs and profit exceed 20 percent of premium), insurers may be required to return the difference to plan members.

Insurers and regulators now have more experience that can be used to develop and review future premiums. S&P Global Ratings recently forecast that insurer financial performance will improve, with smaller aggregate losses in 2016 than in 2015 and continued improvement in 2017 with more insurers becoming profitable.[32]

Nevertheless, continuing uncertainty and ACA legal challenges mean that pricing and solvency challenges in the market remain. This has caused many issuers to question their ability to earn a fair return—resulting in some issuers withdrawing from existing markets and fewer issuers having an interest in entering new markets.

Sufficient health plan participation and plan offerings

Sufficient number of participating health insurers.

Although there is no definitive minimum number of health insurers that are needed to ensure a competitive marketplace, it is generally recognized that competition can be difficult with fewer than three insurers.[33] This threshold may be lower than in other markets due to consumers' ability to compare plans under the ACA.[34]

The average number of ACA marketplace insurers per state increased from 5.0 in 2014 to 6.1 in 2015, and then declined to 5.7 in 2016.[35] Due to the failure of a number of small carriers, especially the CO-OPs, and market withdrawal announcements by some larger carriers (e.g., Aetna, Humana, UnitedHealth), the number of insurers is decreasing further in 2017. These averages mask tremendous variation among states. For instance, in 2017, five federal marketplace states (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming) have only one insurer. On the other end of the spectrum, Wisconsin has 15 insurers, Ohio has 11, and Texas has 10. Within states, the number of insurers offering coverage can vary by county, with rural counties having fewer participating insurers. Avalere estimates that in states using the federal marketplace, the average number of insurers per county has fallen from 5.3 in 2016 to 2.9 in 2017, and 21 percent of enrollees have only one participating insurer for 2017.[36]

It was expected that insurer exits and entries would occur during the early years of the ACA as insurers adjust to the new market rules. Nevertheless, recent marketplace pullbacks, especially among some major insurers, raise a concern that the current ACA marketplace environment is not viable from a business perspective. (Notably, some of the insurers pulling back from offering marketplace coverage continue to offer ACA-compliant coverage outside of the marketplace.) A reduction in competition due to fewer participating insurers can reduce consumer options as well as impact premiums. The ability of insurers to effectively compete depends in large part on their ability to manage costs, which in turn reflects their ability to effectively negotiate with providers to lower utilization and costs (e.g., through narrower networks). Insurers with larger market shares in a particular area may have more leverage in provider contracting. (The dynamic may be different in rural areas with a limited number of providers—rural providers can have more negotiating power even if there is only one insurer.) On the other hand, having a more competitive market could provide insurers more incentives to negotiate aggressively and to pass along savings to consumers. Research based on 2014 and 2015 ACA premiums suggest that the addition of an additional competitor leads to lower premium increases, but the competitive effects shrink after two or three additional entrants.[37]

Due in part to lower potential enrollment, rural areas can support fewer insurers, so it is not surprising that there are fewer participating insurers in rural counties and states. Nevertheless, having only one or even no participating insurers in some areas is a cause for concern.

Sufficient plan offerings.

Consumers have choices with respect to their particular plans. The ACA provides for four metal levels, which reflect relative plan generosity, as well as a catastrophic plan available to young adults and individuals who qualify for a hardship exemption from the individual mandate. Insurers offering marketplace coverage must offer silver and gold metal plans, but are not required to offer the other metal levels. In most states, insurers have flexibility within metal levels to set particular benefit design and cost-sharing requirements. Some state marketplaces impose standardized plan options, but may allow non-standardized options as well. Standardized benefit options may help simplify consumer choices and facilitate plan comparisons,[38] but could also inhibit innovative plan designs. For the 2017 plan year, the federal marketplace is offering standardized benefit designs, called Simple Choice plans, on an optional basis. Insurers can also offer choices across additional plan dimensions, such as plan type (e.g., HMO, PPO), which can affect the level of care management, how broad or narrow the provider network is, and the availability of out-of-network benefits.

Over the first three years of the ACA, the average number of marketplace plans offered per county in federal marketplace states increased from 51 in 2014 to 55 in 2015, and then decreased to 48 in 2016; plan offerings per county is further decreasing to 30 in 2017.[39] Plan offerings and enrollment are concentrated in silver plans, which would be expected given that premium subsidies are based on silver plans and cost-sharing subsidies are available only for silver plans.

Forty-seven percent of 2017 federal marketplace plans are silver plans; 33 percent are bronze. On average, only one platinum plan is offered per county, and many areas have no platinum plan offerings at all. Enrollment has been even more concentrated; as of March 31, 2016, 70 percent of enrollment nationwide is in silver plans and 22 percent is in bronze.[40]

The type of plans offered in the marketplaces has been changing, with a decline in less restrictive network PPO offerings. This shift may reflect consumers' willingness to forgo access to a broad set of providers and looser utilization management in return for lower premiums and cost sharing. Among silver plan offerings, PPO plans have declined from 52 percent of plan offerings in 2014 to 35 percent in 2016, and were expected to decline further in 2017, especially among competitively priced plans.[41] Some areas have few or no PPO marketplace offerings.[42] More restrictive network plans, such as HMOs and exclusive provider organizations (EPOs), are becoming a larger share of marketplace offerings. Low- and moderate-income consumers may be more open to narrower networks,[43] and Medicaid-based marketplace plans are particularly based on HMO and EPO plans.[44] Nevertheless, the high deductibles associated with lower-metal-level plans have generated concerns regarding high out-of-pocket costs.[45] On average, plan offerings are broader off marketplace, both in terms of plan type and metal tier,[46] but premium subsidies are not available for off-marketplace plans.

Insurers are shifting toward narrower provider networks in marketplace plans to lower premiums.[47] Health insurers negotiate provider payment rates and other network participation terms, such as those related to quality and sharing financial risk. Providers often accept lower payment rates in return for being included on a plan's network. Deep provider discounts have been negotiated in some cases, particularly when the health insurer is able to leverage rate negotiations between two competing health care systems.

Slow health spending growth and high quality of care

Because most premium dollars go toward paying medical claims, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires controlling health care costs. Medical spending trends for the individual market reflect those for the health system as a whole. In recent years, health spending has been growing relatively slowly compared with historical averages. Nevertheless, national health spending made up 17.8 percent of the economy in 2015.[48] Because health spending has been growing faster than the gross domestic product (GDP), this share is increasing.

There are signs that health spending growth rates are beginning to increase. Prescription drug spending growth has been particularly high recently, due to price increases and the introduction of high-cost specialty drugs. According to national health spending projections from the CMS Office of the Actuary, annual per capita spending growth for those with private health insurance will increase from 3.2 percent in 2014 to 4.9 percent from 2016 to 2019.[49] This higher growth rate remains lower than the 7.1 percent annual growth rate from 2007 to 2013, but exceeds projected annual per capita GDP growth by 1.0 percentage point. Growth in per capita health spending will directly result in premium increases.

Not only is national health spending high and growing, there is evidence that we are not spending our health care dollars wisely. For instance, the Institute of Medicine estimated that 10-30 percent of health spending is for unnecessary care or other system inefficiencies and that missed prevention opportunities also add to excess spending.[50] Although the medical care that people receive can vary dramatically across and within geographic regions, those variations are unrelated to health outcomes,[51] also indicating inefficient spending. In addition, medical errors are now the third leading cause of death,[52] raising quality concerns.

SECTION 3

Addressing ACA Individual Market Challenges

This section discusses the potential implications—both positive and negative—of several options that have been proposed to address the challenges in the individual market under the ACA. This section focuses on options to improve the risk pool profile, increase insurer participation, and improve the regulatory environment. Although the long-term sustainability of the individual market depends on containing health care spending, this is a health system-wide issue and not unique to the individual market. As such, an examination of payment and delivery system reform options is beyond the scope of this paper.

Options to Achieve Sufficient Enrollment Levels and a Balanced Risk Profile

One of the most popular elements of the ACA is that people with pre-existing health conditions cannot be denied health insurance coverage or charged more for that coverage. For this provision to work, however, healthy people must enroll at levels high enough to spread the costs of those who are sick. Otherwise, average costs, and therefore premiums, will rise. This section explores options related to approaches that aim to increase enrollment and attain a balanced risk profile.

Impose penalties for non-enrollment

One way of increasing enrollment is to penalize individuals who do not enroll. An individual mandate may be the best way of using penalties to increase enrollment, but only if it is effective and enforceable. Other options that impose penalties on individuals who initially forgo coverage but later enroll may provide some incentives to enroll when first eligible. However, their effect on the risk pool may come more from suppressing later enrollment or mitigating the costs of future adverse selection.

- **Individual mandate.** The ACA individual mandate penalty ($695 or 2.5 percent of income, whichever is greater) may not be strong enough to encourage healthy consumers to enroll. For instance, an annual income of $50,000 would result in a tax penalty of $1,250, which is about half of the national average premium for a bronze plan.[53] A larger financial penalty would increase the incentives for individuals to enroll, especially as the amount of the penalty approaches the amount of the premium.

  Strengthening the mandate's enforcement could also increase its effectiveness. Currently, the mandate penalty is reported on the federal income tax form and is deducted from any tax refund. If no refund is owed, however, there are no consequences to the taxpayer if the penalty goes unpaid. Enforcing payment regardless of whether there is a tax refund would increase the mandate's effectiveness.

  Increased outreach to ensure that consumers are aware of and understand the penalty as well as their coverage options and potential eligibility for premium subsidies would help increase the mandate's effectiveness, as would reducing allowed exemptions to the mandate.

- **Continuous coverage requirement/reduce access to coverage for late enrollees.** Another form of a late enrollment penalty would be to remove the pre-existing condition coverage protections for late enrollees or for those who haven't had continuous coverage for a specified period of time, such as 18 months. In other words, insurers would be allowed to underwrite individuals who do not enroll when first eligible or do not meet continuous coverage requirements. Individuals with pre-existing conditions could be denied coverage altogether, provided access to less generous plans only, or charged higher premiums based on their health conditions.

If this type of approach were structured to allow insurers to offer preferred premiums to individuals who meet underwriting requirements, however, the marketplace would in effect return to a pre-ACA environment. Healthy individuals, even those who had continuous coverage, would have an incentive to undergo underwriting. As a result, healthy individuals would be charged lower premiums and less healthy individuals would face higher premiums and potentially less generous or no coverage options. Similarly, if this approach moved away from requiring a single risk pool with risk adjustment among all plans, market fragmentation could occur and plans insuring higher-cost individuals would require higher premiums and could become less viable.

A continuous coverage requirement in effect imposes a one-time open enrollment period. Instead of having only a one-time open enrollment period, or annual open enrollment periods as under the ACA, an intermediate approach would be to offer open enrollment periods every two to five years.

- **Late enrollment premium penalty.** In addition to or instead of an individual mandate penalty, individuals who do not enroll in coverage when it is first available could be subjected to a premium surcharge if they later enroll. For instance, the Medicare program increases Part B and D premiums by 10 percent of premium for every 12 months that enrollment is delayed past the initial eligibility date. (Medicare's high enrollment rates are likely not attributable to this penalty, however. Instead, Medicare's highly subsidized Part B and Part D premiums probably play a larger role.) The higher premium is paid for the lifetime of the enrollee. Such a penalty would be more challenging to implement under the ACA. It would be difficult to track an individual's eligibility and enrollment over time, especially when individuals change employers or move between different coverages. Communicating the nature of the penalty to consumers could also be difficult. In addition, as the penalty accumulates over time, premiums could become prohibitively expensive, potentially further suppressing subsequent enrollment, potentially more so among healthy individuals.

Provide enrollment incentives

In the ACA, the individual mandate is the stick and premium subsidies are the carrot used to encourage enrollment, especially among healthy individuals. Although much attention is focused on the enrollment experience among young adults, who on average have lower health care costs, enrolling low-cost individuals of all ages should be the goal. Enrolling healthy older adults can be even more advantageous than enrolling healthy younger adults, because of the higher premiums paid by older adults. Regardless of age, attracting low-cost individuals depends on whether they deem that the value of the health insurance available exceeds the premiums charged. Reducing premiums through premium subsidies, tax credits, or other means could increase the perceived value of insurance, even to healthy individuals. The impact of any change in subsidies on enrollment, premiums, and government spending would depend on the details of the approach.

- **Premium subsidies.** Premium subsidies for ACA coverage are based on income and the cost of the second-lowest silver tier plan, and are available for individuals with incomes up to 400 percent of the federal poverty level (FPL). Nevertheless, premium affordability appears to continue to be a problem. Premium subsidies could be increased, perhaps targeting different subsets of enrollees. One option would be to increase the premium subsidies for all individuals currently eligible for premium subsidies—those with incomes between 100 and 400 percent of FPL. This would help address the concern that premiums remain unaffordable for low- and moderate-income individuals. Another option would be to increase subsidies for a subset of individuals currently eligible for premium subsidies (e.g., individuals with incomes of 250-400 percent of FPL, younger adults, older adults) if affordability issues are seen as greater for those subgroups. A third approach would be to extend subsidies to individuals with incomes exceeding 400 percent of FPL, in recognition that even higher-income individuals can face affordability problems. By increasing subsidies, net premiums would decline, increasing the incentives for even healthy individuals to obtain coverage.

- **Restructured premium subsidies.** The ACA premium subsidy structure sets a cap on premiums as a share of income, and the cap increases with income as a share of FPL. The difference between the premium cap and the premium for the second-lowest silver tier plan is provided as a premium tax credit, which can be used toward any plan in the marketplace. If the plan chosen costs less than the second-lowest silver tier plan (e.g., the lowest silver tier plan, a bronze tier plan), the enrollee will pay less than the premium cap. Because premiums for older adults are more expensive than premiums for younger adults, older adults will receive a higher premium subsidy than younger adults with the same income. Using that subsidy toward a lower-priced plan could result in an older adult paying a lower net premium than a younger adult with the same income. Conversely, if a higher-cost plan is chosen, older adults would pay a higher net premium than younger adults with the same income.

  The subsidy structure could be changed so that subsidies vary by age, instead of or in addition to varying by income. For instance, subsidies could be targeted to increase enrollment among young adults. Regardless of how they are structured, subsidies need to be sufficient so that premiums are affordable, especially for low- and moderate-income households.

- **Reimbursement for high-risk enrollees.** The ACA includes a transitional reinsurance program that uses contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market. To the extent that the group insurance market (including self-funded plans) has a healthier risk profile than the individual market, this mechanism in effect acts as a risk adjustment program between the individual and group markets. The program was in effect from 2014-2016 only. A permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums. For instance, during the reinsurance program's first year, the $10 billion reinsurance fund was estimated to reduce premiums by about 10-14 percent.[54] Such a program to pool high risks could be implemented at the state or federal level and could use the current funding mechanism or another. For instance, the state of Alaska recently established a comprehensive health insurance fund that will act like a reinsurance program, thereby lowering 2017 premium rate increases.

Modify insurance rules

Under the ACA, premiums cannot vary by health status, but are allowed to vary by age, up to a 3:1 ratio. The ACA also imposes rules regarding the comprehensiveness of coverage. These rules can affect average premiums and out-of-pocket costs. They also affect how premiums vary across individuals.

- **Wider premium variations by age.** Widening the allowable age variation from a 3:1 ratio to a 5:1 ratio would more closely align premiums to underlying costs by age. One study estimates that such a change would reduce premiums for 21-year-olds by 22 percent ($70 per month), resulting in an increase in young adult enrollment.[55] However, premiums for 64-year-olds would increase by 29 percent ($274 per month), likely reducing older adult enrollment while also increasing federal costs for premium subsidies due to the higher premiums. Unsubsidized healthy older adults may be the most likely to drop coverage. On net, the study estimates that loosening the age bands would increase federal premium and cost-sharing subsidies by $11 billion in 2018 under the current ACA subsidy structure.

- **Increased access to catastrophic coverage or the addition of a lower tier "copper" plan.** Less generous coverage could be appealing to younger adults and healthy people of all ages more generally. The ACA offers a catastrophic plan option to adults under age 30 and older adults who have a hardship exemption from the individual mandate. However, individuals are not allowed to use premium tax credits toward catastrophic plans and the actuarial value of catastrophic plans is similar to bronze plans. As a result, current participation in catastrophic plans is quite low—less than 1 percent of marketplace enrollees.[56]

  Allowing broader access to catastrophic coverage with even lower actuarial values and allowing premium tax credits to be used toward this coverage could increase enrollment, especially among healthy individuals. Under current law, however, increased enrollment in catastrophic plans won't affect premiums for the metal level plans—although catastrophic plans are part of the single risk pool, catastrophic plan premiums are allowed to be adjusted to reflect the expected impact of catastrophic plan eligibility. In addition, catastrophic plans are treated separately in the risk adjustment program.

Adding a copper tier plan, with an actuarial value lower than that of the bronze tier plans, could result in increased enrollment among young and healthy individuals. However, the lower premiums associated with these plans mean that it would be more difficult to spread the risk of higher-cost enrollees in more generous plans. In addition, by their nature, both catastrophic plans and copper tier plans would have higher out-of-pocket cost-sharing requirements than other plans. This may be less of an issue for high-income individuals, but these types of plans are a less viable option for low- and perhaps even moderate-income individuals. (Individuals with incomes less than 250 percent FPL are eligible for cost sharing subsidies, but only if they purchase silver tier plans.)

- **Increased benefit design flexibility.** Designing benefit packages that would be more attractive to healthy enrollees could increase their participation. For instance, offering primary care visits or generic drugs with low copayments before the deductible could be a way to increase the value of benefits. Although insurers already have flexibility to vary plan designs within the actuarial value constraints, the HSA rules prohibit paying most non-preventive benefits prior to the deductible. Relaxing those rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits while also potentially reducing costs.

Make risk pools less susceptible to adverse selection

Even with provisions such as an individual mandate and premium subsidies that aim to reduce the adverse selection effects of prohibiting discrimination against individuals with pre-existing conditions, some degree of adverse selection will occur. In addition, many individuals enroll after the year begins, either later during the open enrollment period or during a special enrollment period. And many individuals drop coverage prior to the end of the year. Partial-year enrollment is not unexpected in the individual market, as individuals move between it and other sources of coverage, such as employer group coverage. Nevertheless, partial-year enrollment can be especially prone to adverse selection. Further mitigating adverse selection and encouraging full-year enrollment can improve the risk pool profile and market stability.

- **Modify the open enrollment period.** Shortening the open enrollment period or ending it prior to January 1 would increase the confirmed enrollment in January. As a comparison, the 2017 open enrollment period runs from November 1 to January 31 for ACA plans, but only from October 15 to December 7 for Medicare. Having an ACA open enrollment as short as that for Medicare might not be currently feasible—more time may be needed for outreach and enrollment efforts. In addition, individuals may need until December to know what their financial situation for the next year will be (e.g., whether they get a raise can affect enrollment decisions). Nevertheless, an enrollment period that ends prior to January 1 could reduce the potential for adverse selection, thus improving the average risk profile. In addition, it would help insurers understand their enrollee population sooner, direct members into care management programs earlier, provide more time to send welcome materials to enrollees, and better ensure enrollees access to insurance benefits closer to January 1.

- **Reduce the 90-day grace period.** Individuals receiving premium subsidies are allowed a 90-day grace period for premium payment. This can enable enrollees to select against the market by paying premiums retrospectively only if they use services during that time; those who don't use services can let their coverage lapse. This can destabilize the market and increase average costs per enrollee. Reducing the grace period so that it is the same as that for individuals not receiving subsidies, typically 30 days, could keep enrollees participating regardless of need, and for a longer duration. Concerns regarding premium affordability could be addressed through other mechanisms, such as increased or restructured premium subsidies.

- **Tighten SEP eligibility and enrollment verification.** Recent changes by CMS to eliminate some SEP categories and tighten the eligibility requirements for certain SEPs have been reported to have resulted in a 15 percent decline in SEP enrollment.[57] CMS has also announced plans to test procedures that would verify SEP eligibility.[58] Further limiting SEP eligibility and tightening enforcement could reduce any abuses of SEP eligibility that might be occurring. Although potentially difficult to implement, an additional option is to prohibit SEP enrollees from choosing richer plans than their prior coverage. Any requirements regarding SEP enrollment should not be so onerous as to reduce participation among those legitimately eligible, otherwise the consequence could be to reduce participation among healthy SEP eligibles, thus worsening the risk pool. Because higher claim costs among SEP enrollees likely reflects not only abuse of SEP eligibility, but also higher enrollment among high-cost SEP eligibles, consideration

should be made to increase outreach regarding SEP eligibility and the individual mandate (e.g., notices to employees losing group coverage). Doing so could reduce adverse selection by increasing participation among low-cost SEP eligibles. Nevertheless, late-year SEP enrollment among healthy eligibles could be low because deductibles aren't prorated.

- **Limit third-party premium and cost-sharing payments.** Adverse selection can occur when third parties pay an individual's insurance premiums and cost sharing, as these payments are more typically made on behalf of individuals with high health care needs. Payments from certain third parties may be appropriate. For instance, CMS requires insurers to accept third-party payments from federal, state, and local programs. However, it is less appropriate for providers who will receive payments for their services to be making payments on behalf of enrollees. CCIIO has expressed concerns that provider organizations could be steering Medicaid and Medicare patients to marketplace plans in order to obtain higher reimbursement rates.[59] Dialysis providers in particular appear to be benefiting from such steerage, even if it is not the best coverage option for patients. To address this issue, CMS issued rules to improve dialysis facility disclosure requirements and transparency around third-party premium payments.

- **Establish high-risk pools.** Rather than directly increasing the participation of healthy individuals, high-risk pools could be established to remove high-cost enrollees from the risk pool, reducing premiums for the remaining enrollment. If the issue and rating requirements were relaxed to allow insurers to deny coverage or charge higher premiums to individuals with pre-existing conditions, average standard premiums would be lower but high-risk individuals could have difficulty obtaining coverage. High-risk pools have been used to facilitate coverage for high-risk individuals, but enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss.[60] Substantial funding would be required for high-risk pools to be sustainable. In addition, removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-cost individuals in the individual market can incur high health care costs, which would put upward pressure on premiums. As discussed above, an alternative is to use funding that would have been directed to external high-risk pools toward a program that reimburses plans the costs of high-risk enrollees.

Increase sources of potential individual market enrollment

Another approach to increasing enrollment in the individual market is expanding eligibility to other groups:

- **Incorporate Medicaid expansion population into the individual market.** The ACA expanded Medicaid eligibility to 138 percent of the FPL. Arkansas and New Hampshire received federal waivers to expand Medicaid by purchasing marketplace coverage for newly Medicaid-eligible adults; the Arkansas waiver began in 2014 and the New Hampshire waiver began in 2016. Iowa had implemented a similar program but subsequently terminated it when the remaining marketplace insurer would no longer accept Medicaid enrollees. Other states could pursue the approach of using Medicaid funds to purchase marketplace coverage. Incorporating the Medicaid expansion population into the individual market would increase marketplace enrollment, potentially increasing marketplace stability. But the impact on the risk profile and resulting premiums is unclear—having a lower income is often associated with having poorer health. In 2015, Arkansas had the highest average risk score in the individual market (but closer to the average risk score in the small group market), perhaps reflecting in part the Medicaid waiver. In addition, there is evidence that marketplace premiums are lower on average in states that expanded Medicaid compared to those that have not.[61] These findings suggest that expanding traditional Medicaid could improve marketplace risk profiles, although marketplace enrollment would decline.

- **Merge the individual and small group markets.** Merging the individual and small group markets into a single risk pool would increase the size of the risk pool. Whether it would lead to greater market stability and lower premiums, at least compared to the individual market, would depend on the relative size and risk of the individual market compared to the small group market. For instance, if a state's small group market is relatively large and lower risk than its individual market, the small group market would more easily absorb the individual market, lowering premiums for those previously in the individual market without substantially increasing premiums for those previously in the small group market. In contrast, if the small group market in a state is relatively small compared to the individual market, merging the markets could increase small group premiums without a significant reduction in individual market premiums. Other factors that could impact outcomes are whether merged market premiums would be allowed to vary between individuals and groups and the extent to which a self-funding option is available for small groups with lower expected health care spending. Adverse

selection against the ACA market could occur if low-cost small groups pursue self-funding options. Currently, self-funding is relatively infrequent among small groups. Of establishments with fewer than 100 workers that offer health insurance, 14.2 percent offered a self-funded plan in 2015, up from 13.4 percent in 2014.[62] Nevertheless, to limit additional adverse selection, rules might need to be considered to discourage further self-funding among small groups.

- **Remove option for adult children up to age 26 to remain on a parent's insurance plan.** The ACA allows adult children to remain on a parent's plan up to age 26. This likely suppresses young adult enrollment in the individual market. Eliminating that provision could increase young adult enrollment in the individual market, but could also lead to an increase in uninsured rates among young adults. The potential impact on the individual market risk pool profile depends on the extent of adverse selection among younger adults, with healthy young adults opting to forgo coverage.

