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Obamacare Exchanges Gained Health Insurers for 2022—a Development that New Biden Administration Regulations Could Reverse

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KEY TAKEAWAYS

After nine years in operation, Obamacare's insurance exchanges are still 25 percent less competitive than health insurance markets were before Obamacare was enacted.

While there is more choice and competition in 2022, that is largely the result of actions taken by the Trump Administration to stabilize the exchange market.

The Biden Administration's new regulations, which threaten to push up premiums and spark insurer exits, could undo those gains.

Plan year 2022 is the ninth year of operation for the health insurance exchanges created by the Affordable Care Act (ACA), known as Obamacare. It also marks the fourth consecutive year of increased insurer participation at both the state and county levels—a reversal of the prior trend of decreasing insurer participation during plan years 2016 through 2018, and a reflection of actions taken by the Trump Administration. Yet, new regulations by the Biden Administration could reverse these trends, driving up premiums and sparking renewed insurer exits.

State-Level Insurer Competition in the Exchanges

One way to measure insurer competition is to assess insurer participation on a state-by-state basis.

TABLE 1

Number of Health Insurers Participating in the Exchanges, by State (Page of 1 of 2)

	HEALTH INSURERS PARTICIPATING IN THE EXCHANGES									
	Pre-ACA*	Exchange								
State	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Alabama	4	2	3	3	1	2	2	2	2	3
Alaska	4	2	2	1	1	1	1	2	2	2
Arizona	11	8	11	8	2	2	5	5	5	8
Arkansas	7	3	3	4	3	3	3	2	2	3
California	12	11	10	12	11	11	11	11	11	12
Colorado	14	10	10	8	7	7	7	8	8	8
Connecticut	7	3	4	4	2	2	2	2	2	2
Delaware	4	2	2	2	2	1	1	1	1	1
District of Columbia	4	3	3	2	2	2	2	2	2	2
Florida	18	8	10	7	5	4	5	7	8	10
Georgia	11	5	9	8	5	4	4	6	6	11
Hawaii	2	2	2	2	2	2	2	2	2	2
Idaho	5	4	5	5	5	4	4	4	5	6
Illinois	12	5	8	7	5	4	5	5	8	11
Indiana	11	4	9	8	4	2	2	2	3	4
Iowa	5	4	3	4	4	1	2	2	3	3
Kansas	9	3	3	3	3	3	3	5	6	7
Kentucky	6	3	5	7	3	2	2	2	2	4
Louisiana	8	4	5	4	3	2	2	2	2	4
Maine	4	2	3	3	3	2	3	3	3	3
Maryland	8	4	5	5	3	2	2	2	3	3
Massachusetts	8	9	10	10	9	7	8	8	7	7
Michigan	14	9	13	11	9	7	8	7	7	9
Minnesota	6	5	4	4	4	4	4	4	5	5
Mississippi	5	2	3	3	2	1	1	2	2	4
Missouri	12	3	6	6	4	3	4	7	8	8
Montana	2	3	4	3	3	3	3	3	3	3
Nebraska	4	4	3	4	2	1	1	2	2	4
Nevada	5	4	5	3	3	2	2	3	5	7
New Hampshire	2	1	5	5	4	3	3	3	3	3
New Jersey	3	3	5	5	2	3	3	3	3	4
New Mexico	3	4	5	4	4	4	4	4	5	6
New York	10	16	16	15	14	12	12	12	12	12
North Carolina	12	2	3	3	2	2	3	4	6	9
North Dakota	3	3	3	3	3	2	3	3	3	3
Ohio	12	11	15	14	10	8	9	9	9	9
Oklahoma	8	4	4	2	1	1	2	3	6	8
Oregon	10	11	10	9	6	5	5	5	5	5
Pennsylvania	14	7	9	7	5	5	6	7	7	8
Rhode Island	2	2	3	3	2	2	2	2	2	2
South Carolina	9	3	4	3	1	1	2	4	4	4

TABLE 1

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	HEALTH INSURERS PARTICIPATING IN THE EXCHANGES									
	Pre-ACA*	Exchange								
State	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
South Dakota	4	3	3	2	2	2	2	2	2	2
Tennessee	10	4	5	4	3	3	5	5	6	6
Texas	18	11	14	16	10	8	8	8	9	13
Utah	9	6	6	4	3	2	3	5	5	6
Vermont	3	2	2	2	2	2	2	2	2	2
Virginia	10	5	6	7	8	6	7	8	8	11
Washington	7	7	9	10	7	5	5	7	9	8
West Virginia	4	1	1	2	2	2	2	2	2	2
Wisconsin	15	13	15	16	14	11	12	12	13	13
Wyoming	5	2	2	1	1	1	1	1	2	2
TOTAL	**395**	**252**	**308**	**288**	**218**	**181**	**202**	**224**	**248**	**294**

*Only includes insurers with at least 1,000 covered individuals in the state.
SOURCE: Author's calculations based on federal and state information on exchange participation and Mark Farrah Associates insurer regulatory data for pre-ACA market participation.

