Health Insurance Affordability in the Individual Market

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Study purpose

- Review other states activities to address individual market health insurance affordability
- Identify options that may make health coverage more affordable and available to Virginians
- Estimate impact of each option on costs and number of uninsured

Findings in brief

- Younger, healthier individuals left Virginia's market as premiums increased
- Improved marketing and navigators could bring more healthy people into the market, assist with plan choice
- There are multiple state policy options to improve affordability but impacts are moderate compared to current federal subsidies

Policy options in brief

Option 1: Enhance marketing and navigator services

Option 2: Eliminate tobacco surcharge

Option 3: Establish individual state mandate for coverage

Options 4-5: Implement state funded cost sharing reductions

- Enhance existing federal CSRs
- Create flexible spending account with debit card

Options 6-7: Establish public option with administratively set reimbursement rates

Agenda

Introduction

How Virginia's individual market changed

Goals for affordability

Policy options to improve affordability

Individual market health insurance plans have to meet certain criteria

- Plans sold on the marketplace have to be qualified by the Bureau of Insurance (BOI)
- Plans are labeled by “metal tiers” based on actuarial value
  - Bronze – 60%
  - Silver – 70%
  - Gold – 80%
  - Platinum – 90%

NOTE: Actuarial Value (AV) is the estimated percentage of health care costs for covered benefits paid for through premiums, versus out of pocket costs paid for by the plan’s enrollees.

Virginians without public or group coverage buy individual market coverage

- More than 440,000 Virginians estimated to be enrolled in individual market coverage by 2023 if enhanced subsidies are continued
  - This is 108,000 more than if enhanced subsidies expire
- 80% of non-group coverage will be purchased through individual market exchange

SOURCE: Urban Institute HIPSM model estimates, 2023

Key term – Advanced Premium Tax Credits (APTCs)

- Provided to consumers monthly or taken as a tax deduction when filing taxes to offset premiums
- Calculated using household income and the premium for the second lowest silver plan in the consumer's area
- Can be applied by consumer to any plan on healthcare.gov except catastrophic plans

Key Term - Cost Sharing Reductions (CSRs)

- Only applies to individuals with household income at or below 250% of FPL – phased down as income rises
- Calculated into the “value” of a silver plan based on design of plan
- Only available through the purchase of a silver plan

FPL = federal poverty level

Four changes affected premiums and enrollment between 2016 and 2021

- Elimination of federal funding for CSRs for people under 250% of FPL (2017/2018)
- Elimination of federal individual coverage mandate penalty (2017, effective 2019)
- Virginia adopted Medicaid expansion (effective 2019)
- Enhanced federal APTCs under the American Rescue Plan Act (ARPA)(2021)

FPL = federal poverty level

Medicaid expansion significantly impacted individual market enrollment

- JCHC staff estimate that approximately 100,000 people shifted from the individual marketplace to Medicaid between 2019 and 2020
- The shift from the individual market to Medicaid will be accounted for in enrollment analysis
- JCHC staff modeled the shift based on market enrollment experiences in 5 other states – AR, KS, NC, OH, TN

NOTE: Comparison states were chosen due to having similar market trends to Virginia prior to 2018.

Federal changes drove premium increases between 2016 and 2018

- Federal government stopped paying insurers directly for CSRs in 2017
  - companies incorporated costs into premiums
  - majority of change were in silver plans (“silver loading”) to take advantage of APTCs
  - Congressional Budget Office (CBO) estimated 20% to 25% of premium increases for 2018 due to CSR changes
- Congress ended individual mandate penalty in 2017
  - CBO estimated that premiums would rise by 10% to 20%

Agenda

Introduction

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Goals for affordability

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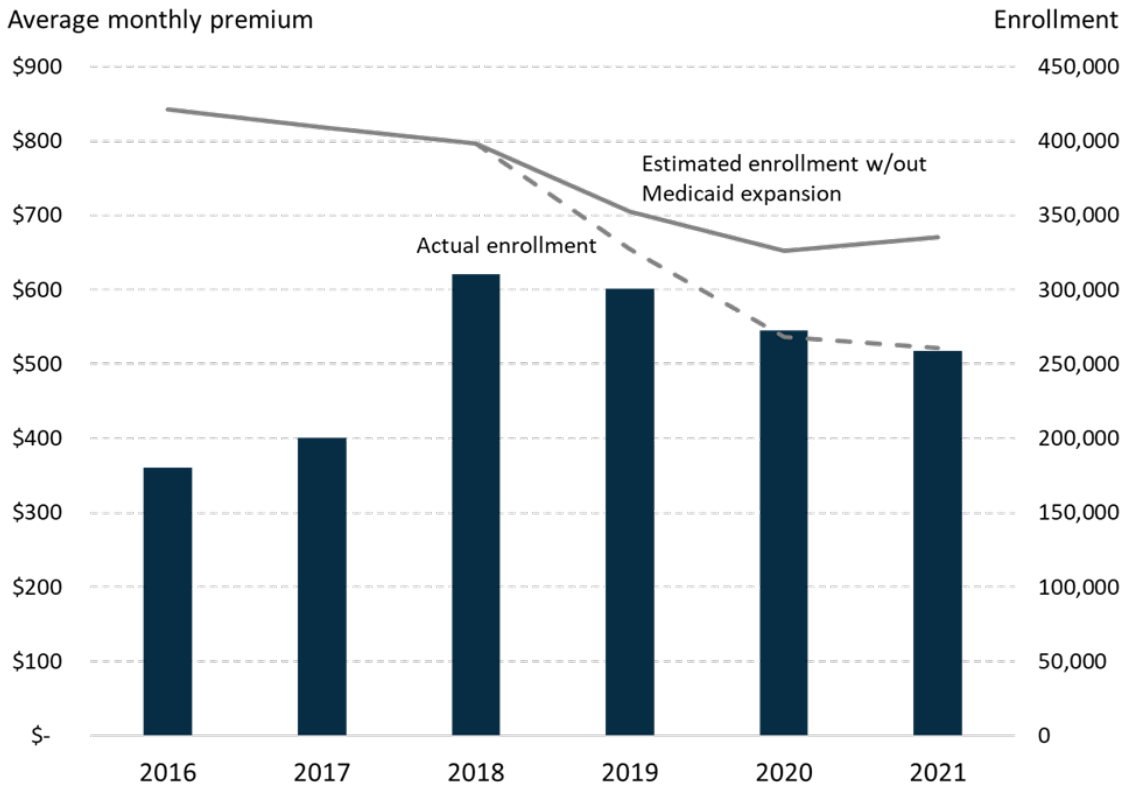
JCHC Finding

Elimination of CSR funding and the individual mandate caused premiums to increase and enrollment to decrease between 2016 and 2018.

