United States Government Accountability Office

Report to Congressional Requesters

August 2014

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied

GAO-14-657

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GAO Highlights

Highlights of GAO-14-657, a report to congressional requesters

Why GAO Did This Study

PPACA required by January 1, 2014, the establishment in each state of health insurance exchanges—marketplaces where eligible individuals and small businesses can compare and select among insurance plans. Issuer participation, including the number of plans these issuers offer, is a key factor in the extent of consumer choice offered by the exchanges.

GAO was asked to examine the number and types of issuers participating in both the individual and small-business exchanges beginning in 2014, as well as how this compared with issuer participation in the individual and small-group markets prior to the exchanges. In this report, GAO describes (1) the extent to which issuers that previously offered health plans in the individual and small-group markets participated in the exchanges in 2014, and (2) the issuers that participated in 2014 exchanges and the health plans they offered.

GAO analyzed data obtained from CMS and states on the health plans offered by issuers that participated in states' exchanges in 2014. GAO also analyzed CMS data on issuers' participation and market share in the 2012 individual and small-group markets, the most recently available national market-wide data. GAO reviewed relevant laws and regulations and interviewed CMS officials to identify federal requirements related to exchange participation. GAO obtained information on state participation requirements from applicable states.

View GAO-14-657. For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

Most of the largest issuers of health coverage from 2012 participated in the exchanges that the Patient Protection and Affordable Care Act (PPACA) required be established in all states in 2014. Previously, in 2012, while a large number of issuers participated in state individual and small-group markets, a small number of these participating issuers held a majority of the market share in terms of enrollment. In 2014, for both those exchanges serving the individual market and those serving the small-group market, in more than two-thirds of states the issuer with the largest share of the 2012 market participated in the 2014 exchange. In addition, in most states, other larger issuers with a 5 percent or more share of the 2012 market participated in the 2014 exchanges. Most smaller issuers with less than 5 percent of the 2012 market did not participate in the 2014 exchanges, although in many states more than one of these smaller issuers did participate. In addition, some issuers that participated in a 2014 individual or small-business exchange had not offered coverage in the respective 2012 market, although they may have offered coverage in other markets within the same state. In most states, for 2014, the issuers participating in the exchanges represented a mix of larger issuers, smaller issuers, and issuers new to that market.

Table: Average Issuer Participation in 2014 Exchanges across States

Type of exchange	Average number of participating issuers	Average number of issuers new to the market in 2014	Average 2012 market share of all participating issuers
Individual	6	3	57
Small-business	4	1	56

Source: Centers for Medicare & Medicaid Services (CMS) and states. | GAO-14-657

Multiple issuers participated in nearly all 2014 exchanges and generally offered more health plans than the minimum of two required by PPACA. Overall, the number of participating issuers varied widely between states, from 1 to 17 issuers in the individual exchanges and from 1 to 13 issuers in the small-business exchanges. However, almost all exchanges—49 individual and 45 small-business—had more than one issuer participating. More than half of participating issuers offered coverage through both the individual and small-business exchange in that state, although more issuers participated in the individual exchanges than in the small-business exchanges. Issuers varied substantially in the number of plans they offered; 257 of the 291 issuers in the individual exchanges, and 183 of the 207 issuers in the small-business exchanges, offered more than the minimum number of plans required by PPACA in all the rating areas in which they offered coverage. For both the individual and small-business exchanges, collectively, issuers in the 25 most populous states tended to offer a higher than average number of plans, while those in less populous states were less likely to do so.

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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Figures

Abbreviations

CMS	Centers for Medicare & Medicaid Services
CO-OP	Consumer Oriented and Operated Plans
OPM	Office of Personnel Management
PPACA	Patient Protection and Affordable Care Act

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August 29, 2014

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

The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Government Affairs
United States Senate

The Patient Protection and Affordable Care Act (PPACA) required, by January 1, 2014, the establishment in each state of health insurance exchanges—marketplaces where eligible individuals and small businesses can compare and select among health plans.[1] PPACA does not require issuers of health coverage to offer plans through these exchanges but, instead, generally relies on market incentives to encourage their participation.[2] For example, it is only through the exchanges that qualifying individuals seeking to purchase coverage can qualify for premium tax credits and cost-sharing reductions to lower the cost of their health plans and certain small businesses may qualify for tax credits to lower the cost of the coverage they purchase on behalf of their employees. PPACA also allows states and the federal government to take

[1]Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119, 173, 186 (Mar. 23, 2010) (hereafter, "PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010) (hereafter, "HCERA"). In this report, references to PPACA include any amendments made by HCERA. The Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS), which is tasked with overseeing the establishment of exchanges, refers to exchanges as marketplaces.

States may establish separate individual and small-business exchanges or a single exchange to serve both individuals and small employers—we refer to the latter as small businesses. Under PPACA, until 2016, states have the option to define "small businesses" either as those having from 1 through 100 full-time equivalent employees or those having from 1 through 50 full-time equivalent employees. Beginning in 2016, small businesses will be defined in all states as those with 100 or fewer full-time equivalent employees.

In this report, the term "state" includes the District of Columbia.

[2]An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

additional steps to encourage or require issuer participation in the exchanges.

Issuers seeking to participate in an individual or small-business exchange must first be approved to do so by the exchange in that state. In about one-third of states, the state chose to operate the exchange in 2014, known as a state-based exchange, and approved issuers for participation. In the remaining states that elected not to operate an exchange, the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) was responsible for carrying out these responsibilities.[3] These are known as federally facilitated exchanges.

Issuer participation is a key factor related to the extent to which an exchange will offer consumers a choice of plans. You asked us to examine the number and types of issuers participating in both the individual and small-business exchanges beginning in 2014, as well as how this compares with issuer participation in the individual and small-group markets prior to the exchanges.[4] In this report we describe:

1. the extent to which issuers that previously offered health plans in the individual and small-group health insurance markets participated in the 2014 exchanges, and
2. the issuers that participated in 2014 exchanges and the health plans they offered.

To answer these objectives, we identified and obtained data on issuers that participated in the 2014 exchanges and the plans that they offered in each state's rating areas.[5] For those exchanges that were federally facilitated—34 individual and 32 small-business—we analyzed data that CMS collected from issuers as part of the agency's certification of issuer

[3]In states not operating an exchange, PPACA requires the federal government to operate an exchange in that state. PPACA, § 1321(c), 124 Stat. at 186.

[4]The small-group market is the health insurance market under which individuals obtain health insurance coverage through a group health plan offered by a small employer.

[5]Under PPACA, issuers are allowed to adjust premium rates within specified limits for plans based on the number of people covered under a particular policy, the covered individual's age, smoking status, and area of residence. Each state can divide up areas of residence in the state into locations called rating areas.

plans to be included in the 2014 exchanges.[6] This source also included data for a small number of state-based exchanges—2 individual and 1 small-business—that chose to have CMS carry out certain functions on their behalf in 2014. To assess the data's reliability, we interviewed CMS officials about the agency's policies and procedures to ensure that the data captured all relevant issuers and that data submitted by issuers were accurate. In addition, we performed electronic tests of the data to identify any outliers or anomalies. We determined the data were sufficiently reliable for the purposes of our analysis. For the remaining 15 individual and 18 small-business exchanges that were state-based, complete data were not available from CMS and we obtained them directly from each state. To assess the reliability of the data obtained from states, we performed electronic tests of the data. When we found missing values or other anomalies, we followed up with state officials and incorporated the corrections we received. We determined the data were sufficiently reliable for the purposes of our analysis. We also identified federal requirements related to exchange participation by interviewing CMS officials and reviewing relevant laws and regulations. To obtain information about state participation requirements, we obtained information from each of the state-based exchanges.[7]

To identify the number of issuers previously offering health plans in the individual market and the small-group market, by state, we analyzed coverage data that PPACA required issuers to report to CMS.[8] Using the most recently available data, we identified issuers that participated in states' 2012 individual and small-group markets and analyzed each issuer's total number of covered life-years to determine their share of the

[6]CMS Qualified Health Plan Landscape data, as of March 31, 2014, downloaded from https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/ and last accessed on June 20, 2014.

[7]According to CMS officials, there were no state requirements related to issuer participation in the federally facilitated exchanges.

