

## UNDERSTANDING RECENT DEVELOPMENTS IN THE INDIVIDUAL HEALTH INSURANCE MARKET

### Introduction

After two years of moderate premium growth, individual market premiums increased more substantially for 2017. This issue brief examines the likely effects of these premium increases on individual market enrollment and the risk pool, the factors that contributed to these premium increases, and the near-term outlook for the individual health insurance market.

The brief reaches three main conclusions:

- **Continued growth in Marketplace sign-ups for 2017 and a range of other evidence show that premium increases are not having substantial adverse effects on either individual market enrollment or the risk pool—rebutting claims that the individual market faces a “death spiral.”** Health Insurance Marketplace (Marketplace) enrollment is currently on track to continue growing in 2017, contrary to predictions that higher premiums would spur large enrollment reductions that would damage the risk pool. As of late December 2016, 11.5 million people were signed up for coverage through the Marketplace for 2017, an increase of nearly 300,000 relative to the comparable period last year. Moreover, growth in plan selections was similar in states that saw larger and smaller increases in benchmark premiums from 2016 to 2017, which also suggests that premium changes had little impact on enrollment and the risk pool. This outcome should not be surprising in light of the fact that the substantial majority of individual market consumers are eligible for tax credits that are linked to premiums and, therefore, protect them from premium increases. It is also consistent with evidence on consumer behavior from before the Affordable Care Act (ACA) and from prior plan years under the ACA.
- **The 2017 premium increases reflect an ordinary process of adjustment to a new market.** There is no evidence that claims costs in the reformed individual market are growing particularly rapidly. Indeed, data

on claims in the ACA-compliant market indicate that claims growth from 2014 to 2015 was slower than claims growth in private insurance overall, likely reflecting an improving risk pool, insurer learning, and other factors. Rather, the higher premium increases in 2017 reflect transitional factors that will not contribute to premium increases over the longer term: insurers’ underpricing in the initial year of the new market; and the failure of the premium increases insurers implemented in 2015 and 2016 to accommodate the phasedown of the ACA’s transitional reinsurance program.

- **Insurers’ premium and plan design changes, together with recent policy changes, appear roughly sufficient to return premiums to a sustainable level, implying that this year’s increases were a one-time correction. This correction will set the stage for more stable pricing and stronger competition, absent disruptive policy changes or developments that create substantial uncertainty.** Premium increases this year, coupled with changes in business practices implemented by insurers and improvements in market rules introduced by the Federal government, appear roughly sufficient to return premiums to a sustainable level. This, in turn, will lay a foundation for more stable pricing in the years to come. It should also foster increased competition, as new entrants seek to capture a share of the profits being earned by incumbents. As such, policymakers should take care to avoid administrative or legislative policy changes that would disrupt this progress and any other steps that would create substantial uncertainty.

### Factors Driving Health Insurance Marketplace Premium Changes in 2017

This section of the brief discusses the factors that led to the premium changes that occurred in 2017. The available data indicate that insurers underpriced for 2014, the first year of the new market, and incurred significant losses. Insurers appear to have then fallen

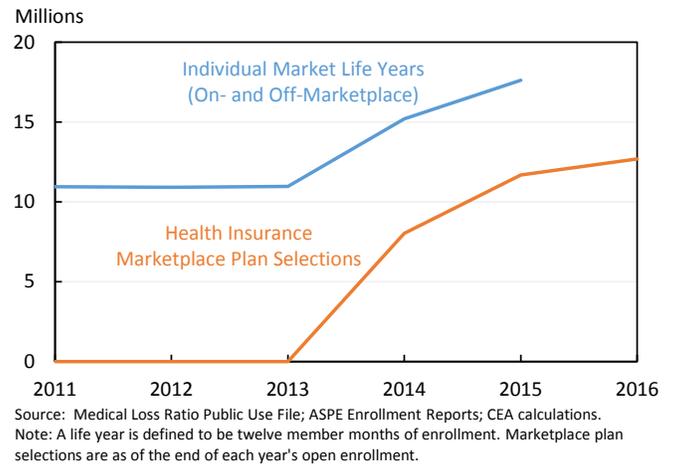
further behind in subsequent years, despite slow growth in underlying claims costs, because they implemented premium increases that were insufficient to accommodate the phasedown of the ACA's transitional reinsurance program. Stemming the resulting losses necessitated larger increases for 2017. The increases implemented in 2017 appear to be roughly sufficient to bring insurers' premium revenue in line with their costs, implying that the 2017 increases were a one-time correction. The remainder of this section of the brief discusses these trends in greater detail.