Estimated enrollment dropped 20.5% after accounting for the Medicaid expansion



SOURCE: JCHC staff analysis of data extracted from FFM QHP landscape files and Marketplace Open Enrollment Period Public Use Files.
NOTE: Enrollment adjusted for Medicaid expansion.

Average adult premiums increased significantly, especially for silver plans

Metal level	2016	2017	2018	2019	2020	2021	Percent change
Bronze	$325	$354	$494	$526	$468	$446	37.1% ($121)
Silver	$375	$418	$662	$720	$639	$599	59.5% ($223)
Gold	$477	$550	$853	$709	$650	$596	25.0% ($119)

SOURCE: JCHC staff analysis of data extracted from FFM QHP landscape files

Premium increases shifted enrollment from silver plans to bronze and gold

Metal level	2016	2017	2018	2019	2020	2021	Percent change
Bronze	95,194	86,878	104,211	109,950	117,537	136,746	43.7% (41,552)
Silver	289,626	303,803	271,953	216,941	182,718	170,842	-41.0% (-118,784)
Gold	27,732	11,159	15,832	19,450	20,819	22,401	-19.2% (-5,331)
Total	412,552	401,840	391,996	346,341	321,074	329,989	-20.0% (82,562)

SOURCE: JCHC staff analysis of data extracted from FFM QHP landscape files

JCHC Finding

Many who left the market were young adults just above the Medicaid expansion income threshold and those ineligible for tax credits.

Most enrollment decrease was 150%-200% FPL or over 400% FPL

Income level (percent of FPL)	2016	2021	Total change	Percent change
≤ 150%	155,117	135,460	(19,657)	-12.7%
> 150% to ≤ 200%	87,790	60,938	(26,852)	-30.6%
> 200% to ≤ 250%	61,592	51,108	(10,484)	-17.0%
> 250% to ≤ 300%	34,199	31,009	(3,190)	-9.3%
> 300% to ≤ 400%	32,951	33,111	160	0.5%
> 400% (ineligible for APTCs)	49,245	33,220	(16,025)	-32.5%
Total	**420,894**	**344,846**	**(76,048)**	**-18.1%**

SOURCE: JCHC staff analysis of Marketplace Open Enrollment Period Public Use Files adjusted for Medicaid expansion.
NOTE: Totals in tables may not match due to differences in how CMS reports data by income, age, and metal tier.

Enrollment declines were most significant for younger, healthier individuals

Age group	2016	2021	Total change	Percent change
< 18	47,443	40,001	(7,442)	-15.7%
18-25	48,980	26,917	(22,063)	-45.0%
26-34	75,885	50,827	(25,058)	-33.0%
35-44	68,044	52,820	(15,224)	-22.4%
45-54	83,023	65,044	(17,979)	-21.7%
55-64	94,379	95,959	1,580	1.7%
65+	2,307	8,450	6,143	266.3%
Total	**420,061**	**340,019**	**(80,042)**	**-19.1%**

SOURCE: JCHC staff analysis of Marketplace Open Enrollment Period Public Use Files adjusted for Medicaid expansion.
NOTE: Totals in tables may not match due to differences in how CMS reports data by income, age, and metal tier.

JCHC Finding

Virginia experienced adverse selection and a lack of competition in the individual market.

Adverse selection occurs when healthier individuals leave the market

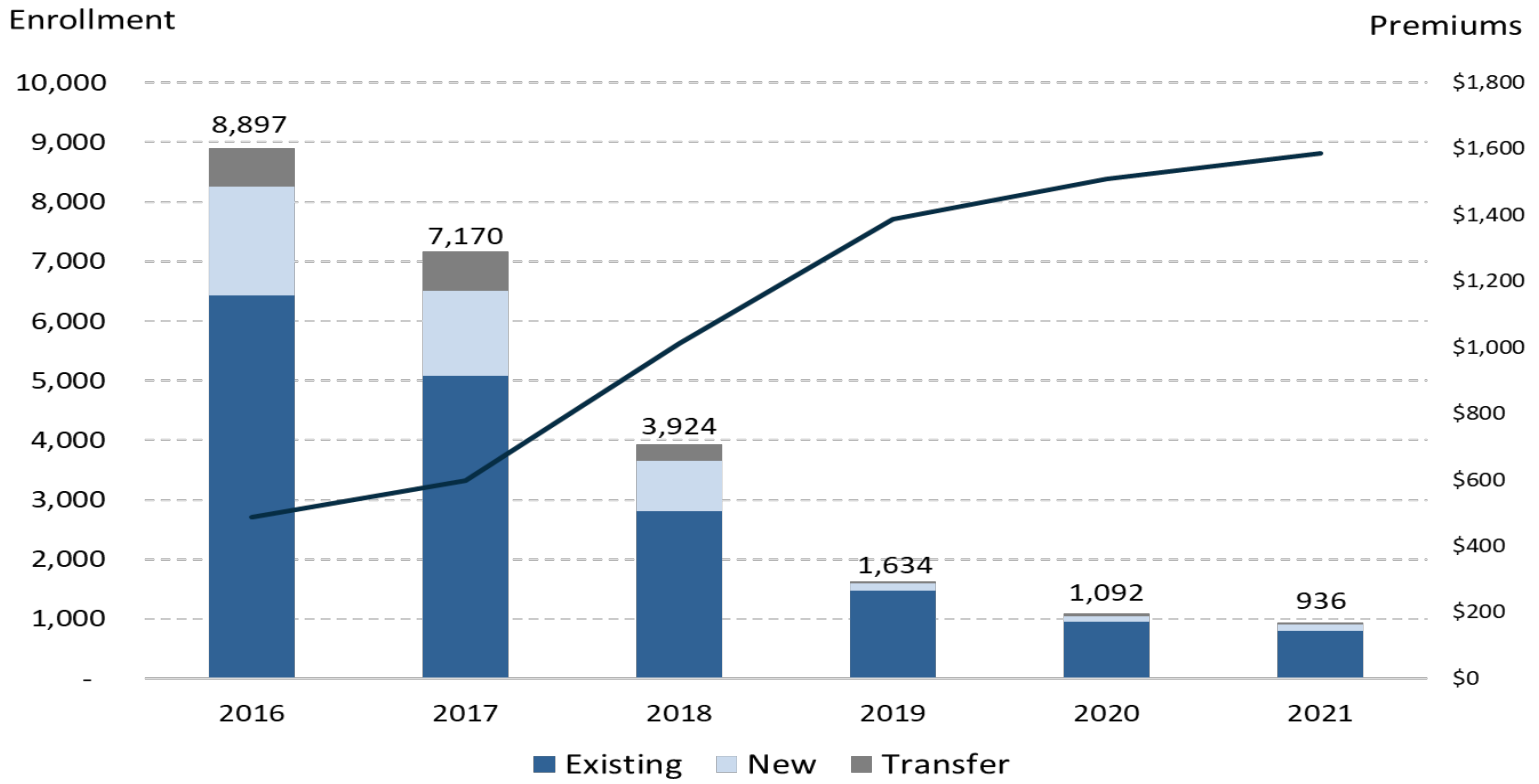
- Lopsided distribution of healthy and unhealthy individuals cause plan premiums to increase
- As premiums rise healthy people are discouraged from buying health insurance due to the costs and drop out of the plan or market
- An example of adverse selection can be found in northern Virginia in 2021

