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Report to Congressional Requesters

August 2015

PRIVATE HEALTH INSURANCE

The Range of Premiums and Plan Availability for Individuals in 2014 and 2015

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GAO-15-687

GAO Highlights

Highlights of GAO-15-687, a report to congressional requesters

August 2015

PRIVATE HEALTH INSURANCE

The Range of Premiums and Plan Availability for Individuals in 2014 and 2015

Why GAO Did This Study

PPACA, as of 2014, changed how insurers determine health insurance premiums and how consumers shop for individual market health insurance plans. For example, PPACA prohibited insurers from denying coverage or varying premiums based on consumer health status or gender. At the same time, PPACA required health plans to be marketed based on their metal tiers (bronze, silver, gold, and platinum), which helps consumers compare the relative value of each plan; it also required the establishment of health insurance exchanges in each state, through which consumers can compare and select from among participating health plans.

GAO was asked to examine variation in the health plan options and premiums available to individuals under PPACA, and how the options available in 2014 compared to those in 2015. GAO examined: (1) the numbers of health plans available to individuals and how they changed from 2014 to 2015, and (2) the range of health insurance premiums in 2014 and 2015, and how they changed for individuals in each state and county for selected consumers. GAO analyzed data from the Centers for Medicare & Medicaid Services (CMS); reviewed applicable statutes, regulations, guidance, and other documentation; and interviewed officials from CMS. Comparisons across years were conducted for states that had sufficiently reliable data in both years—including comparisons of plans offered either on or off an exchange in 28 states (1,886 counties) and comparisons of plans offered only on an exchange for 38 states (2,613 counties) although GAO is reporting some data on 49 states.

View GAO-15-687. For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

As of 2014, key provisions of the Patient Protection and Affordable Care Act (PPACA) resulted in the establishment of health insurance exchanges in each state and changed how insurers determined health insurance premiums. Individual market consumers generally had access to more health plans in 2015 compared to 2014, and in both years the lowest-cost plans were available through exchanges in most of the 1,886 counties GAO analyzed in the 28 states for which it had sufficiently reliable data for plans offered either on or off an exchange. In addition, consumers in most of the counties analyzed had six or more plans to choose from in three of the four health plan metal tiers (bronze, silver, and gold) in both 2014 and 2015, and the percentage of counties with six or more plans in those metal tiers increased from 2014 to 2015. Consumers had fewer options regarding platinum plans, although the availability of platinum plans generally also increased from 2014 to 2015. The lowest-cost plan available in a county was available on an exchange in most counties. For example, among the 1,886 counties analyzed, GAO found that the lowest-cost silver plan for a 30-year-old was available on an exchange in 63 percent of these counties in 2014 and in 81 percent of these counties in 2015—an increase of 18 percentage points.

The range of premiums available to consumers in 2014 and 2015 varied among the states and counties GAO analyzed. For example, in Arizona the lowest-cost silver plan option for a 30-year-old was $147 per month in both years, but in Maine, the lowest-cost silver plan options for a 30-year-old were $252 in 2014 and $237 in 2015. In the 28 states included in GAO's analysis, from 2014 to 2015 the minimum premiums for silver plans available to a 30-year-old increased in 18 states, decreased in 9 states, and remained unchanged in 1 state. At the county level, GAO found that premiums for the lowest-cost silver option available for a 30-year-old increased by 5 percent or more in 51 percent of the counties in the 28 states. GAO also found that the range of premiums—from the lowest to highest cost—differed considerably by state. For example, in Rhode Island, 2014 premiums for silver plans available to a 30-year-old either on or off an exchange ranged from a low of $241 per month to a high of $266 per month, a difference of 10 percent, and in 2015 ranged from a low of $217 per month to a high of $285 per month, a difference of 32 percent. By contrast, in Arizona, 2014 premiums for these plans ranged from a low of $147 per month to a high of $508 per month, a difference of 244 percent, and in 2015 ranged from a low of $147 per month to a high of $545 per month, a difference of 270 percent.

An interactive graphic reporting by state and county the minimum, median, and maximum premium values for all individual market plans (either on or off the exchange) and for exchange-only plans, is available at http://www.gao.gov/products/GAO-15-687. It includes either data for both years, or partial data (e.g., data for one of the two years) for 49 states.

GAO received technical comments on a draft of this report from the Department of Health and Human Services and incorporated them as appropriate.

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Abbreviations

AV	actuarial value
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
FFE	federally facilitated exchange
PPACA	Patient Protection and Affordable Care Act
SBE	state-based exchange

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

August 10, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

Millions of Americans obtain health coverage by purchasing private health insurance plans in the individual market.[1] These Americans purchase health insurance for a variety of reasons, including being self-employed or a small business owner, or because their own employer does not offer insurance. The Patient Protection and Affordable Care Act (PPACA), as of 2014, changed how insurers determine health insurance premiums and how consumers shop for individual market health insurance plans.[2] For example, PPACA prohibited insurers from denying coverage to any individuals and from varying premiums based on consumer health status or gender. It also established limits on premium variation based on age, geographic location, and other factors.[3] In addition, PPACA established requirements for the benefits that must be covered by health plans—referred to as essential health benefits—and required insurers to market

[1]Private health insurance includes individual and group market plans. Participants in the individual market purchase health insurance coverage directly from an insurer. Group market participants generally obtain health insurance coverage through a group health plan, usually offered by an employer.