### *Challenges of Pricing for a New Market*

Insurers faced significant challenges in setting premiums in the years immediately following implementation of the ACA's reforms to the individual market. The ACA barred insurers from denying coverage, limiting benefits, or charging a higher premium to people with pre-existing health conditions. The ACA also introduced financial assistance that has helped more low- and middle-income families newly afford coverage, as well as an individual responsibility provision to encourage healthy individuals to purchase coverage if they could afford to do so.<sup>1</sup>

These reforms brought many new people into the individual health insurance market, causing substantial changes in the size and composition of the enrolled population. Indeed, as illustrated in Figure 1, the individual market has grown rapidly as the ACA's reforms have taken effect, with individual market enrollment rising from around 11 million before 2014 to close to 18 million in 2015, an increase of more than 60 percent. Data on the number of people selecting plans on the Marketplace, the online portals for purchasing health insurance created by the ACA, imply that the individual market has continued to grow since 2015.

**Figure 1: Individual Market Enrollment, 2011-2016**



These changes in the size and composition of the enrolled population made predicting average medical costs in the reformed market difficult, creating a significant possibility that insurers would underestimate or overestimate the level of premiums required to finance claims. In addition, some insurers may have intentionally underpriced in an attempt to attract the many new consumers who entered the individual health insurance market during the first few years of the reformed market; these insurers may have made a choice to accept losses in the short run in exchange for higher market shares in the long run. Whatever the underlying reasons, it is now clear that, on average, insurers underpriced when setting premiums for 2014, the first year of the reformed market. Insurers' financial filings imply that they incurred losses averaging around 6 percent of premium revenue on ACA-compliant health insurance policies in 2014.<sup>2</sup>

### *Factors Affecting the Transition to Sustainable Pricing*

In addition to making up for these initial losses, insurers also needed to accommodate two additional factors to return premiums to a sustainable level for 2017.<sup>3</sup> The first factor was the scheduled phasedown of the ACA's transitional reinsurance program. The reinsurance program was designed to defray a portion of insurers' claims spending on high-cost enrollees in 2014 through

<sup>1</sup> For a more detailed discussion of the ACA's reforms to the individual health insurance market, see CEA (2016).

<sup>2</sup> This estimate reflects CEA analysis of insurer financial information published in the Center for Consumer Information and Insurance Oversight's Medical Loss Ratio Public Use File.

<sup>3</sup> Other factors may have provided a modest tailwind to issuers' effort to return to profitability. Insurers' Medical Loss Ratio filings indicate that issuer spending on administrative costs, taxes, and fees fell on a per member per month basis from 2014 to 2015. It is plausible that this trend will continue, to some degree, in 2016 and 2017.

2016 and thereby allowed insurers to charge lower premiums in those years than they would otherwise have been able to. The generosity of reinsurance payments declined in roughly equal increments over the three years of the program. Offsetting these declines in reinsurance payments required premium increases of around 7 percent in each of 2015, 2016, and 2017.

The second, smaller factor was relatively modest growth in the medical costs of individual market enrollees. Growth in medical costs for private insurance enrollees overall has recently been low by historical standards, averaging around 4 percent per year in nominal terms.<sup>4</sup> However, for a variety of reasons, including steps taken by both insurers and regulators, claims growth in the ACA-compliant individual market appears likely to have been even slower than private insurance as a whole.