[8]PPACA requires issuers to report data on the percent of premiums spent on their enrollees' medical claims, quality initiatives, and other costs, known as their medical loss ratio. Issuers must report these data to CMS every June and these data are based on the issuers' experience for the prior calendar year. The 2012 data were the most recently available data at the time of our analysis. CMS Medical Loss Ratio Data, Public Use File for 2012, as of August 1, 2013, downloaded from http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html and last accessed on June 23, 2014.

individual and small-group market in that state.[9] In addition, we categorized the issuers by size. We defined larger issuers as those with 5 percent or more of the market in that state and smaller issuers as those with less than 5 percent of the market. We reviewed these data for reasonableness and consistency, including screening for outliers. We also reviewed documentation about the data and spoke with CMS officials about steps taken to ensure data reliability. Based on this review, we determined that the data used for our analysis were sufficiently reliable for our purposes. To describe the extent to which issuers participating in the 2014 exchanges also participated in the applicable 2012 market, we matched 2014 issuers with those in the 2012 market using a unique code that CMS assigns to each issuer in each state. When we were not able to identify a match for a 2014 issuer code in the 2012 data, we used other information from CMS and the insurance company to determine whether the issuer participated in the 2012 market.[10] For each 2014 issuer that was participating in its respective market in 2012, we identified its share of that 2012 market. We did not determine whether multiple issuers in a state were affiliated with a parent company. For those 2014 issuers that participated in the 2012 markets, we also used the 2012 data to determine whether they were for-profit or not-for-profit entities, as this information was not available in CMS's 2014 exchange data. For those 2014 issuers that did not participate in the 2012 markets, we used documentation from the issuers and other sources to determine whether the issuers were for-profit or not-for-profit entities.

We conducted this performance audit from January 2014 to August 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

[9]Market share is the percentage of a total market, in terms of either value or volume, accounted for by the sales of a specific entity. In the health insurance industry, market share can be measured as the percentage of the total market held by an issuer in terms of beneficiary enrollment or health insurance premiums paid. One way to measure beneficiary enrollment is through covered life-years. Covered life-years represent the average number of lives insured, including dependents, on a pre-specified day over each of the 12 months in the reporting year.

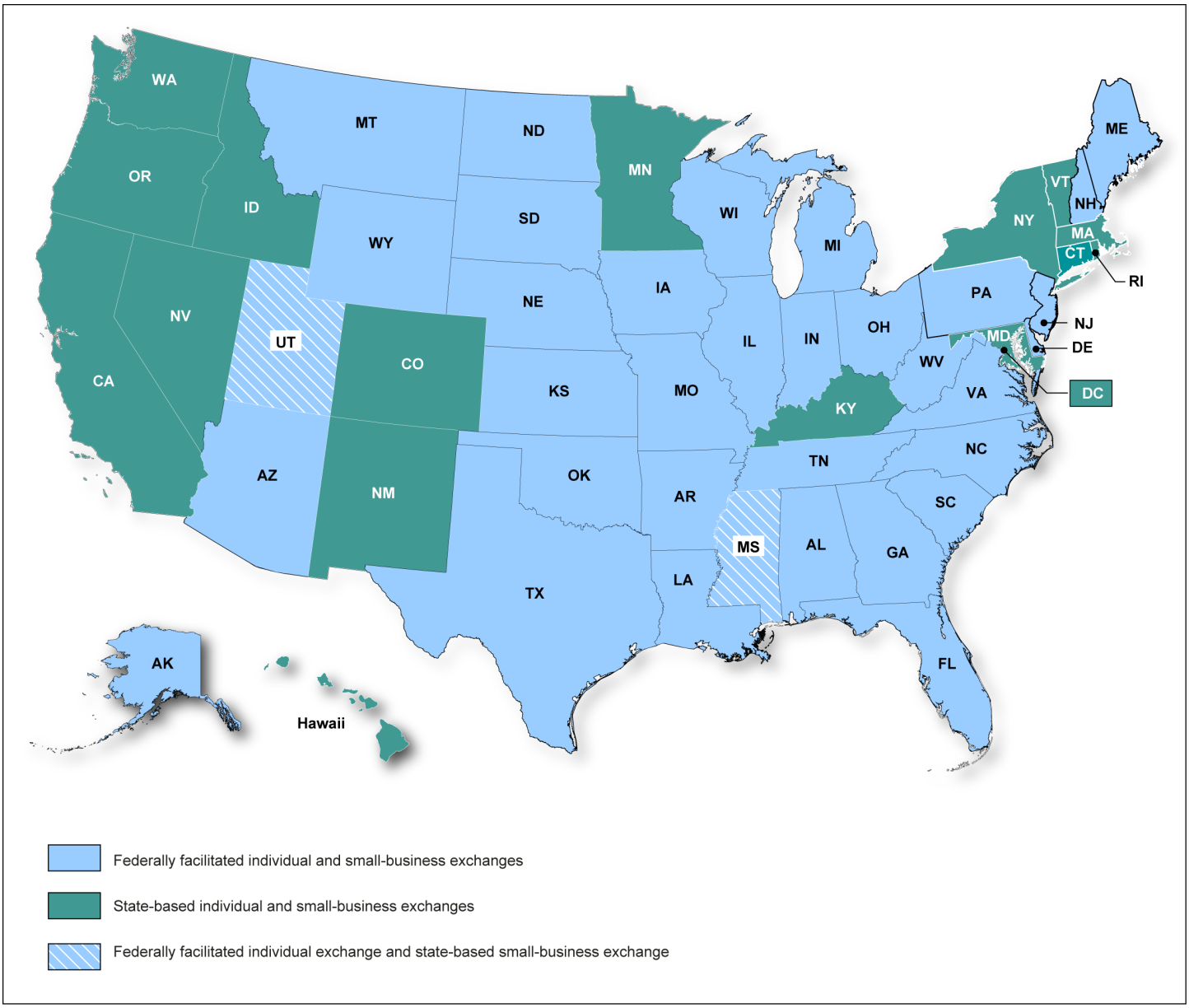
[10]According to CMS officials, each insurance company will generally be assigned a single issuer code for each state in which it offers coverage. The officials indicated, however, that some insurance companies had differing issuer codes assigned within a single state in 2012 and 2014. The officials provided us with data to identify and match issuers with differing codes, and they indicated that this problem had been corrected for future years of data.

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

PPACA contained several provisions with the potential to affect issuer participation in the individual and small-group health insurance markets starting in 2014. Specifically, it directed states to establish exchanges for individuals and small businesses by January 1, 2014. In states electing not to establish and operate either type of exchange, PPACA required the federal government to establish and operate the exchange. For 2014, about one-third of the states chose to operate their individual and small-business exchanges, known as state-based exchanges. Specifically, in 17 states, the state chose to operate both the individual exchange and the small-business exchange, known as the Small Business Health Options Program, or SHOP. In 32 states, the federal government operated both the individual and small-business exchanges, known as federally facilitated exchanges. In the remaining 2 states, the individual exchange was federally facilitated, while the small-business exchange was state-based. (See fig. 1.)

Figure 1: Health Insurance Exchange Arrangements for 2014



Sources: Centers for Medicare & Medicaid Services (data); Map Resources (map). | GAO-14-657

All individual and small-business health plans, whether offered through an exchange or outside of an exchange, must comply with new insurance market reforms enacted under PPACA.[11] These include, for example, a requirement to cover certain categories of benefits at standardized levels of coverage, which are categorized by "metal level" as catastrophic, bronze, silver, gold, or platinum, depending on the portion of health care costs expected to be paid by the health plan. They also include prohibitions on annual and lifetime limits on the dollar value of required benefits and on the denial of coverage or charging of higher premiums due to preexisting conditions. Some of these reforms were in effect in 2012, while others did not take effect until 2014.

To be certified to offer coverage through an exchange, issuers must meet additional requirements, including offering a minimum of one silver and one gold plan in any area in which it participates in an exchange. Catastrophic plans may be offered only in the individual exchanges, and not on the small-business exchanges, and may be offered only to certain individuals. Issuers can offer plans statewide or within different geographic regions, typically defined by rating areas. States could define their rating areas using counties, Metropolitan Statistical Areas,[12] zip codes, or a combination of those options.