Increasing Insurer Participation and Improving the Regulatory Environment

Options to level the playing field

It is important for competing plans to operate under the same rules. For the most part, the ACA applies the same rules to all plans in the individual market. However, there are some instances in which plans are treated differently. Options to address these inconsistencies include:

- **Reduce the grace period for subsidized enrollees.** As noted above, reducing the grace period for subsidized enrollees could improve the risk pool profile. It would also increase consistency between individuals with premium subsidies and those without, including those purchasing coverage off the marketplace.

- **Consistent SEP enforcement mechanisms.** Stricter SEP enforcement mechanisms have the potential to improve the risk profile. In addition, more consistent SEP verification processes between plans on and off the marketplace could reduce any related disadvantages for on-marketplace plans.

- **Modifying marketplace fee assessments.** Marketplace fees should be assessed in a manner that does not disadvantage insurers participating in the marketplace. Currently, marketplace fees are assessed only on insurers selling coverage on the marketplace, but these insurers are required to spread the fee to both their on- and off-marketplace enrollees. Insurers selling off marketplace only avoid these fees. Potential solutions include allowing insurers to vary their administrative charges for on-marketplace and off-marketplace members, with the marketplace business being charged the entire marketplace fee. Another option would be to charge the marketplace fee to all insurers operating in the market, even those operating exclusively off marketplace. This would spread the costs of the marketplace over a broader base and allow the charge to be a lower percentage of premium. Even off-marketplace-only insurers benefit from marketplace functions that increase enrollment, because they can improve the overall market's risk profile.

Prohibit off-marketplace plans

Another option that would create a level playing field is to require all insurers and plans to be offered only through the marketplace. This would prevent insurers from choosing to market only off marketplace to avoid some of the fees and additional marketplace rules and may help with some risk selection problems to the extent that risk adjustment does not fully compensate for risk differences between on- and off-marketplace plans. In general, a wider array of insurance plans is available off the marketplace than on the marketplace. Prohibiting off-marketplace plans could potentially increase the options available to enrollees receiving premium subsidies. On the other hand, insurers may choose to continue offering only the narrower set of on-marketplace options, thus reducing plan choice among individuals previously purchasing off-marketplace plans. Also, some insurers may decide not to participate in the market at all.

Continue to improve the risk adjustment program

The risk adjustment program should fairly compensate insurers for the risk of their enrollees so that insurers do not have incentives to avoid any particular type of potential enrollee. CCIIO has indicated plans to modify the risk adjustment program so that it better reflects differences in the underlying risk among participating insurers. These modifications include the incorporation of prescription drug data, the incorporation of preventive services, and better accounting for partial-year enrollees. In addition, CCIIO will begin using data collected from the ACA-compliant individual and small group markets for purposes of calculating risk scores and making risk adjustment transfers to also calibrate the

model. This will improve the model's accuracy for these markets compared to the current calibration method that uses experience from large employer plans. CCIIO is also exploring the incorporation of a high-risk enrollee pool to improve risk adjustment for extremely high-cost enrollees. The risk adjustment program should continue to be monitored. If experience suggests that the risk model systematically over- or under-compensates for certain enrollee subgroups, the model should be revised as appropriate. Except under exceptional circumstances, changes should be made on a prospective basis only. In addition, CCIIO should continue to provide and improve interim reports to help reduce uncertainty for insurers.

Conduct effective rate review

A sustainable insurance market requires that premiums be adequate but not excessive. Although much focus is often given to ensuring that rates are not too high, it is equally important that rates not be approved if they are too low. Low rates may help an insurer attract a large membership, but rates that are too low have numerous adverse consequences, including:

- **Higher risk of insurer insolvency.** Insurer insolvencies not only cause coverage disruption for enrollees, but the cost can be borne by other insurers through state guaranty funds or special assessments that increase premiums.

- **Inadequate premium subsidies.** If premium subsidies are based on the second-lowest silver tier plan with a premium that is set too low, those subsidies will be insufficient to purchase a more adequately priced plan.

- **Insufficient risk adjustment transfers.** The risk adjustment program bases transfers on market average premiums. If those averages are understated due to an insurer having rates that are too low, the risk adjustment transfers will be too low to adequately adjust for risk profile differences among insurers.

Another issue with the rate review process is the availability of insurer premiums and pricing assumptions to competing insurers. The ACA requires rate filing transparency and an opportunity to allow for consumer feedback, although the level of detail required varies by state. Because there are multiple rate filing rounds, this transparency means that rates could be publically available, even before they are approved. As a result, insurers would be able to mimic another's pricing strategy, sometimes referred to as shadow pricing. In other words, premiums can go up or down relative to initially filed rates for reasons other than the adequacy of rates. This further emphasizes the need for an effective rate review that considers not only whether premiums are excessive, but also whether they are inadequate.

Allow insurance sales across state lines

Under this option, insurers licensed to sell insurance in any particular state would be allowed to sell insurance under that state's rules in other states. The intention is to spur more competition, which could increase consumer choice, lower premiums, and improve services. For instance, an insurer could choose to follow the rules of a state with less restrictive benefit requirements in order to offer lower-cost coverage in another state. Although states currently have the ability to permit the sale of insurance across state lines, few have done so to date and no out-of-state insurers have entered the market in those states.[63]

Health insurance is licensed and regulated primarily by state authority. Prior to the ACA, the rules regarding insurance issue, premium rating, and benefit requirements varied considerably by state. The ACA narrowed state differences in these rules by imposing more standardized requirements. Premium rate review and approvals continue to be conducted primarily at the state level, as are other consumer protections such as network adequacy requirements.

Allowing insurance licensed in one state to be sold in another would raise concerns regarding how insurers would set up local provider networks and how consumer protections would be enforced. In addition, with many of the rules currently harmonized across states, there is less ability for insurers to take advantage of differences in rules in order to lower premiums by avoiding certain requirements.

If the ACA issue, rating, and benefit requirements were relaxed and the state variation in rules returned, there would be more opportunity for insurers to take advantage of these differences. However, this could create an unlevel playing field, with plans in a single market competing under different market rules. Less-healthy individuals would purchase plans licensed in states with stricter regulations (e.g., guaranteed issue, community rating, comprehensive benefit requirements), and healthier people would purchase plans licensed in states with looser regulations. Such a result could lead to healthier people benefiting from less-expensive insurance, but those who are older and have more health issues would face higher premiums. Premiums for the plans licensed in states with stricter regulations would increase accordingly. Such a situation could threaten the viability of the insurance market in states with more restrictive rules and create a situation in which states would have incentives to reduce insurance regulations and consumer protections. This could reduce the ability of individuals with pre-existing health conditions to obtain coverage.

Include a public plan option

In order to increase plan availability and consumer choice, a public plan option could be offered as a marketplace competitor. This could be structured as a fallback option in areas with no or few participating insurers or could be offered more broadly. In order to compete on a comparable basis with private plans, a public plan would need to follow the same rules as those governing private plans and set premiums that are self-supporting. These rules could include the establishment of a premium stabilization fund that would function similarly to private plan surplus and cover any unexpected differences between plan expenditures and premiums, rather than relying on general government funds.

A public plan could provide consumers with an additional option, especially in areas with no or few other participating insurers. Nevertheless, a public plan would face the same underlying issues as private plans, such as low enrollment and sole community providers, which make it difficult for insurers to cover costs and earn a reasonable return. A public plan could potentially support lower premiums than traditional health plans, especially if such plans are able to use the federal government's clout with providers to negotiate payment rates at, or somewhat above, Medicare rates. Such an approach could lead to a more affordable coverage option, but would create an unlevel playing field relative to other competing private plans. If a public plan can achieve much lower provider payment rates than other plans, thereby allowing it to offer lower premiums, the effect could be to eliminate competition, making the public plan the sole option. In addition, there could be concerns regarding health care access if providers opt to not participate at the lower payment rates.

A variant of the public plan option is to allow older adults, (e.g., 50 or 55 and older), to buy into Medicare. There are many design considerations involved, such as whether the benefits would be structured similarly to current Medicare benefits, how the premium would be determined, and whether subsidies would be available. A Medicare buy-in could have a large impact on the individual marketplace. In 2016, 26 percent of individuals enrolling during the open enrollment period were age 55–64.[64] If a large portion of these individuals were to move to a Medicare buy-in, it could lower average premiums in the individual market. However, by reducing the size of the individual market pools, the financing of the marketplaces and the predictability of experience could be affected.

Allowing consumers a choice between the individual market and a Medicare buy-in could create opportunities for adverse selection for both markets, depending on the plan generosity and premium differences between the two options. For instance, because Medicare does not cap out-of-pocket costs, individuals with high expected health care costs could be more likely to opt for individual market coverage rather than Medicare. This selection against the individual market would at least partially offset any premium reductions resulting from a younger average enrollment age.

Offering a Medicare buy-in option would also have implications for employer coverage. Employers are concerned about health care costs for workers and covered retirees in the very age group that a Medicare buy-in program would target. Their support for early retiree coverage has already diminished in the past 25 years. A Medicare buy-in option could be seen as a potential replacement for remaining early retiree coverage, depending on benefit and premium levels. If federal premium subsidies are available for Medicare buy-in coverage, such a shift would increase the costs of federal premium subsidies.

CONCLUSION

To be sustainable, the individual market under the ACA requires sufficient enrollment numbers and a balanced risk profile. It also requires a stable regulatory environment that facilitates fair competition, with sufficient health insurer participation and plan offerings. Experience from the first three years of the ACA varies, with the markets in some states faring relatively well. More typically however, the results thus far indicate the need for improvement along most of these measures.

Although the ACA has dramatically reduced uninsured rates, enrollment in the individual market has generally been lower than expected and enrollees have been sicker than expected. Both of these factors have contributed to substantial premium increases in many, but not all, states. For the most part, competing plans face the same rules; however, some rules might be disadvantaging insurers participating in the marketplaces compared to off the marketplaces. The uncertain and changing regulatory environment, including legal challenges to the ACA, allowing individuals to retain pre-ACA coverage, and constraints on risk corridor payments, contributed to adverse experience among insurers. As a result of these and other factors, insurer participation and consumer plan choice declined in 2016 and is declining further in 2017.

Many options have been put forward to improve the short- and long-term sustainability of the individual market, either through changes to the ACA or by replacing the ACA with a different approach. If as part of this a goal is to provide coverage to people with pre-existing conditions at standard premiums, it is vital to enroll enough healthy people to spread the costs of those who are sick. The ACA's individual mandate, annual open enrollment period, and premium subsidies aim to achieve a balanced risk profile. Increased penalties for non-enrollment could help improve the risk profile, as could improving premium affordability, for instance through increased premium subsidies or additional funding for high-risk enrollees. Weakening the incentives for participation, however, could further exacerbate adverse selection issues and lead to higher premiums and more uninsured.

Achieving a balanced enrollee risk profile, along with providing consistent rules in a timely fashion to insurers, could lead to a more stable and sustainable market. Insurer participation could increase as a result, leading to more consumer choice.

Individual market experience varies by state. The ACA's section 1332 waivers could be used by states to pursue different approaches to improving the individual market. These approaches could reflect the particular situations of each state.

Finally, it's important not to overlook the need for a continued focus on controlling health care spending. Most premium dollars go toward paying medical claims. Therefore, keeping premiums (and taxpayer-funded premium and cost-sharing subsidies) affordable requires keeping health spending in check. Moderating health spending growth is a key to the sustainability of not only the individual market, but also the health care system as a whole.

Endnotes

1. American Academy of Actuaries, *Sustainability in American Financial Security Programs*. June 2015.
2. Department of Health and Human Services, ASPE Issue Briefs, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, May 1, 2014; *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report*, March 10, 2015; *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016. Figures reflect pre-effectuated enrollment—that is, the selection of a plan, with or without the first premium being paid. The open enrollment period for 2014 ran from October 1, 2013-March 31, 2014; enrollment figures cited also include additional special enrollment period activity through April 19, 2014. The open enrollment period for 2015 ran from November 15, 2014-February 15, 2015; enrollment figures cited also include additional special enrollment period activity through February 22, 2015. The open enrollment period for 2016 ran from November 1, 2015-February 1, 2016.
3. CMS, *December 31, 2015 Effectuated Enrollment Snapshot*, March 11, 2016.
4. Department of Health and Human Services, ASPE Issue Brief, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016.
5. Governor David Y. Ige, "News Release: State to Assist with Transition of Private Non-Profit Hawai'i Health Connector Operations." June 5, 2015.
6. Department of Health and Human Services, ASPE Issue Brief, *Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*. March 11, 2016.
7. HHS, *ASPE Data Point: About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies*. October 4, 2016.
8. Grandfathered plans are those already in effect when the ACA was passed in March 2010. Those plans are allowed to be renewed indefinitely as long as they do not undergo substantial changes. Transition plans are those purchased after March 2010, but prior to the ACA's marketplace requirements that went into effect in January 2014. A federal decision was made in the fall of 2013 that gave states the option to permit non-ACA-compliant coverage renewals into 2014. This was later extended to allow coverage renewals of non-ACA-compliant coverage through 2017. A majority of states opted to allow for transitional plans. See Kevin Lucia, Sabrina Corlette, and Ashley Williams, "The Extended "Fix" for Canceled Health Insurance Policies: Latest State Action," The Commonwealth Fund, November 21, 2014.
9. Liz Hamel, et al., *Survey of Non-Group Health Insurance Enrollees, Wave 3*. Kaiser Family Foundation, May 20, 2016.
10. Congressional Budget Office, *The Budget and Economic Outlook: 2014-2024*. February 2014. The CBO 2013 baseline does not include a separate line item for off-marketplace individual market enrollment estimates. However, the baseline estimates indicate that in 2016, 24 million nonelderly individuals would be enrolled in off-marketplace non-group and other coverage, where "other" includes Medicare. According to CMS, nearly 9 million nonelderly individuals were enrolled in Medicare in 2013. Depending on whether "other" coverage includes additional coverage categories, this suggests an estimated off-marketplace non-group enrollment upwards of 15 million in 2016.
11. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 2016.

12. Kaiser Family Foundation, *Key Facts about the Uninsured Population*, September 2016.
13. Emily P. Zammitti, et al., *Health Insurance Coverage: Early Release Estimates from the National Health Interview Survey, January-June 2016*. Centers for Disease Control and Prevention, November 2016.
14. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 2016.
15. Greg Ip, "The Unstable Economics in Obama's Health Law," *Wall Street Journal*, August 17, 2016.
16. Julie M. Donohue, et al., "Early Marketplace Enrollees Were Older and Used More Medication Than Later Enrollees; Marketplaces Pooled Risk." *Health Affairs* 34(6): 1049-1055, June 2015.
17. CCIIO, *Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool*, August 11, 2016.
18. Zachary Goldman, John Bertko, and Jim Watkins, "Health Risk Continues to Improve in Covered California," *Health Affairs Blog*, October 26, 2015.
19. Stacey McMorrow, et al., "Marketplaces Helped Drive Coverage Gains in 2015; Affordability Problems Remained." *Health Affairs* 35 (10): 1810-1815, October 2016.
20. Rebecca Owen, *An Examination of Relative Risk in the ACA Individual Market*, Society of Actuaries, August 2016.
21. CCIIO, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014*, November 19, 2015. CCIIO, *Risk Corridors Payment and Charge Amounts for Benefit Year 2015*, November 18, 2016.
22. Kaiser Family Foundation, "Marketplace Plan Selections as a Share of the Potential Marketplace Population: Timeframe November 1, 2015-February 1, 2016," accessed on August 29, 2016.
23. Chris Carlson and Kurt Giesa, *Special Enrollment Periods and the Non-Group, ACA-Compliant Market*, Oliver Wyman, February 24, 2016.
24. American Academy of Actuaries, *Drivers of 2017 Health Insurance Premium Changes*, May 2016.
25. American Academy of Actuaries, *Insights on the ACA Risk Adjustment Program*, April 2016.
26. CCIIO, *Risk Corridor Payment and Charge Amounts for Benefit Year 2014*, November 19, 2015.
27. Bob Herman, "Kentucky Co-Op Blames Inadequate Risk Corridor Funding for Closure," *Modern Healthcare* October 12, 2015.
28. CCIIO, *Risk Corridors Payment and Charge Amounts for Benefit Year 2015*, November 18, 2016.
29. Under the ACA, health insurers are required to provide cost-sharing reductions to eligible enrollees and the federal government is to reimburse insurers for these reductions. At issue in *House v. Burwell* is whether a congressional appropriation is required to make such reimbursements. If the courts ultimately rule that an appropriation is required and none is made, insurers would need to increase premiums for all plan enrollees in order to fund the cost-sharing reductions. Otherwise, financial losses could occur, potentially threatening insurer solvency. The uncertainty of whether any required appropriations would be made would itself create uncertainty and instability for insurers and premiums, potentially leading to insurers withdrawing from the market.
30. See for example, State of Connecticut Insurance Department, "Insurance Department Places HealthyCT Under Order of Supervision." July 5, 2016.
31. McKinsey; *Exchanges three years in: Market variations and factors affecting performance*, May 13, 2016.

32. S&P Global Ratings, *The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer*. December 22, 2016.
33. Cynthia Cox, Gary Claxton, and Larry Levit, *Analysis of Insurer Participation in 2016 Marketplaces*, Kaiser Family Foundation, November 2015.
34. Paul Jacobs, Jessica Banthin, and Samuel Trachtman, "Insurer Competition in Federally Run Marketplaces is Associated with Lower Premiums," *Health Affairs* 34:12 (2027-2035), December 2015.
35. Cynthia Cox et al., *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces*, Kaiser Family Foundation, November 1, 2016.
36. Caroline F. Pearson, *2017 Open Enrollment Preview*, Avalere, October 25, 2016.
37. Paul Jacobs, Jessica Banthin, and Samuel Trachtman, "Insurer Competition in Federally Run Marketplaces is Associated with Lower Premiums," *Health Affairs*, December 2015.
38. Too many health insurance plan choices can lead to suboptimal consumer decision making. Research suggests that 10 to 15 options can result in a sufficient range of choices and manageable decision making. See Consumers Union, *The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making*, November 2012.
39. ASPE, *Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace*, October 31, 2015; ASPE, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace*, October 24, 2016.
40. CMS, *March 31, 2016 Effectuated Enrollment Snapshot*, June 30, 2016.
41. McKinsey Center for U.S. Health System Reform, "2016 Exchange Market Remains in Flux: Plan Type Trends." December 2015.
42. Katherine Hempstead, *Burnt Offerings? PPOs Decline in Marketplace Plans*, Robert Wood Johnson Foundation Issue Brief, November 3, 2015.
43. California HealthCare Foundation, *Designing Coverage: Uninsured Californians Weigh the Options*, June 2007.
44. McKinsey Center for U.S. Health System Reform, *2016 Exchange Market Remains in Flux: Plan Type Trends*, December 2015. McKinsey Center for U.S. Health Reform, *2017 Exchange Market: Plan Type Trends*, as of November 3, 2016.
45. Robert Pear, "Many Say High Deductibles Make Their Health Law Insurance All but Useless," *New York Times*, November 14, 2015.
46. Harris Meyer, "New Data Expose Mysterious World of Off-Exchange Health Plans," *Modern Healthcare*, October 24, 2016.
47. Daniel Polsky, Zuleyha Cidav, and Ashley Swanson, "Marketplace Plans with Narrow Physician Networks Feature Lower Monthly Premiums than Plans with Larger Networks." *Health Affairs* 35 (10): 1842-1848, October 2016.
48. Anne B. Martin, et al., "National Health Spending: Faster Growth in 2015 As Coverage Expands and Utilization Increases," *Health Affairs* published online December 2, 2016.
49. Sean P. Keehan, et al., "National Health Expenditure Projections, 2015–25: Economy, Prices, And Aging Expected To Shape Spending and Enrollment," *Health Affairs* 35(8):1522-1531. August 2016.
50. Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, September 6, 2012.
51. Institute of Medicine, *Variation in Health Care Spending: Target Decision Making, Not Geography*, July 24, 2013.
52. Martin A. Makary and Michael Daniel, "Medical Error—The Third Leading Cause of Death in the US," *BMJ* May 3, 2016.

53. Internal Revenue Service, "Individual Shared Responsibility Provision—Reporting and Calculating the Payment." Accessed on October 31, 2016.
54. American Academy of Actuaries, *Drivers of 2015 Premium Changes*, June 2014.
55. Evan Saltzman and Christine Eibner, "Insuring Younger Adults through the ACA's Marketplaces: Options to Expand Enrollment," Commonwealth Fund blog post and technical appendix, December 16, 2016.
56. CMS, *March 31, 2016 Effectuated Enrollment Snapshot*. June 30, 2016.
57. CCIIO, "Frequently Asked Questions Regarding Verification of Special Enrollment Periods," September 6, 2016.
58. CCIIO, "Pre-Enrollment Verification for Special Enrollment Periods," December 12, 2016.
59. CMS, "Promoting Transparency and Appropriate Coverage for Dialysis Patients," CMS Fact Sheet, December 12, 2016.
60. Congressional Research Service, "Health Insurance: State High Risk Pools," 2011.
61. Aditi P. Sen and Thomas DeLeire, *The Effect of Medicaid Expansion on Marketplace Premiums*, Department of Health and Human Services, ASPE Issue Brief, September 6, 2016.
62. Employee Benefit Research Institute, *Self-Insured Health Plans: Recent Trends by Firm Size, 1996-2015*, July 2016.
63. Sabrina Corlette, et al., *Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage*, The Center on Health Insurance Reforms, Georgetown University Health Policy Institute, October 2012.
64. Department of Health and Human Services, ASPE Issue Brief, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016.

American Academy of Actuaries

Objective. Independent. Effective.™

1850 M Street NW, Suite 300
Washington, DC 20036

202-223-8196 (tel) | 202-872-1948 (fax)
www.actuary.org

March 13, 2019 | Press Releases | State Policy

State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average

Chris Sloan |

Neil Rosacker |

Elizabeth Carpenter

Summary

New analysis from Avalere finds that states with their own reinsurance programs reduce individual market premiums by 19.9% on average in their first year.

Reinsurance programs provide a combination of state and federal funds to insurance companies to help offset losses they may incur by covering individuals who are sicker than originally anticipated. In response to recent individual market uncertainty and rising premiums, many states are pursuing reinsurance programs to mitigate insurers'

risk and stabilize individual markets, as well as to help residents avoid unexpected premium increases while reducing the number of uninsured.

“For states looking to stabilize their individual markets, reinsurance programs may be an attractive opportunity,” says Chris Sloan, associate principal at Avalere. “State-based reinsurance programs have the potential to reduce premiums and are a good financial deal for states if they can identify a source of funding.”

To date, 7 states (AK, MD, ME, MN, NJ, OR, WI) have created their own reinsurance programs using Section 1332 of the Affordable Care Act (ACA). These states receive federal funding for their reinsurance programs based on the amount the federal government would have spent on advanced premium tax credits (APTCs) to eligible individuals if the programs were not in place; this is known as pass-through funding.

To understand the impact of these programs, Avalere analyzed existing and actuarially estimated data from the 7 states with approved reinsurance programs to estimate changes in individual market premiums, federal pass-through funding levels, and costs to the state.

Avalere’s analysis finds that among the 7 states with state reinsurance programs, premiums were 19.9% lower, on average, in the first year of enactment (Table 1). The premium reductions ranged from -6% to -43.4%.

In addition, Avalere’s analysis estimates that, during the first year of enactment, reinsurance programs led to lower federal spending on APTCs of nearly $1 billion (Table 1) compared to what the federal government would have spent without a reinsurance program. The federal government must “pass through” a portion of these savings to the states to help fund their reinsurance programs. In total, the federal government has contributed nearly twice as much ($990.6M) to state reinsurance programs as states ($509.1M) in the first year of enactment.

Table 1: Estimated Individual Market Impact of State Reinsurance Programs in Year of Enactment

State (Date of Enactment)	Percent Change in Average Individual Market Premiums	Federal Pass-Through Funding (millions)	State Reinsurance Funding (millions)	Percent of Program Cost Born by State	Enrollment in Year of Enactment
AK (2017)	-34.7%	$58.5M	$1.5M	2.5%	14,200
MN (2018)	-20%	$131M	$140M	51.7%	106,500
OR (2018)	-6%	$54.5M	$35.5M	39.4%	143,200
ME (2019)	-9.4%	$65.3M	$27.7M	29.8%	62,100
MD (2019)	-43.4%	$373.4M	$88.6M	19.2%	181,500
NJ (2019)	-15.1%	$180.2M	$143.5M	44.3%	331,000
WI (2019)	-10.6%	$127.7M	$72.3M	36.1%	203,000
State Average	-19.9%	$141.5M	$72.7M	31.9%	148,800
Total	--	$990.6M	$509.1M	--	--

Avalere's analysis also finds that states bear an average of 31.9% (ranging from 2.5% to 51.7%) of the total annual costs to run their reinsurance programs for an average of $72.7M. These additional costs may hinder adoption of reinsurance programs by states with limited budget flexibility.

"Reinsurance programs have been effective at stabilizing individual market premiums and maintaining insurer participation," said Elizabeth Carpenter, practice director at Avalere. "Though the appetite for state reinsurance programs is high, securing state funding is an obstacle to additional states implementing these programs."

Methodology

To conduct the analysis, Avalere analyzed individual market rate filings in states from 2017 to 2019, as well as state ACA Section 1332 waiver application reports, to estimate changes in individual market premiums, spending by the federal government on advanced premium tax credits (APTCs) and subsequent pass-through funding associated with savings from reinsurance programs, and costs to the state as a percentage of total program spending.