As illustrated in Figure 1, individual market enrollment has grown in each year since 2014, and later enrollees are likely somewhat healthier than earlier enrollees, which puts downward pressure on growth in claims costs. In parallel, insurers appear to have been learning from their experience in the reformed individual market to refine their plan designs in ways that improve quality and efficiency, including by improving care management and coordination (McKinsey 2016b; Coughlin 2016). Indeed, the Centers for Medicare and Medicaid Services (CMS) estimate that nominal per member per month medical spending in ACA-compliant plans was approximately flat from 2014 to 2015 (CMS 2016a). An analysis of a private claims database reported by Avalere Health (2016) found similar results. These factors likely placed continued downward pressure on claims growth in 2016 and likely will continue to do so in 2017.

Administrative actions implemented this year are likely to place additional downward pressure on claims growth in 2017 and beyond. For example, CMS recently issued new rules that improve transparency around practices that dialysis facilities use to steer patients with end-stage renal disease (ESRD) away from Medicare and Medicaid coverage, which is often the best coverage option for the

patient, and toward individual market coverage, which is often the most profitable coverage option for the dialysis facility (CMS 2016b). Because ESRD patients have very high claims costs, one recent estimate concluded that CMS action in this area could reduce average claims costs in the ACA-compliant individual market by 4 percent or more (Taylor, Feeley, and Murray 2016). Similarly, another analysis concluded that the new CMS rules will reduce the number of patients with ESRD who enroll in individual market coverage and put significant downward pressure on growth in claims costs in the ACA-compliant individual market in 2017 (Fischbeck et al. 2016). Other administrative actions, including actions by CMS to ensure that individuals transition to Medicare coverage when they reach age 65 (as appropriate) and actions to ensure that “limited duration” policies are not being sold in situations that go beyond what the law intends, will likely further improve the risk pool and put additional downward pressure on growth in claims costs in the near term.

The total effect of these various factors is that returning premiums to a sustainable level by 2017 required premium increases averaging around 10 percent per year in 2015, 2016, and 2017. In fact, however, the premium for the second-lowest silver (or “benchmark”) plan increased by just 2 percent in 2015 and 7 percent in 2016 in the states using the HealthCare.gov enrollment platform. As a result, insurers’ losses rose in 2015 and did not improve substantially in 2016, necessitating much more significant premium increases in 2017.

The increases in benchmark premiums actually implemented for 2017—around 22 percent on average across the HealthCare.gov states and State-Based Marketplaces for which data are available—appear roughly sufficient to close these shortfalls, on average, absent market disruption stemming from administrative or legislative changes or developments that create substantial uncertainty (and assuming that higher premiums will not significantly damage the risk pool, a hypothesis refuted in the next section of this brief). A recent analysis by researchers at Standard and Poor’s,

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<sup>4</sup> The rate of cost growth in employer-sponsored coverage is a reasonable proxy for the underlying trend in medical costs because the employer market was largely unaffected by the ACA’s insurance market reforms. The National Health Expenditure Accounts report that per enrollee spending in employer coverage grew 4 percent in

2015. The Kaiser Family Foundation’s and Health Research and Educational Trust’s Employer Health Benefits Survey also reports that growth in premiums for family coverage averaged around 4 percent over 2015 and 2016. For a detailed discussion of recent health care spending trends, see CEA (2016).

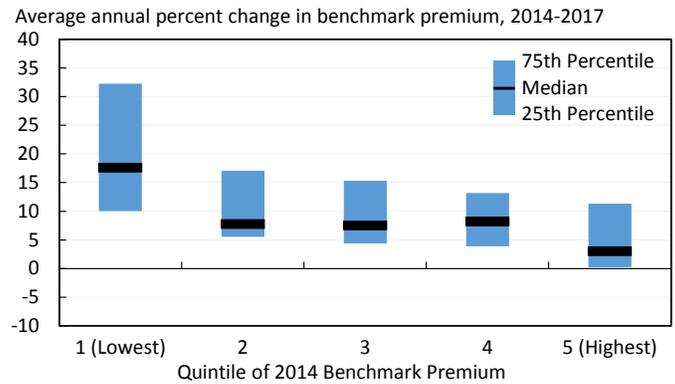
which also incorporated preliminary information on insurers' 2016 financial performance, reached a similar conclusion, describing the 2017 premium increases as a "one-time correction" that will not be repeated in future years (Banerjee et al. 2016).