PPACA also requires that the federal government establish multi-state plans to be offered through each of the individual and small-business exchanges.[13] Specifically, multi-state plans are those that issuers offer under a contract with the U.S. Office of Personnel Management (OPM). PPACA requires the contracted issuers to offer at least two multi-state plans through each exchange and requires that at least one of the issuers with which OPM contracts be not-for-profit. Issuers of multi-state plans are allowed to phase in coverage, but must offer coverage in 60 percent of states in the first contract year and in all states by the third contract year. During the first two contract years, OPM indicated that it would not direct issuers to participate in particular states. For 2014, OPM entered

[11]Certain of these reforms apply only to plans issued after March 23, 2010.

[12]A Metropolitan Statistical Area consists of one or more counties that contain at least one core urban area with a population of 50,000 or more as well as adjacent counties that have a high degree of social and economic integration with the urban core, as measured by commuting ties.

[13]PPACA, §§ 1334,10104(q), 124 Stat. at 902.

into a contract with the Blue Cross and Blue Shield Association to offer coverage in 31 states through the individual and small-business exchanges.

PPACA also established a program to foster the creation of consumer-governed, not-for-profit issuers of health coverage—referred to as Consumer Oriented and Operated Plans (CO-OP)—that would provide additional coverage options in the individual and small-business exchanges.[14] As required by PPACA, CMS established a loan program through which qualified not-for-profit issuers could apply for federal funding to help cover startup costs associated with establishing a CO-OP and to help meet states' solvency and reserve requirements for licensure. A CO-OP issuer may operate within specific areas of a state, statewide, or in multiple states.[15] For 2014, 22 CO-OPs receiving federal loans offered coverage through the exchanges.[16]

The federal government and states instituted other provisions that relate to issuer participation in the exchanges. For example, for federally facilitated exchanges, CMS requires that issuers with more than 20 percent market share in the small-group market participate in the small-business exchange as a condition of participation in the individual exchange.[17] In adopting this requirement, CMS indicated that the purpose of this requirement is to promote robust participation in the small-business exchanges and expand plan choice.[18] In addition, some states that operated their own exchanges enacted statutory, regulatory, or other requirements governing issuer participation in exchanges. Seven states

[14]PPACA, § 1322, 124 Stat. at 187.

[15]Although a CO-OP may operate within specific areas of a state, PPACA requires CMS to prioritize loan applications from applicants that plan to operate on a statewide basis.

[16]CMS awarded loans to two additional organizations. One organization did not offer coverage in the exchange in 2014 and planned to offer coverage in 2015. The second organization was awarded loans, but it was unable to obtain licensure from the state and, as a result, CMS de-obligated a portion of the awarded loans.

[17]45 C.F.R. § 156.200(g). This rule also applies to issuers that are members of an issuer group that has at least one member with greater than 20 percent market share. For this requirement, CMS determines market share based on earned premium data (as opposed to covered life-years) contained in the most recently filed medical loss ratio report issuers must file under PPACA.

[18]78 Fed. Reg. 15410, 15502 (Mar. 11, 2013).

reported requiring issuers participating in exchanges to offer a minimum number of health plans, while four states set maximum limits. Three states also reported requiring participation in individual and small-business exchanges. For example, in Maryland, certain issuers that offered plans outside of the exchanges were also required to offer plans through the exchange. Further, four states reported establishing waiting periods related to exchange participation in future plan years for issuers that chose not to participate in the 2014 exchange. For example, Connecticut prohibited an issuer from re-entering the exchange for 2 years if the issuer voluntarily ceased to participate in the exchange. (See table 1.)

Table 1: State-Based Exchanges with Requirements Related to Issuer Participation

Type of state participation requirements	States that reported having requirements
Requires an issuer participating in the exchange to offer a minimum number of qualified health plans	California, Connecticut, District of Columbia, Maryland, Massachusetts, Minnesota, and New York
Limits the number of qualified health plans offered by an issuer participating in the exchange	Kentucky, Maryland, Nevada, and Oregon
Requires issuer participation in the exchange markets	District of Columbia, Maryland, and Vermont
Imposes waiting periods restricting exchange participation in future plan years for issuers that choose not to participate in the 2014 exchange	Colorado, Connecticut, New York and Oregon

Source: State-based exchanges. | GAO-14-657

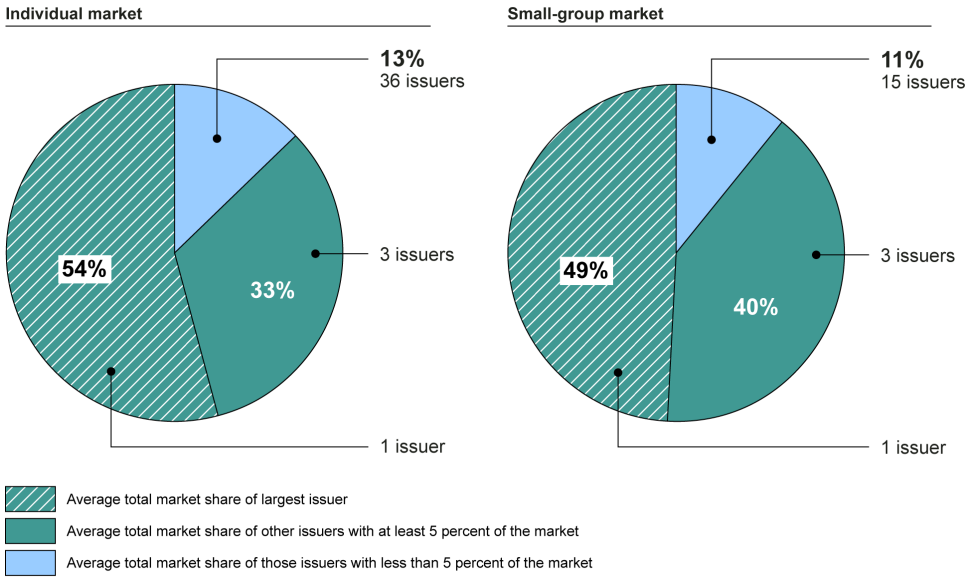
Note: In addition to these categories, states may have additional requirements that affect issuer participation. For example, Washington requires that catastrophic plans can only be sold on the exchange and may not be offered in the non-exchange individual market.

Most of the Largest Issuers in the 2012 Individual and Small-group Markets Participated in the 2014 Exchanges, with Exceptions in Some States

In most states, issuers with the largest share of the 2012 individual and small-group markets participated in the 2014 individual and small-business exchanges. In 2012, a large number of issuers participated in state individual and small-group markets, although coverage was generally concentrated among a small number of these participating issuers. For example, while there was an average of 42 issuers in the 2012 individual market, only 4 had at least a 5 percent share of the market and they accounted for a combined 87 percent of that market. (See fig. 2.) For 2014, in 40 states the issuer with the largest share of the 2012 individual market participated in that state's 2014 individual exchange. For the small-group market, this was the case in 41 states. In addition to participation from the largest issuer, most states had other issuers with at least 5 percent of the market participating in the 2014 exchanges. For example, in 6 states all of the issuers with at least a 5 percent share of the 2012 individual market also participated in the

2014 exchanges; this was the case for the small-business exchanges in 5 states.

Figure 2: Issuer Participation in State Individual and Small-group Markets in 2012



Source: Centers for Medicare & Medicaid Services. | GAO-14-657

However, in some states, issuers with the largest 2012 market share did not participate in the 2014 exchanges. Specifically, in the individual and small-group markets for 11 and 10 states, respectively, the largest issuer in 2012 did not participate in the 2014 exchanges. Among the 11 states for which that was the case for the individual market, there were 5 in which that issuer had the majority of the state's 2012 market share;[19] for the small-business exchange, this was the case in 3 of the 10 states.[20]

Most issuers with less than 5 percent of their 2012 market did not participate in the 2014 exchanges, although in many states more than

[19]In the other 6 states in which the issuer with the largest share of the 2012 individual market did not participate in the exchanges, those issuers held between 20 and 40 percent of the state's 2012 market.

[20]In the other 7 states in which the issuer with the largest share of the 2012 small-group market did not participate in the exchanges, those issuers held between 22 and 39 percent of the state's 2012 market.

one of these smaller issuers did participate. In 2012, states had an average of 36 and 15 issuers with less than a 5 percent share of the individual and small-group markets, respectively. Most of these smaller issuers did not participate in the 2014 exchanges. However, in most states, at least 1 of these smaller issuers did participate in the 2014 individual exchanges; in 9 states, 5 or more smaller issuers participated. All smaller issuers that participated in the 2014 individual exchanges had an average market share of 0.6 percent in 2012.