For states with existing reinsurance program data (AK, MN, OR), Avalere compared

For states with existing reinsurance program data (AK, MN, OR), Avalere compared baseline premium projected growth to actual premium rate filings in the year of enactment to determine the percent reduction in premium growth due to reinsurance. For states with approved ACA Section 1332 waiver applications to establish reinsurance programs (ME, ME, NJ, WI), Avalere compared state 2019 projected premium growth to projected 2019 premium growth under the waiver using approved 1332 waiver application reports.

Avalere used total federal pass-through funding through savings associated with reduction in APTCs from the Center for Consumer Information & Insurance Oversight Section 1332: State Innovation Waivers Resource Center. Avalere then estimated the percent of program costs born by the state as the portion of remaining funds after pass-through funding, divided by total estimated reinsurance program costs.

To estimate enrollment in year of enactment, Avalere used data from state 1332 waiver application reports and CMS effectuated enrollment files for the respective year of operationalization.

To learn more about Avalere's work in this space, connect with us.

Find out the top 2020 healthcare trends to watch.

Related Content

State Policy

Webinar: What's Next for Medicaid Drug…

View the webinar recording to learn more about the latest policy, pricing, and reimbursement challen...

Sarah Butler

State Policy

States Choosing Healthy Adult…

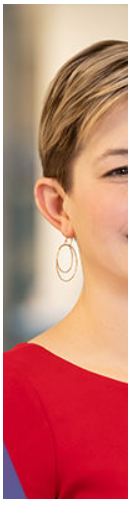
New analysis from Avalere finds that states currently covering non-mandatory adult populations who c...

Chris Sloan

State Policy

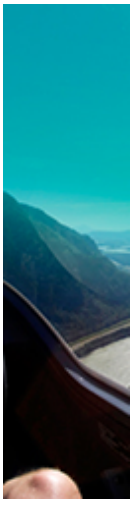
CMS's Healthy Adult Opportunity Program…

The Centers for Medicare & Medicaid Services (



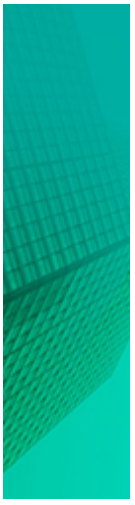
Federal & State Policy

Interpret Uncertainty



Avalere State Reform 360®

Guide Targeted Commercial



Avalere Policy 360®

Knowing Makes All the Difference

Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People

For information on confidentiality protection, sampling error, nonsampling error, and definitions, see <www2.census.gov/programs-

Nation/State	Characteristic	Total		Number	Margin of Error	Percent
		Number	Margin of Error			
United States	All persons	322,249	15	293,684	178	91.1
	Under 65 years	271,112	29	242,948	162	89.6
	Under 19 years	77,817	56	73,762	60	94.8
	19 - 64 years	193,295	45	169,186	169	87.5
	65 years and over	51,137	22	50,736	29	99.2
Alabama	All persons	4,810	2	4,329	15	90.0
	Under 65 years	3,998	4	3,519	15	88.0
	Under 19 years	1,163	5	1,122	7	96.5
	19 - 64 years	2,835	6	2,397	14	84.5
	65 years and over	812	4	810	4	99.7
Alaska	All persons	713	1	623	6	87.4
	Under 65 years	627	2	537	6	85.7
	Under 19 years	193	1	174	3	90.6
	19 - 64 years	434	2	363	5	83.6
	65 years and over	86	2	86	2	99.3
Arizona	All persons	7,065	2	6,315	24	89.4
	Under 65 years	5,818	3	5,077	24	87.3
	Under 19 years	1,746	6	1,599	10	91.6
	19 - 64 years	4,072	6	3,478	18	85.4
	65 years and over	1,247	2	1,238	3	99.2
Arkansas	All persons	2,961	1	2,717	10	91.8
	Under 65 years	2,470	3	2,229	10	90.2
	Under 19 years	747	4	713	6	95.5
	19 - 64 years	1,723	5	1,516	10	88.0
	65 years and over	491	3	488	3	99.5
California	All persons	39,062	6	36,237	43	92.8
	Under 65 years	33,490	7	30,723	42	91.7
	Under 19 years	9,514	10	9,216	14	96.9
	19 - 64 years	23,976	12	21,508	38	89.7
	65 years and over	5,572	4	5,514	5	98.9
Colorado	All persons	5,604	2	5,182	17	92.5
	Under 65 years	4,810	3	4,395	17	91.4
	Under 19 years	1,345	5	1,283	9	95.4
	19 - 64 years	3,465	6	3,113	14	89.8
	65 years and over	794	2	787	3	99.2
Connecticut	All persons	3,524	1	3,337	11	94.7
	Under 65 years	2,932	2	2,749	11	93.8
	Under 19 years	789	3	769	5	97.4
	19 - 64 years	2,143	4	1,980	11	92.4
	65 years and over	592	2	588	2	99.4
Delaware	All persons	952	1	898	6	94.3
	Under 65 years	775	1	722	6	93.2
	Under 19 years	215	2	207	3	96.4

	19 - 64 years	560	2	515	5	91.9
	65 years and over	177	1	176	1	99.5
District of Columbia	All persons	693	1	671	3	96.8
	Under 65 years	609	1	588	3	96.5
	Under 19 years	137	2	135	2	98.2
	19 - 64 years	472	2	453	3	96.0
	65 years and over	83	1	83	1	99.5
Florida	All persons	20,996	3	18,268	41	87.0
	Under 65 years	16,705	6	14,027	40	84.0
	Under 19 years	4,488	9	4,149	16	92.4
	19 - 64 years	12,216	11	9,878	34	80.9
	65 years and over	4,291	5	4,241	7	98.8
Georgia	All persons	10,335	3	8,924	29	86.3
	Under 65 years	8,909	6	7,510	28	84.3
	Under 19 years	2,671	8	2,453	13	91.9
	19 - 64 years	6,239	10	5,057	25	81.1
	65 years and over	1,426	5	1,413	6	99.1
Hawaii	All persons	1,369	3	1,313	6	95.9
	Under 65 years	1,111	3	1,057	5	95.1
	Under 19 years	319	2	311	3	97.4
	19 - 64 years	792	3	746	5	94.1
	65 years and over	257	1	256	1	99.6
Idaho	All persons	1,733	1	1,541	11	88.9
	Under 65 years	1,459	2	1,267	11	86.8
	Under 19 years	471	3	442	6	93.9
	19 - 64 years	988	3	825	10	83.5
	65 years and over	275	2	274	2	99.7
Illinois	All persons	12,564	2	11,689	22	93.0
	Under 65 years	10,638	4	9,781	22	91.9
	Under 19 years	3,028	6	2,925	10	96.6
	19 - 64 years	7,611	7	6,856	20	90.1
	65 years and over	1,926	4	1,908	5	99.1
Indiana	All persons	6,593	1	6,047	19	91.7
	Under 65 years	5,577	3	5,038	19	90.3
	Under 19 years	1,660	6	1,551	9	93.4
	19 - 64 years	3,916	6	3,487	16	89.0
	65 years and over	1,016	3	1,009	3	99.4
Iowa	All persons	3,113	1	2,966	9	95.3
	Under 65 years	2,597	2	2,451	8	94.4
	Under 19 years	781	4	760	5	97.3
	19 - 64 years	1,817	4	1,692	8	93.1
	65 years and over	516	2	515	2	99.8
Kansas	All persons	2,855	2	2,604	10	91.2
	Under 65 years	2,411	3	2,163	10	89.7
	Under 19 years	747	3	709	5	94.9
	19 - 64 years	1,664	4	1,454	9	87.4
	65 years and over	444	3	442	3	99.5
Kentucky	All persons	4,388	1	4,141	11	94.4
	Under 65 years	3,679	3	3,433	12	93.3
	Under 19 years	1,066	4	1,026	7	96.2
	19 - 64 years	2,613	4	2,407	11	92.1
	65 years and over	710	2	707	3	99.7

Louisiana	All persons	4,556	2	4,193	13	92.0
	Under 65 years	3,857	4	3,498	14	90.7
	Under 19 years	1,160	4	1,121	6	96.6
	19 - 64 years	2,697	6	2,377	13	88.1
	65 years and over	699	3	694	4	99.4
Maine	All persons	1,323	1	1,217	6	92.0
	Under 65 years	1,056	1	950	6	90.0
	Under 19 years	264	2	250	3	94.5
	19 - 64 years	792	2	700	6	88.5
	65 years and over	268	1	267	1	99.9
Maryland	All persons	5,943	3	5,586	15	94.0
	Under 65 years	5,035	3	4,686	15	93.1
	Under 19 years	1,420	4	1,373	8	96.7
	19 - 64 years	3,615	6	3,313	12	91.6
	65 years and over	908	2	900	3	99.1
Massachusetts	All persons	6,831	1	6,642	11	97.2
	Under 65 years	5,727	2	5,542	11	96.8
	Under 19 years	1,471	5	1,453	6	98.8
	19 - 64 years	4,257	6	4,090	10	96.1
	65 years and over	1,103	2	1,100	2	99.7
Michigan	All persons	9,889	1	9,354	14	94.6
	Under 65 years	8,208	3	7,679	14	93.6
	Under 19 years	2,295	5	2,217	7	96.6
	19 - 64 years	5,913	6	5,461	11	92.4
	65 years and over	1,681	3	1,675	3	99.7
Minnesota	All persons	5,554	1	5,309	9	95.6
	Under 65 years	4,695	2	4,454	10	94.9
	Under 19 years	1,376	4	1,331	5	96.7
	19 - 64 years	3,319	4	3,123	9	94.1
	65 years and over	858	2	856	2	99.7
Mississippi	All persons	2,920	1	2,566	12	87.9
	Under 65 years	2,459	3	2,106	11	85.6
	Under 19 years	756	5	721	6	95.3
	19 - 64 years	1,703	6	1,385	11	81.4
	65 years and over	461	3	460	3	99.7
Missouri	All persons	6,015	1	5,448	17	90.6
	Under 65 years	5,017	4	4,455	17	88.8
	Under 19 years	1,453	5	1,371	8	94.3
	19 - 64 years	3,564	5	3,085	14	86.6
	65 years and over	998	4	993	4	99.5
Montana	All persons	1,047	1	961	5	91.8
	Under 65 years	852	2	766	6	90.0
	Under 19 years	244	3	229	3	93.9
	19 - 64 years	608	3	537	6	88.4
	65 years and over	195	1	195	1	99.6
Nebraska	All persons	1,900	1	1,743	8	91.7
	Under 65 years	1,608	2	1,451	8	90.3
	Under 19 years	501	3	475	4	94.8
	19 - 64 years	1,107	3	976	7	88.2
	65 years and over	292	2	291	2	99.7
	All persons	2,999	2	2,662	13	88.8
	Under 65 years	2,528	2	2,198	13	87.0

Nevada	Under 19 years	722	3	664	7	92.0
	19 - 64 years	1,806	4	1,534	10	84.9
	65 years and over	471	1	464	2	98.6
New Hampshire	All persons	1,340	1	1,263	5	94.3
	Under 65 years	1,103	1	1,026	5	93.1
	Under 19 years	280	2	273	3	97.4
	19 - 64 years	823	3	754	5	91.6
	65 years and over	237	1	236	1	99.7
New Jersey	All persons	8,804	2	8,149	21	92.6
	Under 65 years	7,403	3	6,762	21	91.3
	Under 19 years	2,059	4	1,979	8	96.1
	19 - 64 years	5,344	5	4,783	19	89.5
	65 years and over	1,401	2	1,387	3	99.0
New Mexico	All persons	2,061	2	1,864	12	90.5
	Under 65 years	1,697	3	1,505	12	88.6
	Under 19 years	511	3	484	5	94.7
	19 - 64 years	1,187	5	1,021	11	86.0
	65 years and over	363	2	360	2	99.1
New York	All persons	19,303	3	18,261	24	94.6
	Under 65 years	16,186	4	15,168	24	93.7
	Under 19 years	4,306	7	4,199	9	97.5
	19 - 64 years	11,879	8	10,969	23	92.3
	65 years and over	3,117	3	3,094	5	99.3
North Carolina	All persons	10,184	4	9,092	25	89.3
	Under 65 years	8,535	6	7,452	26	87.3
	Under 19 years	2,446	7	2,316	11	94.7
	19 - 64 years	6,088	9	5,135	24	84.3
	65 years and over	1,649	4	1,640	4	99.5
North Dakota	All persons	744	1	690	4	92.7
	Under 65 years	634	1	580	4	91.6
	Under 19 years	186	2	175	3	94.0
	19 - 64 years	448	2	405	4	90.6
	65 years and over	110	1	110	1	99.6
Ohio	All persons	11,517	1	10,773	21	93.5
	Under 65 years	9,588	4	8,854	20	92.3
	Under 19 years	2,748	6	2,616	9	95.2
	19 - 64 years	6,840	7	6,238	17	91.2
	65 years and over	1,929	4	1,920	4	99.5
Oklahoma	All persons	3,862	2	3,313	13	85.8
	Under 65 years	3,261	2	2,717	13	83.3
	Under 19 years	1,011	3	928	5	91.8
	19 - 64 years	2,249	4	1,789	11	79.5
	65 years and over	601	2	597	2	99.3
Oregon	All persons	4,151	1	3,858	13	92.9
	Under 65 years	3,423	3	3,134	13	91.6
	Under 19 years	924	3	891	5	96.4
	19 - 64 years	2,498	4	2,242	12	89.8
	65 years and over	728	3	724	3	99.4
Pennsylvania	All persons	12,604	1	11,905	16	94.5
	Under 65 years	10,350	3	9,659	16	93.3
	Under 19 years	2,821	5	2,697	9	95.6
	19 - 64 years	7,529	7	6,962	13	92.5

	65 years and over	2,254	3	2,246	3	99.6
Rhode Island	All persons	1,041	1	999	5	95.9
	Under 65 years	866	2	824	5	95.2
	Under 19 years	219	2	215	2	97.8
	19 - 64 years	647	2	610	5	94.3
	65 years and over	175	1	175	1	99.6
South Carolina	All persons	4,990	2	4,468	18	89.5
	Under 65 years	4,109	3	3,588	18	87.3
	Under 19 years	1,177	4	1,122	7	95.3
	19 - 64 years	2,931	6	2,467	15	84.2
	65 years and over	882	2	879	3	99.7
South Dakota	All persons	865	1	780	5	90.2
	Under 65 years	725	1	641	6	88.4
	Under 19 years	225	3	212	4	94.1
	19 - 64 years	500	3	429	5	85.8
	65 years and over	140	1	139	1	99.6
Tennessee	All persons	6,668	2	5,993	21	89.9
	Under 65 years	5,591	4	4,921	21	88.0
	Under 19 years	1,599	6	1,516	8	94.8
	19 - 64 years	3,992	7	3,405	19	85.3
	65 years and over	1,077	4	1,072	4	99.6
Texas	All persons	28,243	4	23,240	60	82.3
	Under 65 years	24,729	7	19,794	59	80.0
	Under 19 years	7,825	9	6,953	25	88.8
	19 - 64 years	16,903	11	12,841	48	76.0
	65 years and over	3,515	6	3,447	9	98.1
Utah	All persons	3,136	1	2,840	17	90.6
	Under 65 years	2,789	2	2,497	16	89.5
	Under 19 years	983	3	911	8	92.6
	19 - 64 years	1,806	4	1,586	11	87.8
	65 years and over	347	2	343	2	99.0
Vermont	All persons	620	Z	595	3	96.0
	Under 65 years	500	1	475	3	95.1
	Under 19 years	125	2	122	2	98.0
	19 - 64 years	375	2	353	3	94.2
	65 years and over	121	1	120	1	99.5
Virginia	All persons	8,301	5	7,570	20	91.2
	Under 65 years	7,009	5	6,291	20	89.8
	Under 19 years	1,993	7	1,891	8	94.9
	19 - 64 years	5,016	8	4,400	18	87.7
	65 years and over	1,292	4	1,278	4	98.9
Washington	All persons	7,428	3	6,950	16	93.6
	Under 65 years	6,284	4	5,813	15	92.5
	Under 19 years	1,755	4	1,708	7	97.3
	19 - 64 years	4,529	6	4,105	13	90.6
	65 years and over	1,144	3	1,138	3	99.5
West Virginia	All persons	1,777	Z	1,663	8	93.6
	Under 65 years	1,425	2	1,312	8	92.1
	Under 19 years	388	3	375	4	96.6
	19 - 64 years	1,037	4	937	7	90.4
	65 years and over	352	2	351	2	99.6
	All persons	5,741	1	5,428	11	94.5

Wisconsin	Under 65 years	4,779	3	4,469	11	93.5
	Under 19 years	1,350	4	1,299	5	96.2
	19 - 64 years	3,429	4	3,170	11	92.4
	65 years and over	961	3	959	3	99.7
Wyoming	All persons	567	1	508	5	89.5
	Under 65 years	473	2	414	5	87.5
	Under 19 years	142	2	132	3	92.9
	19 - 64 years	331	3	282	5	85.2
	65 years and over	94	2	94	2	99.8

Z - indicates that the value either represents or rounds to zero
Source: U.S. Census Bureau, 2018 American Community Survey. (Numbers in thousands. Margins of Error calculated using replic

e: 2018

surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2018.pdf>.

Margin of Error	Number	Margin of Error	Percent	Margin of Error	Co		
					Employment-based		
					Number	Margin of Error	Percent
0.1	217,623	404	67.5	0.1	177,740	354	55.2
0.1	187,436	354	69.1	0.1	161,423	314	59.5
0.1	46,654	140	60.0	0.2	40,648	120	52.2
0.1	140,783	243	72.8	0.1	120,775	227	62.5
Z	30,186	82	59.0	0.1	16,317	76	31.9
0.3	3,202	26	66.6	0.5	2,578	30	53.6
0.4	2,705	23	67.7	0.6	2,314	27	57.9
0.5	649	14	55.8	1.2	567	15	48.8
0.4	2,055	17	72.5	0.5	1,747	19	61.6
0.1	497	9	61.2	1.1	264	9	32.5
0.9	460	10	64.5	1.4	381	11	53.5
1.0	408	9	65.1	1.5	341	11	54.5
1.3	118	4	61.5	2.3	94	5	49.0
1.2	290	6	66.7	1.5	247	7	56.9
0.3	52	2	60.4	2.3	40	3	46.0
0.3	4,421	36	62.6	0.5	3,560	37	50.4
0.4	3,739	34	64.3	0.6	3,235	36	55.6
0.5	987	16	56.6	1.0	864	18	49.5
0.4	2,751	22	67.6	0.5	2,370	23	58.2
0.1	683	10	54.7	0.8	325	8	26.1
0.3	1,787	20	60.4	0.7	1,399	22	47.2
0.4	1,508	19	61.1	0.8	1,280	21	51.8
0.6	346	10	46.4	1.3	300	9	40.2
0.5	1,162	14	67.4	0.7	980	15	56.9
0.2	279	6	56.9	1.1	119	5	24.2
0.1	24,897	81	63.7	0.2	20,423	88	52.3
0.1	22,104	78	66.0	0.2	18,711	83	55.9
0.1	5,461	38	57.4	0.4	4,692	39	49.3
0.1	16,642	53	69.4	0.2	14,020	55	58.5
0.1	2,794	20	50.1	0.4	1,712	19	30.7
0.3	3,964	26	70.7	0.5	3,186	27	56.9
0.4	3,498	26	72.7	0.5	2,956	28	61.4
0.5	871	15	64.8	1.1	740	15	55.0
0.4	2,627	17	75.8	0.5	2,216	18	63.9
0.2	466	8	58.7	1.0	231	7	29.1
0.3	2,502	22	71.0	0.6	2,125	23	60.3
0.4	2,138	20	72.9	0.7	1,906	21	65.0
0.5	518	9	65.7	1.1	475	9	60.2
0.4	1,620	15	75.6	0.7	1,431	16	66.8
0.2	364	7	61.5	1.3	220	6	37.1
0.7	673	11	70.6	1.1	568	11	59.7
0.8	550	10	70.9	1.3	490	11	63.2
1.0	133	5	62.0	2.2	120	5	55.6

0.9	417	8	74.4	1.4	370	9	66.1
0.3	123	3	69.3	1.9	78	4	44.1
0.5	488	9	70.4	1.3	411	9	59.3
0.5	435	9	71.4	1.5	370	9	60.8
1.0	75	5	54.6	3.8	62	6	45.1
0.5	360	6	76.3	1.2	308	6	65.4
0.5	53	2	63.1	2.8	41	2	48.7
0.2	13,070	62	62.3	0.3	9,548	65	45.5
0.2	10,926	54	65.4	0.3	8,497	61	50.9
0.3	2,408	31	53.6	0.7	1,913	32	42.6
0.3	8,518	38	69.7	0.3	6,583	44	53.9
0.1	2,145	21	50.0	0.5	1,052	19	24.5
0.3	6,796	41	65.8	0.4	5,575	40	53.9
0.3	5,981	38	67.1	0.4	5,119	40	57.5
0.5	1,494	21	56.0	0.8	1,288	21	48.2
0.4	4,487	29	71.9	0.4	3,831	29	61.4
0.2	814	13	57.1	0.9	457	12	32.0
0.4	1,045	11	76.3	0.8	861	14	62.9
0.5	864	9	77.8	0.9	730	13	65.7
0.7	221	6	69.3	1.9	174	8	54.5
0.5	644	6	81.2	0.8	556	9	70.1
0.1	180	4	70.1	1.6	131	4	51.1
0.6	1,208	16	69.7	0.9	905	18	52.2
0.8	1,034	15	70.9	1.1	840	18	57.6
1.0	292	8	61.9	1.7	243	10	51.5
0.9	742	11	75.1	1.1	598	12	60.5
0.1	174	5	63.5	1.6	65	3	23.6
0.2	8,817	37	70.2	0.3	7,455	36	59.3
0.2	7,657	33	72.0	0.3	6,840	32	64.3
0.2	1,907	19	63.0	0.6	1,750	19	57.8
0.2	5,750	24	75.6	0.3	5,090	23	66.9
0.1	1,160	12	60.3	0.6	615	11	32.0
0.3	4,629	37	70.2	0.6	3,908	35	59.3
0.3	4,008	34	71.9	0.6	3,605	33	64.6
0.4	1,048	18	63.1	1.0	962	17	57.9
0.4	2,960	22	75.6	0.6	2,643	23	67.5
0.2	621	9	61.1	0.8	303	8	29.9
0.3	2,328	17	74.8	0.5	1,877	17	60.3
0.3	1,971	16	75.9	0.6	1,746	17	67.2
0.4	525	9	67.3	1.2	469	10	60.0
0.4	1,446	11	79.6	0.6	1,277	11	70.3
0.1	357	4	69.2	0.8	130	5	25.3
0.4	2,121	17	74.3	0.6	1,689	20	59.2
0.4	1,832	16	76.0	0.7	1,583	19	65.7
0.6	510	9	68.3	1.2	444	10	59.5
0.5	1,322	11	79.4	0.6	1,139	12	68.4
0.2	289	5	65.1	1.2	106	5	23.8
0.3	2,818	25	64.2	0.6	2,338	25	53.3
0.3	2,386	24	64.9	0.6	2,104	24	57.2
0.5	591	13	55.4	1.2	525	13	49.2
0.4	1,795	16	68.7	0.6	1,579	16	60.4
0.1	432	8	60.8	1.1	234	7	32.9

0.3	2,694	28	59.1	0.6	2,201	28	48.3
0.4	2,318	27	60.1	0.7	1,982	28	51.4
0.4	557	13	48.0	1.2	483	13	41.6
0.4	1,761	18	65.3	0.7	1,499	20	55.6
0.2	376	7	53.8	1.0	219	7	31.4
0.5	927	11	70.1	0.9	732	13	55.3
0.6	767	10	72.7	0.9	654	11	62.0
0.8	176	5	66.7	1.8	156	5	59.2
0.8	591	8	74.7	0.9	498	9	62.9
0.1	160	5	59.8	1.7	78	4	29.0
0.2	4,398	27	74.0	0.5	3,742	29	63.0
0.3	3,748	28	74.4	0.6	3,287	30	65.3
0.4	930	15	65.5	1.0	820	15	57.8
0.3	2,818	18	77.9	0.5	2,467	21	68.2
0.2	649	7	71.5	0.8	455	9	50.1
0.2	5,053	29	74.0	0.4	4,290	31	62.8
0.2	4,331	28	75.6	0.5	3,847	30	67.2
0.2	1,028	13	69.9	0.9	939	14	63.8
0.2	3,303	19	77.6	0.4	2,908	20	68.3
0.1	722	8	65.4	0.8	443	9	40.2
0.1	7,028	31	71.1	0.3	5,979	33	60.5
0.2	5,822	29	70.9	0.3	5,197	30	63.3
0.3	1,453	15	63.3	0.6	1,334	15	58.1
0.2	4,369	20	73.9	0.3	3,863	21	65.3
0.1	1,206	10	71.7	0.6	783	11	46.6
0.2	4,227	22	76.1	0.4	3,460	21	62.3
0.2	3,618	20	77.1	0.4	3,243	20	69.1
0.3	968	10	70.3	0.8	888	10	64.5
0.2	2,650	14	79.8	0.4	2,355	15	71.0
0.1	610	6	71.0	0.7	217	6	25.3
0.4	1,766	21	60.5	0.7	1,398	21	47.9
0.5	1,518	18	61.8	0.8	1,298	20	52.8
0.5	369	10	48.8	1.3	314	10	41.5
0.7	1,150	13	67.5	0.8	984	13	57.8
0.1	248	6	53.8	1.3	100	5	21.8
0.3	4,228	26	70.3	0.4	3,452	30	57.4
0.3	3,649	26	72.7	0.5	3,182	30	63.4
0.5	933	17	64.2	1.1	828	16	57.0
0.4	2,716	16	76.2	0.4	2,354	18	66.0
0.1	579	7	58.0	0.7	270	7	27.0
0.5	697	11	66.6	1.1	510	12	48.7
0.6	575	11	67.6	1.2	466	12	54.7
0.9	136	5	55.5	2.2	112	6	46.1
0.8	440	7	72.4	1.1	353	8	58.1
0.2	122	4	62.2	1.9	44	3	22.4
0.4	1,427	13	75.1	0.7	1,129	14	59.4
0.5	1,245	13	77.5	0.8	1,064	13	66.2
0.6	349	6	69.6	1.2	304	7	60.6
0.6	897	9	81.0	0.8	760	9	68.6
0.2	181	3	62.1	1.1	65	3	22.3
0.4	1,947	22	64.9	0.7	1,604	22	53.5
0.5	1,704	21	67.4	0.8	1,475	22	58.4