It is important to note that, even after the premium increases implemented for 2017, Marketplace premiums remain roughly in line with CBO's initial projections (ASPE 2016b). The 2017 increases are therefore taking Marketplace premiums back to their originally expected trajectory, consistent with the view that these increases are a one-time correction, not an indication of underlying problems in the individual market.

### *Understanding Patterns of Premium Changes Across Markets*

One notable feature of the premium increases that have occurred in recent years is that they have varied widely across areas. This variation appears to have been driven by variation in the extent to which insurers in different areas of the country underpriced in the early years of the new market. Figure 2 illustrates how the annual percentage increase in the premium for the benchmark plan from 2014 to 2017 varies based on the level of the benchmark premium in 2014. In the four-fifths of the country with higher benchmark premiums in 2014, the median person has seen average annual increases in the benchmark of below 10 percent, less than what would have been needed to cover normal increases in medical costs and the gradual phasedown of the ACA's transitional reinsurance program. By contrast, the fifth of the country with the lowest premiums in 2014 has seen much larger increases since then. This pattern is what would have been expected if insurers in some areas significantly underpriced in 2014 and have been working to bring premiums back in line with costs since then, while insurers in other areas priced appropriately or overpriced.

**Figure 2: Average Annual Change in Benchmark Premium from 2014 to 2017, by Quintile of 2014 Benchmark Premium**



Source: HHS; American Community Survey; CEA calculations.  
 Note: Premiums analyzed at the county level. Quintiles defined to have equal non-elderly populations. Data limited to states using HealthCare.gov in all years.

### **Effects of Premium Changes on Individual Market Enrollment and the Risk Pool**

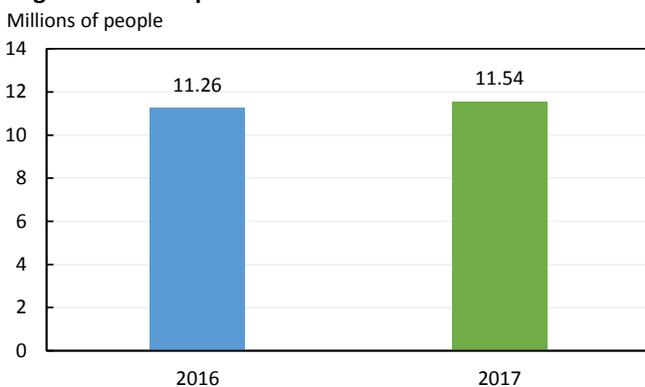
As discussed above, the premium increases implemented for 2017 appear roughly sufficient to bring insurers' premium revenues back in line with their costs, setting the stage for a more stable market in the years ahead. However, some observers have taken a more pessimistic view (see, for example, Cannon 2016; Goodman 2016; Jenkins 2016; Laszewski 2016; Pipes 2016; Roy 2016). They have argued that premium increases will drive large reductions in individual market enrollment, particularly among healthy individuals. This decline in enrollment among the healthy will, they argue, increase average medical costs in the individual market, necessitating further premium increases that trigger further enrollment reductions. Some of these observers have speculated that this feedback loop between higher premiums and falling enrollment will become so intense that it will cause a "death spiral," a scenario in which individual market enrollment ultimately falls nearly to zero. A range of evidence demonstrates, however, that this type of vicious cycle is not occurring today and will not occur in the future.

#### *Early Data on Individual Market Enrollment in 2017*

Early enrollment data for 2017 definitively refute the most extreme of these predictions. The defining feature of a death spiral is sharply declining enrollment. By contrast, as of late December 2016, 11.5 million consumers were signed up for 2017 coverage through the Marketplace, an increase of around 286,000 relative to the comparable period last year, as depicted in Figure

3 (CMS 2017).<sup>5</sup> Because the Marketplace now accounts for a substantial majority of the overall individual market, these data imply that enrollment in the individual market as a whole is very unlikely to substantially decline in 2017. With stable or growing enrollment, it is very unlikely that the individual market risk pool would substantially worsen and more likely that it would modestly improve in 2017.