[2]See the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, (HCERA) Pub. L. No. 111-152,124 Stat.1029. In this report, references to PPACA include any amendments made by HCERA.

[3]See Pub. L. No. 111-148, §§ 1201(2), (4), 1562(c)(1), 10107(b)(1), 10103(a), 10107(b)(1), 124 Stat. 154,155, 264, 892, 911 (codified as amended at 42 U.S.C. §§ 300gg, 300gg-3). PPACA also included an individual mandate that requires most individuals to have health insurance coverage or pay a tax penalty. See Pub. L. No. 111-148, §§ 1501, 10106, 124 Stat. 242, 907, as amended by, Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1032, 1034 (codified as amended at 26 U.S.C. § 5000A).

their plans according to defined categories comparing the extent to which the plans would be expected to cover the costs of enrollees' medical care.[4]

PPACA also required the establishment of health insurance exchanges in each state beginning in 2014[5]—marketplaces through which individual market consumers can compare and select health insurance coverage from among all the health plans participating in the exchange.[6] Some states have established their own exchanges—referred to as state-based exchanges (SBE). For consumers in states that have not done so, a federal exchange has been established—which we refer to as the Federally Facilitated Exchange (FFE). In general, plans available on either an SBE or the FFE are also available for sale outside of the exchange. The combination of all of these provisions allowed consumers to directly compare the individual market health insurance plans available to them based on premium costs, benefits covered, and plan generosity.

You asked us to examine the health plan options available to individual market consumers under this new paradigm, the extent to which plan options and premium costs available to consumers vary throughout the United States, and how the plan options available in 2014 compared to those in 2015. This report examines: (1) the numbers of health insurance plans available to individual market consumers and how they changed from 2014 to 2015, and (2) the range of health insurance premiums in 2014 and 2015 and how they changed for individual market consumers in each state and county for selected consumers.

For both of our objectives we reviewed applicable statutes, regulations, guidance, and other documentation, and we analyzed two sources of data maintained by the Centers for Medicare & Medicaid Services' (CMS), Center for Consumer Information and Insurance Oversight (CCIIO)—the FFE and Plan Finder databases—which included information on health

[4]We refer to the expected impact of the design of plan coverage on enrollee cost sharing as a plan's "generosity." A plan whose enrollees would incur lower out-of-pocket costs is more generous than one whose enrollees would incur higher costs.

[5]Some states use the term "marketplace" to refer to an insurance exchange.

[6]Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 173, 186 (codified at 42 U.S.C. §§ 18031(b), 1841(c). Individuals can apply for plans sold through the exchanges either online, by phone, or with a paper application.

plans offered to consumers in calendar years 2014 and 2015. The FFE database included data on all of the plans that were offered through the FFE. These data were publicly available to consumers shopping for FFE health plans using the Healthcare.gov website.[7] The Plan Finder database included information on plans offered outside an exchange, including those offered exclusively outside the exchanges as well as those available on or off the exchanges. These data were publicly available to consumers shopping for health plans through the Plan Finder online portal.[8] The premium amounts and supporting plan information in the FFE and Plan Finder data sources were self-reported by each insurer, and each insurer was required to comply with a data validation and attestation process.

Using these data, we analyzed aspects of plans offered to certain categories of consumers at the state and county level, whether or not the plans were offered on or off of an exchange. These included analyses of the numbers of plans and premium costs available to the consumers in each year and analyses of the changes in these numbers and costs between 2014 and 2015. We selected the consumer categories to represent the broad range of consumers who would shop for individual market insurance. They included nonsmoking: individuals, aged 19; individuals, aged 30; families of four, parents aged 40; couples aged 55; and individuals, aged 64. We also conducted analyses at the state and county level that focused on plans offered through an exchange for these same categories of consumers. Our analyses focused on two categories of plans—exchange plans (plans that were available on an exchange) and all plans (whether or not they were available on an exchange)—for both 2014 and 2015. Our analyses do not reflect the entire universe of insurers' premiums for plans sold on the SBEs or plans not sold through exchanges, because the data for plans sold on the SBEs or plans not sold through exchanges in the Plan Finder database were incomplete.[9] Because of this, we made certain exceptions in our reporting and only reported data for states for which we had sufficiently reliable data, as follows:

[7]See https://www.healthcare.gov/get-coverage/

[8]See https://finder.healthcare.gov/

[9]In addition, our analyses may include plans with little or no enrollment because enrollment data were not available.

- For our analysis of the numbers of health insurance plans available to individual market consumers and how they changed from 2014 to 2015, we excluded from our analyses states where the percentage of plans that reported premium data was less than 70 percent of the universe of plans in either of the 2 years. We also excluded the state of Virginia from our analyses because the 2014 FFE data for that state included data that appeared to be erroneous. After these exclusions, our analyses of all plans included data from 28 of the 50 states and the 1,886 counties within those states, and our analysis that was limited to exchange plans included data for 38 of the 50 states and the 2,613 counties within those states.[10]
- For our analysis showing the range of health insurance premiums in 2014 and 2015 by county and year, we applied the same exclusions noted above for all comparisons of data across years.
- In an interactive graphic that reports the range of premiums by state and county, we reported all data that was deemed sufficiently reliable for each combination of plan category (exchange or all plans) and year. As a result, we reported data for 49 states, including: complete sets of data for 25 states for which we had sufficiently reliable data for both plan categories in both years; and partial sets of data for 24 states for which we had sufficiently reliable data only for certain elements. For example, in a state where we had information for fewer than 70 percent of exchange plans in a given year, the interactive graphic does not include any values for exchange plans for that state in that year. We did not include any data for one state (Washington) or for the District of Columbia because the data were not sufficiently reliable in either of the plan categories in either year. See Appendix I for details on the reliability of the data for each state.