0.9	432	10	59.9	1.4	375	10	51.9
0.6	1,271	14	70.4	0.8	1,100	16	60.9
0.3	243	6	51.7	1.3	129	4	27.3
0.4	1,015	11	75.8	0.8	852	12	63.6
0.4	858	10	77.8	0.9	772	12	70.0
0.6	200	6	71.4	2.0	185	5	66.0
0.5	658	7	79.9	0.8	588	9	71.4
0.2	158	4	66.6	1.7	80	4	33.6
0.2	6,410	31	72.8	0.3	5,522	33	62.7
0.3	5,546	31	74.9	0.4	4,966	33	67.1
0.3	1,410	13	68.5	0.7	1,264	14	61.4
0.3	4,136	23	77.4	0.4	3,702	24	69.3
0.2	865	9	61.7	0.7	555	9	39.6
0.6	1,119	20	54.3	0.9	901	19	43.7
0.7	925	20	54.5	1.2	790	19	46.5
0.7	222	10	43.6	1.9	194	9	37.9
0.8	703	13	59.2	1.1	596	13	50.3
0.3	194	5	53.4	1.3	111	5	30.5
0.1	12,976	49	67.2	0.3	10,895	50	56.4
0.1	11,171	44	69.0	0.3	9,659	42	59.7
0.2	2,654	22	61.6	0.5	2,236	20	51.9
0.2	8,516	32	71.7	0.3	7,423	31	62.5
0.1	1,805	15	57.9	0.5	1,236	15	39.7
0.2	6,855	39	67.3	0.4	5,363	39	52.7
0.3	5,848	38	68.5	0.4	4,852	38	56.9
0.4	1,372	20	56.1	0.8	1,131	20	46.2
0.3	4,476	26	73.5	0.4	3,721	27	61.1
0.1	1,007	11	61.1	0.6	510	9	30.9
0.6	593	8	79.7	1.1	461	9	61.9
0.7	514	8	81.2	1.2	433	8	68.4
1.0	145	4	77.9	2.1	125	5	67.4
0.7	369	5	82.5	1.1	308	6	68.7
0.3	79	2	71.7	1.7	28	3	25.1
0.2	7,905	35	68.6	0.3	6,754	36	58.6
0.2	6,732	33	70.2	0.3	6,085	33	63.5
0.3	1,716	17	62.4	0.7	1,577	17	57.4
0.2	5,016	26	73.3	0.4	4,508	26	65.9
0.1	1,173	11	60.8	0.6	669	12	34.7
0.3	2,475	19	64.1	0.5	1,963	20	50.8
0.4	2,100	18	64.4	0.5	1,784	19	54.7
0.4	544	8	53.7	0.8	466	9	46.0
0.5	1,556	13	69.2	0.6	1,319	13	58.6
0.2	376	6	62.5	0.9	179	5	29.7
0.3	2,811	23	67.7	0.6	2,231	22	53.8
0.4	2,362	23	69.0	0.7	2,034	22	59.4
0.5	559	11	60.5	1.2	495	12	53.5
0.4	1,803	16	72.2	0.6	1,539	16	61.6
0.2	449	8	61.6	1.1	197	7	27.1
0.1	9,120	34	72.4	0.3	7,488	36	59.4
0.2	7,615	32	73.6	0.3	6,750	34	65.2
0.3	1,810	17	64.2	0.6	1,637	17	58.0
0.2	5,806	22	77.1	0.3	5,113	24	67.9

0.1	1,504	11	66.7	0.5	739	11	32.8
0.5	729	11	70.0	1.0	599	11	57.5
0.6	627	10	72.5	1.1	550	11	63.6
0.8	140	5	63.9	2.3	123	5	56.1
0.7	487	8	75.4	1.1	428	8	66.1
0.3	101	4	57.8	2.4	48	3	27.5
0.4	3,288	30	65.9	0.6	2,587	29	51.8
0.4	2,747	26	66.9	0.6	2,311	27	56.2
0.6	653	14	55.4	1.2	555	14	47.2
0.5	2,094	19	71.4	0.6	1,755	20	59.9
0.1	541	10	61.4	1.1	276	7	31.3
0.6	623	8	72.0	1.0	474	9	54.8
0.7	540	8	74.6	1.1	447	9	61.7
0.9	151	5	67.2	1.8	128	5	57.0
0.9	389	6	77.9	1.1	319	7	63.8
0.3	82	3	58.8	1.9	27	2	19.4
0.3	4,384	35	65.8	0.5	3,499	34	52.5
0.4	3,751	32	67.1	0.6	3,205	33	57.3
0.4	908	15	56.8	1.0	780	16	48.8
0.4	2,843	23	71.2	0.6	2,425	23	60.7
0.1	633	10	58.8	0.9	295	8	27.4
0.2	17,467	82	61.8	0.3	14,413	80	51.0
0.2	15,603	79	63.1	0.3	13,375	77	54.1
0.3	4,098	39	52.4	0.5	3,533	38	45.1
0.3	11,504	54	68.1	0.3	9,843	54	58.2
0.2	1,864	20	53.0	0.5	1,037	18	29.5
0.5	2,463	21	78.5	0.7	2,025	23	64.6
0.6	2,244	20	80.5	0.7	1,909	23	68.4
0.7	764	12	77.7	1.2	658	13	66.9
0.6	1,480	12	82.0	0.7	1,251	13	69.3
0.3	219	4	63.1	1.2	116	5	33.5
0.5	433	8	69.9	1.3	349	8	56.2
0.5	357	7	71.5	1.4	311	8	62.3
0.9	77	4	62.0	3.1	69	3	55.2
0.7	280	5	74.7	1.2	242	5	64.7
0.6	76	3	63.0	2.1	37	2	30.9
0.3	6,258	35	75.4	0.4	4,957	32	59.7
0.3	5,386	32	76.8	0.5	4,479	31	63.9
0.3	1,394	15	70.0	0.8	1,151	14	57.8
0.3	3,991	23	79.6	0.4	3,328	23	66.3
0.2	873	9	67.5	0.7	479	10	37.0
0.2	5,243	33	70.6	0.5	4,278	36	57.6
0.2	4,517	32	71.9	0.5	3,916	34	62.3
0.3	1,091	17	62.2	1.0	945	17	53.9
0.3	3,426	22	75.7	0.5	2,971	23	65.6
0.1	726	8	63.4	0.7	362	9	31.6
0.4	1,116	19	62.8	1.1	949	20	53.4
0.6	895	17	62.8	1.2	808	18	56.7
0.8	211	8	54.4	2.1	192	8	49.4
0.6	684	12	66.0	1.1	616	12	59.4
0.2	221	6	62.7	1.5	141	5	39.9
0.2	4,295	21	74.8	0.4	3,557	21	62.0

0.2	3,692	19	77.2	0.4	3,308	20	69.2
0.3	940	11	69.7	0.7	873	10	64.7
0.3	2,751	14	80.2	0.4	2,435	15	71.0
0.1	603	7	62.8	0.7	249	6	25.9
0.9	424	7	74.9	1.3	342	8	60.2
1.0	365	7	77.3	1.4	318	8	67.2
1.5	106	4	75.0	2.3	96	5	67.3
1.2	259	5	78.3	1.5	222	6	67.2
0.3	59	3	62.7	2.7	24	2	25.2

ate weights. Civilian noninstitutionalized population.)

vered by private health insurance

	Direct Purchase				TRICARE		
Margin of Error	Number	Margin of Error	Percent	Margin of Error	Number	Margin of Error	Percent
0.1	43,191	184	13.4	0.1	8,767	79	2.7
0.1	27,131	147	10.0	0.1	5,817	66	2.1
0.2	5,475	59	7.0	0.1	1,906	32	2.4
0.1	21,656	105	11.2	0.1	3,911	46	2.0
0.1	16,060	65	31.4	0.1	2,950	34	5.8
0.6	642	15	13.4	0.3	219	12	4.6
0.7	387	13	9.7	0.3	132	10	3.3
1.2	67	6	5.8	0.5	39	5	3.4
0.6	320	12	11.3	0.4	93	7	3.3
1.1	255	7	31.4	0.8	86	4	10.7
1.6	53	4	7.4	0.6	70	7	9.8
1.7	41	5	6.6	0.7	60	6	9.6
2.6	9	2	4.8	1.0	23	3	11.9
1.6	32	3	7.3	0.8	37	4	8.6
2.9	12	2	13.5	1.8	10	2	11.2
0.5	905	18	12.8	0.3	233	11	3.3
0.6	521	16	8.9	0.3	138	10	2.4
1.1	117	8	6.7	0.5	39	4	2.2
0.5	403	11	9.9	0.3	99	7	2.4
0.7	384	9	30.8	0.7	95	5	7.6
0.8	401	13	13.5	0.4	99	7	3.3
0.8	231	12	9.3	0.5	57	6	2.3
1.2	37	4	5.0	0.5	19	4	2.5
0.8	194	9	11.2	0.5	38	4	2.2
0.9	170	6	34.7	1.1	42	4	8.6
0.2	4,932	44	12.6	0.1	717	22	1.8
0.2	3,655	40	10.9	0.1	482	19	1.4
0.4	763	20	8.0	0.2	169	10	1.8
0.2	2,892	30	12.1	0.1	313	12	1.3
0.3	1,277	18	22.9	0.3	235	8	4.2
0.5	774	15	13.8	0.3	221	9	4.0
0.6	521	15	10.8	0.3	161	9	3.3
1.1	105	7	7.8	0.5	54	5	4.0
0.5	416	11	12.0	0.3	107	6	3.1
0.9	253	7	31.8	0.9	61	4	7.6
0.6	451	13	12.8	0.4	46	5	1.3
0.7	265	11	9.1	0.4	31	5	1.1
1.1	46	5	5.9	0.6	11	2	1.4
0.7	219	9	10.2	0.4	20	3	0.9
1.0	185	7	31.3	1.2	15	2	2.6
1.1	126	7	13.2	0.7	27	4	2.8
1.4	65	6	8.4	0.8	17	3	2.2
2.3	14	3	6.5	1.2	5	1	2.1

1.5	51	5	9.1	0.8	12	2	2.2
2.1	61	3	34.4	2.0	10	2	5.6
1.3	92	6	13.3	0.8	13	2	1.8
1.4	75	6	12.2	0.9	9	2	1.5
3.9	13	2	9.7	1.8	3	1	2.4
1.2	61	4	13.0	0.9	6	2	1.3
2.7	18	2	21.0	2.3	4	1	4.2
0.3	3,570	40	17.0	0.2	725	23	3.5
0.4	2,392	36	14.3	0.2	427	18	2.6
0.7	440	17	9.8	0.4	119	8	2.7
0.4	1,952	27	16.0	0.2	308	13	2.5
0.4	1,179	18	27.5	0.4	298	13	6.9
0.4	1,229	25	11.9	0.2	407	17	3.9
0.5	827	23	9.3	0.3	293	15	3.3
0.8	156	10	5.8	0.4	98	8	3.7
0.5	671	18	10.8	0.3	195	10	3.1
0.9	403	10	28.2	0.7	114	6	8.0
1.0	167	7	12.2	0.5	125	7	9.2
1.1	102	6	9.2	0.6	102	7	9.2
2.3	21	3	6.6	0.9	43	5	13.6
1.1	81	5	10.2	0.6	59	4	7.4
1.5	66	4	25.5	1.4	23	2	8.9
1.0	309	12	17.8	0.7	64	6	3.7
1.2	191	11	13.1	0.8	42	6	2.9
2.1	41	5	8.7	1.0	14	3	3.0
1.2	150	8	15.1	0.9	27	3	2.8
1.2	118	5	43.0	1.9	23	3	8.3
0.3	1,614	23	12.8	0.2	142	7	1.1
0.3	950	20	8.9	0.2	92	6	0.9
0.6	172	8	5.7	0.3	27	3	0.9
0.3	778	15	10.2	0.2	65	4	0.9
0.6	664	12	34.5	0.6	50	4	2.6
0.5	849	18	12.9	0.3	111	7	1.7
0.6	471	15	8.4	0.3	71	6	1.3
1.0	95	7	5.7	0.4	20	3	1.2
0.6	376	11	9.6	0.3	51	4	1.3
0.7	377	8	37.2	0.8	40	4	4.0
0.5	524	12	16.8	0.4	57	5	1.8
0.6	266	10	10.2	0.4	34	4	1.3
1.2	60	5	7.7	0.6	11	2	1.4
0.6	206	7	11.3	0.4	23	3	1.3
0.9	259	4	50.2	0.8	23	2	4.4
0.7	452	12	15.8	0.4	113	8	4.0
0.8	255	11	10.6	0.4	82	7	3.4
1.4	56	5	7.5	0.7	29	4	3.9
0.7	199	7	11.9	0.4	53	4	3.2
1.0	197	5	44.4	1.1	31	3	6.9
0.6	519	14	11.8	0.3	127	8	2.9
0.7	280	12	7.6	0.3	86	7	2.3
1.2	54	6	5.0	0.5	27	4	2.5
0.6	227	8	8.7	0.3	59	5	2.3
0.9	239	8	33.6	1.1	41	3	5.7

0.6	533	17	11.7	0.4	131	10	2.9
0.7	347	15	9.0	0.4	90	8	2.3
1.1	65	6	5.6	0.5	30	4	2.6
0.7	282	11	10.4	0.4	60	5	2.2
1.0	186	7	26.7	1.1	41	4	5.9
0.9	203	8	15.3	0.6	42	4	3.2
1.0	114	7	10.8	0.6	22	3	2.1
1.9	19	3	7.2	1.0	4	1	1.6
1.1	95	5	12.0	0.7	18	2	2.2
1.7	89	5	33.2	1.7	20	2	7.6
0.5	739	16	12.4	0.3	225	12	3.8
0.6	470	14	9.3	0.3	163	11	3.2
1.1	89	7	6.3	0.5	54	6	3.8
0.5	380	11	10.5	0.3	109	7	3.0
1.0	270	8	29.7	0.9	62	4	6.8
0.5	946	19	13.9	0.3	74	7	1.1
0.5	580	16	10.1	0.3	41	5	0.7
0.9	100	6	6.8	0.4	11	3	0.7
0.5	480	13	11.3	0.3	30	3	0.7
0.9	366	9	33.2	0.8	33	4	3.0
0.3	1,287	19	13.0	0.2	128	8	1.3
0.4	719	16	8.8	0.2	76	7	0.9
0.6	125	7	5.5	0.3	25	3	1.1
0.4	594	12	10.0	0.2	51	4	0.9
0.6	567	9	33.7	0.5	53	3	3.1
0.4	876	14	15.8	0.2	78	6	1.4
0.4	435	11	9.3	0.2	47	5	1.0
0.8	84	5	6.1	0.4	15	2	1.1
0.4	350	9	10.6	0.3	32	3	1.0
0.7	441	7	51.4	0.8	31	3	3.6
0.7	370	12	12.7	0.4	109	8	3.7
0.8	220	11	9.0	0.4	66	6	2.7
1.3	48	4	6.4	0.6	20	3	2.6
0.8	172	8	10.1	0.5	47	5	2.7
1.1	149	5	32.4	1.1	43	3	9.2
0.5	825	16	13.7	0.3	159	9	2.6
0.6	486	15	9.7	0.3	102	7	2.0
1.1	99	7	6.8	0.5	29	3	2.0
0.5	386	11	10.8	0.3	73	5	2.0
0.7	339	7	34.0	0.7	57	4	5.8
1.2	186	8	17.8	0.7	42	5	4.0
1.4	104	7	12.3	0.9	28	4	3.3
2.5	17	3	6.8	1.1	10	2	4.3
1.3	88	6	14.4	1.0	18	3	2.9
1.6	82	3	41.8	1.7	13	2	6.9
0.7	314	9	16.5	0.4	69	5	3.6
0.8	189	7	11.8	0.4	48	5	3.0
1.3	39	3	7.7	0.7	17	3	3.5
0.8	151	5	13.6	0.5	31	3	2.8
1.1	125	4	42.7	1.4	21	2	7.0
0.7	339	11	11.3	0.4	106	7	3.5
0.9	223	10	8.8	0.4	67	5	2.7

1.4	51	5	7.1	0.7	20	3	2.7
0.9	172	7	9.5	0.4	48	4	2.6
0.9	116	5	24.6	1.1	39	3	8.2
0.9	180	7	13.4	0.5	33	4	2.5
1.0	90	6	8.1	0.5	18	3	1.6
1.9	15	2	5.5	0.8	3	1	1.2
1.0	74	4	9.0	0.5	15	2	1.8
1.6	90	4	38.2	1.7	15	2	6.5
0.4	1,076	19	12.2	0.2	89	7	1.0
0.4	671	17	9.1	0.2	55	7	0.7
0.7	157	7	7.6	0.4	17	3	0.8
0.4	514	14	9.6	0.3	38	5	0.7
0.6	405	9	28.9	0.6	34	3	2.4
0.9	212	7	10.3	0.4	88	6	4.3
1.1	125	6	7.4	0.4	57	5	3.4
1.8	22	3	4.3	0.6	18	2	3.5
1.1	103	6	8.7	0.5	39	4	3.3
1.3	87	4	23.9	1.1	31	3	8.5
0.3	2,568	34	13.3	0.2	178	11	0.9
0.3	1,804	30	11.1	0.2	116	9	0.7
0.4	464	15	10.8	0.3	39	5	0.9
0.3	1,341	22	11.3	0.2	77	5	0.6
0.5	763	13	24.5	0.4	63	4	2.0
0.4	1,493	22	14.7	0.2	455	13	4.5
0.4	919	21	10.8	0.2	328	12	3.8
0.8	168	8	6.9	0.3	117	6	4.8
0.4	751	16	12.3	0.3	211	8	3.5
0.6	573	10	34.8	0.6	127	6	7.7
1.2	141	7	19.0	0.9	27	3	3.6
1.3	86	6	13.6	0.9	19	2	3.0
2.4	18	3	9.7	1.5	7	1	3.9
1.2	68	4	15.2	0.9	12	2	2.6
2.4	55	3	50.0	2.3	8	1	7.0
0.3	1,378	22	12.0	0.2	181	8	1.6
0.3	738	18	7.7	0.2	111	8	1.2
0.6	141	8	5.1	0.3	36	5	1.3
0.4	597	13	8.7	0.2	76	5	1.1
0.6	640	9	33.2	0.5	70	4	3.6
0.5	520	12	13.5	0.3	151	9	3.9
0.6	310	11	9.5	0.3	97	8	3.0
0.9	63	4	6.2	0.4	33	4	3.3
0.6	247	8	11.0	0.4	64	5	2.8
0.9	210	5	35.0	0.9	54	3	9.0
0.5	646	16	15.6	0.4	88	6	2.1
0.7	362	14	10.6	0.4	50	5	1.4
1.3	69	6	7.4	0.6	13	2	1.4
0.6	293	11	11.7	0.4	37	4	1.5
0.9	284	8	39.0	1.0	38	3	5.3
0.3	1,896	23	15.0	0.2	193	9	1.5
0.3	998	19	9.6	0.2	113	8	1.1
0.6	189	9	6.7	0.3	33	4	1.2
0.3	809	14	10.7	0.2	79	5	1.1

0.5	899	12	39.9	0.5	80	4	3.6
1.1	148	7	14.2	0.7	24	3	2.3
1.2	86	6	9.9	0.7	14	3	1.6
2.3	17	2	7.9	1.1	4	1	1.6
1.2	69	5	10.6	0.8	10	2	1.6
1.8	62	4	35.4	2.3	10	2	5.6
0.6	707	18	14.2	0.4	239	13	4.8
0.7	417	17	10.1	0.4	144	11	3.5
1.2	77	7	6.5	0.6	45	6	3.8
0.7	340	12	11.6	0.4	99	7	3.4
0.8	291	9	33.0	1.0	95	5	10.8
1.1	151	6	17.5	0.7	35	5	4.1
1.2	95	6	13.1	0.8	25	5	3.5
2.0	20	2	8.8	1.1	9	2	3.9
1.2	75	4	15.0	0.9	17	3	3.3
1.6	56	3	40.4	1.9	10	2	7.1
0.5	907	18	13.6	0.3	240	12	3.6
0.6	535	16	9.6	0.3	161	11	2.9
1.0	102	7	6.4	0.4	54	5	3.4
0.6	434	13	10.9	0.3	107	7	2.7
0.8	372	9	34.6	0.8	79	5	7.3
0.3	3,153	48	11.2	0.2	855	22	3.0
0.3	2,252	44	9.1	0.2	587	22	2.4
0.5	492	18	6.3	0.2	203	14	2.6
0.3	1,760	32	10.4	0.2	384	13	2.3
0.5	901	14	25.6	0.4	268	9	7.6
0.7	465	15	14.8	0.5	80	8	2.5
0.8	349	15	12.5	0.5	54	7	1.9
1.3	102	8	10.4	0.8	21	4	2.2
0.7	247	10	13.7	0.6	33	3	1.8
1.4	116	4	33.4	1.2	25	3	7.3
1.2	92	5	14.9	0.7	15	3	2.4
1.5	47	4	9.5	0.8	8	2	1.6
2.8	7	2	5.5	1.4	3	1	2.1
1.4	40	3	10.8	0.9	6	1	1.5
1.8	45	2	37.3	1.9	7	1	5.5
0.4	1,167	19	14.1	0.2	646	22	7.8
0.4	741	18	10.6	0.3	481	21	6.9
0.7	144	8	7.2	0.4	164	10	8.3
0.4	598	15	11.9	0.3	317	13	6.3
0.8	426	8	33.0	0.6	164	7	12.7
0.5	952	19	12.8	0.3	318	13	4.3
0.5	548	17	8.7	0.3	220	12	3.5
1.0	109	8	6.2	0.5	72	7	4.1
0.5	439	13	9.7	0.3	148	7	3.3
0.8	404	9	35.3	0.8	98	5	8.6
1.1	188	9	10.6	0.5	44	4	2.5
1.2	91	7	6.4	0.5	24	4	1.7
2.1	17	3	4.4	0.8	6	2	1.7
1.1	74	5	7.2	0.5	18	3	1.7
1.3	96	5	27.3	1.3	20	2	5.6
0.4	836	14	14.6	0.2	84	5	1.5

0.4	435	12	9.1	0.2	50	5	1.0
0.7	69	4	5.1	0.3	16	3	1.2
0.4	367	10	10.7	0.3	34	3	1.0
0.6	400	7	41.6	0.7	34	3	3.6
1.4	89	6	15.7	1.1	23	4	4.1
1.7	50	6	10.6	1.2	17	3	3.6
2.9	10	2	6.8	1.7	6	2	4.0
1.7	40	4	12.2	1.2	11	2	3.4
2.4	39	3	41.2	2.7	6	1	6.6