**Figure 3: Marketplace Plan Selections as of Late December**

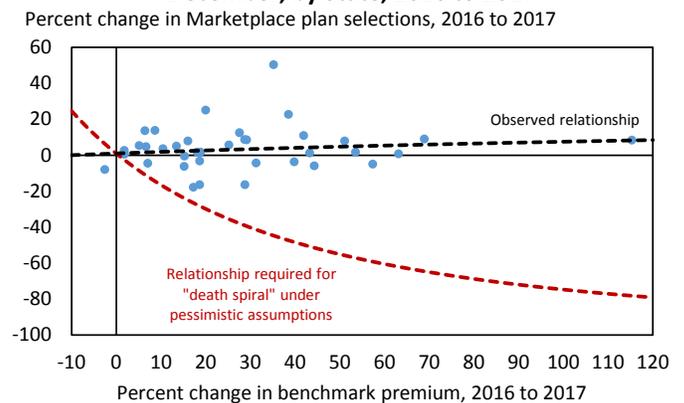


Source: Department of Health and Human Services

Note: Plan selections for 2017 reflect selections occurring from the start of open enrollment through December 24, 2016. Plan selections for 2016 reflect selections occurring from the start of open enrollment through December 26, 2015.

The pattern of enrollment changes across states during this year's open enrollment provides additional evidence that premium increases have not caused meaningful reductions in Marketplace enrollment. Figure 4 demonstrates that there is essentially no relationship between the change in a state's benchmark premium from 2016 to 2017 and the change in Marketplace plan selections in that state as of late December. Notably, Arizona, which saw, by far, the largest premium increase for 2017, has seen an increase in plan selections of 8 percent relative to 2016, slightly above the Marketplace-wide average. If the individual market were at risk of a death spiral, Arizona would have had to have seen a dramatic decline in enrollment. More generally, the observed relationship between premium changes and enrollment growth (the black dashed line) differs dramatically from what would be required for a death spiral (the red dashed line).

**Figure 4: Change in Benchmark Premium versus Change in Marketplace Plan Selections as of Late December, by State, 2016 to 2017**



Source: CMS; HHS; CEA calculations.

Note: Figure includes data for states that used the HealthCare.gov enrollment platform in both years. Plan selections for 2017 reflect selections occurring from the state of open enrollment through December 24, 2016. Plan selections for 2016 reflect selections occurring from the start of open enrollment through December 26, 2015. Changes in benchmark premiums are calculated on an enrollment-weighted basis, as calculated by HHS. Observed relationship reflects a simple log-log fit. The "relationship required for 'death spiral'" lines uses the same intercept coefficient estimated for the "observed relationship" line, but a slope coefficient of -2. For a demand elasticity of -2 to allow a death spiral, individuals who leave the market in response to higher premiums would need to have claims costs half as large as individuals who remain enrolled, a relatively extreme assumption.

The fact that this year's premium increases do not appear to have triggered large enrollment declines, much less a death spiral, should not be surprising. As discussed in the next two sections, the design of the ACA's premium tax credit, pre-ACA evidence on how premiums affect individual market enrollment decisions, and evidence on consumer decisions in 2015 and 2016 already indicated that premium increases like those observed in 2017 would have, at worst, small adverse effects on individual market enrollment and the risk pool.

### *Design of the Premium Tax Credit and Pre-ACA Research*

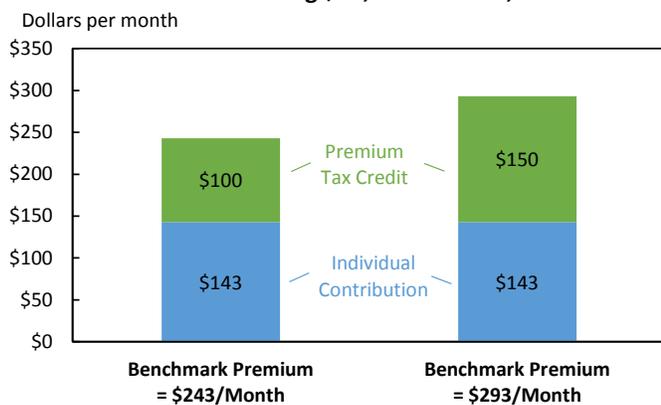
The ACA's premium tax credit is designed so that an eligible individual's contribution to the benchmark plan is capped at a specified percentage of income; the tax credit pays the remainder of the premium for the benchmark plan. Thus, when the benchmark premium rises, the tax credit rises dollar for dollar, and the individual is protected. Figure 5 provides a concrete example of how this works for a single person making \$25,000 per year. This individual's required contribution to the benchmark plan is \$143 per month in 2017. If the