To assess the reliability of the FFE data we interviewed CCIIO officials with knowledge of these data. Officials confirmed that because the data we obtained included all of the FFE health plan information that was publicly available to consumers shopping for FFE insurance plans using the Healthcare.gov website, those data effectively represented the full universe of FFE plans and premium values available to consumers in each year. To assess the reliability of the Plan Finder data, we reviewed the requirements for the data validation and attestation process; reviewed

[10]The analysis that was limited to plans offered through the exchanges included data from 33 of the 34 states that used the FFE, and data for 5 of 16 states that used SBEs.

documentation on the database that houses the information submitted to CCIIO; and interviewed key CCIIO officials responsible for overseeing the submission and maintenance of the data. This allowed us to determine that the data were sufficiently reliable for our purposes.

We conducted this performance audit from August 2014 to August 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Individual Market Insurance under PPACA

Beginning January 1, 2014, PPACA required that health insurance plans, whether sold on or off an exchange, offer a comprehensive package of items and services—known as essential health benefits. At the same time, PPACA required most individuals to maintain minimum essential coverage for themselves and their dependents or pay a tax penalty—this requirement is commonly referred to as the individual mandate.[11] Individuals who do not have other insurance coverage, such as from an employer, may satisfy this requirement by maintaining coverage under health plans offered in the individual market.

Certain PPACA provisions affected the way individual market plans are marketed for consumers. In particular, PPACA standardized health insurance plans into four “metal” tiers of coverage—bronze, silver, gold, and platinum—which reflect out-of-pocket costs that may be incurred by an enrollee. Bronze plans tend to have the lowest premiums but leave consumers subject to the highest out-of-pocket costs when they receive

[11] Individuals whose incomes are below statutory thresholds are exempt from the penalty.

health care services, while platinum plans tend to have the highest premiums and the lowest out-of-pocket costs.[12]

- The generosity of each metal tier is measured by the plan's actuarial value (AV). AV is expressed as the percentage of covered medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges for in-network providers.[13] The higher the AV percentage, the lower the expected enrollee cost sharing. For example, for a plan with an AV of 70 percent, it is expected that, on average, enrollee cost sharing under that plan will be 30 percent of the cost of care, while for a plan with an AV of 80 percent, it is expected that, on average, enrollee cost sharing under that plan will be 20 percent of the cost of care.
- PPACA includes standards related to AV and assigns a specific actuarial value to each of the four metal tiers: bronze (AV = 60 percent); silver (AV =70 percent); gold (AV = 80 percent); and platinum (AV = 90 percent). If an insurer sells a plan on an exchange, it must at least offer one plan at the silver level and one plan at the gold level. Insurers are not required to offer bronze or platinum versions of their plans in order to participate on exchanges.

PPACA provisions also affected the way individual market plans are priced for consumers. For example, PPACA prohibited health insurers from varying health insurance plan premiums on the basis of factors other than age, geographic location and tobacco use—for which limits were established. For example, the age factor used to adjust premiums may vary by no more than a 3 to 1 ratio for adults aged 21 and older and must use a uniform age rating curve to specify the rates across all adult age bands. Premium variation based on health status or gender was effectively prohibited.

[12]In addition to these metal tiers, catastrophic plans are available to those under 30 years of age or to those who are exempt from the requirement to have minimum essential coverage because of a hardship or because the lowest-cost plan available would cost more than 8 percent of their household income. Catastrophic plans' actuarial value must be lower than that of a bronze plan.

[13]Health plans typically establish a network of providers with which they negotiate reimbursement rates. The actuarial value for each plan is calculated assuming all services are obtained within the network. Consumers who choose to access services from providers outside of their plans' networks may incur higher cost sharing.

Incentives to Shop for Plans Offered through Exchanges

PPACA does not require insurers to offer plans through the state or federal exchanges. Similarly, it does not require consumers to purchase plans through the exchanges; however, there are incentives for many consumers to do so. For example, certain consumers earning from 100 to 400 percent of the federal poverty level are eligible to receive premium tax credits that can reduce premium costs, but only for plans purchased through an exchange.[14] Similarly, certain consumers earning from more than 100 percent to 250 percent of the federal poverty level are eligible to receive additional subsidies that help them pay for the out of pocket costs, but only for silver plans purchased through an exchange.[15] Also, the SBEs and FFE allow consumers to comparison shop for plans and enroll in a plan online, whether or not consumers are eligible for premium tax credits or cost sharing subsidies.

[14]Premium tax credits will generally be available to eligible tax filers and their dependents who are (1) enrolled in one or more qualified health plans through an exchange, and (2) not eligible for other health insurance coverage. More specifically, to qualify for the premium tax credit, an individual or family must generally have income from 100 to 400 percent of the federal poverty level and not qualify for other health care coverage, such as Medicare, Medicaid, or employer-sponsored coverage that meets a minimum value standard specified in PPACA. The premium tax credit is calculated based on the second lowest-cost silver plan available to the consumer. Also, see GAO, *Private Health Insurance: Early Evidence Finds Premium Tax Credit Likely Contributed to Expanded Coverage, but Some Lack Access to Affordable Plans,* GAO-15-312 (Washington, D.C.: March 23, 2013). We reported that, among those enrolling in federally facilitated exchanges during the 2014 open enrollment period, most (85 percent) were deemed eligible for the advance premium tax credit and that, on average, the premium tax credit reduced premiums by 76 percent.

