November 21, 2017

John R. Graham
Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Concerns with Recent ASPE Reports Regarding Individual Marketplace Costs, Enrollment and Trends

Assistant Secretary Graham:

We would like to bring to your attention concerns with regard to the interpretation of data and research contained in recent reports released by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Specifically, we are concerned that recent reports regarding individual marketplace costs, enrollment and trends have not conveyed the appropriate context and analysis that would allow readers of ASPE's data and research to draw accurate conclusions and foster a better understanding of the complex issues being evaluated, and more importantly that their "Key Findings" could lead to readers being confused about the actual impacts reflected in the underlying data. Given ASPE's role as an advisor to the U.S. Health and Human Services secretary, and its role in informing a broad array of policy makers and the public, we share these concerns in hopes that they will be viewed as constructive and advance policy-making that is truly "evidence-based."

ASPE has a clear charge of advising the secretary of the U.S. Department of Health and Human Services on "*policy development in health, disability, human services, data, and science*" and *"provid[ing] advice and analysis on economic policy."* ASPE's work also informs the broader policy-making community. Given its important charge, ASPE's efforts must be anchored in solid analysis of complex information so that it is viewed as a trusted source of data and research to be used to drive policy decisions. Over the years, the rigorous methods and careful attention to detail that is the hallmark of most ASPE research is a standard that has earned it respect and appreciation nationally, and served as a model for other national and state-level agencies to follow.

To the extent ASPE produces and shares meaningful and useful information, it not only ensures the Health and Human Services Secretary can most ably advise the president on policy options, but also helps policy makers, academic researchers and the media professionals who educate the broader public about federal programs and frame complex issues of importance to millions of Americans. To that end, we offer observations about some of ASPE's recent work. Two ASPE reports on health coverage in the individual insurance market were recently released: Individual Market Premium Changes: 2013-2017 (which compares premium changes for plans purchased in 2013 and 2017) and Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange (which is an annual report that analyzes health plan choices and premiums for the upcoming benefit year). The reports appear to provide data and research in a

way that limits readers' ability to accurately interpret findings, and which could easily mislead readers to erroneous conclusions.

As is always the case with reports that look only at the "Federal Health Insurance Exchange," these reports exclude from their analysis the 12 state-based marketplaces — which represent the experience of 25 percent of Americans.[1] We understand that in some cases, ASPE may not have available the data required to report on State-Based Marketplace states, but their exclusion means ASPE reports do not provide a complete perspective on the experience Americans are having in the individual markets. While it is certainly the case that the federal government has a more direct role in managing the federal marketplace, ASPE and HHS are responsible for ensuring the effective implementation of the Patient Protection and Affordable Care Act in all 50 states. And, the extent to which state-based efforts to implement the Affordable Care Act are more or less effective is a vital piece of information that should inform the Secretary and policy makers at the national and state levels.

For example, while the Key Findings of the report on 2018 Health Plan Choice and Premiums highlights the fact that eight states in the Federal Exchange will only have one carrier in their state, the fact that none of the State-Based Marketplaces have only one carrier is not highlighted. Similarly, the reality that in twenty states, when the State-Based Marketplace (SBM) states are included, have more than four carriers in their state is not highlighted. Understanding state variation is vital to diagnosing the reasons for different performance across states and this cannot be done without examining the entire nation.

The extent to which state-based efforts to implement the Affordable Care Act are more or less effective is a vital piece of information that should inform the secretary and policy makers at the national and state levels. We would welcome ASPE initiatives to research impacts on all 50 states. In the interim, we believe it is essential to clearly denote in any "key findings" or summaries that the analysis may not reflect the experience in the SBM states.

Beyond the issue of the exclusion of State-Based Marketplaces, however, even with the limited data considered we found that:

- The "Key Findings" do not reflect the actual impact experienced by most consumers.
- Data is reported with incomplete context and analysis.

Observations in more detail on these reports can be found in the attached "Review of ASPE Reports on Individual Market Trends and Premiums." Two examples of "findings" recently used by Acting Secretary Hargan that were taken directly from the lead "Key Highlights/Summaries" from the ASPE reports highlight why the framing and presentation of the data are misleading. While the points are technically accurate, they are misleading because they narrowly interpret the data and fail to reflect the realities of the vast majority of consumers about whom, in theory, the data is supposed to represent. The result are "findings" that are misleading and create unfair representations of the consumer experience in the individual market.