<sup>5</sup> Notably, Louisiana expanded its Medicaid program during 2016, which put downward pressure on Marketplace enrollment in that State since some individuals previously covered through the Marketplace

are now covered through Medicaid. CMS estimates that the total increase in Marketplace enrollment relative to the comparable period last year would have been well over 300,000 if Louisiana had not expanded Medicaid.

premium for the benchmark plan in the individual's area were \$243 per month, the tax credit would then pay the remaining \$100 per month, as illustrated in the left column of the Figure. If the premium for the benchmark plan were \$50 per month higher, as in the right column of the Figure, the individual's contribution would remain at \$143 per month, and the tax credit would increase to \$150 per month.

**Figure 5: Premium for the Benchmark Plan for an Individual Making \$25,000 Per Year, 2017**



Source: CEA calculations

Around 85 percent of individuals who get coverage through the Marketplace receive the premium tax credit, and about two-thirds of people in the individual market as a whole are eligible for tax credits (ASPE 2016a). The premium tax credit therefore ensures that the overwhelming majority of Marketplace enrollees and the sizeable majority of individuals in the individual market overall are protected against premium increases and have no reason to leave the market when premiums rise. This, in turn, ensures that any negative effects of higher premiums on enrollment and the risk pool will be greatly attenuated.<sup>6</sup>

<sup>6</sup> Larger tax credits have a cost for the Federal government, but, as noted above, this year's premium increases merely put premiums back in line with CBO's original projections, so Federal per person costs will also remain in line with CBO's original projections.

<sup>7</sup> The average elasticity of individual market enrollment with respect to premiums reported in these studies is -0.4, meaning that a 1 percent increase in premiums results in an approximately 0.4 percent reduction in enrollment. With around two-thirds of individual market enrollees eligible for tax credits, a 22 percent premium increase like that observed in 2017 would suggest an enrollment decline of 2.6 percent ( $= \text{Exp}[-0.4 * \ln\{1+0.22\} * \{1/3\}] - 1$ ).

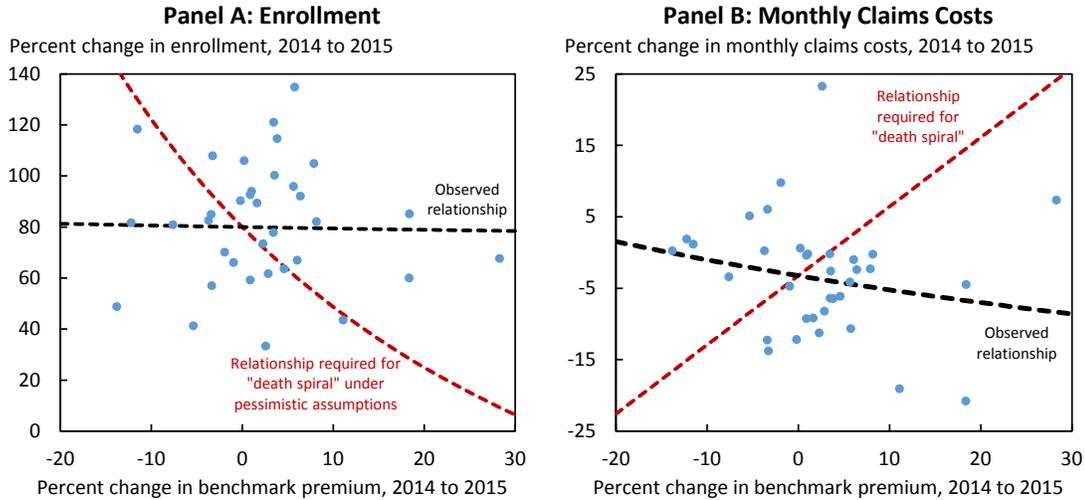
Furthermore, evidence examining the pre-ACA individual market generally concluded that enrollment decisions were only moderately sensitive to premiums (Marquis and Long 1995; Marquis et al. 2004; Auerbach and Ohri 2006). Together with the estimates of the share of individual market enrollees not eligible for tax credits, these estimates imply that premium increases like those observed in 2017 would be expected to reduce individual market enrollment by less than 3 percent, with negligible effects on the individual market risk pool.<sup>7</sup> If anything, the data on actual 2017 enrollment decisions presented above suggests that experience has been more favorable than would have been anticipated based on this prior evidence.