Covered by any health insurance							
Margin of Error	Number	Margin of Error	Percent	Margin of Error	Number	Margin of Error	Percent
Z	114,750	205	35.6	0.1	65,965	234	20.5
Z	65,664	218	24.2	0.1	58,862	221	21.7
Z	30,282	144	38.9	0.2	29,985	141	38.5
Z	35,382	103	18.3	0.1	28,878	108	14.9
0.1	49,087	36	96.0	0.1	7,103	40	13.9
0.2	1,790	19	37.2	0.4	946	19	19.7
0.3	996	19	24.9	0.5	836	18	20.9
0.4	513	14	44.1	1.2	507	14	43.6
0.2	483	12	17.0	0.4	328	10	11.6
0.5	794	4	97.8	0.3	110	5	13.6
0.9	247	8	34.6	1.1	157	8	22.0
1.0	165	8	26.3	1.2	142	8	22.7
1.8	67	4	34.7	2.3	66	5	34.1
1.0	98	5	22.6	1.1	77	5	17.7
2.0	82	2	94.7	1.3	15	2	16.9
0.2	2,776	29	39.3	0.4	1,581	30	22.4
0.2	1,574	29	27.1	0.5	1,420	29	24.4
0.3	687	16	39.3	0.9	679	16	38.9
0.2	887	19	21.8	0.5	741	19	18.2
0.4	1,202	4	96.4	0.3	161	7	12.9
0.3	1,307	17	44.2	0.6	803	16	27.1
0.2	826	16	33.5	0.7	733	15	29.7
0.5	390	10	52.3	1.3	388	10	52.0
0.2	436	11	25.3	0.6	344	10	20.0
0.7	481	4	98.0	0.4	70	4	14.3
0.1	14,995	75	38.4	0.2	10,324	79	26.4
0.1	9,733	73	29.1	0.2	9,171	74	27.4
0.1	4,140	39	43.5	0.4	4,104	39	43.1
Z	5,592	44	23.3	0.2	5,067	45	21.1
0.1	5,262	10	94.4	0.2	1,153	17	20.7
0.2	1,832	24	32.7	0.4	1,045	23	18.6
0.2	1,071	23	22.3	0.5	959	22	19.9
0.4	462	14	34.4	1.0	458	14	34.1
0.2	608	14	17.6	0.4	501	13	14.4
0.5	761	4	95.9	0.4	86	4	10.8
0.2	1,261	20	35.8	0.6	725	19	20.6
0.2	698	19	23.8	0.7	646	19	22.0
0.3	280	9	35.5	1.1	279	9	35.3
0.1	418	14	19.5	0.7	367	14	17.1
0.3	563	3	95.1	0.4	79	4	13.4
0.4	379	9	39.8	1.0	204	9	21.4
0.4	207	9	26.7	1.2	185	9	23.9
0.6	82	5	38.0	2.2	82	5	37.9

0.4	125	7	22.3	1.3	104	7	18.5
0.9	172	1	97.2	0.6	18	2	10.4
0.3	248	9	35.8	1.4	185	10	26.7
0.3	172	9	28.3	1.5	163	9	26.8
1.0	67	5	48.5	3.5	65	5	47.4
0.4	106	6	22.4	1.3	98	6	20.8
1.2	76	2	90.9	2.0	21	2	25.6
0.1	7,790	49	37.1	0.2	3,829	48	18.2
0.1	3,680	47	22.0	0.3	3,179	46	19.0
0.2	1,897	32	42.3	0.7	1,873	31	41.7
0.1	1,783	26	14.6	0.2	1,306	25	10.7
0.3	4,111	10	95.8	0.2	650	16	15.1
0.2	3,220	31	31.2	0.3	1,799	31	17.4
0.2	1,848	30	20.7	0.3	1,587	29	17.8
0.3	1,046	22	39.2	0.8	1,032	22	38.6
0.2	802	17	12.9	0.3	555	15	8.9
0.4	1,371	7	96.2	0.3	212	8	14.9
0.5	482	10	35.2	0.7	242	9	17.7
0.6	239	9	21.5	0.8	211	9	19.0
1.4	103	6	32.4	1.8	103	6	32.2
0.5	135	6	17.1	0.7	108	5	13.7
0.8	244	2	94.8	0.7	31	3	12.0
0.3	563	12	32.5	0.7	287	12	16.5
0.4	294	12	20.2	0.8	255	11	17.5
0.7	171	8	36.4	1.6	170	8	36.0
0.3	123	7	12.4	0.7	85	6	8.6
1.0	269	3	97.9	0.5	32	3	11.6
0.1	4,255	31	33.9	0.2	2,418	29	19.2
0.1	2,419	29	22.7	0.3	2,206	28	20.7
0.1	1,115	19	36.8	0.6	1,107	19	36.5
0.1	1,303	18	17.1	0.2	1,099	16	14.4
0.2	1,836	5	95.4	0.2	212	7	11.0
0.1	2,227	27	33.8	0.4	1,187	25	18.0
0.1	1,240	27	22.2	0.5	1,088	25	19.5
0.2	576	16	34.7	1.0	572	16	34.4
0.1	664	16	17.0	0.4	516	14	13.2
0.3	987	4	97.2	0.3	99	4	9.7
0.1	1,102	15	35.4	0.5	597	15	19.2
0.2	600	15	23.1	0.6	547	14	21.1
0.3	282	9	36.1	1.1	279	9	35.8
0.1	318	10	17.5	0.5	267	9	14.7
0.4	502	3	97.4	0.4	50	3	9.6
0.3	850	14	29.8	0.5	397	14	13.9
0.3	421	14	17.5	0.6	355	13	14.7
0.5	226	8	30.3	1.1	222	9	29.7
0.3	195	8	11.7	0.5	133	7	8.0
0.6	428	3	96.6	0.5	42	3	9.5
0.2	1,909	22	43.5	0.5	1,181	22	26.9
0.2	1,218	22	33.1	0.6	1,081	21	29.4
0.3	479	13	44.9	1.1	476	12	44.6
0.2	739	14	28.3	0.5	605	14	23.2
0.5	691	3	97.4	0.3	100	4	14.1

0.2	2,023	25	44.4	0.6	1,339	25	29.4
0.2	1,353	26	35.1	0.7	1,233	25	32.0
0.3	619	13	53.3	1.0	615	13	53.0
0.2	734	17	27.2	0.6	618	16	22.9
0.6	670	4	95.9	0.4	106	5	15.2
0.3	494	10	37.3	0.7	245	9	18.5
0.3	234	9	22.1	0.9	200	9	18.9
0.4	87	5	32.9	1.8	86	5	32.5
0.3	147	6	18.5	0.8	114	5	14.4
0.8	260	2	97.3	0.4	46	3	17.1
0.2	1,978	26	33.3	0.4	1,115	26	18.8
0.2	1,126	25	22.4	0.5	1,000	25	19.9
0.4	493	15	34.7	1.0	481	15	33.8
0.2	633	16	17.5	0.4	520	15	14.4
0.4	852	4	93.8	0.4	115	5	12.7
0.1	2,499	28	36.6	0.4	1,570	29	23.0
0.1	1,455	28	25.4	0.5	1,384	28	24.2
0.2	507	13	34.5	0.9	505	13	34.3
0.1	948	18	22.3	0.4	879	18	20.6
0.3	1,044	4	94.6	0.4	186	7	16.9
0.1	3,865	28	39.1	0.3	2,226	27	22.5
0.1	2,226	27	27.1	0.3	2,019	27	24.6
0.2	884	15	38.5	0.7	879	15	38.3
0.1	1,342	17	22.7	0.3	1,139	16	19.3
0.2	1,639	3	97.5	0.2	208	6	12.4
0.1	1,843	19	33.2	0.4	999	20	18.0
0.1	1,011	19	21.5	0.4	921	19	19.6
0.2	432	12	31.4	0.8	431	12	31.3
0.1	579	12	17.4	0.4	490	12	14.8
0.3	832	3	96.9	0.3	78	4	9.1
0.3	1,134	16	38.9	0.6	685	16	23.4
0.3	683	17	27.8	0.7	604	15	24.6
0.4	377	10	49.8	1.3	374	11	49.4
0.3	306	10	18.0	0.6	230	9	13.5
0.7	452	3	98.0	0.4	81	4	17.5
0.1	1,964	24	32.7	0.4	912	23	15.2
0.1	993	23	19.8	0.5	820	22	16.3
0.2	498	15	34.2	1.0	489	15	33.6
0.1	495	12	13.9	0.3	331	10	9.3
0.4	971	4	97.3	0.2	92	4	9.2
0.4	421	10	40.2	1.0	223	11	21.3
0.5	230	11	27.0	1.2	204	10	24.0
0.8	105	6	43.1	2.4	105	6	42.9
0.5	125	6	20.6	1.0	100	6	16.4
1.0	191	2	97.7	0.5	18	2	9.4
0.3	548	9	28.8	0.5	257	9	13.5
0.3	265	9	16.5	0.6	227	9	14.1
0.5	145	7	28.9	1.3	144	7	28.6
0.2	120	5	10.9	0.4	83	5	7.5
0.7	283	2	96.8	0.4	30	2	10.3
0.2	1,045	16	34.9	0.5	577	17	19.2
0.2	597	17	23.6	0.7	521	16	20.6

0.5	261	9	36.2	1.3	259	9	35.8
0.2	335	11	18.6	0.6	263	10	14.5
0.7	449	3	95.3	0.6	56	4	11.8
0.3	432	10	32.3	0.7	186	10	13.9
0.3	205	10	18.6	0.9	169	9	15.3
0.4	82	5	29.3	1.9	82	5	29.1
0.3	123	6	14.9	0.7	87	5	10.6
0.8	227	2	95.9	0.7	17	2	7.1
0.1	2,750	29	31.2	0.3	1,477	30	16.8
0.1	1,421	29	19.2	0.4	1,298	29	17.5
0.1	637	17	31.0	0.8	631	17	30.6
0.1	784	16	14.7	0.3	667	16	12.5
0.2	1,328	5	94.8	0.3	179	6	12.8
0.3	1,018	16	49.4	0.8	679	17	32.9
0.3	669	16	39.4	1.0	621	17	36.6
0.5	288	9	56.3	1.8	286	9	55.9
0.3	381	11	32.1	0.9	335	11	28.2
0.8	350	3	96.2	0.5	58	4	16.1
0.1	7,693	39	39.9	0.2	5,054	43	26.2
0.1	4,719	38	29.2	0.2	4,442	40	27.4
0.1	1,796	19	41.7	0.5	1,786	20	41.5
Z	2,923	27	24.6	0.2	2,656	29	22.4
0.1	2,974	8	95.4	0.2	611	12	19.6
0.1	3,537	27	34.7	0.3	1,853	28	18.2
0.1	1,934	27	22.7	0.3	1,652	27	19.4
0.3	1,022	19	41.8	0.8	1,016	20	41.5
0.1	912	17	15.0	0.3	636	16	10.4
0.4	1,603	5	97.2	0.2	202	7	12.2
0.4	197	6	26.5	0.8	84	6	11.3
0.4	90	6	14.2	0.9	74	6	11.7
0.8	38	3	20.7	1.8	38	3	20.5
0.4	51	4	11.5	0.8	36	3	8.1
1.3	107	1	97.0	0.7	10	1	9.2
0.1	4,323	33	37.5	0.3	2,392	33	20.8
0.1	2,459	32	25.6	0.3	2,199	31	22.9
0.2	1,015	18	36.9	0.6	1,008	18	36.7
0.1	1,444	20	21.1	0.3	1,192	19	17.4
0.2	1,864	5	96.6	0.2	193	7	10.0
0.2	1,335	14	34.6	0.4	683	15	17.7
0.2	752	13	23.1	0.4	620	14	19.0
0.4	434	9	42.9	0.9	422	10	41.7
0.2	317	7	14.1	0.3	198	7	8.8
0.5	583	2	97.1	0.3	63	4	10.5
0.1	1,627	21	39.2	0.5	919	21	22.2
0.2	922	21	26.9	0.6	833	20	24.3
0.3	376	12	40.7	1.2	374	12	40.4
0.1	545	13	21.8	0.5	459	12	18.4
0.5	705	4	96.8	0.4	87	5	11.9
0.1	4,709	31	37.4	0.2	2,553	34	20.3
0.1	2,526	32	24.4	0.3	2,282	32	22.0
0.1	1,065	19	37.7	0.7	1,059	20	37.5
0.1	1,461	19	19.4	0.2	1,223	18	16.2

0.2	2,183	5	96.9	0.2	272	7	12.0
0.3	403	10	38.7	1.0	245	11	23.6
0.3	233	10	26.9	1.1	214	10	24.7
0.6	86	5	39.0	2.2	85	5	38.7
0.3	148	7	22.9	1.1	129	7	20.0
1.0	170	2	96.9	0.6	31	3	17.7
0.3	1,888	19	37.8	0.4	983	19	19.7
0.3	1,025	19	25.0	0.5	875	18	21.3
0.5	520	13	44.2	1.1	516	13	43.8
0.3	505	12	17.2	0.4	359	11	12.3
0.6	863	3	97.9	0.3	108	5	12.3
0.6	263	7	30.4	0.8	119	7	13.8
0.6	127	7	17.5	0.9	106	7	14.7
1.0	70	5	30.9	2.1	68	4	30.4
0.6	58	4	11.5	0.8	38	3	7.6
1.2	136	1	97.0	0.7	13	1	9.3
0.2	2,475	28	37.1	0.4	1,373	29	20.6
0.2	1,428	28	25.5	0.5	1,235	28	22.1
0.3	686	18	42.9	1.1	681	18	42.6
0.2	742	15	18.6	0.4	555	14	13.9
0.4	1,047	4	97.3	0.3	138	6	12.8
0.1	8,200	44	29.0	0.2	4,807	48	17.0
0.1	4,884	45	19.8	0.2	4,305	45	17.4
0.2	3,055	37	39.0	0.5	3,020	37	38.6
0.1	1,829	27	10.8	0.2	1,285	24	7.6
0.3	3,316	9	94.4	0.2	502	12	14.3
0.3	667	14	21.3	0.5	325	13	10.4
0.2	338	14	12.1	0.5	293	13	10.5
0.4	179	10	18.2	1.1	175	10	17.8
0.2	159	7	8.8	0.4	118	6	6.5
0.8	328	3	94.7	0.6	33	3	9.4
0.4	252	7	40.6	1.2	141	7	22.8
0.4	136	7	27.2	1.4	125	7	25.0
1.0	50	4	40.1	3.1	50	4	39.8
0.3	86	4	22.9	1.1	75	4	20.1
1.0	116	1	96.4	1.0	16	2	13.4
0.3	2,374	24	28.6	0.3	1,001	22	12.1
0.3	1,141	24	16.3	0.3	888	22	12.7
0.5	553	15	27.8	0.7	539	15	27.1
0.3	588	15	11.7	0.3	349	12	7.0
0.5	1,233	5	95.4	0.3	113	5	8.7
0.2	2,669	30	35.9	0.4	1,546	29	20.8
0.2	1,569	30	25.0	0.5	1,411	28	22.5
0.4	698	17	39.8	0.9	694	17	39.6
0.2	871	19	19.2	0.4	717	17	15.8
0.4	1,100	4	96.2	0.3	135	6	11.8
0.3	837	14	47.1	0.8	469	14	26.4
0.3	491	14	34.5	1.0	424	13	29.8
0.5	185	8	47.7	1.9	183	8	47.2
0.3	306	9	29.5	0.9	241	8	23.2
0.6	346	2	98.3	0.4	46	3	12.9
0.1	1,897	16	33.0	0.3	963	17	16.8

0.1	958	17	20.1	0.4	851	16	17.8
0.2	425	10	31.5	0.8	418	11	31.0
0.1	533	11	15.6	0.3	433	10	12.6
0.3	939	3	97.7	0.2	112	4	11.6
0.6	155	6	27.3	1.0	58	5	10.3
0.7	64	6	13.5	1.2	50	5	10.6
1.2	30	3	21.0	2.3	29	3	20.8
0.6	34	4	10.2	1.1	21	3	6.3
1.4	91	2	96.8	0.9	8	1	8.6

							Covered by public health insuran
Covered by Medicaid							
Margin of Error	Also covered by private insurance				Number	Margin of Error	Percent
	Number	Margin of Error	Percent	Margin of Error			
0.1	9,336	71	2.9	Z	56,869	63	17.6
0.1	6,857	62	2.5	Z	7,851	55	2.9
0.2	3,087	40	4.0	0.1	464	19	0.6
0.1	3,770	38	2.0	Z	7,387	48	3.8
0.1	2,479	29	4.8	0.1	49,018	37	95.9
0.4	153	8	3.2	0.2	985	9	20.5
0.4	105	6	2.6	0.2	192	8	4.8
1.2	40	4	3.4	0.4	8	3	0.7
0.4	66	4	2.3	0.2	184	8	6.5
0.7	48	3	5.9	0.4	793	4	97.7
1.1	25	3	3.5	0.5	95	3	13.4
1.3	20	3	3.2	0.5	14	2	2.2
2.4	10	2	5.3	1.0	1	Z	0.5
1.2	10	2	2.3	0.4	13	2	3.0
1.8	5	1	5.5	1.3	82	2	94.4
0.4	211	11	3.0	0.2	1,355	7	19.2
0.5	156	10	2.7	0.2	154	7	2.6
0.9	71	6	4.1	0.3	11	2	0.6
0.5	85	6	2.1	0.1	143	6	3.5
0.5	55	4	4.4	0.3	1,201	4	96.3
0.5	95	6	3.2	0.2	606	9	20.5
0.6	68	5	2.7	0.2	125	8	5.1
1.3	23	3	3.1	0.4	8	2	1.0
0.6	45	3	2.6	0.2	118	7	6.8
0.9	27	3	5.6	0.6	480	4	97.8
0.2	1,109	28	2.8	0.1	5,948	20	15.2
0.2	861	26	2.6	0.1	693	15	2.1
0.4	375	19	3.9	0.2	56	5	0.6
0.2	485	12	2.0	0.1	638	13	2.7
0.3	248	8	4.5	0.1	5,255	10	94.3
0.4	148	7	2.6	0.1	859	7	15.3
0.5	111	7	2.3	0.1	100	6	2.1
1.0	50	4	3.7	0.3	8	3	0.6
0.4	61	4	1.8	0.1	92	5	2.7
0.5	37	2	4.7	0.3	759	4	95.7
0.6	95	6	2.7	0.2	634	6	18.0
0.6	65	5	2.2	0.2	71	5	2.4
1.1	30	3	3.7	0.4	4	2	0.5
0.6	36	4	1.7	0.2	67	4	3.1
0.6	30	2	5.0	0.4	563	3	95.0
0.9	34	4	3.6	0.4	198	3	20.8
1.1	24	4	3.1	0.5	27	3	3.4
2.2	8	2	3.6	0.9	1	1	0.3

1.2	16	2	2.9	0.4	26	3	4.6
1.0	10	1	5.7	0.8	172	1	97.1
1.4	21	3	3.0	0.4	92	4	13.3
1.6	14	2	2.3	0.4	16	4	2.6
3.8	5	2	3.9	1.2	3	2	2.1
1.3	9	2	1.8	0.4	13	2	2.8
2.3	7	1	8.5	1.3	76	2	90.8
0.2	548	17	2.6	0.1	4,632	17	22.1
0.3	357	14	2.1	0.1	526	15	3.1
0.7	149	9	3.3	0.2	34	6	0.8
0.2	209	9	1.7	0.1	492	13	4.0
0.4	191	8	4.4	0.2	4,106	10	95.7
0.3	275	12	2.7	0.1	1,644	11	15.9
0.3	193	11	2.2	0.1	274	10	3.1
0.8	82	7	3.1	0.2	21	4	0.8
0.2	111	6	1.8	0.1	253	9	4.1
0.5	82	5	5.7	0.3	1,370	7	96.1
0.7	40	4	2.9	0.3	264	3	19.3
0.8	29	4	2.6	0.3	21	3	1.9
1.7	14	3	4.2	0.8	1	1	0.5
0.6	15	2	1.9	0.3	20	3	2.5
1.1	11	2	4.2	0.6	243	2	94.4
0.7	53	5	3.0	0.3	314	5	18.1
0.8	39	5	2.7	0.3	46	4	3.1
1.6	20	3	4.3	0.7	2	1	0.5
0.6	19	2	1.9	0.2	43	4	4.4
1.0	13	2	4.9	0.7	269	3	97.8
0.2	261	11	2.1	0.1	2,087	10	16.6
0.3	191	10	1.8	0.1	252	9	2.4
0.6	94	6	3.1	0.2	12	2	0.4
0.2	97	6	1.3	0.1	241	8	3.2
0.4	69	3	3.6	0.1	1,834	5	95.3
0.4	181	9	2.7	0.1	1,163	9	17.6
0.5	137	9	2.5	0.2	177	8	3.2
1.0	70	7	4.2	0.4	7	2	0.4
0.4	67	5	1.7	0.1	170	7	4.3
0.4	44	3	4.3	0.3	985	4	97.0
0.5	115	6	3.7	0.2	566	4	18.2
0.6	90	6	3.5	0.2	64	3	2.5
1.1	46	4	5.9	0.5	4	1	0.5
0.5	43	3	2.4	0.2	60	3	3.3
0.6	25	2	4.9	0.4	502	3	97.3
0.5	76	5	2.7	0.2	497	6	17.4
0.6	55	5	2.3	0.2	70	5	2.9
1.2	26	3	3.4	0.4	6	2	0.8
0.4	29	3	1.8	0.2	64	4	3.9
0.7	21	2	4.7	0.5	428	3	96.4
0.5	147	7	3.4	0.2	866	8	19.7
0.6	109	7	3.0	0.2	175	7	4.8
1.1	43	4	4.1	0.4	9	2	0.8
0.5	66	5	2.5	0.2	166	7	6.4
0.6	38	2	5.4	0.3	690	3	97.3

0.5	159	8	3.5	0.2	827	9	18.1
0.6	126	8	3.3	0.2	158	8	4.1
1.1	54	5	4.6	0.4	7	2	0.6
0.6	72	5	2.7	0.2	151	7	5.6
0.7	33	3	4.8	0.4	669	4	95.7
0.7	52	4	3.9	0.3	306	4	23.1
0.8	34	4	3.2	0.3	46	3	4.3
1.8	13	2	4.8	0.9	1	Z	0.4
0.7	21	2	2.6	0.3	45	3	5.7
1.2	18	2	6.7	0.7	260	2	97.1
0.4	177	8	3.0	0.1	986	10	16.6
0.5	121	7	2.4	0.1	135	8	2.7
1.0	48	5	3.4	0.4	15	4	1.1
0.4	73	4	2.0	0.1	119	7	3.3
0.6	55	4	6.1	0.4	851	4	93.7
0.4	272	11	4.0	0.2	1,188	8	17.4
0.5	203	11	3.5	0.2	146	7	2.5
0.9	80	6	5.5	0.4	5	1	0.3
0.4	123	6	2.9	0.1	141	7	3.3
0.6	69	4	6.2	0.4	1,042	4	94.4
0.3	362	10	3.7	0.1	1,939	10	19.6
0.3	262	10	3.2	0.1	302	9	3.7
0.7	118	7	5.2	0.3	9	2	0.4
0.3	143	6	2.4	0.1	292	8	4.9
0.4	100	4	6.0	0.2	1,638	3	97.4
0.4	159	8	2.9	0.1	929	5	16.7
0.4	126	8	2.7	0.2	98	4	2.1
0.8	68	5	5.0	0.4	3	1	0.2
0.3	58	4	1.7	0.1	94	4	2.8
0.4	33	2	3.8	0.3	831	3	96.8
0.5	86	7	2.9	0.2	569	7	19.5
0.6	62	7	2.5	0.3	118	6	4.8
1.3	24	4	3.2	0.5	5	2	0.7
0.5	38	4	2.2	0.2	113	5	6.6
0.9	23	2	5.1	0.5	451	3	97.8
0.4	143	8	2.4	0.1	1,167	8	19.4
0.4	108	7	2.2	0.1	197	7	3.9
1.0	58	5	4.0	0.4	14	3	1.0
0.3	50	4	1.4	0.1	183	7	5.1
0.4	34	3	3.4	0.3	970	4	97.2
1.0	34	3	3.3	0.3	217	3	20.7
1.2	26	3	3.1	0.4	26	2	3.0
2.4	12	2	4.7	0.8	1	Z	0.2
0.9	15	2	2.4	0.3	25	2	4.2
0.8	8	1	4.1	0.6	191	2	97.5
0.5	52	5	2.8	0.2	319	3	16.8
0.6	37	4	2.3	0.3	36	3	2.3
1.3	18	3	3.6	0.6	1	1	0.2
0.4	19	2	1.7	0.2	35	3	3.2
0.7	16	2	5.3	0.5	283	2	96.7
0.6	83	8	2.8	0.3	514	5	17.1
0.6	64	7	2.5	0.3	67	4	2.7