[15]People who are eligible to receive a premium tax credit and have household incomes from 100 percent to 250 percent of poverty are also eligible for cost-sharing subsidies.

Individual Market Consumers Generally Had Access to More Plans in 2015 Compared to 2014, and the Lowest-Cost Plans Were Available through Exchanges in Most Counties in Both Years

Individual market consumers in every county in our analysis had access to a variety of plan options each year, and the number of plans available to consumers generally increased from 2014 to 2015. For example, in 28 states for which we had reliable data for all plans (offered either on or off exchanges), the percentage of counties for which six or more plan options were available to consumers increased from 2014 to 2015 for three of the metal tiers—bronze, silver, and gold—and in 2015 consumers in every county in these states had access to six or more plans in each of these three metal tiers.[16] Further, in 2015, among the 38 states where we focused our analysis on plans offered on an exchange, we found that consumers in 88 percent of the counties had access to six or more bronze exchange plans, consumers in 94 percent of counties had access to six or more silver exchange plans, and consumers in 71 percent of counties had access to six or more gold exchange plans. Not all consumers had access to platinum plans, however, the availability of platinum plans generally also increased from 2014 to 2015. (See table 1.)

[16] If an insurer sells a plan on an exchange, it must at least offer one plan at the silver level and one plan at the gold level. Insurers are not required to offer bronze or platinum versions of their plans in order to participate on exchanges.

Table 1: The Percentages of Counties in Which Various Numbers of Health Plans Were Offered to Individual Market Consumers, by Market Category and Metal Tier, 2014 and 2015

		Percentage of counties in 2014			Percentage of counties in 2015		
Market Category	Metal tier	No plans available	Between 1 and 5 plans available	6 or more plans available	No plans available	Between 1 and 5 plans available	6 or more plans available
All plans (available on or off exchange) [Note A]	Bronze	0%	3%	97%	0%	0%	100%
	Silver	0	3	97	0	0	100
	Gold	0	5	95	0	0	100
	Platinum	9	31	60	1	15	84
Plans available on an exchange [Note B]	Bronze	0	20	80	0	12	88
	Silver	0	20	80	0	6	94
	Gold	0	41	59	0	29	71
	Platinum	46	48	7	31	63	6

Source: GAO analysis of Center for Consumer Information and Insurance Oversight data. | GAO-15-687

Note: Figures may not total 100 across rows within each year due to rounding.

Note A: Includes data for plans in the 1,886 counties in the 28 states for which we had sufficiently reliable data on plans whether or not they were sold through an exchange.

Note B: Includes data for plans in the 2,613 counties in the 38 states for which we had sufficiently reliable data on plans sold through exchanges.

We also found that the lowest-cost plan options available in a county were available on an exchange in a majority of the counties included in our analysis. For example, among the 1,886 counties in the 28 states for which we had sufficiently reliable data for plans both on and off an exchange, we found that the lowest-cost silver plan option for a 30-year old was available on an exchange in 63 percent of the counties in 2014 and in 81 percent of the counties in 2015—an increase of 18 percentage points.

The Range of Premiums Available to Consumers Varied among the States and Counties in Our Analysis in Both 2014 and 2015

Premiums Varied Widely among the States in Our Analysis, and from 2014 to 2015 Premiums Were More Likely to Increase than Decrease

The premiums for the lowest-cost plan options available in each state included in our analysis varied significantly from state to state. For example, in Arizona (a state for which the lowest-cost premiums were among the lowest in the country) the lowest-cost silver plan options for a 30-year-old were $147 per month in both years for plans both on and off an exchange. By contrast, in Maine (a state for which the lowest-cost premiums were among the highest in the country) the lowest-cost silver plan options for a 30-year-old were $252 in 2014 and $237 in 2015 for plans both on and off an exchange. Based on the full premium costs, on an annual basis in 2015 a 30-year-old in Arizona who was not eligible for a premium tax credit could have spent $1,082 less on the lowest-cost silver plan available to them compared to what the same consumer in Maine could have spent on the lowest-cost silver plan available to them.[17] The findings were similar when we conducted our analysis of plans offered on exchanges in 38 states. Because each state in our analysis uses a uniform age rating curve to specify the rates across all adult age bands, each state would have the same relative differences in premiums for all adult age categories. (See table 2.)

[17] In either state, the premium amount paid by individuals receiving the premium tax credit would be limited to a percentage of their income. As a result, individuals in Arizona and Maine with the same income would pay the same amount in premiums for the second-lowest-cost silver plan in 2015.