One northern Virginia plan had the highest premiums in the state and country in 2021

- Despite being in a competitive market Group Hospital and Medical Services (GHMS) premiums were almost 3 times higher than the next closest plan
- GHMS plan is the only PPO plan in the state – a legacy plan that allows enrollees to choose their own providers
- Actuarial reports indicate that:
  - 87% to 90% of enrollees were existing members by 2021
  - New enrollees were less healthy than existing members

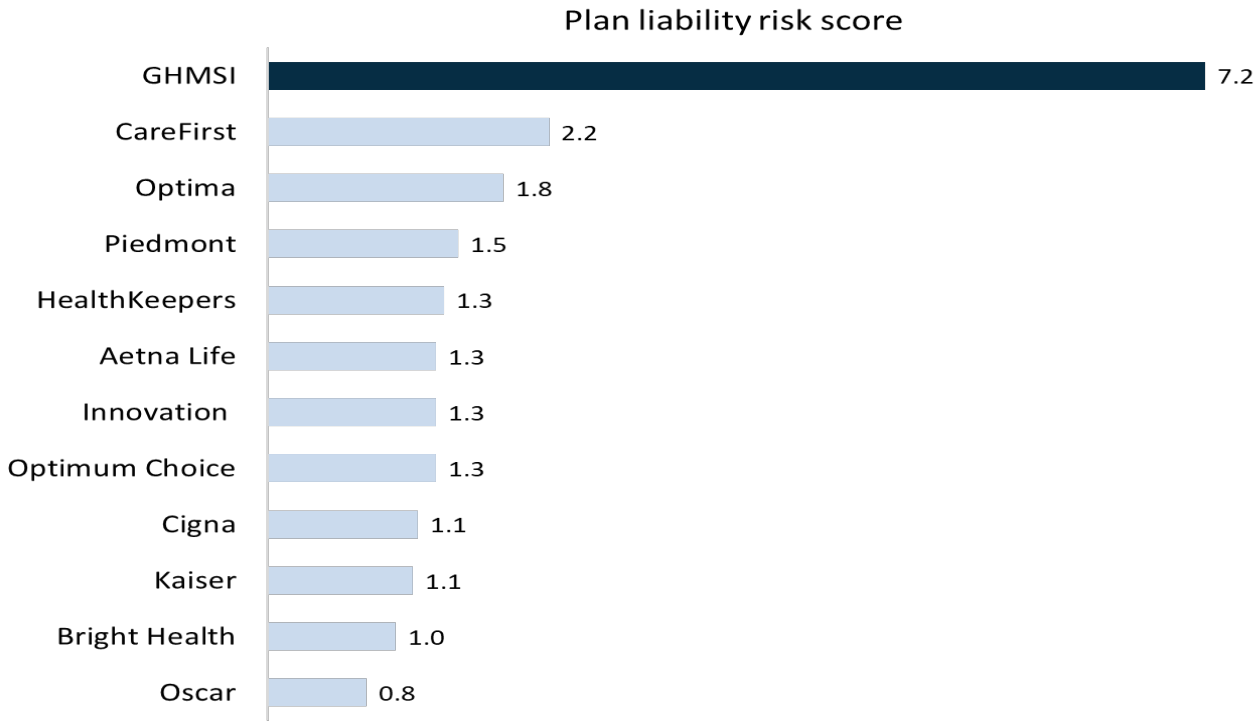
SOURCE: Group Hospitalization and Medical Services, Inc. (GHMSI) rate filings and actuarial memorandums, 2016 through 2021

GHMS saw declining enrollment, leading to premium increases



SOURCE: JCHC analysis of Group Hospitalization and Medical Services, Inc. (GHMSI) rate filings and actuarial memorandums, 2016 through 2021.

GHMS' risk score is over 3 times the next highest risk score in the state



SOURCE: Individual market risk adjustment calculation from Virginia rate filing data, Virginia State Corporation Commission, Bureau of Insurance

Lack of competition can lead to higher than necessary prices in some cases

- Insurers can pick and choose which cities and counties to sell plans in
- In 2021, 53 counties had only one insurer even though there were 9 insurers in Virginia
- National research literature consistently finds that a lack of competition leads to higher premiums
- In 2018, Charlottesville Virginia had only one insurer and the highest premiums in the country

Actuaries struggled to establish premiums for 2018 due to political uncertainty

- Congress zeroed out the individual mandate penalty – CBO estimated 10% to 20% increase in premiums
- The administration stopped paying insurers to cover ACA CSRs – CBO est. 20% to 25% increase in premiums
- Political uncertainty led some insurers to withdraw from the Virginia marketplace
  - Anthem announced withdrawal and then re-entered the marketplace
  - Aetna and United Health Care withdrew completely

Optima was only insurer offering plans in four localities

- Optima's premiums for 2018 were the highest in the country
  - Avg. adult premium of $1,151/month
- Avg. premium increase was 81.8% from 2017 - 2018
  - 70% of marketplace enrollees qualified for assistance
  - remaining 30% paid the full cost of the increase
- Originally planned a 20% increase but added
  - 21% for silver plans to cover the CSR payments
  - 38% from assuming unknown risk in a new market

Lack of competition has not led to higher premiums in most cases

- Anthem was the only insurer in 63 counties in 2018
  - Average adult premium was $593/month, almost half of Optima's premium
  - $28 lower than the overall average of all adult premiums in 2018