1. **"Individual market premiums in 39 states on the federal exchange rose 105 percent" from 2013 (immediately prior to the Affordable Care Act).[2]**

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[1] Based on the CMS-issued effectuated enrollment report, the 39 states on healthcare.gov collectively have 7.7 million enrollees, or 75 percent, and the 12 state-based marketplaces have 2.6 million enrollees, or 25 percent. Available at: https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf

[2] Remarks by Acting Secretary Hargan on Health Reform to the U.S. Chamber of Commerce, Oct. 17, 2017. Available at: https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/remarks-on-health-reform-to-the-us-chamber-of-commerce.html

This "key finding" does not accurately represent the premium experience of most consumers in the individual market during 2013 to 2017, as reflected in ASPE data.

- Based on the CMS-issued report on open enrollment for 2017 coverage, 10 million Americans — representing a majority (58 percent) of those in the individual market — were receiving Advance Premium Tax Credits (APTC).[3] For these individuals, their average monthly premium was $106 in 2017 — *a 54 percent decline from the 2013 average premium*.[4]

- For those who do not receive financial help, premiums may have indeed risen by the reported amount for the federal marketplace states, but in virtually all cases, the benefits purchased for these premiums are far more robust than what consumers received prior to implementation of the Affordable Care Act. While there is passing reference to the fact that these are not "apples-to-apples" comparisons, there is no attempt to measure or indicate that for many of these individuals who needed and received care, they were better off financially.

- The pre-Affordable Care Act premiums also reflect a very different market, one that denied applicants seeking coverage and often excluded consumers with pre-existing conditions. This situation yielded 2013 premiums for a very different cohort of enrollees.

2. **"Now, for the 2018 plan year, we have seen benchmark premiums increase 37 percent."[5]**

   This "key finding" only reflects data for consumers who do not receive financial help. It fails to reflect the data for consumers who receive financial help and, for those without subsidies, does not accurately reflect their experience:

   - *On average the eighty-four percent of enrollees in Healthcare.gov who receive tax credits saw their premiums drop by about 3 percent in 2018 from 2017* (see Table 6, page 10: from $142 per month to $138 per month for a 27-year-old). While the data relevant to this fact can be found embedded in the report, it is not included in the "Key Findings." Instead, readers must do their own calculation of premium and the impact of the Advance Premium Tax Credit to see what average consumers would see when they renewed their coverage or enrolled through healthcare.gov.

   - The "Key Findings" section also reports that the portion of "enrollees with access to a plan for $200 or less" declined to 6 percent. However, this finding only reflects data pertaining to consumers who do not receive financial help. It fails to report that for the 84 percent of enrollees who get financial help, this is *not* the premium that they will pay. The body of the report itself identifies the fact that in 2018, 80 percent of enrollees will be able to purchase a plan for $75 or less (see

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[3] A recent Congressional Budget Office report identified 17 million people purchasing individual health coverage inside and outside of the marketplace. Available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf

[4] The $106 average premium after APTC for the 39 states on the federal marketplace is the best publicly available number reported by CMS in its final enrollment report. While this report does not focus on effectuated enrollment, the average net premium should be the same or fairly similar. See more at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.

[5] "Remarks by Acting Secretary Hargan on Health Reform to the American Action Forum and the Council for Affordable Health Coverage." Nov. 1, 2017. Available at: https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/remarks-on-health-reform-to-the-american-action-forum-and-the-council-for-affordable-health-care.html.

Table 9, page 14), but this is not included as a "Key Finding" even though it is a clearer representation of consumers' experience.

- *For individuals who do not receive a subsidy, the reported 37 percent increase figure is misleading because it is largely inapplicable.* The reported premium is for the second-lowest-cost Silver plan on healthcare.gov. However, the vast majority of consumers who purchase individual coverage without financial help do so off-exchange.[6] For 2018, given the fact that across the nation most health plans loaded the cost of paying for the cost-sharing reduction (CSR) program in the form of a surcharge on their Silver subsidized premium and not on their off-exchange products, the vast majority of those who do not get a subsidy will pay much less than the reported premium increase.