Table 2: Monthly Minimum and Median Premiums Available to a 30-Year-Old by State in 2014 and 2015, for Silver Tier Health Plans Available either on or off an Exchange

	Minimum premium value (in dollars) [Note A]			Median premium value (in dollars) [Notes A, B]		
State	**2014**	**2015**	**Difference**	**2014**	**2015**	**Difference**
Alabama	$199	$215	$16	$227	$279	$52
Arkansas	188	233	45	278	278	0
Arizona	147	147	0	273	309	36
California	201	205	4	286	310	24
Colorado	213	173	(40)	343	369	26
Connecticut	245	206	(39)	305	307	2
Florida	181	195	14	279	315	36
Georgia	188	202	14	296	321	25
Hawaii	157	173	16	217	180	(37)
Iowa	171	173	2	262	290	28
Illinois	170	185	15	294	302	8
Indiana	215	175	(40)	310	339	29
Kansas	167	170	3	243	239	(4)
Kentucky	163	148	(15)	279	259	(20)
Louisiana	218	245	27	309	340	31
Maine	252	237	(15)	324	323	(1)
Massachusetts	222	192	(30)	364	361	(3)
Michigan	169	194	25	278	285	7
Mississippi	233	219	(14)	317	322	5
Nebraska	194	217	23	318	337	19
Ohio	192	206	14	287	313	26
Oklahoma	163	172	9	287	315	28
Pennsylvania	145	151	6	220	274	54
Rhode Island	241	217	(24)	261	255	(6)
South Dakota	224	226	2	377	279	(98)
Tennessee	160	161	1	243	269	26
Utah	162	186	24	253	251	(2)
Wisconsin	214	211	(3)	299	336	37

Source: GAO analysis of Center for Consumer Information and Insurance Oversight data. | GAO-15-687

Note: Includes data for plans in 1,886 counties in the 28 states included in our analysis for which we had sufficiently reliable data on plans whether or not they were sold through an exchange.

Note A: The premium amounts paid by individuals who received premium tax credits would have been offset and therefore effectively lower than the premium costs we provide in this report. Similarly, cost sharing subsidies would reduce the out-of-pocket costs to the enrollee which would, in effect, make the actual benefit of the plans higher that what the actuarial values implied.

Note B: The median plan value represents either 1) the plan with the median premium value in the category (when there was an odd number of plans within that category), or 2) the average of the premiums of the two plans that were closest to the median (when there was an even number of plans within the category).

The premiums for the median-cost plan options available in each state included in our analysis also varied widely. For example, in both years Hawaii had among the lowest median premium costs for silver plans offered to a 30-year-old either on or off the exchange—$217 per month in 2014 and $180 per month in 2015. By contrast, in both years Colorado had among the highest median premium costs for such plans—$343 per month in 2014 and $369 per month in 2015.

In most states, the costs for the minimum and median premiums for silver plans increased from 2014 to 2015. For example, in the 28 states included in our analysis, from 2014 to 2015 the minimum premium values for silver plans available to a 30-year-old increased in 18 states, decreased in 9 states, and remained unchanged in 1 state. Similarly, in these same states the median premium values for silver plans available to 30-year-old increased in 19 states, decreased in 8 states and remained unchanged in 1 state.

Further, in general, states with higher than average minimum premiums in 2014 were more likely to have declines in 2015 premiums than the states with lower than average minimum premiums in 2014. For example, the average minimum monthly premium value for the silver plan option for a 30-year-old in 2014 in the 28 states included in our analysis was $193 for plans offered on or off an exchange. Of the 13 states with 2014 premiums for this group of consumers that were greater than $193, eight had lower minimum premiums in 2015. Of the 15 states with 2014 premiums for this group of consumers that were less than $193, only one state had a lower minimum premium in 2015.

When analyzing premium costs at the county level, we found that from 2014 to 2015, premiums were more likely to increase than decrease. For example, our analysis of the minimum premiums for silver plans in states where we analyzed data on plans offered either on or off exchanges found that premiums for a 30-year-old increased by 5 percent or more in 51 percent of the counties. During the same time period, premiums for these plans decreased by 5 percent or more in nearly 17 percent of the counties, and increased or decreased by less than 5 percent in 32 percent of the counties. The findings were similar when we repeated this analysis using the median premium value in each county and when we limited the analysis to plans offered on exchanges. Because each

state in our analysis uses a uniform age rating curve to specify the rates across all adult age bands, each state would have the same relative differences in premiums for all adult age categories. (See table 3.)

Table 3: The Percentages of Counties for Which the Minimum and Median Premiums for a Silver Health Plan for a 30-Year-Old Decreased, Held Steady, or Increased from 2014 to 2015

		Decreased			Held steady	Increased		
		10 percent or more	Between 5 and less than 10 percent	Between 1 and less than 5 percent	Change of less than 1 percent	Between 1 and less than 5 percent	Between 5 and less than 10 percent	10 percent or more
Minimum premium value	**All plans (available on or off eschange [Note A]**	7.8%	9.1%	8.3%	8.7%	15.4%	29.4%	21.4%
	Plans available on an exchange[Note B]	10.0	8.4	7.8	8.3	14.0	30.8	20.8
Median premium value	**All plans (available on or off exchange) [Note A]**	6.6	7.1	11.1	6.3	16.1	22.0	30.9
	Plans available on an exchange[Note B]	10.6	7.7	10.3	6.4	11.7	19.6	33.6

Source: GAO analysis of Center for Consumer Information and Insurance Oversight data. | GAO-15-687

Note: Because each state in our analysis uses a uniform age rating curve to specify the rates across all adult age bands, these same findings would apply to premiums for all adult age categories.

Note A: Includes data for plans available in the 1,886 counties in the 28 states included in our analysis for which we had sufficiently reliable data on plans whether or not they were sold through an exchange.