In addition, some issuers that participated in the 2014 individual or small-business exchanges had not participated in that respective 2012 market. For example, with regard to the individual market, there were 39 states in which at least 1 issuer that offered coverage through the exchange had not provided coverage in that respective 2012 market. The number of such issuers in each individual exchange ranged from 1 to 11, for a nationwide total of 99 (out of the 291 total issuers that participated in the individual exchanges). Of these, 23 were newly established through the federally funded CO-OP program.[21] Some of the other issuers, however, had previously provided coverage in other markets. For example, in Iowa, we identified 3 issuers that were new to the 2014 individual market. While one of these was a newly established CO-OP, the other two had previously participated in the small-group market in that state. There were also several new issuers that had previously issued coverage in the Medicaid managed care market.[22] For example, one insurance company that issued coverage in multiple Medicaid managed care markets in 2012 was a new entrant to the individual markets through 6 state exchanges.

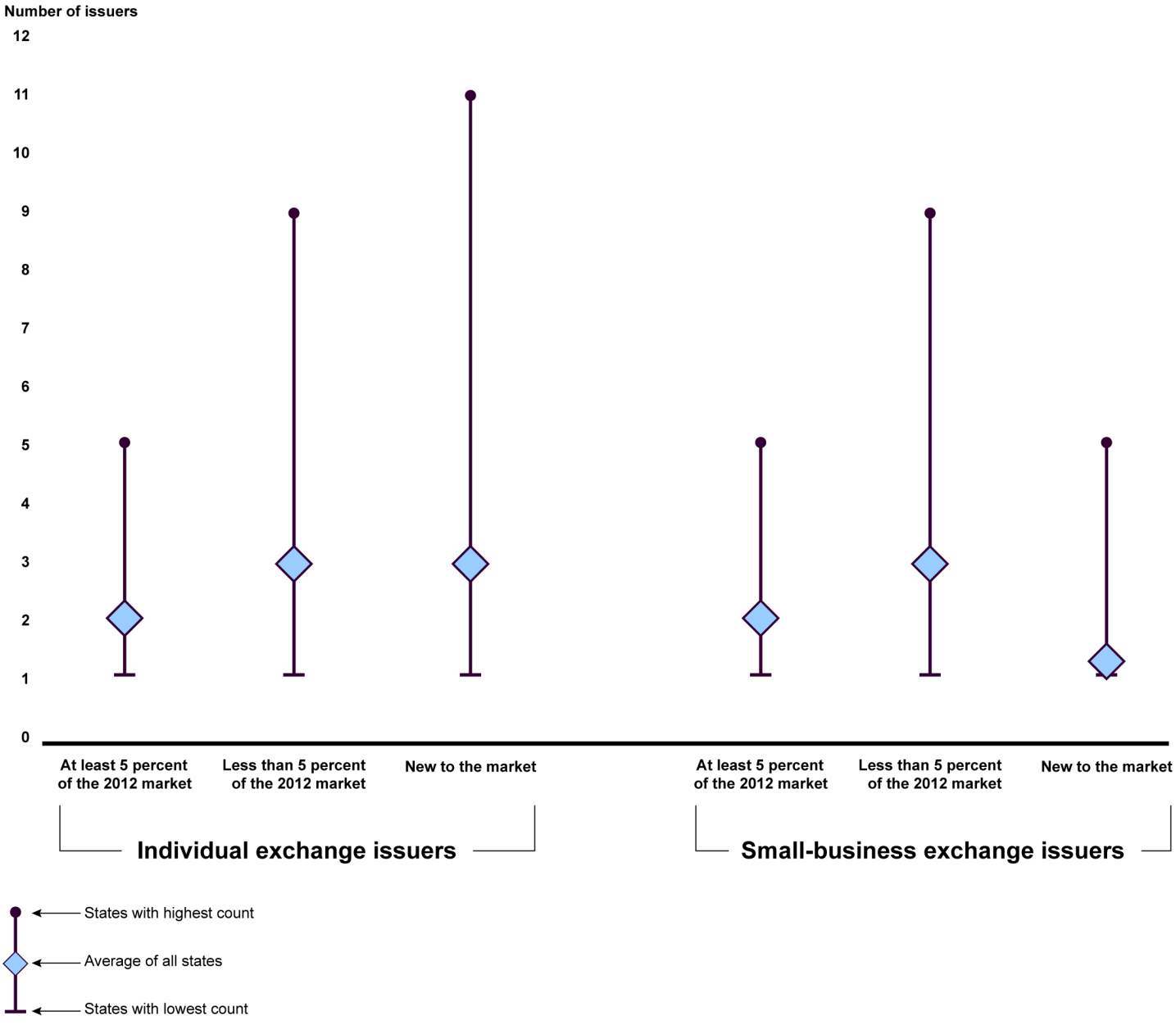
In most states, for 2014 the issuers participating in the exchanges represented a mix of larger issuers, smaller issuers, and issuers new to that market. Overall, the issuers in each 2014 exchange that participated in the 2012 markets represented from 3 to 98 percent of that state's 2012 individual market and from 1 to 100 percent of that state's 2012 small-group market, averaging about 56 percent in each market. An average of

[21]Although there are 22 CO-OPs, 1 CO-OP offers coverage in two states, which are counted uniquely in the data. Therefore, 23 issuers are counted.

[22]The Medicaid program is a joint federal-state program that finances health insurance coverage for certain categories of low-income individuals. Nearly all states enroll some Medicaid beneficiaries in a form of managed care. Under Medicaid managed care, states contract with health plans and prospectively pay the plans a fixed monthly rate per enrollee to provide or arrange for health services.

4 larger issuers in the individual market and 3 issuers in the small-group market accounted for the majority of these market-share totals in each state and, on average, more smaller issuers—those that had less than 5 percent of the 2012 market—than larger issuers participated in the individual exchanges in 2014. (See fig.3 for the number of participating issuers, by category of 2012 market share. Also, see app. I for state-by-state information on issuer participation in the exchanges and their 2012 market share.)

Figure 3: Issuers Participating in the 2014 Exchanges across All States, by Category of Market Share in 2012



Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

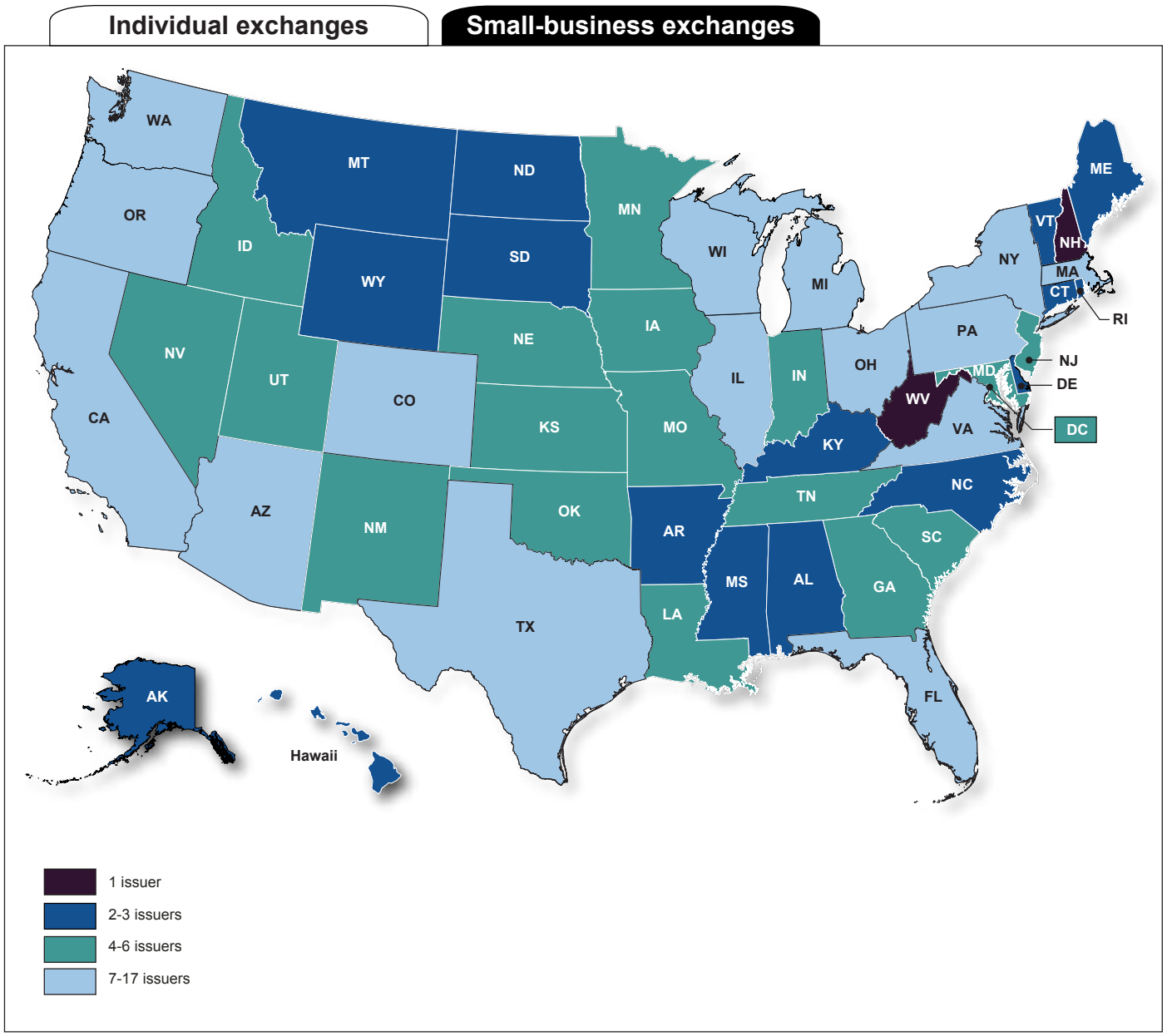
Nearly All 2014 Exchanges Had Multiple Participating Issuers, Which Generally Offered More Plans than the Minimum Required by PPACA