Agenda

Introduction

How Virginia's individual market changed

Goals for affordability

Policy options to improve affordability

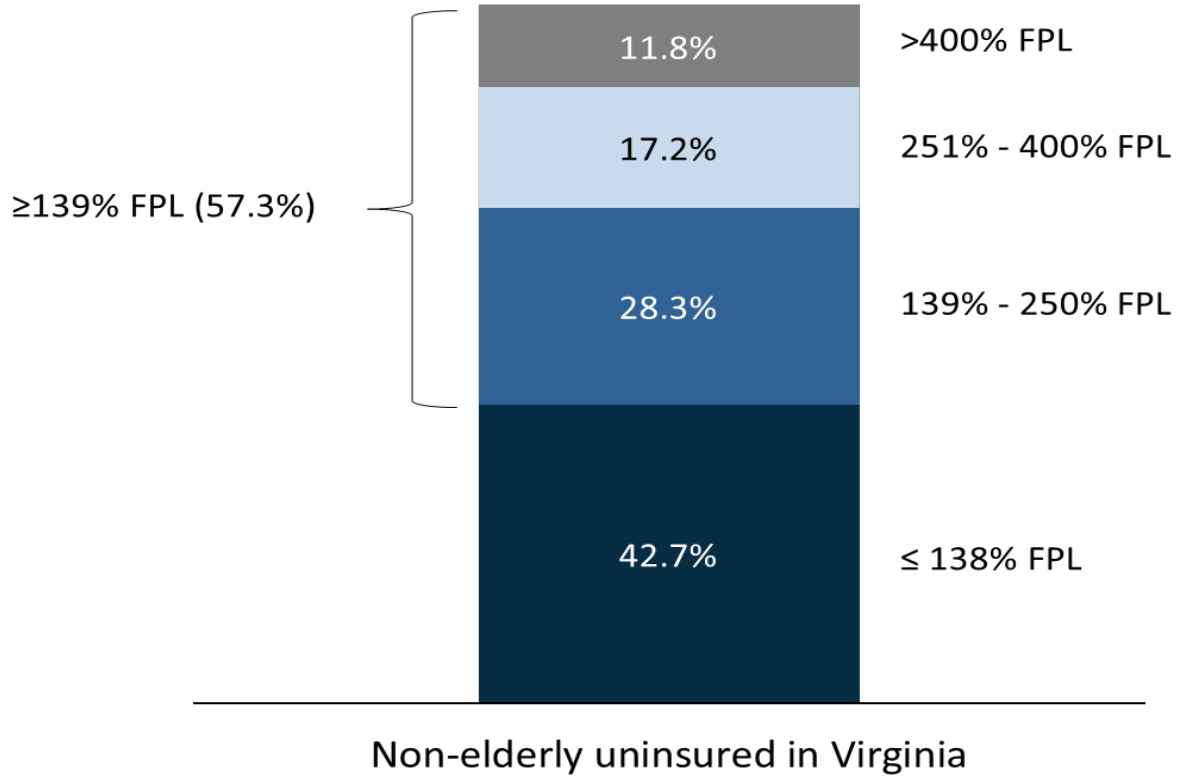
Primary affordability goals are to reduce uninsured and out-of-pocket costs

- Virginia's uninsured rate dropped from 14.2% (2013) to 8.5% (2021)
- National studies show that having coverage and a regular source of health care:
  - Leads to better health outcomes
  - Leads to a better quality of life
  - Improves financial security

JCHC Finding

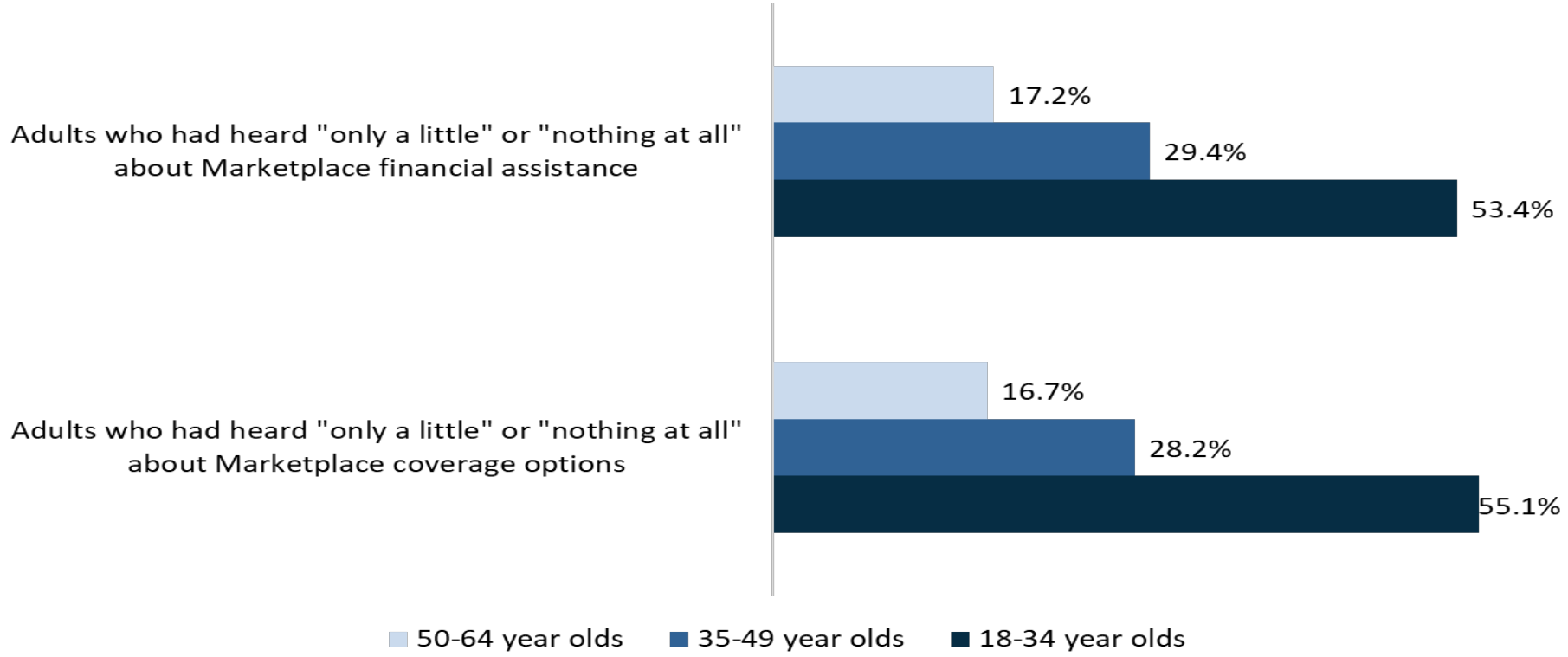
Most uninsured nonelderly adults in Virginia are working and almost half are unaware of the ACA.

Over 80% of uninsured Virginians were part of working families



SOURCE: Virginia Health Care Foundation, Profile of Virginia's Uninsured, 2019.

Half of individuals unaware of marketplace options are younger



SOURCE: Health Reform Monitoring Survey, 2021.