Note B: Includes data for plans available in the 2,613 counties in the 38 states included in our analysis for which we had sufficiently reliable data on plans sold through exchanges.

The Ranges of Premiums Available to Consumers Were Much Narrower in Some States Compared to Others

We found that the range of premiums—from the lowest to highest cost—available to consumers differed considerably for the states included in our analysis. For example, our analysis of premiums for silver plans available to a 30-year-old either on or off an exchange found that the ranges of premiums available were much more narrow in Rhode Island compared to Arizona. In Rhode Island, 2014 premiums for plans ranged from a low of $241 per month to a high of $266 per month, a difference of 10 percent, and in 2015 ranged from a low of $217 per month to a high of $285 per month, a difference of 32 percent. By contrast, in Arizona, 2014 premiums for these plans ranged from a low of $147 per month to a high of $508 per month, a difference of 244 percent, and in 2015 ranged from a low of $147 per month to a high of $545 per month, a difference of 270 percent. In addition, between 2014 and 2015, the range from the lowest- to highest-cost premiums available by state became wider in

18 out of the 28 states included in this analysis. The findings were similar when we conducted our analysis for plans offered on exchanges in 38 states.

We also found that the percentage difference between the minimum and maximum premium in the states included in our analysis was generally higher in states where the average number of plans available per county was higher. For example, in both years, states with an average of 30 or more plans per county had among the widest ranges between the lowest and highest premium amounts. By contrast, states with an average of 15 or fewer plans per county had among the narrowest ranges between the lowest and highest premium amounts. (See table 4.) Because each state in our analysis uses a uniform age rating curve to specify the rates across all adult age bands, each state would have the same relative differences in premiums for all adult age categories.

Table 4: The Range of Premiums Available to a 30-Year-Old by State in 2014 and 2015, for Silver Tier Health Plans Available either on or off an Exchange

	2014				2015			
	Monthly premiums (dollars) [Note A]				Monthly premiums (dollars) [Note A]			
State	Average number of plans per county	Minimum premium value	Maximum premium value	Percent difference	Average number of plans per county	Minimum premium value	Maximum premium value	Percent difference
Alabama	5	$199	$332	67%	22	$215	$425	98%
Arkansas	31	188	386	105	31	233	369	59
Arizona	35	147	508	244	42	147	545	270
California	19	201	427	112	18	205	492	141
Colorado	39	213	592	178	40	173	680	294
Connecticut	21	245	391	60	38	206	410	99
Florida	29	181	428	137	42	195	503	158
Georgia	38	188	444	136	48	202	525	160
Hawaii	10	157	223	42	11	173	196	14
Iowa	36	171	383	125	37	173	377	118
Illinois	39	170	434	155	45	185	558	201
Indiana	15	215	372	73	40	175	548	213
Kansas	36	167	356	114	32	170	362	112
Kentucky	20	163	387	137	14	148	343	131
Louisiana	27	218	418	92	32	245	446	82
Maine	8	252	400	59	19	237	475	100
Massachusetts	102	222	522	135	196	192	534	179
Michigan	18	169	428	153	40	194	407	110
Mississippi	25	233	422	81	24	219	507	131
Nebraska	18	194	346	79	25	217	396	82
Ohio	25	192	408	112	47	206	532	158
Oklahoma	26	163	358	119	27	172	437	154
Pennsylvania	22	145	403	178	32	151	412	172
Rhode Island	7	241	266	10	10	217	285	32
South Dakota	36	224	504	125	33	226	505	124
Tennessee	62	160	393	146	73	161	413	156
Utah	38	162	389	140	65	186	419	125
Wisconsin	67	214	490	129	67	211	533	152

Source: GAO analysis of Center for Consumer Information and Insurance Oversight data. | GAO-15-687

Note: Includes plans available in the 28 states included in our analysis for which we had sufficiently reliable data on plans whether or not they were sold through an exchange. Because each state in our