In nearly all states, multiple issuers participated in the individual and small-business exchanges in 2014; an average of 6 issuers and 4 issuers, respectively. Overall, the number of participating issuers varied widely between states; from 1 to 17 issuers through the individual exchange and from 1 to 13 issuers through the small-business exchanges. However, almost all exchanges had more than 1 issuer participating—49 individual exchanges and 45 small-business exchanges. Further, in 31 states, both the individual and small-business exchanges had 3 or more participating issuers.[23] (See fig. 4 and app. II.)

[23]In general, states that had a higher number of issuers participating in the 2014 exchanges also had a higher number of issuers participating in the 2012 markets.

Figure 4: Number of Issuers Participating in the 2014 Individual and Small-business Exchanges, by State

Interactivity instructions: Roll over on one of the two tabs to see data for each category. See appendix II for the non-interactive, printer-friendly version.



Sources: Centers for Medicare & Medicaid Services and state-based exchanges (data); Map Resources (map). | GAO-14-657

More than half of participating issuers offered coverage through both the individual and small-business exchanges, although more issuers participated in the individual exchanges than in the small-business exchanges. Of the 323 issuers that participated in the exchanges, 175 participated in both the individual and small-business exchanges in their state. Of the remaining 148 issuers, 116 participated in the individual exchange only and 32 participated in the small-business exchange only. In 30 states, there were more issuers participating in the individual exchange than the small-business exchange.[24]

Most issuers offering coverage through the 2014 exchanges were for-profit entities, although the portion that was not-for-profit was greater than in the 2012 markets. In 2014, about 40 percent of issuers participating in the exchanges were not-for-profit with the remaining 60 percent for-profit. In comparison, in 2012, 9 percent of all issuers were not-for-profit and 91 percent were for-profit. In part, the difference in the percentage of not-for-profit issuers between the 2012 individual market and the 2014 individual exchanges could be because issuers with the largest share of the 2012 market were more likely to be not-for-profit and more likely to participate in the exchanges.[25] In addition, both the multi-state plan and CO-OP programs established under PPACA require inclusion of not-for-profit issuers.[26] For example, of the 116 not-for-profit issuers offering coverage through the exchanges, 20 percent were the 22 newly created CO-OPs. In 9 individual and 9 small-business exchanges, a CO-OP represented the only not-for-profit issuer on the exchange.

Issuers varied substantially in the number of plans they offered in each rating area through the 2014 exchanges. In the individual exchanges, each issuer offered an average of 10 plans in each rating area. Of the 291 issuers, 257 offered more than the minimum number of plans

[24]In 2012, the small-group market generally had less than half as many participating issuers as the individual market, with less than one third of all issuers participating in both markets.

[25]Among those issuers with the largest market share in 2012, 57 percent were not-for-profit. In comparison, 7 percent of those issuers with less than 5 percent market share in 2012 were not-for-profit. Additional issuers may have offered coverage outside of the 2014 exchanges.

[26]PPACA requires that all CO-OP issuers be not-for-profit and that at least one contracted multi-state plan program issuer in each state be not-for-profit. Of the 36 issuers offering multi-state plans in 31 states in 2014, 14 were not-for-profit, and 22 were for-profit.

required by PPACA—one gold and one silver plan—in all the rating areas in which they offered coverage. Of the 207 issuers in the small-business exchanges, each issuer offered an average of 12 plans in each rating area and 183 offered more than the minimum number of plans required in all the rating areas they offered coverage in. (See table 2 for the range of plans offered. Also see app. III for a state-by-state listing of the number of rating areas and number of plans offered through the exchanges.)

Table 2: Number of Plans Offered by Issuers Participating in the 2014 Exchanges across Rating Areas

	Number of plans offered in each rating area in 2014		
Type of exchange	**Minimum**	**Average**	**Maximum**
Individual	2	10	72
Small-business	2	12	129

Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

Similarly, the total number of plans available to consumers in a given rating area through the exchanges varied greatly. For example, in the individual exchanges, the total number of plans available in a given rating area ranged from 7 to 178, averaging about 41 plans. (See fig. 5 and app. IV.) In all rating areas, consumers could select from at least one bronze, one silver, and two gold level plans and about 58 percent of rating areas had plans available at all five metal levels. However, in the remaining 42 percent of rating areas, consumers did not have access to a platinum plan. The trends for the small-business exchanges were similar, and all rating areas had at least one silver and one gold plan available.[27] While these represent the number of plans available to consumers through the exchanges, the total number of plans available to a consumer in each market would include the additional plans that were available outside the exchanges.[28] These plans were required to meet many of the same requirements as the exchange plans, but individuals enrolling in plans outside the exchanges were not eligible for premium tax credits and

[27]Catastrophic plans are offered only in the individual exchanges; therefore, there are only four metal levels of coverage offered in the small-business exchanges.