National surveys find that uninsured workers are mostly unaware of the ACA

- 2021 survey of independent contractors and “gig” workers found
  - 31% lacked health insurance
  - 64% of those were concerned about cost
  - 78% of those were unaware that they might be eligible for assistance
- 2018 Commonwealth Fund survey found
  - 50% of uninsured adults may have been eligible for assistance
  - 67% did not apply due to concerns about affordability and eligibility for financial assistance, or were not aware of the ACA, marketplace, or did not think they needed coverage

JCHC Findings

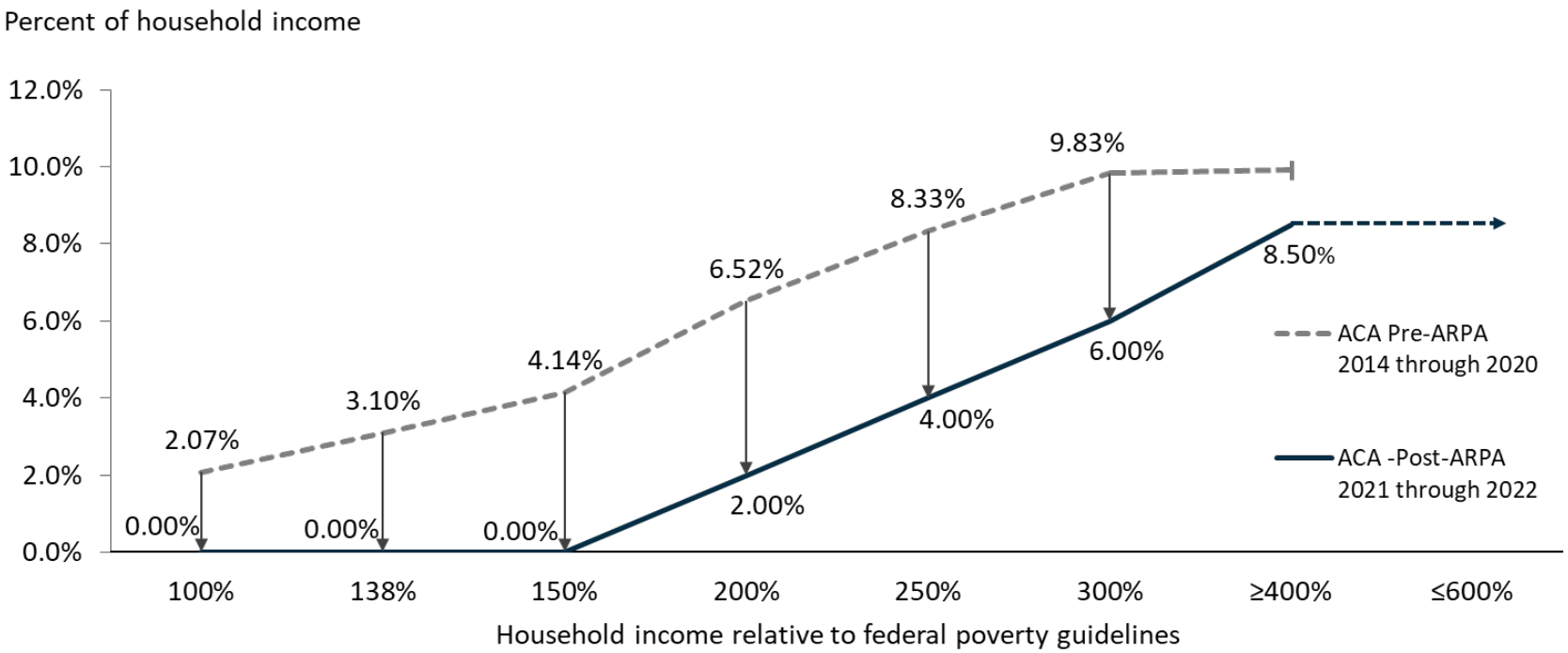
Federal government subsidizes premiums for most Virginians on the individual market.

Out-of-pocket costs remain a burden for many Virginians on the individual market, and were not expanded through ARPA.

APTC make premiums more affordable based on household income

- ACA limited cost of premiums to a percentage of income
  - Premiums exceeding the percentage offset with APTCs
  - Originally, only household income between 100% and 400% could receive tax credits
- The American Rescue Plan Act of 2021 (ARPA) increased affordability by:
  - Reducing the percentages of income applied to premiums
  - Making APTCs available to everyone
- ARPA is temporary and will expire at the end of 2022 if not extended

ARPA reduced premiums for almost everyone in the individual market



SOURCE: JCHC staff analysis of ACA and ARPA.

Most Virginians on the individual market receive APTCs

- 83.6% of Virginians in the individual market received premium subsidies before the passage of ARPA
- More than 48,000 additional individuals enrolled in coverage after ARPA passed
  - 37% paid $10 or less for their premium
- HIPSM estimates that by 2023, 108,000 more people will enroll in marketplace coverage if ARPA is extended

CSRs lower out of pocket expenses for individuals under 250% of poverty

- 36% of the 261,943 Virginians that purchased coverage on the marketplace received CSRs (2021, pre-ARPA)
- Individuals over 250% of FPL, or not purchasing silver plans, are ineligible for CSRs

FPL = federal poverty level

Value of CSRs vary with household income

Income as a percent of federal poverty level	Actuarial value for standard silver plan	Actuarial value for CSR silver plan	Percentage point difference
100% - 150%	70%	94%	+ 24%
150% - 200%	70%	87%	+ 17%
200% - 250%	70%	73%	+ 3%

SOURCE: Affordable Care Act.

Out of pocket costs remain a burden for many Virginians

- 12% of Virginians went without care at some point in 2019 due to cost
- 8.3% of Virginians had high out-of-pocket-costs compared to income

Individuals over 250% FPL have the highest out of pocket cost burden

Cost sharing calculations using 2021 federal poverty levels				
Percent of FPL	150%	250%	300%	500%
Income	$19,320	$32,200	$38,640	$64,400
Maximum out-of-pocket	$1,400	$6,800	$8,550	$8,550
Maximum out-of-pocket as % of income	7.3%	21.1%	22.1%	13.3%
Medical deductible	$50	$2,400	$6,250	$6,250
Medical deductible as % of income	0.3%	7.5%	16.2%	9.7%

SOURCE: JCHC staff analysis of the ACA and ARPA.
NOTE: Examples are based on a 40-year old individual health insurance plan purchased in Loudoun County, VA. Household income and premiums are based on 2021 plan year guidelines and marketplace data.

CSRs included in health plans are often confusing to consumers

- 6 out of 10 regional navigators said callers are often confused and do not understand the differences between the plans offered on the marketplace
- Complexity of CSR plan choice leads some consumers to choose plans with higher costs, even if eligible for CSRs

Agenda

Introduction

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Goals for affordability

Policy options to improve affordability

Policy Option 1

JCHC Members could introduce a budget amendment to appropriate $3.7 million in general funds to the Virginia state-based exchange for marketing and navigators in FY2023.