1.3	29	4	4.0	0.6	3	1	0.5
0.6	35	4	1.9	0.2	64	4	3.5
0.8	20	3	4.2	0.5	447	3	95.0
0.7	28	3	2.1	0.2	265	3	19.8
0.9	19	3	1.7	0.2	38	3	3.5
1.9	9	2	3.2	0.6	1	1	0.4
0.6	10	2	1.2	0.2	37	3	4.5
0.7	9	1	3.7	0.5	227	2	95.9
0.3	215	10	2.4	0.1	1,500	9	17.0
0.4	152	10	2.0	0.1	172	7	2.3
0.8	66	7	3.2	0.4	10	2	0.5
0.3	85	4	1.6	0.1	162	6	3.0
0.4	64	3	4.5	0.2	1,328	5	94.8
0.8	83	6	4.0	0.3	413	5	20.0
1.0	67	5	3.9	0.3	64	4	3.8
1.8	26	4	5.0	0.7	5	2	0.9
0.9	41	3	3.5	0.3	59	4	5.0
1.0	16	2	4.4	0.5	348	3	95.9
0.2	756	20	3.9	0.1	3,434	16	17.8
0.2	585	19	3.6	0.1	462	13	2.9
0.5	248	12	5.8	0.3	23	4	0.5
0.2	338	12	2.8	0.1	439	12	3.7
0.4	170	7	5.5	0.2	2,972	8	95.3
0.3	277	10	2.7	0.1	1,891	12	18.6
0.3	187	9	2.2	0.1	289	10	3.4
0.8	75	6	3.1	0.2	9	2	0.4
0.3	112	5	1.8	0.1	281	10	4.6
0.4	90	4	5.4	0.3	1,602	5	97.1
0.8	20	2	2.7	0.3	121	2	16.3
0.9	14	2	2.2	0.4	15	2	2.3
1.9	9	2	4.6	1.0	1	1	0.8
0.7	5	1	1.2	0.3	13	2	3.0
1.1	6	1	5.5	0.9	107	1	96.9
0.3	302	13	2.6	0.1	2,172	10	18.9
0.3	223	12	2.3	0.1	311	10	3.2
0.6	113	7	4.1	0.3	12	2	0.4
0.3	109	7	1.6	0.1	299	9	4.4
0.4	79	4	4.1	0.2	1,861	5	96.5
0.4	105	5	2.7	0.1	704	6	18.2
0.4	78	5	2.4	0.1	122	6	3.8
1.0	47	4	4.7	0.4	15	3	1.5
0.3	31	3	1.4	0.1	107	4	4.8
0.6	27	2	4.5	0.3	581	2	96.8
0.5	145	8	3.5	0.2	798	7	19.2
0.6	107	7	3.1	0.2	94	6	2.8
1.2	43	4	4.6	0.5	3	1	0.4
0.5	64	4	2.6	0.2	91	5	3.6
0.7	38	3	5.2	0.4	704	4	96.6
0.3	482	13	3.8	0.1	2,507	12	19.9
0.3	354	12	3.4	0.1	326	10	3.1
0.7	175	8	6.2	0.3	14	2	0.5
0.2	179	7	2.4	0.1	312	9	4.1

0.3	128	5	5.7	0.2	2,181	5	96.7
1.0	37	4	3.6	0.4	199	4	19.1
1.1	26	4	3.0	0.4	29	3	3.4
2.3	11	3	4.9	1.1	1	1	0.5
1.1	15	2	2.4	0.4	28	3	4.3
1.6	11	2	6.2	0.9	170	2	96.9
0.4	159	8	3.2	0.2	1,017	8	20.4
0.4	114	7	2.8	0.2	154	7	3.8
1.1	49	4	4.2	0.4	6	2	0.5
0.4	64	5	2.2	0.2	149	7	5.1
0.6	45	3	5.1	0.3	862	3	97.8
0.8	21	3	2.5	0.3	155	3	17.9
0.9	16	3	2.2	0.4	20	2	2.7
2.0	9	2	3.8	0.9	2	1	0.7
0.7	7	2	1.4	0.3	18	2	3.6
1.0	6	1	4.0	0.7	135	1	96.7
0.4	226	12	3.4	0.2	1,263	9	18.9
0.5	170	12	3.0	0.2	217	8	3.9
1.1	76	8	4.8	0.5	11	3	0.7
0.3	93	7	2.3	0.2	206	7	5.2
0.6	56	4	5.2	0.4	1,047	4	97.2
0.2	576	18	2.0	0.1	3,868	19	13.7
0.2	414	16	1.7	0.1	560	16	2.3
0.5	194	11	2.5	0.1	49	7	0.6
0.1	220	9	1.3	0.1	511	14	3.0
0.3	162	7	4.6	0.2	3,309	10	94.1
0.4	76	6	2.4	0.2	373	5	11.9
0.5	60	6	2.1	0.2	45	4	1.6
1.0	31	4	3.2	0.5	5	2	0.5
0.3	28	3	1.6	0.2	40	4	2.2
0.8	16	2	4.6	0.5	328	3	94.5
1.1	19	2	3.1	0.3	134	2	21.6
1.4	13	2	2.6	0.4	18	2	3.5
3.0	5	1	4.0	1.0	Z	Z	0.3
1.1	8	1	2.2	0.4	17	2	4.6
1.4	6	1	4.8	0.6	116	1	96.3
0.3	148	10	1.8	0.1	1,431	8	17.2
0.3	99	8	1.4	0.1	199	7	2.8
0.8	51	6	2.5	0.3	14	3	0.7
0.2	48	4	1.0	0.1	186	6	3.7
0.3	50	3	3.8	0.3	1,231	5	95.3
0.4	240	12	3.2	0.2	1,260	8	17.0
0.4	181	11	2.9	0.2	162	7	2.6
0.9	80	7	4.6	0.4	8	2	0.5
0.4	101	7	2.2	0.1	153	7	3.4
0.5	59	4	5.1	0.3	1,098	4	96.0
0.8	66	6	3.7	0.3	424	5	23.9
0.9	49	5	3.4	0.4	79	5	5.6
1.9	21	4	5.4	0.9	3	1	0.7
0.8	28	3	2.7	0.3	76	5	7.4
0.9	17	2	4.9	0.5	345	2	97.9
0.3	180	7	3.1	0.1	1,075	7	18.7

0.3	129	6	2.7	0.1	137	7	2.9
0.8	65	4	4.8	0.3	12	3	0.9
0.3	64	4	1.9	0.1	125	5	3.6
0.5	50	3	5.2	0.3	938	3	97.6
0.9	12	2	2.1	0.4	102	3	18.0
1.0	8	2	1.6	0.5	11	2	2.3
2.3	4	2	3.1	1.1	1	1	0.5
0.9	3	1	1.0	0.4	10	2	3.1
1.5	4	1	4.4	1.1	91	2	96.7

ce							
Covered by Medicare							
Margin of Error	Also covered by private insurance				Also covered by Medicaid		
	Number	Margin of Error	Percent	Margin of Error	Number	Margin of Error	Percent
Z	30,578	94	9.5	Z	10,902	55	3.4
Z	2,075	25	0.8	Z	3,799	35	1.4
Z	89	6	0.1	Z	231	11	0.3
Z	1,986	24	1.0	Z	3,568	31	1.8
0.1	28,503	86	55.7	0.2	7,103	40	13.9
0.2	540	11	11.2	0.2	195	8	4.0
0.2	59	5	1.5	0.1	84	6	2.1
0.3	1	Z	0.1	Z	3	1	0.2
0.3	58	5	2.1	0.2	82	6	2.9
0.3	481	10	59.3	1.1	110	5	13.6
0.4	51	2	7.2	0.3	23	2	3.2
0.3	3	1	0.5	0.1	9	1	1.4
0.3	Z	Z	0.1	0.1	Z	Z	0.1
0.4	3	1	0.7	0.2	8	1	1.9
1.3	48	2	55.6	2.2	15	2	16.9
0.1	685	10	9.7	0.1	233	9	3.3
0.1	39	3	0.7	0.1	72	6	1.2
0.1	2	1	0.1	Z	6	2	0.4
0.2	37	3	0.9	0.1	66	5	1.6
0.3	646	10	51.8	0.8	161	7	12.9
0.3	298	7	10.1	0.2	132	8	4.4
0.3	26	3	1.1	0.1	61	6	2.5
0.3	Z	Z	Z	Z	6	2	0.8
0.4	26	3	1.5	0.2	55	5	3.2
0.4	272	6	55.4	1.2	70	4	14.3
0.1	2,698	22	6.9	0.1	1,516	20	3.9
Z	159	6	0.5	Z	363	10	1.1
0.1	9	1	0.1	Z	29	3	0.3
0.1	150	6	0.6	Z	334	9	1.4
0.2	2,539	20	45.6	0.4	1,153	17	20.7
0.1	466	9	8.3	0.2	135	6	2.4
0.1	28	3	0.6	0.1	49	4	1.0
0.2	Z	Z	Z	Z	5	2	0.4
0.1	27	3	0.8	0.1	44	3	1.3
0.4	439	9	55.3	1.1	86	4	10.8
0.2	353	7	10.0	0.2	115	5	3.3
0.2	15	2	0.5	0.1	36	3	1.2
0.2	1	1	0.1	0.1	2	1	0.3
0.2	14	2	0.6	0.1	33	3	1.6
0.4	339	7	57.2	1.2	79	4	13.4
0.3	126	4	13.2	0.4	30	3	3.1
0.4	8	2	1.0	0.2	12	2	1.5
0.3	Z	Z	Z	Z	1	1	0.3

0.5	8	2	1.4	0.3	11	2	2.0
0.7	118	3	66.9	1.9	18	2	10.4
0.6	51	4	7.3	0.6	31	3	4.5
0.6	5	4	0.8	0.6	10	2	1.6
1.5	2	2	1.2	1.6	1	1	0.9
0.5	3	1	0.7	0.3	8	2	1.8
2.0	46	2	54.5	2.9	21	2	25.6
0.1	2,134	22	10.2	0.1	893	18	4.3
0.1	122	7	0.7	Z	243	10	1.5
0.1	6	2	0.1	Z	16	3	0.4
0.1	116	6	1.0	0.1	226	9	1.9
0.2	2,012	20	46.9	0.5	650	16	15.1
0.1	845	14	8.2	0.1	341	10	3.3
0.1	74	5	0.8	0.1	129	7	1.4
0.2	5	3	0.2	0.1	8	2	0.3
0.1	69	4	1.1	0.1	120	7	1.9
0.3	772	13	54.1	0.9	212	8	14.9
0.2	176	5	12.8	0.4	41	3	3.0
0.2	8	2	0.7	0.2	10	2	0.9
0.3	Z	Z	0.1	0.1	1	1	0.3
0.3	7	2	0.9	0.2	9	2	1.1
0.8	168	4	65.3	1.6	31	3	12.0
0.3	183	6	10.6	0.3	57	4	3.3
0.3	14	2	1.0	0.2	25	3	1.7
0.2	1	Z	0.1	0.1	1	1	0.2
0.4	14	2	1.4	0.2	24	3	2.4
0.5	169	5	61.7	1.7	32	3	11.6
0.1	1,154	12	9.2	0.1	325	8	2.6
0.1	67	5	0.6	Z	113	6	1.1
0.1	2	1	0.1	Z	5	1	0.2
0.1	65	4	0.8	0.1	108	5	1.4
0.2	1,087	11	56.5	0.6	212	7	11.0
0.1	647	10	9.8	0.1	180	6	2.7
0.1	49	4	0.9	0.1	81	5	1.5
0.1	2	1	0.1	0.1	4	1	0.2
0.2	47	3	1.2	0.1	77	5	2.0
0.3	598	8	58.8	0.8	99	4	9.7
0.1	364	5	11.7	0.2	87	5	2.8
0.1	20	2	0.8	0.1	37	3	1.4
0.1	1	Z	0.1	0.1	2	1	0.2
0.2	19	2	1.0	0.1	36	3	2.0
0.4	344	4	66.8	0.8	50	3	9.6
0.2	295	6	10.3	0.2	75	4	2.6
0.2	19	3	0.8	0.1	33	3	1.4
0.3	1	1	0.2	0.1	2	1	0.2
0.3	18	2	1.1	0.1	32	3	1.9
0.5	275	5	62.1	1.1	42	3	9.5
0.2	459	9	10.5	0.2	179	7	4.1
0.2	44	3	1.2	0.1	79	5	2.1
0.2	Z	Z	Z	Z	6	2	0.6
0.3	43	3	1.7	0.1	73	5	2.8
0.3	415	8	58.6	1.1	100	4	14.1

0.2	385	9	8.5	0.2	184	8	4.0
0.2	34	3	0.9	0.1	77	6	2.0
0.1	1	1	0.1	0.1	4	1	0.3
0.3	33	3	1.2	0.1	74	6	2.7
0.4	351	8	50.3	1.1	106	5	15.2
0.3	163	5	12.3	0.4	76	4	5.8
0.3	10	1	1.0	0.1	30	3	2.9
0.1	Z	Z	0.1	0.1	1	Z	0.3
0.4	10	1	1.3	0.2	30	3	3.8
0.5	153	5	57.2	1.7	46	3	17.1
0.2	639	9	10.8	0.1	177	6	3.0
0.2	39	4	0.8	0.1	62	5	1.2
0.3	2	1	0.1	Z	4	1	0.3
0.2	37	3	1.0	0.1	58	5	1.6
0.4	601	8	66.1	0.8	115	5	12.7
0.1	704	9	10.3	0.1	287	9	4.2
0.1	38	4	0.7	0.1	100	6	1.8
0.1	2	1	0.1	0.1	3	1	0.2
0.2	37	4	0.9	0.1	98	6	2.3
0.4	665	8	60.3	0.8	186	7	16.9
0.1	1,264	11	12.8	0.1	364	9	3.7
0.1	96	5	1.2	0.1	156	6	1.9
0.1	4	1	0.2	0.1	5	1	0.2
0.1	93	5	1.6	0.1	150	6	2.5
0.2	1,168	10	69.5	0.6	208	6	12.4
0.1	617	7	11.1	0.1	123	5	2.2
0.1	32	3	0.7	0.1	45	3	0.9
0.1	1	1	0.1	Z	2	1	0.2
0.1	30	3	0.9	0.1	42	3	1.3
0.3	586	6	68.2	0.6	78	4	9.1
0.2	265	7	9.1	0.2	146	7	5.0
0.2	25	3	1.0	0.1	66	5	2.7
0.3	1	1	0.1	0.1	2	1	0.3
0.3	24	3	1.4	0.2	63	5	3.7
0.4	240	6	52.0	1.3	81	4	17.5
0.1	603	8	10.0	0.1	177	8	2.9
0.1	47	4	0.9	0.1	85	6	1.7
0.2	1	1	0.1	Z	7	3	0.5
0.2	46	4	1.3	0.1	78	5	2.2
0.3	556	7	55.7	0.7	92	4	9.2
0.3	125	4	11.9	0.4	31	2	3.0
0.3	7	1	0.8	0.1	13	2	1.5
0.1	Z	Z	0.1	0.1	Z	Z	0.1
0.4	7	1	1.1	0.2	13	2	2.1
0.5	118	4	60.3	1.9	18	2	9.4
0.2	184	4	9.7	0.2	49	3	2.6
0.2	11	1	0.7	0.1	19	2	1.2
0.1	Z	Z	0.1	Z	Z	Z	0.1
0.2	11	1	1.0	0.1	18	2	1.7
0.4	173	4	59.2	1.2	30	2	10.3
0.2	244	7	8.2	0.2	86	5	2.9
0.2	18	2	0.7	0.1	30	3	1.2

0.2	1	Z	0.1	0.1	1	1	0.2
0.2	17	2	1.0	0.1	29	3	1.6
0.6	227	6	48.1	1.3	56	4	11.8
0.3	158	4	11.8	0.3	32	3	2.4
0.3	10	2	0.9	0.2	15	2	1.3
0.2	Z	Z	0.1	0.1	1	Z	0.2
0.4	9	2	1.1	0.2	14	2	1.7
0.8	149	4	62.8	1.8	17	2	7.1
0.1	858	11	9.7	0.1	254	8	2.9
0.1	52	4	0.7	0.1	75	5	1.0
0.1	2	1	0.1	Z	4	2	0.2
0.1	50	4	0.9	0.1	70	5	1.3
0.3	806	10	57.5	0.7	179	6	12.8
0.3	196	5	9.5	0.3	95	5	4.6
0.3	13	2	0.8	0.1	37	3	2.2
0.3	1	Z	0.2	0.1	3	1	0.6
0.3	12	2	1.0	0.2	33	3	2.8
0.5	183	5	50.4	1.3	58	4	16.1
0.1	1,820	17	9.4	0.1	873	14	4.5
0.1	136	7	0.8	Z	261	9	1.6
0.1	6	2	0.1	Z	15	2	0.3
0.1	129	7	1.1	0.1	247	9	2.1
0.2	1,685	15	54.1	0.5	611	12	19.6
0.1	1,053	13	10.3	0.1	333	10	3.3
0.1	83	5	1.0	0.1	131	6	1.5
0.1	2	1	0.1	Z	4	1	0.2
0.2	81	5	1.3	0.1	127	6	2.1
0.2	970	11	58.8	0.7	202	7	12.2
0.3	81	2	10.8	0.3	16	2	2.2
0.3	5	1	0.7	0.2	6	1	1.0
0.4	Z	Z	Z	Z	1	1	0.5
0.4	5	1	1.0	0.2	5	1	1.2
0.7	76	2	69.0	1.8	10	1	9.2
0.1	1,192	12	10.3	0.1	335	10	2.9
0.1	76	5	0.8	Z	142	6	1.5
0.1	2	1	0.1	Z	7	1	0.2
0.1	74	4	1.1	0.1	136	6	2.0
0.2	1,116	10	57.8	0.5	193	7	10.0
0.2	392	6	10.2	0.2	104	5	2.7
0.2	31	3	1.0	0.1	41	3	1.3
0.3	3	1	0.3	0.1	4	1	0.4
0.2	28	2	1.3	0.1	37	3	1.6
0.3	361	5	60.2	0.9	63	4	10.5
0.2	456	9	11.0	0.2	134	6	3.2
0.2	27	3	0.8	0.1	47	3	1.4
0.1	1	1	0.1	0.1	2	1	0.2
0.2	26	3	1.0	0.1	45	3	1.8
0.4	429	8	58.9	1.0	87	5	11.9
0.1	1,545	13	12.3	0.1	434	10	3.4
0.1	105	6	1.0	0.1	162	6	1.6
0.1	5	1	0.2	0.1	9	2	0.3
0.1	100	5	1.3	0.1	153	6	2.0

0.2	1,441	12	63.9	0.5	272	7	12.0
0.3	105	4	10.0	0.4	49	4	4.7
0.4	8	2	0.9	0.2	18	3	2.1
0.4	Z	Z	0.1	0.1	1	1	0.3
0.5	8	2	1.2	0.2	17	3	2.7
0.6	97	4	55.1	2.3	31	3	17.7
0.2	564	10	11.3	0.2	176	7	3.5
0.2	39	3	1.0	0.1	68	5	1.7
0.1	1	1	0.1	Z	2	1	0.2
0.2	38	3	1.3	0.1	65	5	2.2
0.3	525	10	59.5	1.1	108	5	12.3
0.3	83	3	9.6	0.4	23	2	2.6
0.3	5	1	0.6	0.1	10	2	1.3
0.4	1	1	0.3	0.2	Z	Z	0.2
0.5	4	1	0.8	0.2	9	2	1.8
0.7	78	3	56.0	2.0	13	1	9.3
0.1	665	11	10.0	0.2	237	8	3.5
0.1	56	4	1.0	0.1	99	6	1.8
0.2	3	1	0.2	0.1	8	3	0.5
0.2	54	4	1.3	0.1	91	5	2.3
0.3	608	10	56.5	0.9	138	6	12.8
0.1	1,861	21	6.6	0.1	770	16	2.7
0.1	130	6	0.5	Z	267	11	1.1
0.1	5	1	0.1	Z	21	4	0.3
0.1	125	6	0.7	Z	246	11	1.5
0.3	1,731	19	49.2	0.5	502	12	14.3
0.2	217	5	6.9	0.1	52	3	1.7
0.2	13	2	0.5	0.1	20	3	0.7
0.2	Z	1	0.1	0.1	1	1	0.1
0.2	13	2	0.7	0.1	18	3	1.0
0.6	204	5	58.7	1.3	33	3	9.4
0.4	76	2	12.2	0.4	27	2	4.3
0.4	4	1	0.7	0.2	10	2	2.1
0.2	Z	Z	Z	Z	Z	Z	0.1
0.5	4	1	0.9	0.2	10	2	2.8
1.0	72	2	60.0	2.1	16	2	13.4
0.1	884	9	10.7	0.1	182	7	2.2
0.1	59	3	0.8	Z	69	5	1.0
0.2	5	2	0.2	0.1	5	2	0.2
0.1	54	3	1.1	0.1	64	4	1.3
0.3	826	9	63.9	0.7	113	5	8.7
0.1	736	9	9.9	0.1	216	9	2.9
0.1	49	4	0.8	0.1	81	5	1.3
0.1	2	1	0.1	Z	5	2	0.3
0.2	47	4	1.0	0.1	76	5	1.7
0.3	687	8	60.1	0.7	135	6	11.8
0.3	235	6	13.2	0.3	78	5	4.4
0.3	20	2	1.4	0.2	32	3	2.3
0.3	Z	Z	Z	Z	2	1	0.4
0.5	20	2	1.9	0.2	31	3	3.0
0.4	215	6	61.2	1.5	46	3	12.9
0.1	621	8	10.8	0.1	186	6	3.2

0.1	38	3	0.8	0.1	74	5	1.5
0.2	2	1	0.2	0.1	7	2	0.5
0.2	35	3	1.0	0.1	67	4	1.9
0.2	583	8	60.7	0.8	112	4	11.6
0.4	59	3	10.3	0.5	14	2	2.4
0.4	2	1	0.5	0.2	6	2	1.2
0.5	Z	Z	Z	Z	Z	1	0.3
0.5	2	1	0.7	0.2	5	1	1.6
0.9	56	3	59.7	2.8	8	1	8.6

					Uninsured		
	Covered by VA care						
	Number	Margin of Error	Percent	Margin of Error	Number	Margin of Error	Percent
Margin of Error							
Z	7,477	44	2.3	Z	28,566	183	8.9
Z	3,420	28	1.3	Z	28,165	178	10.4
Z	105	9	0.1	Z	4,055	44	5.2
Z	3,316	28	1.7	Z	24,109	152	12.5
0.1	4,057	30	7.9	0.1	401	13	0.8
0.2	138	6	2.9	0.1	481	15	10.0
0.1	66	5	1.7	0.1	479	15	12.0
0.1	2	1	0.2	0.1	41	6	3.5
0.2	64	5	2.3	0.2	438	12	15.5
0.7	71	4	8.8	0.4	2	1	0.3
0.3	33	3	4.6	0.4	90	6	12.6
0.2	20	3	3.2	0.4	89	6	14.3
0.1	1	1	0.3	0.3	18	3	9.4
0.3	19	2	4.4	0.5	71	5	16.4
1.8	13	1	14.8	1.6	1	Z	0.7
0.1	215	7	3.0	0.1	750	24	10.6
0.1	92	6	1.6	0.1	740	23	12.7
0.1	4	3	0.2	0.2	146	10	8.4
0.1	87	5	2.1	0.1	594	17	14.6
0.5	123	4	9.9	0.3	10	2	0.8
0.3	92	5	3.1	0.2	244	10	8.2
0.2	41	3	1.6	0.1	241	10	9.8
0.3	1	Z	0.1	0.1	34	5	4.5
0.3	40	3	2.3	0.2	207	8	12.0
0.9	51	3	10.4	0.7	3	1	0.5
0.1	615	12	1.6	Z	2,826	43	7.2
Z	293	9	0.9	Z	2,767	41	8.3
Z	13	2	0.1	Z	299	13	3.1
Z	280	8	1.2	Z	2,468	36	10.3
0.3	322	8	5.8	0.2	59	4	1.1
0.1	135	7	2.4	0.1	422	17	7.5
0.1	76	6	1.6	0.1	415	17	8.6
0.1	2	1	0.1	0.1	62	6	4.6
0.1	74	5	2.1	0.2	353	14	10.2
0.5	59	3	7.4	0.4	7	2	0.8
0.1	57	4	1.6	0.1	187	11	5.3
0.1	21	3	0.7	0.1	183	11	6.2
0.1	1	Z	0.1	0.1	20	4	2.6
0.1	21	3	1.0	0.1	163	9	7.6
0.6	35	3	5.9	0.5	4	1	0.6
0.3	19	2	2.0	0.2	54	6	5.7
0.3	8	1	1.0	0.2	53	6	6.8
0.3	Z	Z	Z	Z	8	2	3.6