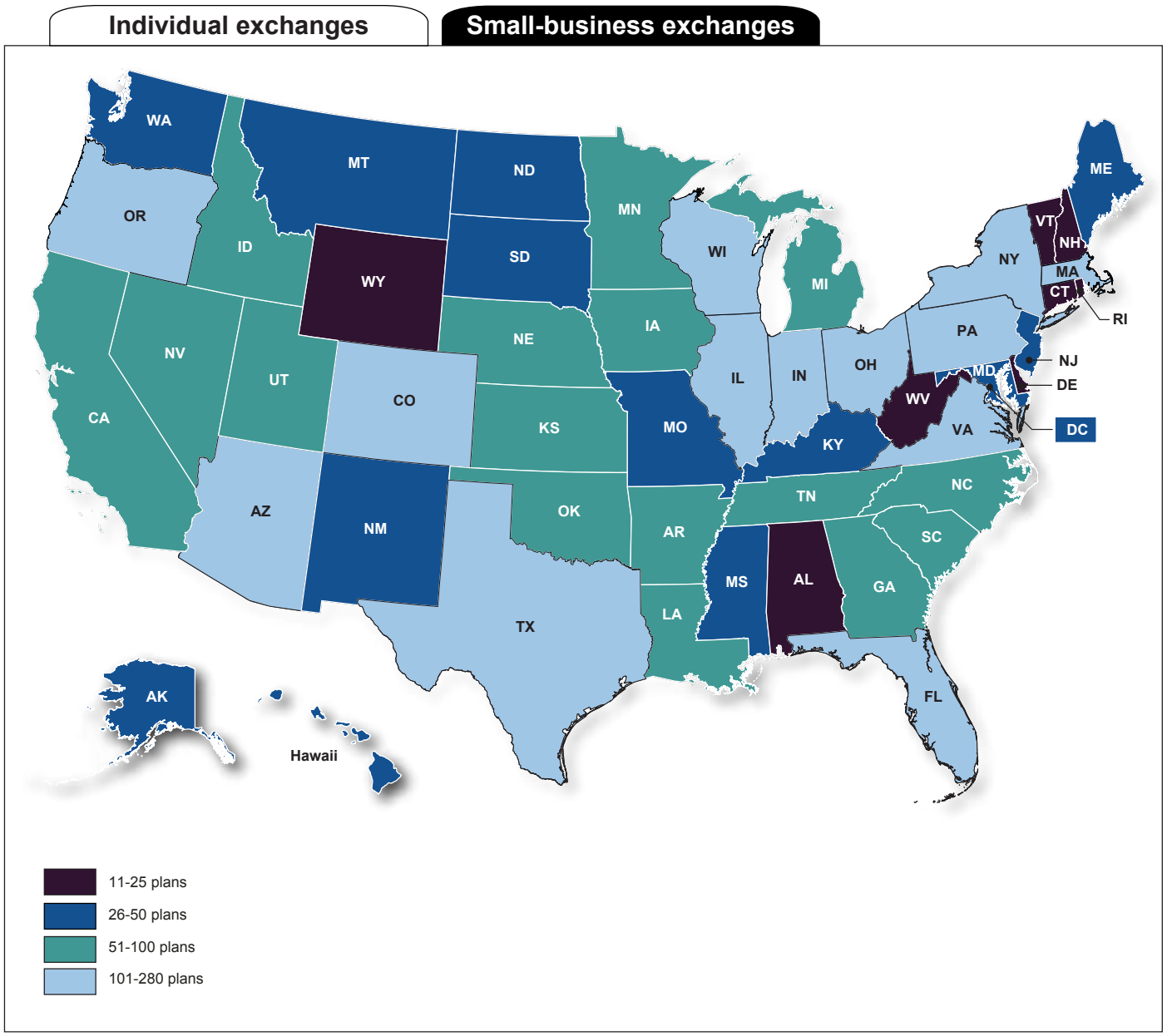
[28]Consistent national data on issuers and plans available outside of the exchanges were not available at the time we prepared this report.

cost-sharing reductions to make the coverage more affordable.[29] Small businesses enrolling in coverage outside of the exchanges were similarly ineligible for tax credits.

[29]Individuals purchasing coverage through the exchanges may be eligible for income-based tax credits to reduce the premiums they pay, and may also be eligible for subsidized plans that lower their out-of-pocket costs, such as deductibles and copayments.

Figure 5: Number of Plans Offered by Issuers in the 2014 Individual and Small-business Exchanges, by State

Interactivity instructions: Roll over on one of the two tabs to see data for each category. See appendix IV for the non-interactive, printer-friendly version.



Sources: Centers for Medicare & Medicaid Services and state-based exchanges (data); Map Resources (map). | GAO-14-657

Some of this variability in plan availability may be related to the population of the state, although we did not find consistent differences between states when we examined other factors. One factor that could influence an issuer's decision to participate in a market is the number of potential consumers.[30] We found, overall, that more populous states tended to have more plans available than less populous states. For both the individual and small-business exchanges, collectively, issuers in the 25 most populous states tended to offer a higher than average number of plans, while those in less populous states were less likely to do so.[31] (See fig. 6 and fig. 7) However, other factors we examined did not appear to influence issuers' decisions to participate in exchanges. A key difference between exchanges was that about one-third of states chose to operate their exchanges, and these states had the ability to impose limitations on exchange participation and plan offerings. Based on our review, the state-based exchanges did not appear to have either a greater or lesser number of available plans. For example, among the 10 states with the highest average number of plans, 3 states had state-based exchanges and 7 had federally facilitated exchanges.[32] Similarly, among the 10 states with the lowest average number of plans, 3 states had state-based exchanges and 7 had federally facilitated exchanges.[33] In addition, of the 7 state-based exchanges that set requirements for a minimum number of plans that issuers must offer in each metal level, only the New York exchange had higher than the average number of plans per rating area in both the individual and small-business exchanges, while Maryland, Massachusetts, Minnesota and the District of Columbia had higher than

[30]The pooling of risk is fundamental to insurance. For example, a large pool of consumers of similar risks exhibit stable and measurable characteristics that enable health insurance companies to estimate future costs with an acceptable degree of accuracy. This, in turn, enables actuaries to determine premium levels that will be stable over time, relative to overall trends.

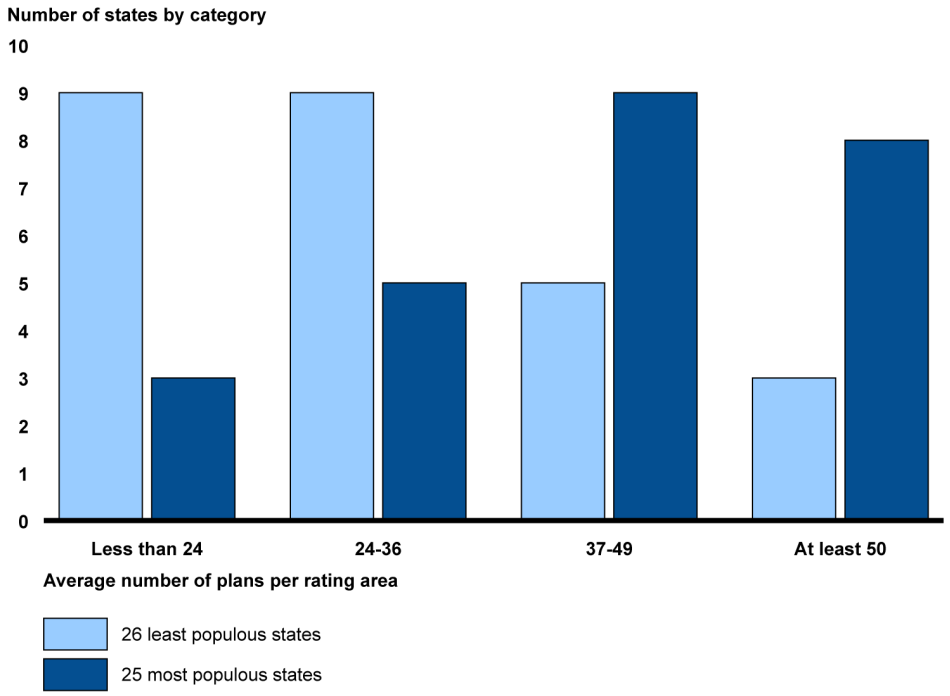
[31]Although we did not have information on the number of plans available in 2012, we found that states with a larger number of 2012 issuers also tended to have a larger number of issuers participate in the 2014 exchanges.

[32]Among the 10 states with the highest average number of plans, Colorado, Oregon, and Utah had state-based exchanges, while Arizona, Florida, Ohio, Oklahoma, Pennsylvania, Tennessee, and Wisconsin had federally facilitated exchanges.

[33]Among the 10 states with the lowest average number of plans, Connecticut, Rhode Island, and Vermont had state-based exchanges, while Alabama, Delaware, Missouri, New Hampshire, North Carolina, West Virginia, and Wyoming had federally facilitated exchanges.

the average number of plans per rating area in the small-group market.[34] We did not assess other factors that could lead to the variability in plan availability.