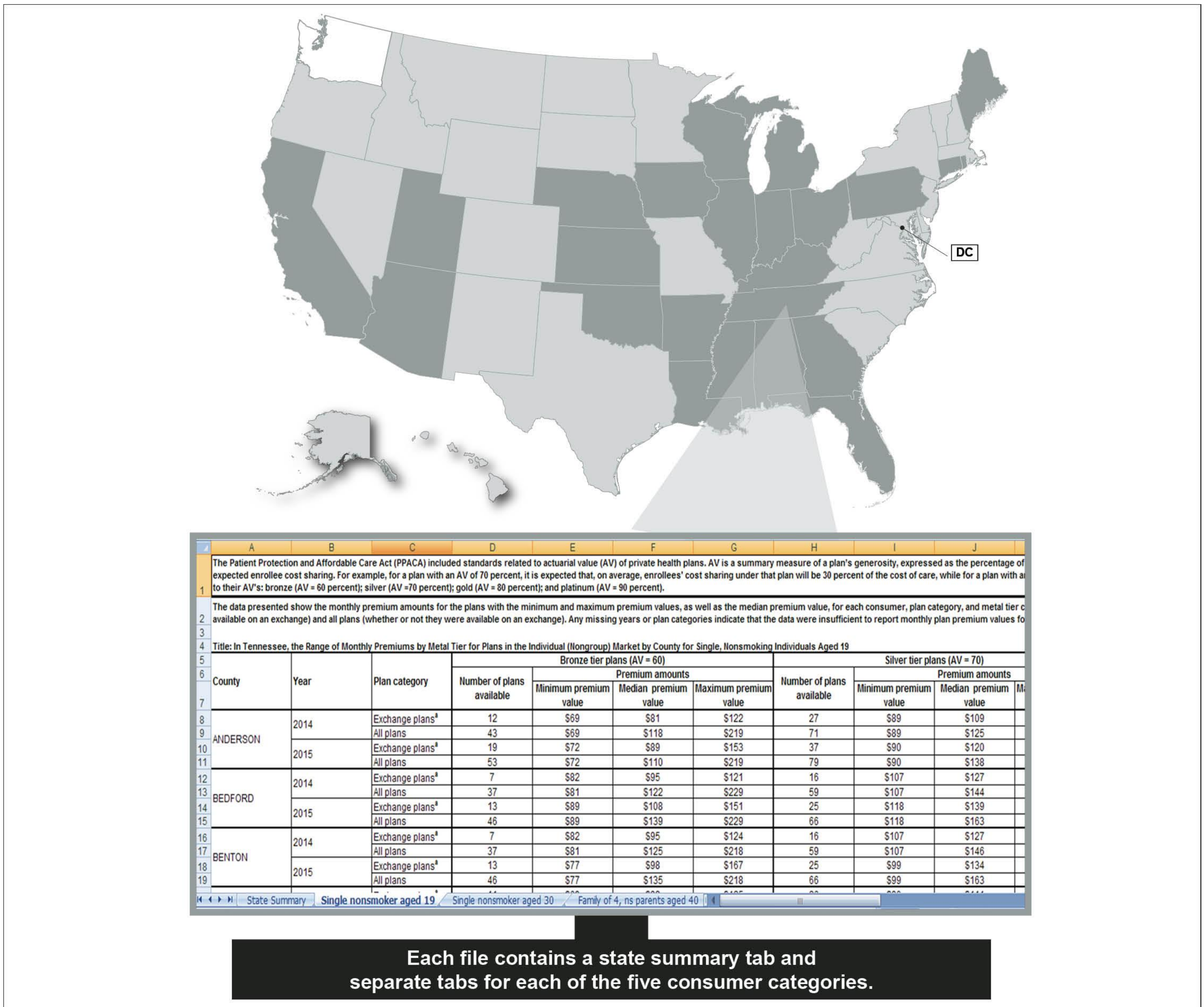
analysis uses a uniform age rating curve to specify the rates across all adult age bands, these same relative differences in premiums would apply to premiums for all adult age categories.

Note A: The premium amounts paid by individuals who received premium tax credits would have been offset and therefore effectively lower than the premium costs we report. Similarly, cost sharing subsidies would reduce the out-of-pocket costs to the enrollee, which would, in effect, make the actual benefit of the plan higher that what the actuarial values implied.

When analyzing ranges at the county level, we found that among all the counties in our analysis, the range of premiums available for different plan options generally widened from 2014 to 2015. For example, among the 1,886 counties in the 28 states for which we had sufficiently reliable data on all plans offered on or off an exchange, we found that the range in silver plan premiums for a 30-year-old in 2015 was wider in 79 percent of the counties compared to 2014. The findings were similar when we conducted our analysis for plans offered on exchanges in 38 states.

In the interactive graphic linked to below, we provide files showing the range of health insurance premiums, by county, that were available to selected categories of consumers for exchange plans and all plans (whether or not they were available on an exchange)—for both 2014 and 2015. Twenty-five states include complete sets of data for both years. Twenty-four states include partial data if certain date elements were not sufficiently reliable to report. For example, in a state where we had information for fewer than 70 percent of exchange plans in a given year, we do not report any values for exchange plans for that state in that year. We do not include any data for the state of Washington or the District of Columbia because the data were either not available or not sufficient in both years. See figure 1 for an illustration of premium information available via the interactive map available at the website.

Figure 1: Illustration of Premium Interactive Map



The Patient Protection and Affordable Care Act (PPACA) included standards related to actuarial value (AV) of private health plans. AV is a summary measure of a plan's generosity, expressed as the percentage of expected enrollee cost sharing. For example, for a plan with an AV of 70 percent, it is expected that, on average, enrollees' cost sharing under that plan will be 30 percent of the cost of care, while for a plan with a to their AV's: bronze (AV = 60 percent); silver (AV =70 percent); gold (AV = 80 percent); and platinum (AV = 90 percent).

The data presented show the monthly premium amounts for the plans with the minimum and maximum premium values, as well as the median premium value, for each consumer, plan category, and metal tier c available on an exchange) and all plans (whether or not they were available on an exchange). Any missing years or plan categories indicate that the data were insufficient to report monthly plan premium values fo

Title: In Tennessee, the Range of Monthly Premiums by Metal Tier for Plans in the Individual (Nongroup) Market by County for Single, Nonsmoking Individuals Aged 19