0.4	8	1	1.4	0.3	45	5	8.1
1.0	11	2	6.3	0.9	1	1	0.5
0.4	8	1	1.1	0.2	22	3	3.2
0.3	4	1	0.6	0.2	21	3	3.5
0.7	Z	Z	0.1	0.1	2	1	1.8
0.4	4	1	0.8	0.2	19	3	4.0
2.3	4	1	4.5	1.0	Z	Z	0.5
0.1	633	12	3.0	0.1	2,728	40	13.0
0.1	267	10	1.6	0.1	2,678	40	16.0
0.1	8	3	0.2	0.1	339	15	7.6
0.1	259	9	2.1	0.1	2,339	33	19.1
0.4	366	8	8.5	0.2	51	6	1.2
0.1	262	9	2.5	0.1	1,411	29	13.7
0.1	138	7	1.6	0.1	1,399	29	15.7
0.1	3	1	0.1	Z	217	12	8.1
0.1	136	7	2.2	0.1	1,181	25	18.9
0.5	123	5	8.7	0.4	12	2	0.9
0.2	38	3	2.8	0.2	56	5	4.1
0.2	18	2	1.6	0.2	55	5	4.9
0.3	Z	Z	0.1	0.1	8	2	2.6
0.2	18	2	2.3	0.2	46	4	5.9
1.1	20	2	7.8	0.7	1	Z	0.4
0.2	57	4	3.3	0.2	193	11	11.1
0.2	24	3	1.6	0.2	192	11	13.2
0.2	Z	Z	0.1	0.1	29	4	6.1
0.3	23	2	2.4	0.3	163	9	16.5
1.0	33	2	12.2	0.9	1	Z	0.3
0.1	216	7	1.7	0.1	875	22	7.0
0.1	90	5	0.8	Z	857	22	8.1
Z	3	2	0.1	0.1	102	7	3.4
0.1	87	4	1.1	0.1	755	19	9.9
0.4	126	5	6.5	0.2	17	3	0.9
0.1	158	6	2.4	0.1	545	19	8.3
0.1	68	4	1.2	0.1	539	19	9.7
0.1	1	Z	Z	Z	109	7	6.6
0.1	68	4	1.7	0.1	430	15	11.0
0.4	90	4	8.9	0.4	6	2	0.6
0.1	84	4	2.7	0.1	147	9	4.7
0.1	32	3	1.2	0.1	146	9	5.6
0.1	1	1	0.1	0.1	21	3	2.7
0.1	31	3	1.7	0.2	125	7	6.9
0.6	51	3	10.0	0.6	1	1	0.2
0.2	75	4	2.6	0.2	250	10	8.8
0.1	36	4	1.5	0.1	248	10	10.3
0.1	2	1	0.2	0.1	38	4	5.1
0.2	35	3	2.1	0.2	210	8	12.6
0.7	39	2	8.7	0.5	2	1	0.5
0.2	124	5	2.8	0.1	248	11	5.6
0.1	56	4	1.5	0.1	245	11	6.7
0.2	1	1	0.1	0.1	40	5	3.8
0.2	54	4	2.1	0.1	205	9	7.9
0.6	68	3	9.6	0.5	2	1	0.3

0.2	106	5	2.3	0.1	363	13	8.0
0.2	52	4	1.3	0.1	359	14	9.3
0.1	1	Z	0.1	Z	39	4	3.4
0.2	51	4	1.9	0.2	320	12	11.9
0.7	54	3	7.7	0.4	4	2	0.6
0.3	53	3	4.0	0.2	106	6	8.0
0.2	23	3	2.2	0.3	106	6	10.0
0.1	1	Z	0.3	0.2	15	2	5.5
0.3	22	3	2.8	0.3	91	6	11.5
1.2	30	2	11.1	0.7	Z	Z	0.1
0.1	118	5	2.0	0.1	357	15	6.0
0.1	63	5	1.3	0.1	349	15	6.9
0.1	2	1	0.1	0.1	47	6	3.3
0.1	61	4	1.7	0.1	302	11	8.4
0.6	55	3	6.0	0.4	8	2	0.9
0.1	97	5	1.4	0.1	189	11	2.8
0.1	35	3	0.6	Z	185	11	3.2
0.1	1	Z	Z	Z	18	3	1.2
0.1	35	3	0.8	0.1	167	9	3.9
0.6	62	4	5.6	0.3	4	1	0.3
0.1	209	6	2.1	0.1	535	14	5.4
0.1	85	5	1.0	0.1	529	14	6.4
0.1	3	1	0.1	Z	78	6	3.4
0.1	82	4	1.4	0.1	451	12	7.6
0.4	124	4	7.4	0.2	5	1	0.3
0.1	136	5	2.5	0.1	244	10	4.4
0.1	48	3	1.0	0.1	242	9	5.1
0.1	1	1	0.1	Z	45	4	3.3
0.1	47	3	1.4	0.1	196	8	5.9
0.4	88	4	10.3	0.4	3	1	0.3
0.2	71	5	2.4	0.2	354	12	12.1
0.2	33	4	1.3	0.2	353	12	14.4
0.1	Z	Z	0.1	Z	35	4	4.7
0.3	32	4	1.9	0.2	318	11	18.6
0.9	38	3	8.3	0.6	1	1	0.3
0.1	166	6	2.8	0.1	566	18	9.4
0.1	74	5	1.5	0.1	561	17	11.2
0.2	3	1	0.2	0.1	83	7	5.7
0.1	72	4	2.0	0.1	479	13	13.4
0.4	92	4	9.2	0.4	5	1	0.5
0.2	41	3	3.9	0.3	86	5	8.2
0.2	16	2	1.9	0.2	85	5	10.0
0.1	Z	Z	Z	0.1	15	2	6.1
0.3	16	2	2.7	0.3	70	5	11.6
0.8	24	2	12.4	1.1	1	Z	0.4
0.2	56	3	2.9	0.1	158	8	8.3
0.1	25	2	1.5	0.1	157	8	9.7
0.1	1	1	0.2	0.2	26	3	5.2
0.2	24	2	2.1	0.2	130	7	11.8
0.7	31	2	10.5	0.6	1	Z	0.3
0.2	101	5	3.4	0.2	336	13	11.2
0.1	47	4	1.9	0.2	330	13	13.0

0.1	1	1	0.1	0.1	58	7	8.0
0.2	47	4	2.6	0.2	272	10	15.1
0.8	53	3	11.3	0.6	6	2	1.4
0.2	37	3	2.7	0.2	77	5	5.7
0.2	15	2	1.3	0.2	76	5	6.9
0.2	Z	Z	Z	Z	7	2	2.6
0.2	15	2	1.8	0.2	69	4	8.4
0.7	22	2	9.3	0.8	1	Z	0.3
0.1	94	4	1.1	Z	655	21	7.4
0.1	34	3	0.5	Z	641	21	8.7
0.1	1	Z	Z	Z	80	7	3.9
0.1	33	3	0.6	Z	561	18	10.5
0.4	60	3	4.3	0.2	14	2	1.0
0.3	63	4	3.1	0.2	196	12	9.5
0.2	28	3	1.7	0.2	193	11	11.4
0.3	1	Z	0.1	0.1	27	4	5.3
0.2	28	3	2.3	0.2	166	10	14.0
1.0	35	2	9.7	0.7	3	1	0.9
0.1	269	7	1.4	Z	1,041	24	5.4
0.1	106	6	0.7	Z	1,018	24	6.3
0.1	3	1	0.1	Z	107	8	2.5
0.1	103	5	0.9	Z	911	20	7.7
0.4	163	5	5.2	0.2	23	3	0.7
0.1	301	8	3.0	0.1	1,092	25	10.7
0.1	146	7	1.7	0.1	1,083	24	12.7
0.1	2	1	0.1	Z	130	10	5.3
0.1	144	7	2.4	0.1	953	21	15.7
0.4	155	5	9.4	0.3	9	2	0.5
0.2	22	2	2.9	0.3	54	4	7.3
0.2	8	1	1.3	0.2	53	4	8.4
0.4	Z	Z	Z	Z	11	2	6.0
0.3	8	1	1.8	0.3	42	3	9.4
1.1	13	1	12.0	1.3	Z	Z	0.4
0.1	274	8	2.4	0.1	744	20	6.5
0.1	115	5	1.2	0.1	735	20	7.7
Z	3	1	0.1	Z	133	9	4.8
0.1	112	5	1.6	0.1	602	17	8.8
0.4	158	6	8.2	0.3	9	2	0.5
0.1	131	4	3.4	0.1	548	13	14.2
0.1	60	3	1.8	0.1	544	13	16.7
0.1	2	Z	0.2	Z	83	5	8.2
0.1	58	3	2.6	0.1	461	11	20.5
0.6	72	2	12.0	0.4	4	1	0.7
0.1	135	6	3.2	0.1	293	13	7.1
0.1	56	4	1.6	0.1	289	13	8.4
0.1	1	1	0.1	0.1	33	5	3.6
0.1	55	4	2.2	0.2	256	11	10.2
0.7	79	4	10.8	0.6	4	1	0.6
0.1	279	8	2.2	0.1	699	17	5.5
0.1	107	5	1.0	Z	691	17	6.7
0.1	2	1	0.1	Z	124	8	4.4
0.1	105	5	1.4	0.1	567	14	7.5

0.3	171	5	7.6	0.2	8	2	0.4
0.4	24	3	2.3	0.3	42	5	4.1
0.3	9	2	1.1	0.2	42	5	4.8
0.2	Z	Z	Z	Z	5	2	2.2
0.4	9	2	1.4	0.2	37	4	5.7
1.6	15	2	8.3	1.1	1	1	0.4
0.1	164	8	3.3	0.2	522	19	10.5
0.1	78	6	1.9	0.1	520	19	12.7
0.1	1	1	0.1	0.1	56	7	4.7
0.2	76	6	2.6	0.2	464	16	15.8
0.6	86	4	9.8	0.4	2	1	0.3
0.2	31	2	3.6	0.3	85	5	9.8
0.2	13	2	1.8	0.2	84	5	11.6
0.1	Z	Z	Z	Z	13	2	5.9
0.4	13	2	2.5	0.3	71	5	14.2
1.0	18	2	13.1	1.2	1	Z	0.4
0.1	180	8	2.7	0.1	675	21	10.1
0.1	93	6	1.7	0.1	670	21	12.0
0.2	3	2	0.2	0.1	83	7	5.2
0.1	90	5	2.3	0.1	587	18	14.7
0.6	87	5	8.1	0.5	5	1	0.4
0.1	625	14	2.2	0.1	5,003	60	17.7
Z	335	11	1.4	Z	4,935	59	20.0
0.1	11	3	0.1	Z	873	24	11.2
0.1	324	9	1.9	0.1	4,062	47	24.0
0.3	289	8	8.2	0.2	68	7	1.9
0.1	53	4	1.7	0.1	295	17	9.4
0.1	25	4	0.9	0.1	292	17	10.5
0.1	3	2	0.3	0.3	72	7	7.4
0.1	22	3	1.2	0.1	220	12	12.2
0.8	28	2	8.0	0.7	3	1	1.0
0.4	15	2	2.5	0.3	25	3	4.0
0.3	5	1	1.0	0.2	24	3	4.9
0.1	Z	Z	0.1	0.1	2	1	2.0
0.4	5	1	1.3	0.3	22	2	5.8
1.4	10	1	8.5	0.9	1	1	0.5
0.1	243	10	2.9	0.1	731	21	8.8
0.1	143	9	2.0	0.1	717	21	10.2
0.1	10	2	0.5	0.1	102	7	5.1
0.1	133	8	2.7	0.2	616	17	12.3
0.3	100	5	7.8	0.4	14	2	1.1
0.1	195	7	2.6	0.1	477	15	6.4
0.1	100	5	1.6	0.1	471	15	7.5
0.1	2	1	0.1	0.1	47	6	2.7
0.1	98	5	2.2	0.1	424	13	9.4
0.5	95	4	8.3	0.3	6	2	0.5
0.3	67	4	3.8	0.2	114	8	6.4
0.2	27	3	1.9	0.2	113	8	7.9
0.2	1	1	0.3	0.1	13	3	3.4
0.3	26	3	2.5	0.2	100	6	9.6
0.9	41	3	11.6	0.8	1	1	0.4
0.1	143	5	2.5	0.1	313	11	5.5

0.1	55	3	1.1	0.1	311	11	6.5
0.1	2	1	0.1	0.1	51	4	3.8
0.1	53	3	1.5	0.1	259	9	7.6
0.5	88	4	9.2	0.4	3	1	0.3
0.4	21	2	3.7	0.4	59	5	10.5
0.3	9	2	2.0	0.4	59	5	12.5
0.5	Z	Z	Z	0.1	10	2	7.1
0.4	9	2	2.8	0.5	49	4	14.8
1.5	11	1	12.1	1.5	Z	Z	0.2

Margin of Error
0.1
0.1
0.1
0.1
Z
0.3
0.4
0.5
0.4
0.1
0.9
1.0
1.3
1.2
0.3
0.3
0.4
0.5
0.4
0.1
0.3
0.4
0.6
0.5
0.2
0.1
0.1
0.1
0.1
0.1
0.3
0.4
0.5
0.4
0.2
0.3
0.4
0.5
0.4
0.2
0.7
0.8
1.0

0.9
0.3
0.5
0.5
1.0
0.5
0.5
0.2
0.2
0.3
0.3
0.1
0.3
0.3
0.5
0.4
0.2
0.4
0.5
0.7
0.5
0.1
0.6
0.8
1.0
0.9
0.1
0.2
0.2
0.2
0.2
0.1
0.3
0.3
0.4
0.4
0.2
0.3
0.3
0.4
0.4
0.1
0.4
0.4
0.6
0.5
0.2
0.3
0.3
0.5
0.4
0.1

0.3
0.4
0.4
0.4
0.2
0.5
0.6
0.8
0.8
0.1
0.2
0.3
0.4
0.3
0.2
0.2
0.2
0.2
0.2
0.1
0.1
0.2
0.3
0.2
0.1
0.2
0.2
0.3
0.2
0.1
0.4
0.5
0.5
0.7
0.1
0.3
0.3
0.5
0.4
0.1
0.5
0.6
0.9
0.8
0.2
0.4
0.5
0.6
0.6
0.2
0.4
0.5

0.9
0.6
0.3
0.4
0.4
0.6
0.5
0.2
0.2
0.3
0.3
0.3
0.2
0.6
0.7
0.7
0.8
0.3
0.1
0.1
0.2
0.2
0.1
0.2
0.3
0.4
0.3
0.1
0.6
0.7
1.0
0.7
0.3
0.2
0.2
0.3
0.2
0.1
0.3
0.4
0.4
0.5
0.2
0.3
0.4
0.5
0.4
0.2
0.1
0.2
0.3
0.2

0.1
0.5
0.6
0.8
0.7
0.3
0.4
0.4
0.6
0.5
0.1
0.6
0.7
0.9
0.9
0.3
0.3
0.4
0.4
0.4
0.1
0.2
0.2
0.3
0.3
0.2
0.5
0.6
0.7
0.6
0.3
0.5
0.5
0.9
0.7
0.6
0.3
0.3
0.3
0.3
0.2
0.2
0.2
0.3
0.3
0.1
0.4
0.6
0.8
0.6
0.2
0.2

0.2
0.3
0.3
0.1
0.9
1.0
1.5
1.2
0.3

via electronic submission

March 3, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: ACS CAN's Comments on Proposed 1332 Waiver

Dear Administrator Verma:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Phase I of Georgia's Section 1332 waiver proposal. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. Access to health care coverage is paramount for persons with cancer and survivors. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[1] In the United States, more than 1.8 million Americans will be diagnosed with cancer this year – an estimated 55,190 in Georgia.[2] An additional 15.5 million Americans are living with a history of cancer – 446,900 in Georgia.[3] For these Americans access to affordable health insurance is a matter of life or death.

Our comments in this letter focus only on Phase I of the proposal. We have serious concerns with the proposed Phase II of the waiver proposal which is not yet complete and we have shared those concerns with the state.[4] If Georgia decides to pursue the second phase of its

---

[1] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.

[2] American Cancer Society. Cancer Facts & Figures: 2020. Atlanta: American Cancer Society, 2020.

[3] American Cancer Society. Cancer Treatment & Survivorship: Facts & Figures 2019-2021. Atlanta: American Cancer Society, 2019.

[4] https://medicaid.georgia.gov/patientsfirst.

1332 waiver, we strongly urge CMS to ensure that stakeholders have a renewed opportunity to provide input on the application before CMS determines the application to be complete.

Phase I: Reinsurance Program

ACS CAN supports Georgia's proposed reinsurance program. A well-designed reinsurance program can help to lower premiums and mitigate the plan risk associated with high-cost enrollees. We note that the waiver application anticipates the reinsurance program will reduce premiums by 10 percent in plan year 2021.[5] These savings could reduce federal government subsidy payments, and lower premiums for consumers who enroll in coverage through the exchange but are not eligible for subsidies.

Georgia's proposed reinsurance waiver is similar to that adopted in Colorado, which has been shown to reduce premiums. A reinsurance program may encourage insurance carriers to enter the market. A reinsurance program may also encourage plans already in the market to continue offering plans through the exchange. Further, the expected maintenance or increase in plan competition due to the reinsurance program may help to keep premiums from rising. These premium savings could help cancer patients and survivors afford health insurance coverage and may enable some individuals to enroll who previously could not afford coverage – the waiver application anticipates increased enrollment of 0.4 percent.[6]

We are pleased that the proposal states that Phase I of the waiver will not impact the comprehensiveness of coverage in Georgia. ACS CAN believes that patient protections in current law – like the prohibition on pre-existing condition exclusions, prohibition on lifetime and annual limits, and Essential Health Benefits requirements – are crucial to making the healthcare system work for cancer patients and survivors. We strongly urge Georgia to proceed with its Phase I proposed 1332 waiver request for the creation of a reinsurance program.

---

[5] Office of the Governor. Georgia Section 1332 State Empowerment and Relief Waiver Application. December 23, 2019. https://medicaid.georgia.gov/document/document/georgia1332draftwaiver11042019pdf/download.
[6] Id.

Conclusion

On behalf of the American Cancer Society Cancer Action Network, we thank you for the opportunity to comment on Phase I of Georgia's section 1332 waiver application. We strongly support Georgia's proposed reinsurance waiver, which we believe will provide long-term viability of the individual market while not eroding important consumer protections. If you have any questions, please feel free to contact Jennifer Hoque, Senior Policy Analyst at Jennifer.Hoque@cancer.org or 202-585-3233.

Sincerely,

Kirsten Sloan
Vice President, Public Policy
American Cancer Society Cancer Action Network

March 5, 2020

The Honorable Alex M. Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Steven Mnuchin
Secretary, U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20200

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

The Honorable David J. Kautter
Assistant Secretary for Tax Policy
1500 Pennsylvania Avenue NW
Washington, DC 20220

Submitted via stateinnovationwaivers@cms.hhs.gov

Dear Secretary Azar, Secretary Mnuchin, Administrator Verma, and Assistant Secretary Kautter,

Thank you for the opportunity to comment on the reinsurance phase of Georgia's 1332 waiver application. The undersigned organizations work collaboratively to ensure all Georgia consumers and patients have affordable, quality health coverage. We represent Georgia families and individuals, people with chronic and acute illnesses, Georgians with mental health and substance use conditions, and health care providers.

While we have considerable concerns about the Georgia Access phase of Georgia's waiver proposal, we are pleased to support the approval of the reinsurance phase of the application. A strong, robust marketplace benefits all of the Georgians we represent and facilitates access to affordable, comprehensive coverage. Georgia's reinsurance program is an important tool to stabilize the state's marketplace and help issuers cover high cost claims, which keeps premiums affordable for Georgia consumers. The proposed reinsurance program will help people with pre-existing conditions purchase affordable and comprehensive coverage, may allow some individuals to enroll who previously could not afford coverage, and will offer critical premium assistance to areas of the state with the highest costs. Our organizations are pleased that this phase of the waiver would not alter important consumer protections, including the essential health benefits requirement under section 2707 of the Public Health Service Act.

Thank you in advance for your consideration of our comments on the reinsurance phase of Georgia's 1332 waiver application.

Sincerely,

Advocates for Responsible Care
Georgia Budget & Policy Institute
Georgia Equality
Georgia Watch
Georgians for a Healthy Future
Indivisible Georgia Coalition
Jewish Community Relations Council
Jewish Democratic Women's Salon
Mental Health America of Georgia
Mercy Care
National Association on Mental Illness, Georgia chapter
Planned Parenthood Southeast
Protect Our Care Georgia
Rx in Reach Georgia Coalition
The Health Initiative
Voices for Georgia's Children
159 Georgia Together

KAISER PERMANENTE®

Submitted electronically to: *StateInnovationWaivers@cms.hhs.gov*

March 5, 2020

The Honorable Alex M. Azar
Secretary of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: *State of Georgia 1332 Waiver Application, Phase I*

Dear Secretary Azar:

Kaiser Permanente appreciates the opportunities that Section 1332 waivers present for states to address their market needs. We offer the following comments in response to Phase I of Georgia's 1332 Waiver Application submitted on December 23, 2019 by the Georgia Office of the Governor and deemed complete by the Centers for Medicare and Medicaid Services (CMS) on February 6, 2020.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to 12.3 million members in eight states and the District of Columbia. Kaiser Permanente of Georgia provides and coordinates health care services for over 300,000 members living in Metro Atlanta and Athens. The reinsurance program proposed by Georgia will impact Kaiser Permanente and our members. As one of four carriers currently operating in Georgia's individual market, Kaiser Permanente provides care and coverage to approximately 12 percent of Georgia's on-exchange market as of January 2020.

Kaiser Permanente supports Phase I of Georgia's Section 1332 Waiver Application and the proposed reinsurance program. We pride ourselves on being an active partner with the State of Georgia, and we appreciate that Georgia has welcomed Kaiser Permanente's continued engagement through the *Patients First Act* Stakeholder Advisory Council. We offer the following recommendations to further strengthen the proposed reinsurance program:

1. Georgia's reinsurance program should fully account for federal risk adjustment payments and pay only for uncompensated high risks beginning with the start of the program in 2021.

2. Georgia's reinsurance program should apply a uniform coinsurance rate to ensure equitable premium reductions statewide.

3. Beyond the first year, Georgia should continue to fund the reinsurance program using independent, sustainable funding sources.

We believe these modifications have important and constructive policy implications for Georgia. They ensure coordination between the federal risk adjustment and state reinsurance programs and make more efficient use of federal pass-through dollars. They also promote market stability and maximize carrier participation. We discuss the specific requests below.

Georgia's Section 1332 Waiver Should Fully Account for Risk Adjustment in Structuring the Reinsurance Program.

The federal risk adjustment program compensates carriers for high-risk members by transferring money among carriers based on their enrollment of individuals with high cost diagnoses. CMS has long recognized that the scale of such transfers plays a crucial role in issuer decisions to participate in the individual market.

Georgia's reinsurance program should fully account for federal risk adjustment payments and pay only for uncompensated high risk beginning with the start of the program in 2021. This will ensure that reinsurance funds have the broadest impact for all consumers, incentivize new market entrants and encourage current participants to remain in the market. Kaiser Permanente is concerned that the reinsurance program proposed in Georgia's 1332 Waiver Application will lead to duplicate payments for the same members – first from the federal risk adjustment program and a second time for claims reimbursable under the Georgia reinsurance program.

An actuarial analysis can support work to maximize use of federal dollars and optimize the market stabilization effect of the reinsurance program. Such an analysis can quantify double payments under Georgia's 1332 Waiver proposal.

Actuarial experts endorse the reinsurance-level adjustments for risk adjustment as sound policy. For example, Milliman notes that "the current federal risk adjustment methodology does not account for payments from a state-based reinsurance program and can result in double compensation for high-risk members, both from the reinsurance program and from risk adjustment. This finding may be important to many other states considering reinsurance-like proposals under Section 1332 to help stabilize their markets. Specifically, if appropriate changes to risk-adjustment are not made, a reinsurance program could lead to pricing inefficiencies and distortions that negatively impact the market and could work against the goals of the reinsurance program overall."[1] Similarly, the American Academy of Actuaries has recommended against compensating insurers twice for the same risk.[2]

---

[1] Milliman. (August 2017). *Paring Risk Adjustment to Support State 1332 Waiver Activities*. Retrieved from http://www.milliman.com/uploadedFiles/insight/2017/risk-adjustment-state-1332-waiver-activities.pdf. *See also* American Academy of Actuaries. (May 2017). *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*. Retrieved from http://www.actuary.org/content/how-changes-health-insurance-market-rules-would-affect-risk-adjustment.

[2] American Academy of Actuaries. (May 2017). *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment*. Retrieved from http://www.actuary.org/content/how-changes-health-insurance-market-rules-wouldaffect-risk-adjustment.

Kaiser Permanente operates in other states that have implemented reinsurance programs, and it has been our experience that if the program does not correct for the overlap, low-risk members and the stability of the market are negatively impacted by concentrating relief in the highest cost plans. In Maryland, we found that even partially accounting for federal risk adjustment payments in PY 2019 increased total individual market participation by 2,100 members, or roughly one percent.[3] These data show that correcting for the overlap would attract more consumers to the marketplace, improving the risk mix of the overall pool.

We appreciate Georgia's acknowledgement of the overlap issue in its response to comments received during the State's public comment period. We encourage Georgia to implement a risk adjustment dampening factor to address this issue.

Georgia retained Deloitte Consulting LLP (Deloitte Consulting) to analyze potential reinsurance payment parameters, and as a result, Deloitte Consulting possesses the data necessary to quantify the extent of the overlap between the federal risk adjustment program and the proposed reinsurance program. Georgia could request that Deloitte Consulting determine the extent of the overlap and study methodologies to correct for the overlap. This analysis should be completed expeditiously to inform 2021 individual market rates, as issuers will need to update 2021 rates to reflect expected reinsurance recoveries after the correction of the overlap.

Georgia's Reinsurance Program Should Ensure Equitable Premium Reductions Statewide.

Kaiser Permanente supports rural Georgia and understands the desire to focus premium reduction efforts on rural areas. We also believe reinsurance programs should provide equitable premium reductions statewide. A geographically tiered model could create excessive disadvantages to residents in urban areas, who will not realize the same premium reduction benefits as those in rural areas.

Geographic tiering could lead to unforeseen adverse impacts on carrier participation, affordability and access to care in areas that receive lower rates of reinsurance. We support a reinsurance program that works for all Georgians.

Beyond the First Year, Georgia Should Continue to Fund the Reinsurance Program Using Independent, Sustainable Funding Sources.