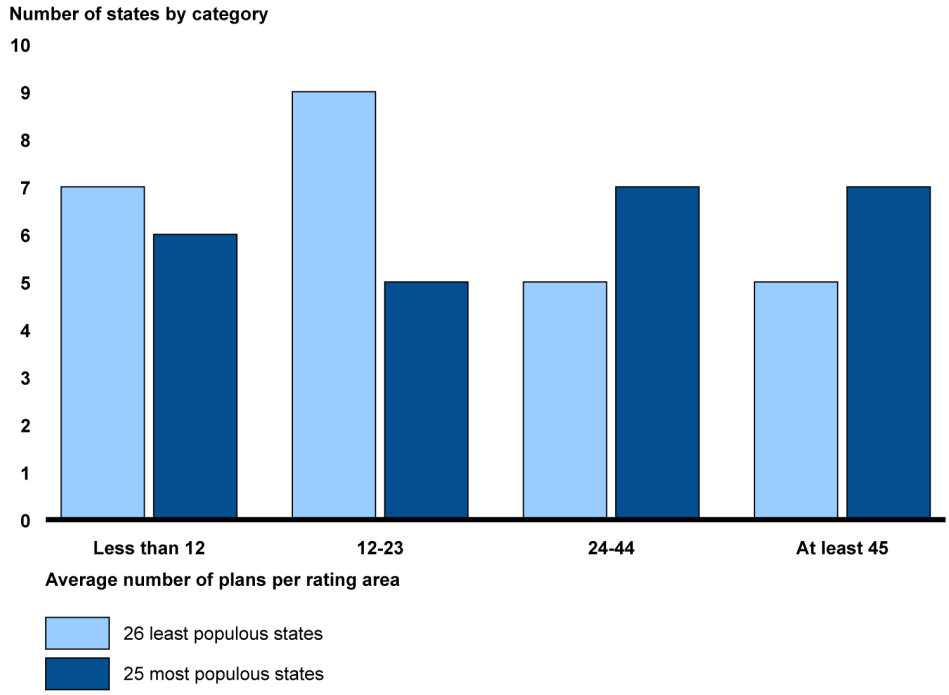
Figure 6: Number of Plans Available in Each 2014 Individual Exchange, by State Population Category



Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

[34]California, Massachusetts, and New York required participating issuers to offer between five and seven plans in any rating area in which they participate. In comparison, three other states, Connecticut, the District of Columbia, and Maryland—each required a minimum of three plans. While Minnesota did not require issuers to offer a certain minimum number of plans, the state did require issuers to offer health plans at the same metal level and rating areas that the issuer currently offered in the non-exchange individual and small-group markets.

Figure 7: Number of Plans Available in Each 2014 Small-business Exchange, by State Population Category



Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

Plans offered under the two new federal programs—the multi-state plan program and CO-OP program—were generally among several plans offered in a rating area and, in those rating areas, tended to comprise a more significant portion of the plans offered in the small-business exchanges. Issuers offered multi-state plans, under contract with OPM, in about half of the rating areas in the 2014 individual exchanges, but in only about 2 percent of the small-business exchanges.[35] Within these rating areas, the multi-state plans constituted an average of 10 percent (1 to 67 percent) of the individual exchange plans and 18 percent (1 to

[35]Issuers of multi-state plans are allowed to phase in coverage by state, but must offer coverage in 60 percent of states in the first contract year and in all states by the third contract state. In the final rule implementing the multi-state plan program, OPM encouraged issuers to expand coverage to all rating areas within a state, but did not require it; OPM has indicated it will continue to assess issuers' capacity to expand statewide through its annual contract negotiations.

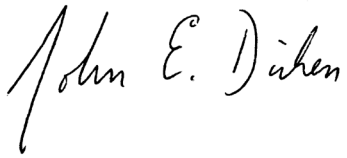
50 percent) of the small-business exchange plans. Similarly, CO-OP plans were offered in about one-third of the rating areas. Within these, the CO-OP plans constituted an average of 23 percent (3 to 87 percent) of the individual exchange plans and 39 percent (7 to 100 percent) of the small-business exchange plans.

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 to the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about 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 key contributions to this report are listed in Appendix V.



John E. Dicken
Director, Health Care

Appendix I: Issuers' Participation in the 2014 Exchanges and Their 2012 Market Share

In this appendix, we present the 2012 market share of issuers that participated in the 2014 individual and small-business exchanges. Table 3 provides this information for those issuers in the 2014 individual exchanges; table 4 provides this information for those issuers in the 2014 small-business exchanges.

Table 3: 2012 Market Share of Issuers Participating in the 2014 Individual Exchanges, by State

	Count of issuers participating in the 2014 exchanges				2012 market share of issuers participating in the 2014 exchanges	
State	Total	5 percent or more share of 2012 market	Less than 5 percent share of 2012 market	Did not participate in 2012 market	Highest (Percent)	Total for all issuers (Percent)
Alabama	2	1	1	0	91*	92
Alaska	2	2	0	0	60*	65
Arizona	10	3	2	5	50*	60
Arkansas	3	2	1	0	79*	85
California	12	2	7	3	17	30
Colorado	10	1	5	4	9	12
Connecticut	3	1	0	2	45*	45
Delaware	3	2	0	1	49*	57
District of Columbia	4	4	0	0	51*	90
Florida	11	1	6	4	48*	52
Georgia	5	2	2	1	18	34
Hawaii	2	2	0	0	52*	98
Idaho	4	2	1	1	45*	62
Illinois	8	2	5	1	67*	83
Indiana	4	1	1	2	61*	63
Iowa	4	0	1	3	3	3
Kansas	4	3	1	0	42*	78
Kentucky	3	2	0	1	80*	96
Louisiana	5	3	1	1	64*	83
Maine	2	1	0	1	49*	49
Maryland	6	3	1	2	39*	69
Massachusetts	11	5	3	3	39*	95
Michigan	12	1	6	5	52*	59
Minnesota	5	1	2	2	59*	63
Mississippi	2	1	0	1	10	10
Missouri	4	3	0	1	33*	61
Montana	3	2	0	1	62*	67

State	Count of issuers participating in the 2014 exchanges				2012 market share of issuers participating in the 2014 exchanges	
	Total	5 percent or more share of 2012 market	Less than 5 percent share of 2012 market	Did not participate in 2012 market	Highest (Percent)	Total for all issuers (Percent)
Nebraska	4	1	1	2	69*	70
Nevada	4	1	1	2	7	7
New Hampshire	1	0	0	1	0	0
New Jersey	4	1	2	1	64*	70
New Mexico	4	1	0	3	49*	49
New York	17	2	4	11	15*	36
North Carolina	2	1	1	0	85*	89
North Dakota	3	1	1	1	75*	76
Ohio	12	1	7	4	36*	41
Oklahoma	6	1	3	2	63*	70
Oregon	11	5	1	5	17	58
Pennsylvania	14	5	9	0	33*	74
Rhode Island	2	1	0	1	94*	94
South Carolina	4	2	1	1	51*	59
South Dakota	3	2	1	0	8	17
Tennessee	4	2	1	1	39*	45
Texas	12	3	4	5	58*	76
Utah	6	2	0	4	41*	47
Vermont	2	1	1	0	90*	90
Virginia	8	1	5	2	7	13
Washington	8	2	2	4	39*	48
West Virginia	1	1	0	0	61*	61
Wisconsin	13	2	7	4	12	36
Wyoming	2	1	1	0	38*	40

Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

Notes: We did not determine whether multiple issuers in a state were affiliated with a parent company; therefore, a particular issuer in the individual exchange may be new to that market in 2014 even though other issuers that were part of the same parent company may have participated in the 2012 individual market.

*Represents the issuer with the highest market share in that state in 2012.

Table 4: 2012 Market Share of Issuers Participating in the 2014 Small-business Exchanges, by State

	Count of issuers participating in the 2014 exchanges				2012 market share of issuers participating in the 2014 exchanges	
State	Total	5 percent or more share of 2012 market	Less than 5 percent share of 2012 market	Did not participate in 2012 market	Highest (Percent)	Total for all issuers (Percent)
Alabama	2	1	0	1	97*	97
Alaska	2	2	0	0	69*	75
Arizona	5	2	1	2	25*	45
Arkansas	1	1	0	0	48*	48
California	6	2	4	0	31*	41
Colorado	7	2	4	1	25	37
Connecticut	3	1	1	1	37*	37
Delaware	2	2	0	0	65*	88
District of Columbia	7	3	4	0	50*	98
Florida	5	1	3	1	28*	31
Georgia	3	1	2	0	25*	30
Hawaii	2	2	0	0	45*	67
Idaho	3	2	1	0	50*	64
Illinois	3	1	1	1	59*	63
Indiana	2	2	0	0	55*	61
Iowa	5	0	4	1	1	2
Kansas	2	2	0	0	59*	66
Kentucky	4	1	2	1	70*	78
Louisiana	4	2	1	1	64*	82
Maine	2	1	0	1	48*	48
Maryland	13	3	9	1	57*	100
Massachusetts	11	4	4	3	39*	96
Michigan	10	3	5	2	42*	82
Minnesota	3	2	1	0	35*	63
Mississippi	1	0	0	1	0	0
Missouri	2	2	0	0	39*	48
Montana	3	2	0	1	69*	79
Nebraska	4	2	0	2	56*	71
Nevada	2	0	1	1	1	1
New Hampshire	1	1	0	0	68*	68
New Jersey	4	2	1	1	23	32
New Mexico	5	4	0	1	29*	76