- Finally, in the body of the report there is reference to the fact that "many states required issuers to load an additional premium increase onto silver plans to account for uncertainty associated with ongoing CSR litigation." However, there is no attempt to put in context the fact that in many states, the largest single contributing factor to the cited 37 percent increase is the added surcharge included in the premium price to offset the loss of federal funding for the cost-sharing reduction program. As an ASPE research product describing recent individual market premium increases, the full context, amount and implications of the CSR price impact should be reflected in the report. As policy discussions continue regarding the cost-sharing reduction program, it is critical that the premium impacts on consumers and on taxpayers of the loss of federal funding to the program be made clear.

At Covered California, we can relate to the challenge and responsibility ASPE faces in distilling and communicating to the public and policy-makers complex health policy issues. From a mass of data, a public agency must choose what it interprets, summarizes and includes in "Key Findings" – which many readers may rely on exclusively to draw conclusions, without taking a deeper look into the data and research. Presenting isolated data points without appropriate explanation does not serve and could mislead policy makers. Data in context and with accurate framing can become useful information for policy makers as they seek to find the best path forward to construct policies that balance the issues related to:

- Affordability of coverage, for those who do and do not receive financial assistance;
- The nature and implications of coverage for those who are getting the care they need; and
- The costs to individuals, taxpayers and other key stakeholders.

As part of our ongoing efforts to inform the national policy discussion, Covered California regularly shares data and research that describes our marketplace, the enrollee risk mix and premium impacts on both subsidized and unsubsidized Californians in the individual market. The news from California has been generally positive: we have robust and continued plan competition and choice for consumers; benefit designs that foster consumer-driven markets; premium trends that over the past four years have averaged in single digits; a good risk mix; and a huge reduction in the uninsured.

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[6] A recent Congressional Budget Office Report estimates 2 million unsubsidized consumers purchasing coverage through marketplaces and 5 million consumers purchasing coverage outside marketplaces for 2018. Available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53091-fshic.pdf.

That said, we have also been consistent about reporting “bad news.” For example, when releasing the premium increases for 2018, we headlined the 12.5 percent overall rate increase, even though on average for those receiving subsidies their costs will go down. We seek to make information available both about the overall premium increase and the impact on those receiving subsidies in order to paint a full and clear picture of the marketplace, and will continue to do so to ensure that we remain a credible source of research, data, and policy analysis that policy makers and the public can trust.

As an organization that seeks to practice and inform evidence-based policy-making, we are consumers of the data and research that is developed by ASPE. We look forward to future reports, and will continue to offer comments and feedback as they arise, and we similarly invite your review and feedback of our own analyses. We hope you will find helpful the attached “Review of ASPE Reports on Individual Market Trends and Premiums” and we will be happy to make ourselves available for any questions you may have.

Please know that we send these comments with sincere interest in continuing to work with the administration, providing technical assistance based on our own latest research and findings, and learning together so that we can improve health coverage and health care outcomes for all.

Sincerely,

Peter V. Lee
Executive Director

cc: Eric D. Hargan, Acting Secretary, U.S. Department of Health and Human Services
Seema Verma, Administrator, the Centers for Medicare and Medicaid Services

Attachment: Review of ASPE Reports on Individual Market Trends and Premiums

Review of ASPE Reports on Individual Market Trends and Premiums

November 21, 2017

ASPE Data Point: Individual Market Premium Changes: 2013-2017, May 23, 2017 **Key Findings in ASPE Report (Verbatim)**	**Policy and Market Context Discussion**
Premiums for individual market coverage have increased significantly since the Affordable Care Act's key provisions have taken effect, but most estimates have focused on annual increases and have not captured the comprehensive increase in premiums since 2013, and thus do not accurately capture the ACA's true effect.	The assertion that the report is intended to "accurately capture the ACA's true effect" is challenged by the report's failing to discuss (a) the impact of financial assistance that immediately lowers the reported *gross* premiums for a majority of consumers; and (b) the changes in product quality (level of coverage, guaranteed issue) that accompanied the changes in prices. **Impact of financial assistance:** When ASPE released the Data Point report, CMS had already released the final enrollment report for Nov. 1, 2016, through Jan. 31, 2017. This report stated that 10.1 million Americans were receiving an Advance Premium Tax Credit (APTC), and their net premium was on average $106 (a 54 percent decline from the "average premium" in 2013).[7] (The only reference to APTC in the Data Point report is in a note to Appendix B, which states APTC was not taken into account in the analysis of average premiums.) **What was covered by the premium in 2013 was substantively different from what was covered in 2017:** This is not an "apples-to-apples" comparison. Prior to 2014, coverages varied very dramatically and many important categories of care were not covered. In some cases the addition of this coverage certainly increased premiums, but this also directly resulted in lower costs to consumers for the care they received. The 2013 data looks at the entire individual market, and the 2017 data excludes from its analysis the estimated 32 percent of enrollment that is off-exchange (which includes the grandfathered plans that are certainly lower cost and subject to pre-Affordable Care Act underwriting and health screening). (The potential that the exclusion of the off-exchange market may "potentially bias" the "premium increase slightly upward" is referenced in the "Limitations"