### *Evidence on Individual Market Consumer Behavior in 2015 and 2016*

Consumers' behavior during 2015 and 2016 similarly suggested that this year's premium increases were unlikely to trigger significant market unraveling. Panel A of Figure 6 examines the relationship between changes in the average benchmark premium in each state from 2014 to 2015 and the corresponding changes in enrollment in the state's ACA-compliant individual market (including both on- and off-Marketplace plans). For there to be any risk of a death spiral, premium changes would need to have very large negative effects on enrollment, akin to the scenario illustrated by the red dashed line. In fact, there was essentially no difference in enrollment growth across areas experiencing larger and smaller increases in the benchmark premium from 2014 to 2015, as illustrated by the black dashed line.

Drawing on evidence from Massachusetts health reform reported by Hackmann, Kolstad, and Kowalski (2015), a reasonable estimate is that claims costs for individuals who leave the market when premiums rise are around 73 percent of claims costs for enrollees who remain. In that case, an enrollment decline of this size would translate into an increase in average claims costs of 0.7 percent. Even if claims costs for individuals who leave the market when premiums rise were only about half those of enrollees who remain, a relatively extreme assumption, enrollment declines of this size would have increased average claims costs by just 1.3 percent.

**Figure 6: Change in Benchmark Premium vs. Change in Individual Market Enrollment and Claims Costs, by State, 2014 to 2015**



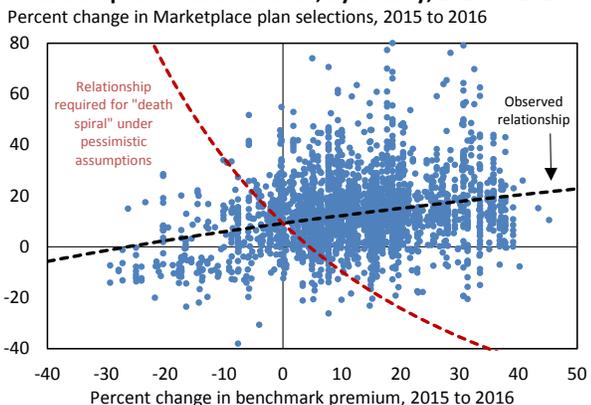
Source: CMS; HHS; Census Bureau; CEA calculations.  
 Note: Sample is limited to States that used HealthCare.gov in all years due to availability of data on benchmark premiums. Changes in benchmark premiums are calculated on a population-weighted basis. Enrollment and monthly claims spending for the ACA-compliant market are measured using data submitted to CMS for the risk adjustment and reinsurance programs. Enrollment is measured as the number of member months of enrollment during the year. Monthly claims spending is measured as aggregate claims in the State’s individual market divided by the aggregate number of member months of enrollment. Observed relationships use a simple log-log fit. The “relationship required for ‘death spiral’” lines use the same intercept coefficient estimated for the “observed relationship” lines, but different slope coefficients. In Panel A, the “relationship required for ‘death spiral’” line reflects a slope coefficient of -2; for a demand elasticity of -2 to allow a death spiral, individuals who leave the market in response to higher premiums would need to have claims costs half as large as individuals who remain enrolled, a relatively extreme assumption. In Panel B, the “relationship required for ‘death spiral’” line depicts a slope coefficient of 1, which is sufficient to ensure that additional revenue from higher premiums is fully offset by higher claims costs.