State	Count of issuers participating in the 2014 exchanges				2012 market share of issuers participating in the 2014 exchanges	
	Total	5 percent or more share of 2012 market	Less than 5 percent share of 2012 market	Did not participate in 2012 market	Highest (Percent)	Total for all issuers (Percent)
New York	9	3	2	4	29	54
North Carolina	1	1	0	0	62*	62
North Dakota	3	1	2	0	86*	87
Ohio	6	1	4	1	39*	47
Oklahoma	4	2	2	0	55*	65
Oregon	8	3	1	4	22*	53
Pennsylvania	11	5	6	0	23*	71
Rhode Island	3	1	1	1	75*	77
South Carolina	3	2	0	1	59*	71
South Dakota	3	2	1	0	22	34
Tennessee	2	1	0	1	68*	68
Texas	2	1	1	0	46*	47
Utah	3	1	1	1	41*	41
Vermont	2	1	1	0	34	35
Virginia	5	4	1	0	16	46
Washington	1	0	1	0	5	5
West Virginia	1	1	0	0	63*	63
Wisconsin	9	0	8	1	3	13
Wyoming	2	2	0	0	56*	62

Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

Notes: We did not determine whether multiple issuers in a state were affiliated with a parent company; therefore, a particular issuer in the small-business exchange may be new to that market in 2014 even though other issuers that were part of the same parent company may have participated in the 2012 small-group market.

*Represents the issuer with the highest market share in that state in 2012.

Appendix II: Number of Issuers Participating in the 2014 Individual and Small-business Exchanges, by State

Table 5 presents information from interactive figure 4 on the number of issuers participating in the individual and small business exchanges in 2014, by state.

Table 5: Number of Issuers Participating in the 2014 Exchanges, by State

	Number of issuers participating in the 2014 Exchanges	
State	**Individual Exchange**	**Small-business Exchange**
Alabama	2	2
Alaska	2	2
Arizona	10	5
Arkansas	3	1
California	12	6
Colorado	10	7
Connecticut	3	3
Delaware	3	2
District of Columbia	4	7
Florida	11	5
Georgia	5	3
Hawaii	2	2
Idaho	4	3
Illinois	8	3
Indiana	4	2
Iowa	4	5
Kansas	4	2
Kentucky	3	4
Louisiana	5	4
Maine	2	2
Maryland	6	13
Massachusetts	11	11
Michigan	12	10
Minnesota	5	3
Mississippi	2	1
Missouri	4	2
Montana	3	3
Nebraska	4	4
Nevada	4	2
New Hampshire	1	1
New Jersey	4	4

State	Number of issuers participating in the 2014 Exchanges	
	Individual Exchange	Small-business Exchange
New Mexico	4	5
New York	17	9
North Carolina	2	1
North Dakota	3	3
Ohio	12	6
Oklahoma	6	4
Oregon	11	8
Pennsylvania	14	11
Rhode Island	2	3
South Carolina	4	3
South Dakota	3	3
Tennessee	4	2
Texas	12	2
Utah	6	3
Vermont	2	2
Virginia	8	5
Washington	8	1
West Virginia	1	1
Wisconsin	13	9
Wyoming	2	2

Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

Appendix III: Number of Plans Offered by Issuers Participating in the 2014 Exchanges across Rating Areas

Table 6 presents information on the number of plans issuers offered in each state in the individual and small-business exchanges across rating areas in 2014.

Table 6: Number of Plans Offered by Issuers Participating in the 2014 Exchanges across Rating Areas

		Number of plans offered per rating area					
		Individual exchange			Small-business exchange		
State	Number of rating areas in state	Average	Minimum	Maximum	Average	Minimum	Maximum
Alabama	13	8	7	12	17	17	17
Alaska	3	36	36	36	24	24	24
Arizona	7	99	79	124	73	56	104
Arkansas	7	25	11	41	3	3	3
California	19	29	19	45	16	8	23
Colorado	11	110	90	149	79	56	90
Connecticut	8	19	19	19	12	12	12
Delaware	1	21	21	21	11	11	11
District of Columbia	1	34	34	34	267	267	267
Florida	67	68	27	169	6	2	40
Georgia	16	31	15	68	8	3	16
Hawaii	1	36	36	36	27	27	27
Idaho	7	37	17	49	36	18	44
Illinois	13	49	35	71	31	18	39
Indiana	17	31	16	63	81	5	134
Iowa	7	44	35	63	35	21	63
Kansas	7	41	36	47	5	5	7
Kentucky	8	26	18	38	17	12	24
Louisiana	8	39	28	58	30	26	33
Maine	4	22	19	31	9	8	11
Maryland	4	37	36	40	100	95	104
Massachusetts	3	37	8	67	36	7	65
Michigan	16	46	25	62	46	19	68
Minnesota	9	37	14	77	43	19	63
Mississippi	6	23	18	24	11	11	11
Missouri	10	19	12	25	3	2	3
Montana	4	29	29	29	22	22	22
Nebraska	4	37	25	57	31	23	43
Nevada	4	34	15	50	12	3	19

State	Number of rating areas in state	Number of plans offered per rating area					
		Individual exchange			Small-business exchange		
		Average	Minimum	Maximum	Average	Minimum	Maximum
New Hampshire	1	11	11	11	3	3	3
New Jersey	1	36	36	36	29	29	30
New Mexico	5	39	38	45	51	49	57
New York	8	131	91	174	156	96	192
North Carolina	16	21	14	31	9	9	9
North Dakota	4	33	33	33	22	20	23
Ohio	17	54	32	122	28	9	73
Oklahoma	5	52	29	70	46	24	65
Oregon	7	72	63	96	57	51	67
Pennsylvania	9	56	27	103	42	17	65
Rhode Island	1	12	12	12	16	16	16
South Carolina	46	29	27	32	12	12	12
South Dakota	4	35	35	35	16	16	16
Tennessee	8	52	30	74	7	2	10
Texas	26	37	18	99	18	16	21
Utah	6	74	59	91	52	32	70
Vermont	1	20	20	20	18	18	18
Virginia	12	43	24	69	20	3	39
Washington	5	38	34	46	5	5	5
West Virginia	11	13	13	13	4	4	4
Wisconsin	16	86	16	175	52	14	103
Wyoming	3	18	18	18	16	16	16

Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

Appendix IV: Number of Plans Offered by Issuers in 2014 Individual and Small-business Exchanges

Table 7 presents information from interactive figure 5 on the number of plans issuers offered in each state for the individual and small-business exchanges in 2014.

Table 7: Number of Plans Offered by Issuers in the 2014 Exchanges, by State

	Number of Plans Offered in the 2014 Exchanges	
State	**Individual Exchange**	**Small-business Exchange**
Alabama	17	17
Alaska	36	24
Arizona	199	104
Arkansas	71	3
California	90	40
Colorado	149	90
Connecticut	19	12
Delaware	21	11
District of Columbia	34	267
Florida	247	63
Georgia	74	16
Hawaii	36	27
Idaho	61	55
Illinois	122	45
Indiana	114	134
Iowa	88	75
Kansas	65	7
Kentucky	38	24
Louisiana	77	45
Maine	31	11
Maryland	44	104
Massachusetts	111	107
Michigan	73	68
Minnesota	78	63
Mississippi	34	11
Missouri	48	5
Montana	29	22
Nebraska	57	43
Nevada	61	19
New Hampshire	11	3

State	Number of Plans Offered in the 2014 Exchanges	
	Individual Exchange	Small-business Exchange
New Jersey	36	30
New Mexico	45	57
New York	280	320
North Carolina	65	11
North Dakota	33	23
Ohio	210	196
Oklahoma	75	65
Oregon	102	74
Pennsylvania	161	112
Rhode Island	12	16
South Carolina	52	12
South Dakota	35	16
Tennessee	84	10
Texas	129	21
Utah	96	70
Vermont	20	18
Virginia	106	39
Washington	46	5
West Virginia	13	4
Wisconsin	257	197
Wyoming	18	16

Sources: Centers for Medicare & Medicaid Services and state-based exchanges. | GAO-14-657

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, William Hadley (Assistant Director), Sandra George, Laurie Pachter, Ann Tynan, and Stephen Ulrich made key contributions to this report.