Kaiser Permanente supports independent, sustainable funding sources for the state reinsurance program that will adequately address the costs of high-risk individuals and adjust over time to remain a stabilizing element in the individual market. A state-based reinsurance program could be supported through state appropriations dollars (e.g., $104 million projected contribution from the state in the first year) and appropriately tailored federal pass-through sources; we support this combination of state and federal funds. We also support the state's intent not to collect a state-

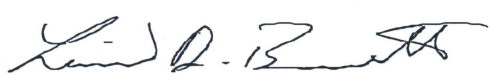
[3] Data showing the impact of overlap correction on membership and rate increases in Maryland are included as Appendix I.

based user fee for the program in the first year; however, we remain concerned about future state-based funding sources.

* * *

We appreciate the opportunity to comment on this waiver application and hope to continue to partner with Georgia throughout the implementation of its reinsurance program. Please contact me at Laird.Burnett@kp.org or 202-216-1900 with any questions.

Sincerely,



Laird Burnett
Vice President
Government Relations
Kaiser Permanente

Appendix I: Impact of Overlap Correction in Maryland Individual Market

The data below show the impact of partial overlap correction on the two carriers operating in the individual market in Maryland in 2019, Kaiser Permanente (KP) and CareFirst (CF).

2019 MD Individual Rate Increases	**KP**	**CF HMO**	**CF PPO**	**Total**
Estimated 2019 Membership	75,000	123,000	14,000	212,000
Estimated 2019 Market Share	35%	58%	7%	100%
2019 Rate Increase without Reinsurance (RI)	27%	14%	68%	22%
2019 Rate Increase with RI **without** Overlap Correction	0%	-20%	-18%	-13%
2019 Rate Increase with RI **with** Overlap Correction	-7%	-17%	-11%	-13%
2019 Bronze Rates (40yo) **without** Overlap Correction	$322	$303	$511	$323
2019 Silver Rates (40yo) **without** Overlap Correction	$377	$371	$579	$387
2019 Gold Rates (40yo) **without** Overlap Correction	$441	$423	$613	$442
2019 Bronze Rates (40yo) **with** Overlap Correction	$298	$313	$552	$323
2019 Silver Rates (40yo) **with** Overlap Correction	$349	$383	$626	$387
2019 Gold Rates (40yo) **with** Overlap Correction	$408	$437	$663	$442
Membership gained with Overlap Correction				**2,100**
% of Market				1.0%

Notes:

1. Data pulled from 2019 approved rate filings and 2019 pre-Section 1332 waiver filings.
2. 2019 CF rate increase with no overlap correction estimated based on KP data based on revenue neutrality.
3. CF rates without overlap correction are estimated based on the above calculated rate increases.
4. Estimated 2019 membership based on a January 2019 report from the Maryland Health Benefit Exchange.

National Alliance on Mental Illness

March 6, 2020

Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Georgia 1332 Waiver Application - Reinsurance

Dear Secretary Azar:

NAMI, the National Alliance on Mental Illness, appreciates the opportunity to comment on Georgia's Section 1332 Waiver Application. NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

Access to affordable health coverage and care is essential for people with mental illness to successfully manage their condition and get on a path of recovery. Reinsurance is an important tool to help stabilize health insurance markets. Reinsurance programs help insurance companies cover the claims of very high cost beneficiaries, which in turn keeps premiums affordable for other individuals buying insurance on the individual market. Reinsurance programs have been used to stabilize premiums in a number of health care programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[1] A recent analysis by Avalere of seven states that have already created their own reinsurance programs through Section 1332 waivers found that these states reduced individual market premiums by an average of 19.9 percent in their first year.[2]

Georgia's proposal will create a reinsurance program starting for the 2021 plan year and continuing for five years. Based on the initial analysis commissioned by the state, this program is projected to reduce premiums by 10.0 percent in 2020 and increase the number of individuals obtaining health insurance through the individual market. This would help patients with pre-existing conditions like mental illness obtain affordable, comprehensive coverage.

NAMI urges you to approve Georgia's reinsurance application. We also appreciate your decision to separate Georgia's reinsurance application from the state's "Pathways to Coverage" application, consideration of which is paused pending additional information and analysis from the state. We believe close scrutiny of that waiver will necessitate that HHS deny the request and protect quality and affordable health care coverage for individuals with mental illness and other pre-existing conditions. Thank you for the opportunity to provide comments.

Sincerely,

/s/

Jennifer Snow
Director of Public Policy
NAMI, National Alliance on Mental Illness

---

[1] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

[2] Avalere. *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average.* March 2019. Retrieved from https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average.

February 24, 2020

Via Electronic Mail at
StateInnovationWaivers@cms.hhs.gov

The Honorable Alex M. Azar II, Secretary
U.S. Department of Health and Human Services

The Honorable Steven T. Mnuchin, Secretary
U.S. Department of Treasury

Seema Verma, Administrator
Centers for Medicare and Medicaid Services

Re: Georgia Reinsurance Program – State Relief and Empowerment Waiver (Section 1332 Waiver)

Dear Secretary Azar, Secretary Mnuchin and Ms. Verma:

On behalf of the Georgia Hospital Association (GHA) and its 161 hospital and health system members, we welcome the opportunity to submit comments on Georgia's State Relief and Empower Waiver application to establish a reinsurance program (the "1332 Waiver"). **GHA appreciates the state's hard work under the *Patients First Act*[1] to develop a Georgia solution to reduce premiums, increase coverage, and promote a more competitive private insurance marketplace.**

Georgia currently has the second highest percentage of uninsured residents in the nation,[2] and health insurance premiums on the individual market are unaffordable for many. This is a significant contributor to the current health care crisis in our state, which has led to seven hospital closures since 2010 and resulted in a rank of 46 out of 50 for access to quality health care and preventative services.[3] The *Patients First Act* provides the state with a historic opportunity to not only increase access to affordable, comprehensive health care coverage, but also improve the overall health of Georgia citizens in all parts of the state. With these goals in mind, GHA respectfully offers the following comments in support of Georgia's 1332 Waiver.

---

[1] O.C.G.A. § 49-4-142.3. The *Patients First Act* (Senate Bill 106) into law by Governor Brian Kemp on March 27, 2019. The Act authorizes the Governor to submit a Section 1332 Innovation Waiver to identify innovative health insurance coverage solutions for the commercial health insurance marketplace and also authorizes the state's Medicaid agency to submit a Section 1115 Medicaid Demonstration Waiver application to the Centers for Medicare and Medicaid Services.

[2] Kaiser Family Foundation, 2018 Health Insurance Coverage of the Total Population, available at: https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Feb. 17, 2020).

[3] Georgia Department of Community Health Waiver Project, Georgia Environmental Scan Report (July 8, 2019).

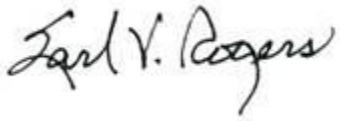
Georgia Hospital Association
1675 Terrell Mill Road, Marietta, Georgia 30067 / Phone: 770-249-4500 / Fax: 770-955-5801 / http://www.gha.org

Reinsurance programs have been approved in 12 states[4] and are proving to be effective at reducing premiums and maintaining insurer participation in the individual market.[5] Action is needed to stabilize the Georgia marketplace for individual health plans where choice is limited and the cost is high. In 2020, residents from over half of Georgia counties can choose a plan from only one insurer. The number of individuals purchasing plans on the federal Marketplace dropped each year from 2016 to 2019 and remained relatively stable in 2020 as premiums have continued to rise for plans purchased on and off the federal Marketplace. In order to afford health insurance, many individuals end up purchasing plans with lower premiums, but high deductibles or other cost-sharing. These types of plans often leave patients under-insured. They have coverage, but the deductible is so high, health care services remain unaffordable.

Without access to coverage with both affordable premiums and cost-sharing, patients often put off treating illnesses when they first appear and are the most treatable. As the illness progresses, patients often end up in the emergency room where they know they will receive treatment regardless of their ability to pay. This helps to explain why the amount of uncompensated care provided by hospitals, which was $2.21 billion in 2018, has increased over the last three years.[6] (Note this amount represents the cost of providing care, not the charges for care.) The tiered reinsurance program in Georgia's 1332 Waiver will help improve the health of Georgians both by increasing coverage and allowing those who already have coverage afford to use it. **For these reasons, GHA strongly supports the reinsurance program in the 1332 Waiver.**

We look forward to continuing to work with the state to help implement this important program in an efficient and effective manner. Please feel free to contact me at 770-249-4531 or erogers@gha.org with any questions or if you desire to discuss these comments further.

Respectfully submitted,



Earl V. Rogers
President and CEO

---

[4] Kaiser Family Foundation, Tracking Section 1332 State Innovation Waivers (2019), available at: https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/ (last visited Dec. 2, 2019).

[5] Chris Sloan, Neil Rosacker and Elizabeth Carpenter, *State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average*, Avalere (2019), available at: https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average (last visited Dec. 2, 2019).

[6] Department of Community Health, Hospital Financial Survey (2018).

#1
2/07/20

This proposal would be a huge plus for my family. I make a decent income but every year we are struggling with healthcare costs as we are a single family income house. We have 4 boys and every year insurance costs go up while the benefits cover less and less. I'm currently paying over $1600 for a plan that is basically a high deductible plan. I need sinus surgery but we can't afford it since my plan doesnt cover outpatient surgeries. We also pay $60 for every specialist visit. When my wife tore her plantar fasciitis it was another large cost. PLEASE PASS THIS WAIVER. WE NEED IT

MR

#2
2/07/20

Hello,

https://www.ajc.com/news/state--regional/feds-push-georgia-plan-subsidize-health-insurance-next-step/qPC0XAB8PwTKyyVtC2R5XM/

While I applaud the effort to tackle the enormous healthcare challenges, who will pay for these subsidies? The taxpayer? How does that help us?

When will the government go after the greedy insurance companies and the out of control cost of healthcare?

Thank you for your time.
SP

#3
2/08/20

The cost of healthcare is absolutely devastating. Especially, if you have an illness like cancer. Provider costs for cancer treatment are outrageous and will leave people broke. They will treat you until the insurance which in itself is outrageous along with co-pays, deductibles etc. It is a double slam financially to financially rape sick people. I have the most deadly of all Women's cancers, Ovarian. I am also BRCA1+ a genetic mutation I was born with and had all my life is responsible for breast, ovarian cancers. BRCA hasn't receive any visibility until recent years. I was tested and it was a shock because I had no family history of breast or ovarian cancer and it is a heredity gene. I have had this terrible incurable disease for 7 years. I cannot tell you enough about how financially stressed I am. I see the Dr. every month because I need labs, I

need CT scans, MRIs, mammography. I take a special cancer drug orally called Lynparza now designed for BRCA ovarian cancer patients. Its use has expanded to some other cancers. It was approved by the FDA in 12/2014 I started taking it in 1/2015. The cost of this medication for me is between $15,000 - $16,000 a month. I had to eventually leave my job. I paid out of pocket the total cost for COBRA which ends 2/29/2020. I am applying through Healthcare.gov. There is only one insurance [*name of hospital*] will take it is Peach State Ambetter. I plan on having it 3/1/2020. However, it covers nothing of the Lynparza or much on any drugs that aren't generic but I needed [*name of hospital*] to manage my cancer care. I will be able to receive Medicare 10/1/2020. I am bridging a 7 month gap until I can get Medicare which I had to wait 2 yrs after being declared disabled because of the deadly cancer diagnosis I have. I will be 63 in October. I do have some Lynparza to carry me through a few months but not all. My only hope is AstraZeneca will have some kind of charity for probably the first person that was put on the drug after it was approved by the FDA. I cannot afford $16,000 for medicine. This is a targeted therapy and is oral which is shipped from a specialty pharmacy. We need some improvements to our current system because this is just morally wrong on any level the cost of healthcare. Why does a country not want its citizens to be healthy? I don't understand? It is not in anyone's benefit to treat the sick this way or maintain a healthy population. It is counter productive.
If you have questions, please call me.

RP
Atlanta, GA 30309

#4
2/08/20

How does this address the uninsured????? GA needs money to expand Medicaid.

KM

#5
2/08/20

I am totally against the state taking over my access to healthcare.gov. Why can't the state offer its subsidies to those who want them and let the rest of us use the federal system if we so choose? Why not let us compare the state plan with the federal plan and see which plan offers us the best deal? Right now, the federal plan is working for me. I don’t want to see my options further limited.

BG

#6
2/09/20

Hi,
The BEST WAY to solve everyone's health insurance issue is to 1) REMOVE this MIDDLE-MAN insurance companies. Because having such middle-man increases costs by 30%. 2) Make a law listing FIXED price for EACH AND EVERY procedures (i.e. CPT codes as per the language of insurance companies billing department) per zip code. 3) Make a law listing FIXED salary (compensation) for NON-HEALTHCARE workers such as CEO, CFO, CONTROLLER, ADMINISTRATORS,..etc in hospitals.
What would be effects of these policy changes on the cost to the patients?
A) Implementing just 1) above will reduce cost by minimum 30%
B) Implementing just 2) above will reduce cost by minimum 82% as hospitals and doctors as such gets paid ONLY 18% of what they bill.
C) Implementing just 3) above will reduce cost by minimum 10%

If you want me to support this with actual data- I will be glad to email you publicly available financial documents from one of top tier- Trauma level 1 hospital- Grady Memorial hospital in Atlanta, GA or you can just download it from their websites.

Note: Changes you are proposing in your proposal will just distribute money from one person to another but will not help reduce the administrative cost in the current healthcare system. so, you either implement this way or just leave it "as it is" currently.

KY

#7
2/10/20

Hello,
I currently get my health care coverage through the ACA and qualify for a premium subsidy. I strongly oppose Georgia's plan to take the premium subsidies and re-distribute as they see fit. This plan puts my own health insurance more at risk than allowing me to continue to apply for coverage myself. Without a solid long term plan and administrative budget, this state proposal cannot even be evaluated for its viability.
Please do not approve this.

Sincerely,
WP & NP

#8
2/10/20

The Obamacare rules should stand. Georgia had its chance to increase Medicare for the state and failed because of Republican politics which take from the poor and give to the rich.
A family that makes $104 thousand a year can afford insurance and they don't need the governments help.

KS

#9
2/10/20

I am the CEO of a medical billing company and reside at [*Address*]., Atlanta 30327. My experience with healthcare affords me a complete view of the waiver program. It would be a huge mistake to let these funds offset costs for plans that are not ACA compliant. Patients are incredibly confused with the coverage they buy and what should or should not be covered. It is very sad to see patients who buy plans that don't cover their needs. Often the plan shortcomings don't become apparent until the patient tries to use the plan. Many of the non-ACA plans have such skimpy coverages that they really are not worth the money spent on them. I think to offset losses for non-ACA plans would be a waste of funds.

MNM

#10
2/10/20

Dear Sirs:
I want to provide a list of my concerns regarding the waiver request by the State of Georgia, and some questions I would want full and complete answers and related documented historical examples to support the assumptions of the waiver.

1. The State wants to pay some of the health insurance claims of people who bought insurance under the ACA under the assumption that the insurers would "save money and need to charge less."
a. Is there a requirement in the waiver to make insurers lower their premiums in exchange for the State to pay some of the claims?
b. How is this partial payment work in conjunction with the deductibles inside the individual policies written by the insurers?
c. What incentive do the insurers have to lower premiums if there is no requirement to do so?
d. How does the State know that premiums will be lowered in such a plan?
e, Where is there any historical instance where a similar plan has successfully achieved any reduction of private health insurance premiums for the government to make partial payments of

insurance claims.
f. Furthermore, what is the exact method to determine which claims qualify for such government payment?

Unless there is a requirement for **meaningful and substantial** premium reductions the State is relying on the "goodness" of the private, **for profit**, insurance company to voluntarily lower its rates. I do not have much faith in that assumption. Do you?

Let me remind you that even the Federal government has a poor track record of actually meeting its assumptions that certain economic results will follow the implementation of laws effecting the US population of businesses and individuals. I direct you to the current history of the rate of GDP growth since the beginning of the 2018 Internal Revenue Code, which was "promised" to generate 3 or more per cent growth each year and pay for itself. I believe the current deficit projection for this year is at $1 trillion. So much for the tax cuts "paying for themselves."

2. The State wants to take control of the federal subsidies that lower costs for lower-income policyholders in the ACA so that they can be used to pay premiums on health insurance policies that do not currently qualify for ACA. There is a reason they do not qualify, and it is not just because the law says so. In crafting the ACA the intent was to make sure that private health insurance provided **meaningful** economic benefit for the premiums collected. What is the benefit of paying on something that does not actually cover a policyholders' probable and possible medical needs?

The health insurance industry is very talented in selling policies which are called health insurance policies that can easily leave out needed coverage. For most individuals who have not had much interaction with the medical industry it is very hard to think of all the general types of coverage an individual would need. However, the health insurance industry is very much aware of those needs and related costs. How is the individual going to know what to ask for?

Is the State of Georgia going to make sure that for the premiums paid the individuals are getting a reasonable "return" on their premium dollars?

Is there anything in the Waiver to make sure that health insurance company policies actually provide usable coverage?

One of the biggest issues in our health care system in the US is the number of people seeking health care who have no health insurance or inadequate health insurance. Since providers are required to treat these people in an emergency situation, which is pretty much the case when these people show up at the ER, this creates noncollectable debt which we all pay by higher overall health costs charged by the providers to cover the shortfall. The health insurance premiums also pay this noncollectable portion.

I contend that the State takeover of the Federal subsidies in order to lower the quality of the health insurance policies in exchange for lower premiums will exacerbate the noncollectable debt situation in Georgia, thereby increasing health insurance premiums in the future...the exact opposite result the State is trying to achieve.

I recommend non-approval of the waiver as currently configured.

EK, CPA
Atlanta, Georgia 30338-5457

#11
2/10/20

Governor Brian Kemp of Georgia is trying to get approval for his version of this health insurance waiver. I am concerned because the biggest beneficiaries under this proposal would be those who already have above-average incomes. I am also very concerned that this proposal would seek to eliminate Georgian's access to the healthcare.gov website.

It seems to be another way to undermine the success and intent of the Affordable Care Act. I feel very strongly that this proposal would NOT prove helpful to the people of Georgia who are the most in need of assistance to access basic health care.

Sincerely,
BP

#12
2/17/20

The proposed Georgia Waiver raises one big question for me. The state claims that by providing money to insurance companies to help pay for the more expensive claims, insurance companies will be able to lower premiums. My question is what assurance do we have that the insurance companies will use this benefit to lower premiums? Is there some requirement that they use the state monies to lower premiums or will this just become another form of corporate welfare?

Thank you,
CYW
Palmetto GA 30268

#13

2/20/20

I do NOT support Georgia's request for a waiver.
I do NOT trust Georgia to fairly implement, fully fund, and adequately administer any health insurance program.
I do NOT believe the program will work -- insurers will game the system and politicians will divert other healthcare dollars weakening the overall system.
I do NOT believe insurance companies will reduce premiums since they will continue to justify increases.
I do NOT believe Georgians will benefit from the proposed program.

Many Georgians such as myself, do not have employer based health insurance and purchase insurance through Healthcare.gov. Some purchase through the marketplace in order to get the Advance Premium Tax Credit while others do so to reserve their ability to claim the Premium Tax Credit when filing their taxes. These individual purchase insurance through the marketplace simply because they don't have employer based coverage or affordable employer based coverage.

Governor Kemp wants to provide subsidies to employer based plans; however, most employer based health plans are already subsidized by Section 125 premium-only plans, HSA plans, employer payments, and large group discounts. To divert federal PTC dollars to employer based plans will take money from other citizens who don't receive employer based subsidies. These individuals will end up paying more for coverage.

The purpose of the PTC is to encourage individuals to purchase qualifying ACA compatible health insurance instead of scaled-down, limited benefit policies which don't cover pre-existing conditions and leave the insured subject to bankruptcy. The PTC was not designed to cover short-term policies and non-ACA policies. To do so, would be to squander money on insufficient coverage.
Governor Kemp wants to remove Georgian's ability to access the healthcare marketplace. This will make finding and comparing policies more onerous on the citizens of Georgia.

Unless and until the federal government comes up with be better health care solution such as universal healthcare, the federal government should keep control of the money. Republican politicians and Republican state governments have not supported the Affordable Care Act and have made every attempt to dismantle the ACA. Governor Kemp's request is just another attempt to weaken and destroy the ACA. Governor Kemp's request is just another attempt to control healthcare dollars in Georgia -- and direct them for political motivations.

I request that Georgia's waiver be denied.

Sincerely,
JJ, CPA
Canton, GA 30114

#14
2/21/20

I do not support Governor Kemp's 1332 waiver.

1. Short term policies do not cover enough services and are a bad option for most Georgians. They are also deceptive in that they do not adequately disclose what they don't cover.

2. In your proposal, you do not have a plan for regulating web brokers and private insurers. Healthcare.gov has rules in place regarding conduct, marketing practices and consumer privacy and should be available to Georgians to enroll in healthcare and as a tool for comparison shopping.

3. Since the waiver would let consumers use subsidies to buy plans that exclude essential health benefits, healthier people would buy these lower-benefit, lower-premium plans, while less-healthy people would use their subsidies to enroll in comprehensive coverage. This would increase premiums for comprehensive plans and per-person subsidy costs would rise. If you don't budget enough, the subsidies will have to be rationed. This would end up denying subsidies to those who would benefit from them if not for the waiver.
There are better options to help Georgians with their healthcare. Expand ACA Medicaid and try the reinsurance program to bring down middle-class consumer premiums. It's much simpler for the state and consumers.

Thank you,
TJ

#15
2/24/20

Hi
I stopped working after a difficult recovery from spinal fusion surgery. I'm 63, my husband is on Medicare. We're very lucky he has a modest pension. With that, his Social Security, and the Required Minimum Distribution from his 401K, we're a tad above eligibility for the ACA subsidy on my health insurance.
My monthly premium is $995.00 with a $5000 deductible.
To afford my coverage, I took my Social Security at age 62. Not something I really wanted to do, but we found necessary.
This waiver would help people in my situation.
I'm sure many women in their 60's make a decision between working or quitting to stay home to care for an elderly parent. This waiver would help them.
And if course, self-employed people struggle with high premiums if they make too much money.
What per cent of the population buying insurance through ACA does NOT qualify for a subsidy? It looks to be about 13%, from what I can find.

The 368 million cost for Georgia in the Atlanta Journal Constitution seems high.
https://www.npr.org/sections/health-shots/2018/12/14/674791999/health-costs-bear-down-on-families-who-dont-qualify-for-aca-subsidies

Thank you,
BK
Lilburn

#16

2/25/20

Dear HHS
I am a physician practicing in the State of Georgia. I am against the Section 1332 waiver. As the State has made changes, they have had terrible consequences, both seen and unforeseen. For example, the State of Georgia required Pediatricians to register with the State to receive higher reimbursement rates via Medicaid. The State failed to inform Pediatric Sub-specialists which I also am and was practicing at the time. I am not practicing general pediatrics and have to take a lower reimbursement rates.

The State of Georgia uses large Dow Jones Listed companies to administer Medicaid. These companies make many millions of profits and still refuse to provided medically necessary care. It is impossible to complain to the state, because complaints must flow through these companies. They have nurses, pharmacist, and non same specialty physicians making decisions to deny care and refuse true peer to peer communication.

This change will cause people to lose their coverage and put additional profits outside of what ACA allows into the pockets of large companies. This is a form of transferring social welfare to corporate welfare. It is unacceptable and should not be allowed.

Thank you
MP, MD

#17

2/27/20

I am writing to oppose Phase II, Georgia Access Model. The current ACA using Healthcare.gov website has been wonderful. It is easy to use and has provided my daughter, 40, with bipolar, excellent health insurance and with the current subsidy very affordable. For us the system is not broken and it has saved my daughter's life. Prior to ACA we could not purchase health insurance for her because of preexisting condition.

It makes no logical sense to deny us the ability to use Healthcare.gov which is a proven system, efficient and effective. Why would the state need to waste money to develop a new system? The current silver plans meet our needs. We must have comprehensive plans that include behavioral health services.

The State of Georgia has a deplorable track record in meeting the health needs of its citizens. The investment in community mental health services has been inadequate to meet the needs and has resulted in higher suicide and incarceration rates. The state is more interested in assisting Insurance brokers and faith based plans over providing real qualified health plans which meet the comprehensive health needs of those who are unable to work a regular job and get employer sponsored insurance but with ACA they can work part time as their illness allows and be contributing citizens.

We have to look to the federal government to see the wisdom of maintaining the current ACA and not allowing the state to dilute the coverage and subsidy by taking care of business over the needs of the uninsured.

I implore you to reject Phase II of the Georgia Plan, I feel that my daughter's life has been saved by ACA and would be in jeopardy under the state's ill conceived waiver.

Regards,
LB

#18
2/28/20

There is no reason to destroy Medicaid. But, this is the whole point of the same process tried before in Washington, DC. It would take as much money as that which would be spent on just expanding Medicaid. Why would you add funds for those already with insurance? This proposed scheme would give less and less funds each year, until no money would be available for the poor. Please don't demonize the poor. As I am on SSDI, I fear for the future. Now, I have no hope at all. Ask those who work with people every day. Please expand Medicaid, and keep it as is.

ME