Similarly, Panel B of Figure 6 examines the relationship between the change in the benchmark premium in each state from 2014 to 2015 and the change in average claims costs in the ACA-compliant market in that state. For there to be any risk of a death spiral, increases in premiums would have to result in substantial increases in claims costs (as a result of healthy individuals leaving the market), akin to the relationship between premium and cost changes illustrated by the red dashed line. In fact, consistent with the evidence from Panel A that premium increases did not meaningfully affect enrollment, there is no evidence that premium increases adversely affected the risk pool. If anything, larger premium increases appeared to be associated with slightly slower year-over-year growth in monthly claims costs, as illustrated by the black dashed line.

substantial declines in plan selections, akin to the scenario illustrated by the red dashed line. To the contrary, counties that saw larger increases in the benchmark premium from 2015 to 2016 actually seem to have seen slightly *larger* increases in Marketplace plan selections over that period. Notably, while average premium increases were lower in 2016 than 2017, some counties saw premium increases of 30 percent or more in 2016, and even these counties show no evidence of slower enrollment growth.

Complete data on how enrollment and claims in the ACA-compliant individual market changed from 2015 to 2016 are not yet available. However, the county-level relationship between changes in benchmark premiums and changes in the number of people selecting Marketplace plans, depicted in Figure 7, reinforces the conclusion that the individual market is at no risk of unraveling. As above, for the individual market to be at risk of a death spiral, counties experiencing large increases in the benchmark premium would have to see

**Figure 7: Change in Benchmark Premium versus Change in Marketplace Plan Selections, by County, 2015 to 2016**



Source: CMS; HHS; Census Bureau; CEA calculations.  
 Note: Figure includes data for states that used the HealthCare.gov enrollment platform in both years. Observed relationship reflects a simple log-log fit. The “relationship required for ‘death spiral’” lines uses the same intercept coefficient estimated for the “observed relationship” line, but a slope coefficient of -2. For a demand elasticity of -2 to allow a death spiral, individuals who leave the market in response to higher premiums would need to have claims costs half as large as individuals who remain enrolled, a relatively extreme assumption.

## Outlook for the Individual Health Insurance Market

The evidence presented in the preceding sections of this brief implies that—absent disruptive administrative or legislative changes or developments that create substantial uncertainty—a combination of insurer premium and plan design changes, administrative changes, and an improving risk pool will return insurers’ pricing to a roughly sustainable position in 2017, although circumstances will vary across insurers and markets, with some having farther to go and others potentially having overcorrected in 2017. This has two implications for the future of the individual health insurance market.

First, premium growth is likely to moderate for 2018 and subsequent years. With premiums close to sustainable levels, individual market premium growth should begin to track premium growth in private insurance as a whole, with both being driven by growth in the underlying cost of medical care. As discussed in detail in CEA (2016), overall growth in per enrollee private insurance spending remains relatively subdued, thanks in part to reforms in provider payment and other actions included in the ACA. As long as that remains the case, individual market premium growth will likely be subdued as well.

Second, there is significant potential for the level of competition in the individual market to increase in the years to come. With premiums returning to a sustainable level, incumbent insurers are likely to become less likely

to exit markets and more likely to expand their participation into additional areas. Sustainable pricing will also create attractive opportunities for insurers to re-enter markets they may have left and for new insurers to enter markets for the first time.

A number of policy actions could further improve affordability and competition in this market; President Obama, for example, has proposed increasing financial assistance to people who purchase insurance on the Marketplace and introducing a public plan fallback in areas with limited competition (Obama 2016). Conversely, disruptive administrative or legislative changes, or developments that create substantial uncertainty, could easily undo recent progress. The individual market now provides coverage to around 18 million people, and the evidence presented in this brief implies that, absent disruptive policy changes or developments that create substantial uncertainty, it is likely to continue to do so for the foreseeable future. Policymakers should therefore take a measured approach when considering administrative and legislative changes that could have major implications for these individuals’ coverage, access to care, and financial security.

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