JCHC Finding

Improved marketing and access to navigators would bring more individuals into the market.

Marketing and access to navigators can bring more individuals into the market

- Many younger, uninsured individuals are unaware of marketplace insurance options and available subsidies
- Comparing differences between premiums, out of pocket costs, and coverage can be overwhelming to consumers
- Navigators help consumers understand plan differences and make good choices for their circumstances

Marketing and navigation coordinated through state-based exchange

- Virginia state based exchange is in transition
  - Started in 2020 for plan year 2021, fully operational in 2024
  - Open enrollment for 2024 begins in November 2023
  - Federal exchange manages eligibility and enrollment; State manages marketing and navigators
- The state is currently spending about $2.0 million for navigators; will spend $1.3 million on marketing in 2022
- Industry standard for healthcare marketing is 11% of total revenues (total revenues estimated to be $65 million by 2024)

The Urban Institute modeled several options for JCHC

Strategies	Affordability goal
Elimination of smoking surcharge (Option 2)	Improve affordability and access to health care
Health Insurance Coverage Mandate (Option 3)	Increase enrollment in the marketplace, reduce the number of uninsured, and improve access to health care
State funded cost-sharing program (Options 4 and 5)	Improve access to health care for enrollees by making cost sharing more affordable
Public option (Options 6 and 7)	Improve competition in the marketplace – standardized and affordable health plans

Policy option 2

Eliminate the tobacco surcharge by amending § 38.2-3447 of the Code of Virginia and changing the tobacco use rate to 1:1.

JCHC Finding

Eliminating the tobacco surcharge would reduce premiums and bring more uninsured individuals into the market.

ACA permits insurers to charge higher premiums to tobacco users

- Tobacco use of any kind is less than 20% of adults
  - May be as high as 40% of low-income adults
- The tobacco surcharge may be a barrier to coverage
  - Original intent was to encourage tobacco cessation but majority of studies indicate policy does not work
- The tobacco surcharge is calculated after APTCs and CSRs and charged directly to consumer

Tobacco surcharges can result in higher premiums for the low-income

Premium calculations using 2021 federal APTC and poverty guidelines			
Percent of FPL	150%	250%	500%
Income	$19,320	$32,200	$64,400
Annual premium (2021)	$5,651	$5,651	$5,651
Maximum amount of income paid toward premium	0.00%	4.00%	8.50%
Individual responsibility for premium before surcharge	$0	$1,288	$5,474
20% tobacco surcharge	$1,130	$1,130	$1,130
Total premium including tobacco surcharge	$1,130	$2,418	$6,604
Percent of income for premiums	5.8%	7.5%	10.3%

SOURCE: JCHC staff analysis of the ACA and ARPA.
NOTE: Examples are based on an individual health insurance plan purchased by a 40-year-old in Loudoun County, VA. Household income and premiums are based on 2021 plan year guidelines and marketplace data.

Most insurers in VA imposed a reduced surcharge in 2021

Insurers	Tobacco surcharge (2021)
Piedmont	0-50%
Anthem	0-30%
Kaiser Permanente	20%
Optima Health	20%
United Healthcare	0-20%
Oscar	0-12.5%
CareFirst	0%
Cigna	0%

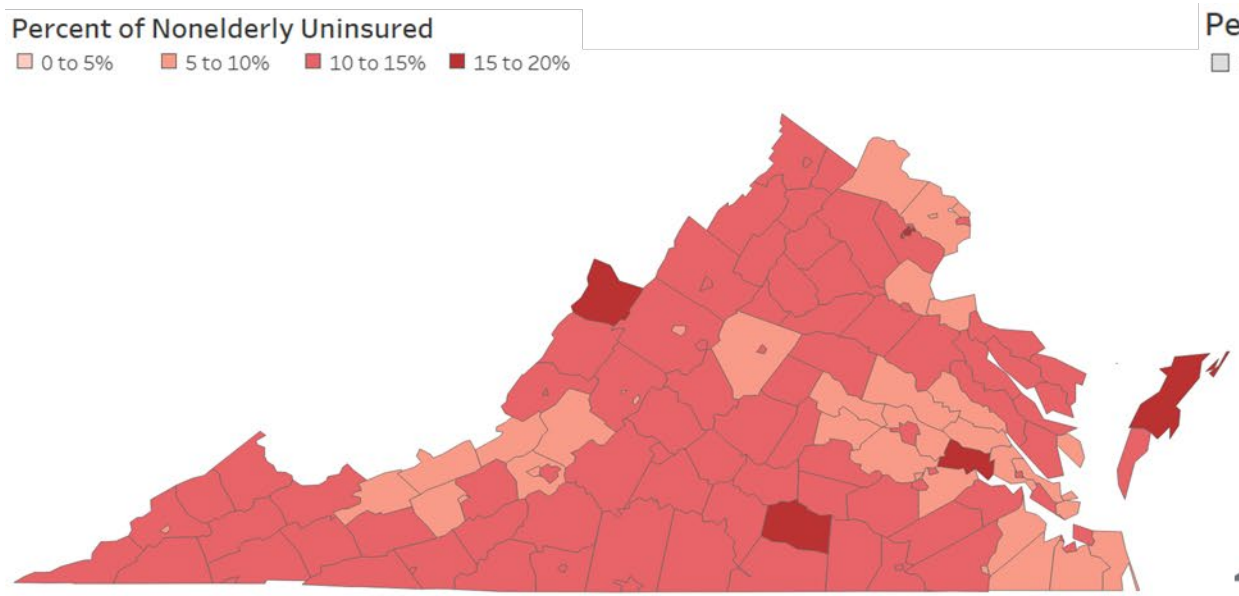
SOURCE: Enroll Virginia data on tobacco surcharge use in Virginia.
NOTE: For insurers with a range, the actual amount of the surcharge varies with the age of the enrollee.