County	Year	Plan category	Bronze tier plans (AV = 60)				Silver tier plans (AV = 70)		
			Number of plans available	Premium amounts			Number of plans available	Premium amounts	
				Minimum premium value	Median premium value	Maximum premium value		Minimum premium value	Median premium value
ANDERSON	2014	Exchange plans[a]	12	$69	$81	$122	27	$89	$109
		All plans	43	$69	$118	$219	71	$89	$125
	2015	Exchange plans[a]	19	$72	$89	$153	37	$90	$120
		All plans	53	$72	$110	$219	79	$90	$138
BEDFORD	2014	Exchange plans[a]	7	$82	$95	$121	16	$107	$127
		All plans	37	$81	$122	$229	59	$107	$144
	2015	Exchange plans[a]	13	$89	$108	$151	25	$118	$139
		All plans	46	$89	$139	$229	66	$118	$163
BENTON	2014	Exchange plans[a]	7	$82	$95	$124	16	$107	$127
		All plans	37	$81	$125	$218	59	$107	$146
	2015	Exchange plans[a]	13	$77	$98	$167	25	$99	$134
		All plans	46	$77	$135	$218	66	$99	$163

Sources: GAO (data); Map Resources (map). | GAO-15-687

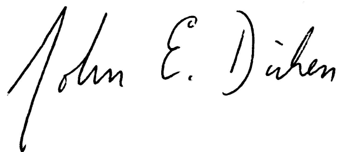
This graphic can be viewed by linking to the interactive map found at http://www.gao.gov/products/GAO-15-687.

Agency Comments

We received technical comments on a draft of this report from the Department of Health and Human Services and incorporated them as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions regarding this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.



John E. Dicken
Director, Health Care

Appendix I: States Included and Excluded from GAO's Analyses

State	Market type: federally facilitated exchange (FFE) or state based exchange (SBE)	Percent of plans offered on an exchange for which we have data		State included in analyses limited to plans available on an exchange(Y or N)	Percent of all plans for which we have data		State included in "all plans" analyses (Y or N)
		2014	2015		2014	2015	
Alaska	FFE	100%	100%	Y	53%	96%	N
Alabama	FFE	100	100	Y	81	99	Y
Arkansas	FFE	100	100	Y	96	100	Y
Arizona	FFE	100	100	Y	82	95	Y
California	SBE	71	93	Y	83	91	Y
Colorado	SBE	82	61	N	87	80	Y
Connecticut	SBE	71	74	Y	71	78	Y
Delaware	FFE	100	100	Y	36	86	N
District of Columbia [Note A]	SBE	0	0	N	0	0	N
Florida	FFE	100	100	Y	78	90	Y
Georgia	FFE	100	100	Y	98	89	Y
Hawaii	SBE	61	100	N	72	100	Y
Iowa	FFE	100	100	Y	97	100	Y
Idaho	SBE	72	76	Y	61	86	N
Illinois	FFE	100	100	Y	99	98	Y
Indiana	FFE	100	100	Y	72	90	Y
Kansas	FFE	100	100	Y	96	93	Y
Kentucky	SBE	80	95	Y	72	97	Y
Louisiana	FFE	100	100	Y	88	91	Y
Massachusetts	SBE	45	72	N	71	79	Y
Maryland	SBE	17	67	N	22	83	N
Maine	FFE	100	100	Y	100	99	Y
Michigan	FFE	100	100	Y	88	99	Y
Minnesota	SBE	61	89	N	32	34	N
Missouri	FFE	100	100	Y	45	100	N
Mississippi	FFE	100	100	Y	74	79	Y
Montana	FFE	100	100	Y	50	100	N
North Carolina	FFE	100	100	Y	57	72	N
North Dakota	FFE	100	100	Y	69	100	N

State	Market type: federally facilitated exchange (FFE) or state based exchange (SBE)	Percent of plans offered on an exchange for which we have data		State included in analyses limited to plans available on an exchange(Y or N)	Percent of all plans for which we have data		State included in "all plans" analyses (Y or N)
		2014	2015		2014	2015	
Nebraska	FFE	100	100	Y	97	100	Y
New Hampshire	FFE	100	100	Y	45	100	N
New Jersey	FFE	100	100	Y	61	88	N
New Mexico	SBE	27	90	N	51	83	N
Nevada	SBE	22	100	N	36	65	N
New York	SBE	40	74	N	52	79	N
Ohio	FFE	100	100	Y	79	93	Y
Oklahoma	FFE	100	100	Y	85	93	Y
Oregon	SBE	58	98	N	44	99	N
Pennsylvania	FFE	100	100	Y	95	90	Y
Rhode Island	SBE	100	90	Y	100	94	Y
South Carolina	FFE	100	100	Y	46	89	N
South Dakota	FFE	100	100	Y	81	100	Y
Tennessee	FFE	100	100	Y	96	100	Y
Texas	FFE	100	100	Y	41	96	N
Utah	FFE	100	100	Y	86	88	Y
Virginia [Note B]	FFE	100	100	N	84	91	N
Vermont	SBE	45	100	N	22	100	N
Washington	SBE	17	42	N	44	60	N
Wisconsin	FFE	100	100	Y	80	95	Y
West Virginia	FFE	100	100	Y	53	98	N
Wyoming	FFE	100	100	Y	22	100	N

Source: GAO analysis of Center for Consumer Information and Insurance Oversight data. | GAO-15-687

Note A: CCIIO did not provide individual market data for the District of Columbia.

Note B: We excluded 2014 data for Virginia from our analyses because, even though the percentage of plans that reported premiums data was greater than 70 percent of the universe of plans in 2014, there were several outliers that made the data unreliable for this year.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

John Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, individuals making key contributions to this report include Gerardine Brennan, Assistant Director; Todd Anderson; George Bogart; Matthew Byer; and Laurie Pachter.

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