[7] The $106 average premium after APTC for the 39 states on the federal marketplace is the best publicly available number reported by CMS in its final enrollment report. While this report does not focus on effectuated enrollment, the average net premium should be the same or fairly similar. See more at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html.

	section of the report, but with no context of the potential importance of this difference.) The fact that the premiums in 2013 were the product of millions of Americans either being excluded from any coverage due to pre-existing conditions, or granted coverage at lower costs due to some conditions being excluded from coverage, is referenced obliquely as an area for "further work."
Comparing the average premiums found in 2013 MLR data and 2017 CMS MIDAS data shows average exchange premiums were 105% higher in the 39 states using Healthcare.gov in 2017 than average individual market premiums in 2013. Average monthly premiums increased from $232 in 2013 to $476 in 2017, and 62% of those states had 2017 exchange premiums at least double the 2013 average.	As noted above, in 2013, there was no guaranteed issue in the individual market. Medical underwriting allowed insurers to deny coverage based on pre-existing conditions or effectively price consumers out of the market based on health status, as well as rate based on gender.[8] Coverage sold in the individual market also lacked standards for minimum actuarial value and essential health benefits. This often resulted in bare-bones coverage and plans that did not cover benefits such as maternity care and prescription drugs, and some even excluded inpatient care, labs and imaging.[9] Under the Affordable Care Act, from 2014 through 2017, consumers had guaranteed issue in the individual market, access to coverage that covered essential health benefits, actuarial levels that defined the amount of financial coverage a plan must provide, and Advanced Premium Tax Credits that defrayed the cost of coverage.

[8] It is estimated that prior to the ACA, 52 million Americans faced difficulty enrolling in coverage in the individual market due to a declinable pre-existing condition. See more at: https://www.kff.org/other/state-indicator/estimated-number-of-non-elderly-adults-with-declinable-pre-existing-conditions-under-pre-aca-practices/

[9] U.S. Department of Health & Human Services. "Essential Health Benefits: Individual Market Coverage." 2011. https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage

ASPE Data Point: Individual Market Premium Changes: 2013-2017, May 23, 2017 **Additional Potential Key Findings**	**Policy and Market Context Discussion**
The availability of Advanced Premium Tax Credits directly lowered costs of coverage for a majority of those in the individual market (58 percent).	Based on the CMS-issued report on open enrollment 2017 — issued on March 15, 2017 (two months before this data point) — 10.1 million Americans received APTC. Taken with the other on-exchange enrollment and the estimate of 32 percent off-exchange enrollment, this means most Americans in the individual market received APTC. While the Key Finding references this fact, by never "doing the math" on the impact of this assistance or reflecting it in premium reported in the two "lead" findings, the relevance to most Americans in the individual market is hard to interpret.
For the majority of individuals who received a tax credit on the federal marketplace in 2017, their cost of coverage for 2017 was $106 per month; this means that for these individuals the cost of receiving a far richer and comprehensive set of benefits dropped $126 (a 59 percent reduction from 2013 average premium costs).	Understanding the actual impact on consumers is critical to evaluating the impact and the potential effect of increased enrollment from subsidized individuals on improving the health mix of the individual market overall.