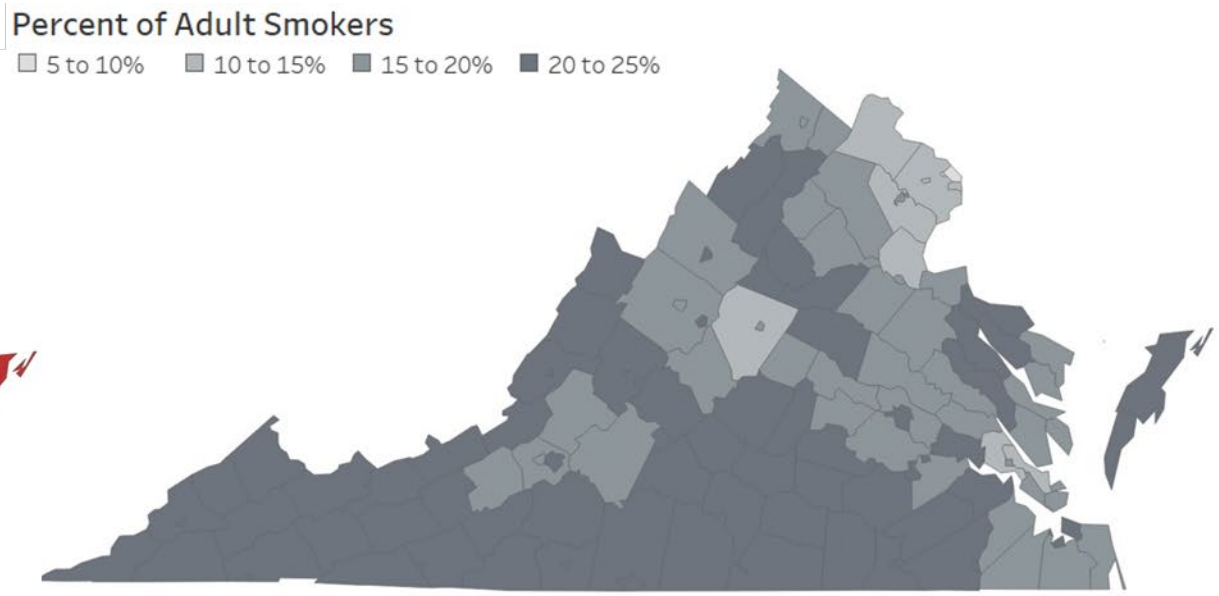
Nine states plus Washington, D.C. prohibit or restrict tobacco surcharge

States that prohibit a tobacco surcharge	California, Massachusetts, New Jersey, New York, Rhode Island, Vermont, and Washington, D.C.
States that restrict the amount of the tobacco surcharge	Colorado – up to 15% of the premium Arkansas – up to 20% of the premium Kentucky – up to 40% of the premium

SOURCE: Health Markets Insurance Agency

Localities with highest uninsured rates have the highest rates of smokers





SOURCE: University of Wisconsin – Robert Wood Johnson Foundation, County Health Rankings, 2021.

Estimated impact of eliminating the tobacco surcharge (2023)

	Reduction in premiums	Reduction in uninsured
Impact if APRA APTCs not extended	3%	14,000
Impact if ARPA APTCs extended	4.5%	3,000

SOURCE: Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

Policy option 3

Create an individual mandate with state income tax penalties to encourage marketplace enrollment.

JCHC Finding

Instituting an individual mandate penalty in Virginia would have a marginal impact on premiums and enrollment.

Virginia could implement an individual mandate penalty in state tax code

- Include a self-attestation check box on all individual state income tax returns, match the check box with the W-2 form or the federally required “IRS-1095” form
- Include a tax penalty in Code
  - Maximum would be lesser of (a) 2.5% of annual household income, or (b) the annual premium cost for a bronze plan
  - Exemptions for people not required to file taxes — a large share of the uninsured

Estimated impact of implementing an individual mandate in Virginia (2023)

	Reduction in premiums	Reduction in uninsured	Tax penalty collections
Impact if APRA APTCs not extended	0.5%	6,000	$9 million
Impact if ARPA APTCs extended	0.2%	4,000	$7 million

SOURCE: Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

A state individual mandate may increase Medicaid and CHIP enrollment

- As people sign up for coverage to comply with the individual mandate HIPSM estimates
  - CHIP enrollment may increase by up to 5,000
  - Medicaid enrollment may increase by 1,000 adults
- The increased cost to the state may be between $7 and $8 million

Policy options 4 and 5

Enhance CSRs by increasing actuarial value of silver plans for individuals up to 400% of FPL.

Create a healthcare flexible spending account (FSA) using a debit card for exchange enrollees.

JCHC Findings

Providing state funding to reduce out-of-pocket costs would reduce the number of uninsured.

The method of providing cost-sharing will determine the impact of the policy.

CSRs reduce out-of-pocket expenses

- CSRs are built into the actuarial value of silver plans based on income
- Benefit is applied by insurers through modifications of the out-of-pocket cost structure of their plans to meet the required actuarial value
  - Copays
  - Deductibles
  - Out of pocket maximums

Example of how federal CSRs impact out-of-pocket expenses

	Standard silver plan	CSR silver plan 201-250% FPL	CSR silver plan 151-200% FPL	CSR silver plan up to 150%
Medical deductible	$5,300	$2,250	$400	$70
Physician office visit	$20	$15	$10	$5
Specialist office visit	must meet deductible before 25% coinsurance	must meet deductible before 25% coinsurance	must meet deductible before 25% coinsurance	must meet deductible before 5% coinsurance
Generic drug copay	$20	$15	$15	$5
Maximum out-of-pocket cost	$8,550	$6,800	$2,850	$1,500

SOURCE: JCHC staff analysis of FFM QHP landscape files: Health and dental datasets for researchers and issuers, 2021.

Modeled state-funded CSRs increase AV of plans for those with highest OOP costs

	Actuarial Value		
	Current Law	Modeled Scenario	Difference
Standard Silver – No CSR	70%	70%	0%
CSR Plan 301% to 400%	70%	85%	15%
CSR Plan 251% to 300%	70%	90%	20%
CSR Plan for 201-250% FPL	73%	90%	17%
CSR Plan for 151-200% FPL	87%	95%	8%
CSR Plan for up to 150% FPL	94%	95%	1%

SOURCE: Urban Institute An Analysis of Policy Options for Virginia, 2021.

Estimated impact of enhancing CSRs (2023)

	Change in premiums	Reduction in uninsured	Reduction in OOP costs	Implementation costs
Impact if APRA APTCs not extended	−2.5%	37,000	$1,000	$44 million
Impact if ARPA APTCs extended	+0.6%	4,000	$1,000	$49 million

SOURCE: Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.
NOTE: Increasing the number of people in the individual market involves shifting of individuals from employer-sponsored coverage and other non-group coverage, and a reduction in the uninsured to the individual market.

Modeled debit card scenario available to all individual market enrollees

- Value of debit card varies with age and income
  - $500/adult and $300/child for those with income ≤ 400% of FPL
  - $250/adult and $150/child for > 400% of FPL
- Exclude card value from state income tax, meet IRS definition of “general welfare” to be exempt from federal income tax
- Allow FSA debit card to be used for over-the-counter health costs, similar to state employee program

An FSA-like policy encourages healthier enrollees to purchase insurance

- HIPSM model does not take into account consumer "behavioral" economics
- Perceived value of an FSA/debit card, especially if over-the-counter medicines are included, may attract more enrollees
- Money from the FSA is available immediately

Estimated impact of implementing a FSA debit card policy (2023)

	Impact on Premiums	Reduction in uninsured	Reduction in OOP costs	Implementation costs
Impact if APRA APTCs not extended	−5.0%	19,000	$250-500	$114 million
Impact if ARPA APTCs extended	−0.9%	7,000	$250-500	$161 million

SOURCE: Results of the Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

Policy options 6 and 7

Establish a public option health plan with administratively set rates to create competition in the marketplace.

JCHC Finding

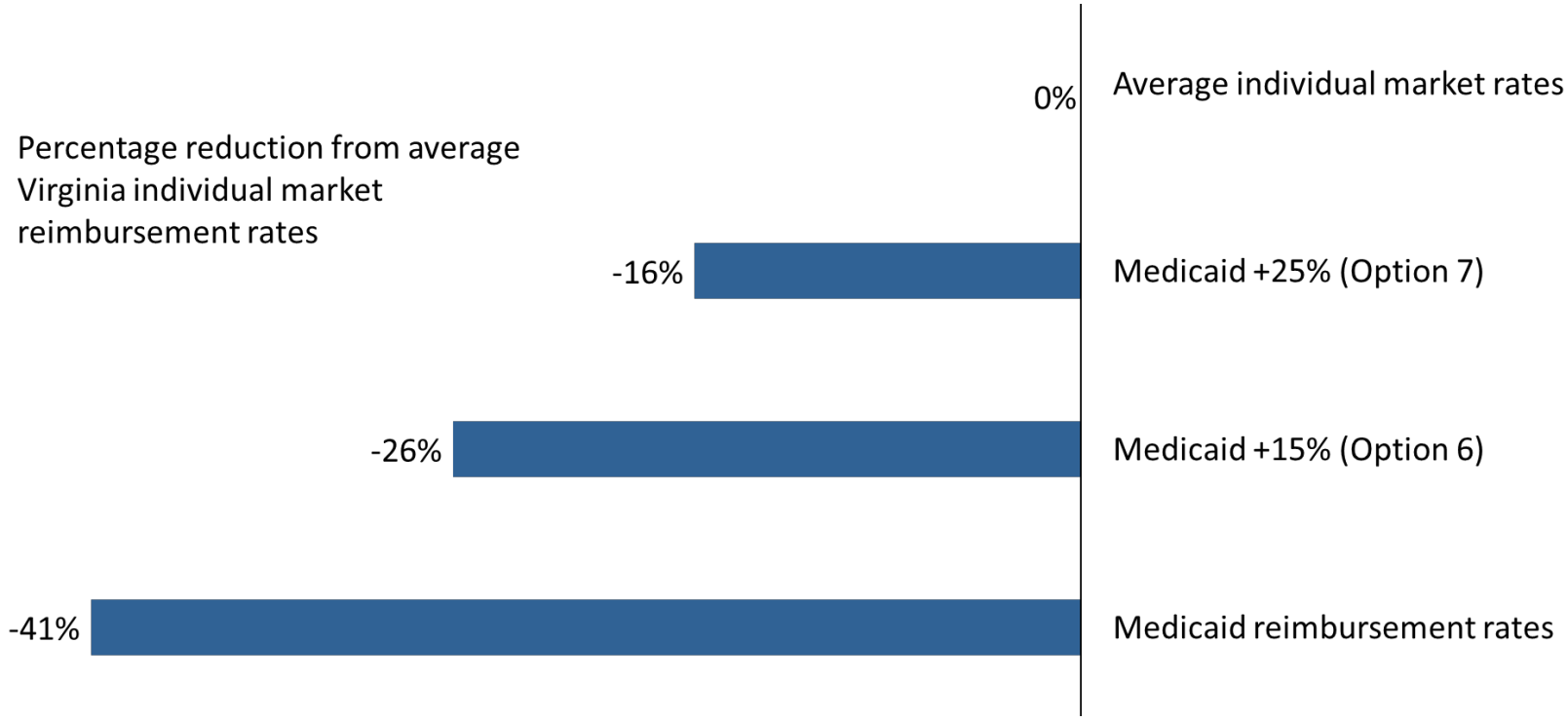
A public option with lower reimbursement rates would reduce premiums, but have limited impact on the number of uninsured.

A public option with competitive reimbursement rates is unlikely to significantly impact premiums or the number of uninsured.

Background on public option scenarios

- Public option may be administered by contract between an insurer and the state, similar to WA model
- Plan includes all state mandated and ACA required benefits
- Two options modeled based on percentages above Medicaid, one with commercially competitive rates
- Virginia Health Information (VHI) claims data used to compute ratios between individual market, Medicare, and Medicaid rates

Scenarios set provider rates between Medicaid and individual market rates



SOURCE: JCHC staff and Urban Institute analysis of aggregated claims data provided by VHI.

Setting provider reimbursement rates may be challenging

- Providers may not accept rates and may not contract with public option for services
- Any rates set administratively will be reductions from commercial rates paid in individual market
- WA addressed provider participation by requiring hospitals that accept public programs to also accept the state public option

Estimated impacts of public options with set provider rates (2023)

Medicaid plus 15%

	Reduction in premiums	Reduction in uninsured
Impact if APRA APTCs not extended	21.1%	10,000
Impact if ARPA APTCs extended	22.2%	3,000

Medicaid plus 25%

	Reduction in premiums	Reduction in uninsured
Impact if APRA APTCs not extended	9.7%	8,000
Impact if ARPA APTCs extended	13.0%	5,000

SOURCE: Results of the Urban Institute's Health Insurance Policy Simulation Model, estimates for 2023.

Current data is inconclusive on whether increasing competition in Virginia will improve affordability

	Bureau of Insurance rating area					
	1	4	5	7	8	11
Anthem premiums	$458	$437	$404	$391	$426	$423
Average premiums of other insurers		$483		$462		$470
Total insurers	1	2	1	5	1	2
Average uninsured rate	9.6%	13.5%	10.9%	11.1%	9.7%	12.4%

SOURCE: JCHC staff analysis of FFM QHP landscape files for researchers and issuers, and data on the uninsured from the Wisconsin Population Health and Robert Wood Johnson Foundation County Health Rankings, 2018.

Opportunities for public comment

- Submit written public comments by close of business on Friday, November 26th

  Email: jchcpubliccomments@jchc.Virginia.gov

  Fax: 804-786-5538

  Mail: PO Box 1322
  Richmond, VA 23218

- Sign up to provide public comments at the JCHC workgroup meeting on Monday, November 29th

NOTE: All public comments are subject to FOIA and must be released upon request.

Joint Commission on Health Care

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