ASPE Research Brief: Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange, Oct. 30, 2017 **Key Findings (Verbatim)**	**Policy and Market Context Discussion**
Benchmark Premiums: The average monthly premium for the second-lowest cost silver plan (SLCSP), also called the benchmark plan, for a 27-year-old increased by 37% from plan year 2017 (PY17) ($300) to PY18 ($411).	Premium increase is a potentially important indicator for policy makers, but it has very different impacts for consumers who are and are not receiving financial assistance. The "37 percent increase" figure is misleading for both populations. For those receiving subsidies, their costs are on average going down in 2018. For those not receiving subsidies, the vast majority do not purchase through Healthcare.gov and will likely experience a much lower premium increase than the 37% highlighted in the report. This report looks only at healthcare.gov products, pricing and hence consumer enrollment. Highlighting the "gross" premium increase on exchange is misleading for three reasons: 1. The vast majority of those who enroll through Healthcare.gov (84 percent in 2017; see Table 5, page 10) have premiums that are reduced by the Advance Premium Tax Credit. For these individuals, their effective premium *decreased* by about 3 percent (based on calculating changes in actual consumer expense after applying APTC for sample households. See Table 6, page 10). 2. Most Americans who do not receive a subsidy purchase their health insurance "off-exchange." Since about half of the growth in benchmark premiums for 2018 is attributed to the administration's discontinuance of reimbursements for Affordable Care Act cost-sharing reduction plans,[10] and in most states insurers have offset CSR funding by increasing premium rates for *only* "on-exchange Silver" (using the second-lowest-cost Silver, or "benchmark" plan, as the basis for annual premium increases) this finding misrepresents what unsubsidized consumers would ever experience.

[10] A Kaiser Family Foundation analysis found that Silver marketplace premiums would have to increase by 19 percent to offset the loss of CSR funds. The CSR surcharge placed by insurers on Silver plans ranges from 7.1 percent to 38 percent. See more at: https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/.

	3. By selecting the second-lowest-cost Silver plan as the basis of comparison (and not Bronze, Gold or other metal tiers that did not generally include the "CSR surcharge") the report tips the scales to show inaccurate and artificially inflated premium increases.
Premium Growth: For the first time, annual growth in the average monthly premium available to a 27- year-old for the SLCSP, at 37%, outpaced that of the lowest-cost plan (LCP), at 17%. For enrollees who are eligible to receive advance premium tax credits (APTCs), the larger increase for the benchmark plan premium may result in these enrollees paying a lower portion of their premiums compared to prior plan years; especially if they select plans from metal levels other than silver.	It is hard to understand why the change in the relationship between the "second-lowest-cost Silver plan" and the "lowest-cost Silver plan" is a "Key Finding." Without more context, it is not clear what "key takeaway" this finding is meant to provide to readers. By repeating the inaccurate and misleading finding regarding the "annual growth in the average monthly premium" to be 37 percent, and using the policy shorthand of SLCSP — instead of highlighting that the whole point of the "second-lowest-cost Silver plan" is relevant only to the determination of the subsidy level for those who receive it — the finding appears to simply reinforce confusing data in the prior finding.
Subsidies: The average APTC ($555) will increase by an estimated 45% from PY17 ($382) and by 114% from PY14 ($259). In PY14 through PY17, more than 80% of enrollees were in plans for which APTCs were paid, while approximately 60% were in plans to which cost-sharing reductions were paid.	The fact that the vast majority of Healthcare.gov enrollees receive a subsidy ("more than 80 percent." See Table 5, page 10, which states 84 percent for 2017, a share that has held steady during from 2014 to 2017) and a substantial increase in APTC (from $382 in 2017 to $555 in 2018) is indeed a critical "Key Finding." Given that the first finding focused solely on gross premiums, a finding on changes to tax credits would shed important light on the more fundamental issue -- affordability. Yet the ASPE findings leave it to the reader to "do the math," obscuring the bottom line fact that "on average" the cost of coverage for about 84 percent of HealthCare.gov enrollees went down for 2018.

Lowest-Cost Plan Available: The percentage of current enrollees with access to a plan for $200 or less decreased from 16% for PY17 to 6% to PY18. If enrollees were to stay within their current metal level, only 2% will have access to coverage with premiums of $200 or less for PY18.	For the 16 percent of Healthcare.gov enrollees who do *not* receive APTC, understanding what they need to pay in premium, how that is changing over time and how it relates to their ability to pay are all important and potentially instructive to policy makers. That said, a statistic about the percentage of enrollees who have access to a plan with a gross premium less than $200 (see Table 8, Page 13) is not itself meaningful and is potentially misleading to policy makers, given the fact that: 1. The vast majority of Healthcare.gov enrollees (84 percent) receive APTC to offset this cost (see Table 5, page 10) and for these individuals, coverage in 2018 is even *more* affordable in 2018 than 2017, with their average premium after APTC going down about 3 percent (see Table 6, page 10). 2. For the consumers who receive the federal tax credit, the premium is *not* their financial bottom line. Rather, the report identifies that more consumers have access to a "lowest-cost plan" that is less than $75 per month, from 71 percent of enrollees in 2017 to 80 percent of enrollees in 2018 (see Table 9, page 14), but chooses not to identify this fact in the "Key Findings." 3. Similarly, nearly 9 in 10 (86 percent) of consumers in 2018 can obtain coverage for less than $150 per month after the Advanced Premium Tax Credit (APTC) (see Table 9, Page 14). 4. For individuals *not* receiving a subsidy, as discussed earlier, the premium figures for 2018 are misleading since they reflect health insurance companies' loading the cost of the CSR program, which can, for most unsubsidized individuals, be avoided by purchasing a Silver plan off-exchange (or switching to a different metal tier on-exchange).

Issue Participation: Issuer participation in the Exchange continue to decline with 132 total state issuers in PY18, down from 167 in PY17. Eight states in PY18 will have only one issuer: Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina and Wyoming.

The following summary data builds on a shortcoming of the report itself with regard to issuer participation and plan choice, in that it describes only the federal marketplace states.[11] When the 12 state-based marketplaces are included, the overall picture is a better representation of the individual markets nationally.

	Federally Facilitated Marketplace (FFM) States	State-Based Marketplace (SBM) States	All States
2017			
1 Issuer	5	0	5
2 Issuers	7	4	11
3 Issuers	9	1	10
4 Issuers	7	1	8
5+ Issuers	11	6	17
2018			
1 Issuer	8	0	8
2 Issuers	12	5	17
3 Issuers	6	0	6
4 Issuers	5	2	7
5+ Issuers	8	5	13

Useful information that would help make data on issuers and the number of plan and product offerings more meaningful would include conveying the reality that “all care is local.” Instead of the “Key Findings” reflect only totals and the circumstances of consumers with only one carrier, important information can be found in the fact of significant variation across states. While there are eight states in the federally facilitated marketplace with only one issuer, as of 2018 even just among Federal

[11] This table was created using two data sources: 1) The number of issuers for the 39 states on the federally facilitated marketplace is from Table 1A (page 19) of the ASPE report; and 2) the number of issuers for state-based marketplaces was obtained from a recent Kaiser Family Foundation analysis examining insurer participation, available at: https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/.

	Exchange states there were also eight states that had five or more issuers. When State-based Marketplaces are included in the analysis, we see that no State-based Marketplaces have only one carrier and across the nation twenty states have four or more carriers (among them California, which has eleven). For example, with this information, what we see is that a majority of states (26 states, or 51 percent) have three or more issuers in 2018. The importance of this data is not to describe the glass as "half full" versus "half empty," but to draw attention to policy makers to the wide variation, and flag for further research why even in the face of unprecedented uncertainty in the individual market there remain so many states with robust competition and the need to better understand the contributing factors to fostering more effective individual markets.

Issuer and Plan Options: 29% of current enrollees will have only one issuer to choose from, up from 20% in PY17. The average number of qualified health plans (QHPs) available to enrollees is 25 for PY18, down from 30 in PY17. Alaska, Arizona, Iowa, and Mississippi enrollees will have the fewest QHPs in PY18 (an average of 5 QHPs per county), while Florida will have the highest (an average of 55 QHPs per county).	As with the prior notes, context is critical to the data presented. Beyond providing averages and the change in enrollees with only one issuer, there are no summary findings that could be very relevant in areas such as: 1. Because of the wide variation in issuer and health plan availability, displaying averages only and focusing on the one-issuer states means the report does not help understand the variability across the nation. Additional key findings in this area could include: • Almost half (45 percent) of enrollees have three or more issuers from which to choose. (See Table 2, page 5.) • The "glass half full" portrayal of the single issuer option is that over 70 percent of enrollees have multiple choices of carriers — even in the face of carrier exits. 2. What number of issuers is "enough" to promote effective competition at the health-plan level? How many Americans are in markets that meet or exceed that level? • The key finding related to the number of health plans in a region does not assist consumers or policy makers in assessing what is either good or bad (beyond the clearly challenging data point of only one issuer, which translates to five health plans in the four states referenced, since each carrier offers standard metal tiers). • There is no evaluation or framing of what number of carriers or health plans is potentially good or bad. Behavioral-economics literature is clear that "more choice" is not always good for consumers.[12] But what does that mean for a single carrier offering more benefit-design variations or the nature of consumers' choices?

[12] Hanoch, Yaniv, Thomas Rice, Janet Cummings, and Stacey Wood, "How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit," *Health Services Research*, Vol. 44, No. 4, August 2009, pp. 1157–1168; Barnes, Andrew J., Yaniv Hanoch, and Thomas Rice, "Determinants of Coverage Decisions in Health Insurance Marketplaces: Consumers' Decision-Making Abilities and the Amount of Information in Their Choice Environment," *Health Services Research*, Vol. 50, No. 1, February 2015, pp. 58–80; Johnson, Eric J., Ran Hassin, Tom Baker, Allison T. Bajger, and Galen Treuer, "Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture," *PLOS ONE*, Vol. 8, No. 12, December 18, 2013, p. e81521; and Abaluck, Jason, and Jonathan Gruber. *Improving the Quality of Choices in Health Insurance Markets*. Working Paper No. 22917. National Bureau of Economic Research, Dec. 2016. Web. 28 Feb. 2017.

	3. What is the nature of the choice consumers have and the products available to them? • The "Key Findings" provide summary data of what is presented in the detailed tables describing numbers of issuers, health plans and health plans per issuer. None of those descriptions, however, helps one understand what sort of designs are available to consumers. For example, one major concern raised about benefit designs in general is the impact of high deductibles resulting in care being effectively out of reach for many consumers. Instead of reporting on just the number of health plans, the report could collect and total the number of health plans through which consumers do *not* need to meet a deductible prior to seeing clinicians in outpatient settings. (Note: In California, this would be all health plans at the Silver, Gold and Platinum tiers.)

ASPE Data Point: Individual Market Premium Changes: 2013-2017, May 23, 2017

Additional Potential Key Findings

Affordability: Advance Premium Tax Credits adjust to insulate consumers from rate changes and, on average, the cost of coverage for consumers receiving the APTC is going down about 3 percent in 2018 (see Table 6):

- A 27-year-old earning $25,000 in 2018 will on average get a monthly tax credit of $273, a 73 percent increase compared to the tax credit in 2017. As a result, this consumer's net premium is $138 per month for a $411 benchmark plan in 2018. This amount is $4 lower than the consumer's net premium of $142 per month in 2017 for a $300 benchmark plan, after receiving $158 in APTC.

- A family of four earning $60,000 in 2018 will on average get a monthly tax credit of $1,088, a 60 percent increase compared to the tax credit in 2017. As a result, this family's net premium is $397 per month for a $1,485 benchmark plan in 2018. This amount is $10 lower than the family's net premium of $407 in 2017 for a $1,088 benchmark plan, after receiving $678 in APTC.

The display of "Benchmark Premiums" and "APTC" in Table 6 (page 10) does not facilitate the interpretation of what happens to the vast majority (84 percent) of marketplace enrollees who receive APTC. These consumers are not only insulated, but their actual costs will on average go down in 2018 — but not only is this not a "Key Finding" for the report, but the data on this issue is presented in way that requires readers to do their own math to calculate the impact. When calculated the clear fact that for the 84 percent of market place enrollees who receive APTC will have <u>their</u> premium costs go down about 3 percent in 2018 – it is hard to comprehend that this is not a "Key Finding".

Variation on Cost and Affordability: In the body of the report and in the attached exhibits, the report provides extensive description of the "Second Lowest Cost Plan" and the "Lowest Cost Plan" (See Figure 1 and Tables 3, 4, 8, 9 and Tables 5A and following in the Appendix). The detail provided is then summarized in the very few "Key Findings" identified above, which provide very little context or help to readers to understand the wide variation in costs both across states and within states.

As the summary chart that follows begins to explore, the cost variation is substantial both between states and within states. For 2018, what is potentially "misleading" about the discussions of the Second Lowest Cost Silver Plan is, as discussed above, this is not what consumers getting subsidies pay and for those who do not get subsidies in most states they can by silver products without the CSR-surcharge.

Nonetheless, with appropriate context, gross premiums – at silver and bronze – can be important reference points for understanding both health care costs, risk mix of those coverage and market competitiveness. Understanding these factors requires looking at variation. For example, while the Average SLCSP for a 27-Year Old for all Healthcare.gov states is $411; it ranges from a low of $312 (Ohio – 24 percent lower than average) to a high of $710 (Wyoming – 73 percent higher than the average).

As interesting as these figures are, averages rarely tell the whole story or provide the best tools for policy makers. As detailed in the attached, while California's Average SLCSP for a 27-Year Old is $352 (14 percent less than the national average); in major metropolitan

areas it ranges from $277 (Los Angeles – 32 percent lower than the national average) to $414 (Oakland – 1 percent higher than the average) – and a spread between Los Angeles and Oakland of 49 percent.

Similarly, the variation within Pennsylvania is as or more interesting than is the fact that it's Average SLCSP for a 27-Year Old is $472 (15 percent higher than the national average).

- In Pittsburgh the rate is $293 (29 percent lower than the national average)
- In Philadelphia it is $521(27 percent higher than the national average)
- A spread between Pittsburgh and Philadelphia of 78 percent.

These examples seek to flag the sort of variation that policy makers need to understand and grapple with in terms of understanding the cost drivers and potential ways to address them.

HIGHLIGHTS OF REGIONAL VARIATION IN 2018 GROSS PREMIUMS FOR 27 YEAR OLD: SECOND LOWEST SILVER (SLS) AND LOWEST-COST PLAN (LCP)

Data for OH and PA from ASPE brief (https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf) and Covered California from internal estimates.

	Statewide	Lower Cost Region			Higher Cost Region			Range	
	Average Premium	Average Premium	Difference From Statewide		Average Premium	Difference From Statewide		Difference Between Lower and Higher Regions	
		$	$	%	$	$	%	$	%
California		Los Angeles			Oakland				
Second Lowest Silver	$ 352	$ 277	$ (75)	-21%	$ 414	$ 62	18%	$ 137	49%
Lowest-Cost Plan	$ 233	$ 206	$ (27)	-12%	$ 262	$ 29	12%	$ 56	27%
Florida		Miami			Jacksonville				
Second Lowest Silver	$ 382	$ 349	$ (33)	-9%	$ 376	$ (6)	-2%	$ 27	8%
Lowest-Cost Plan	$ 256	$ 243	$ (13)	-5%	$ 267	$ 11	4%	$ 24	10%
Pennsylvania		Pittsburgh			Philadelphia				
Second Lowest Silver	$ 472	$ 293	$ (179)	-38%	$ 521	$ 49	10%	$ 228	78%
Lowest-Cost Plan	$ 300	$ 199	$ (101)	-34%	$ 329	$ 29	10%	$ 130	65%

Choice: Consumers can save by switching plans, including the lowest-cost option in the same metal tier, or a Bronze or Gold plan due to a larger increase in the benchmark plan for 2018.

Quantifying potential savings associated with shopping would not only benefit consumer's pocketbook, but also the federal government, which would pay out less in APTC.

On page 18 of the report, it notes that prior reports included analysis of the impacts on consumers of shopping and switching plans, as well as income stratification and other analysis. The report states this information is "not included" for the 2018 federal marketplace.

One of the key values of marketplaces is the value of being able to shop and switch plans. In California, the potential rate increases have been substantially lower because consumers do shop and switch.

While Healthcare.gov provides consumers decision-support tools, consumers first need to get to the marketplace. For this reason, rate changes should be messaged within the context of encouraging consumers to shop for a better deal.

Reasons for Premium Increases: The report makes no attempt to describe the reasons behind 2018 rate increases, when the data is public and would help inform policy makers.

What follows are the reasons cited by different sources examining the individual market:

- Medical inflation (ranging from 5 to 9 percent).
- Expiration of the health insurance tax holiday (ranging from 2 to 4 percent).
- Morbidity corrections and change in health status (ranging from 1 to 4 percent).
- Cost-sharing reduction pricing: most often loaded on Silver exchange products only (ranging from 7 to 38 percent).
- Federal policy uncertainty, such as the continued enforcement of the tax penalty (ranging from 2 to 9 percent).