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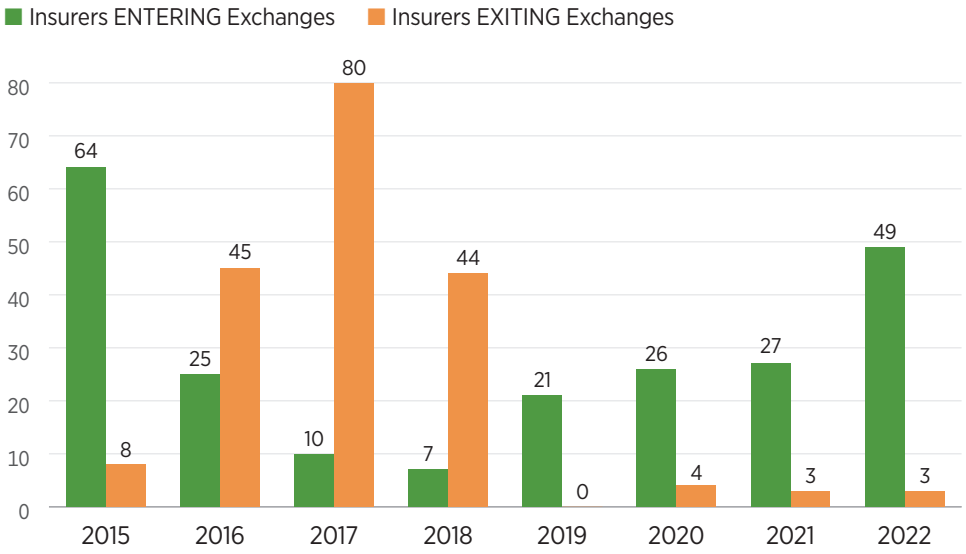
That analysis, summarized in Table 1, shows the number of carriers in each state and the District of Columbia in the individual market in 2013, as well as in the exchanges each year since they began in 2014. Insurers that offer exchange coverage through more than one subsidiary in a state are counted as one carrier (the parent company), while insurers that offer coverage in more than one state are counted for each state (as exchange participation is a state-level decision).

In 2013, the last year before Obamacare's implementation, 395 insurers sold coverage in the individual market across all states and the District of Columbia. In 2022, 294 insurers are offering coverage through the Obamacare exchanges. That is an increase of 113 insurers over the low of 181 in 2018, but it still leaves the 2022 exchanges 25 percent less competitive than the individual market was before the implementation of Obamacare.

Table 1 shows that state-level exchange competition dropped significantly over the three plan years of 2016 to 2018 but rebounded in subsequent years (2019 to 2022). For plan year 2022, 24 states saw a net increase in

CHART 1

Insurers Entering and Exiting State Exchanges



SOURCE: Author's calculations based on federal and state information on exchange participation.

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the number of insurers offering exchange coverage, while one state (Washington) had a net decrease.

Over the past four plan years, the net number of insurers offering exchange coverage increased in 37 states and remained unchanged in 13 states and the District of Columbia. The year-to-year pattern of insurers entering and exiting the exchanges is shown in Chart 1.

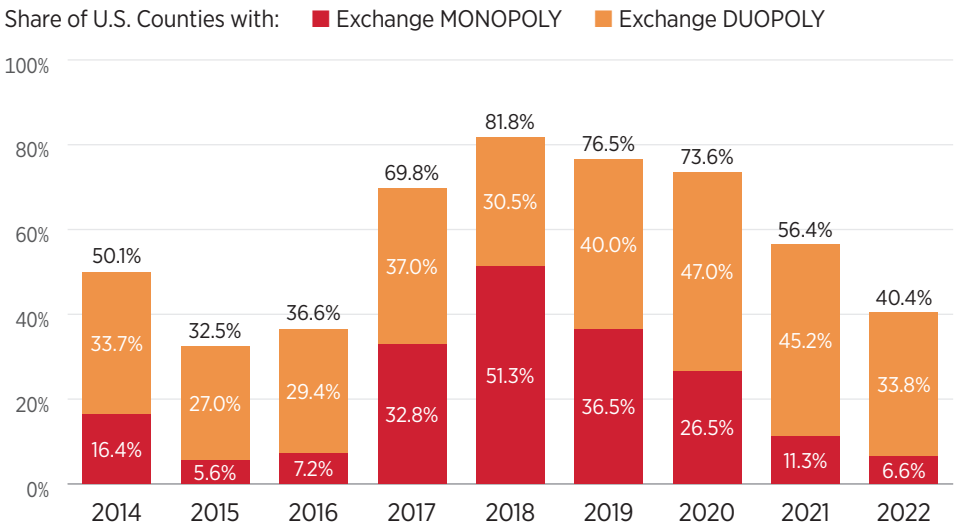
Yet, even with the increase in insurer participation over the past four years, only nine states have more insurers offering Obamacare exchange coverage in 2022 than were offering individual market coverage before the ACA, while seven states have the same number and 34 states and the District of Columbia have fewer.

2022 County-Level Insurer Competition in the Exchanges

Though state-level data are informative, the most tangible measure of competition for consumers is data at the county level. That is because health plans are offered, and priced, locally. Also, because many insurers only offer Obamacare exchange coverage in certain parts of a state, county-level data provide a more precise picture of the choices available to consumers.

CHART 2

Counties with Little or No Insurer Choice on the Exchanges



SOURCE: Author's calculations based on federal and state information on county-level insurer exchange offerings.

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The state-level pattern of decreasing insurer participation in the years 2016 through 2018, followed by increasing participation in the years since then, was echoed at the county level.

As Chart 2 shows, while the share of counties with only one exchange insurer grew to more than half (51.3 percent) of all counties in 2018, it has since fallen to 6.6 percent of counties in 2022—or about where it was in 2015 at the peak of insurer participation. Chart 2 also shows that the return of insurers to the exchanges has brought the share of counties with an insurer monopoly or duopoly back down from 81.8 percent in 2018 to 40.4 percent in 2022.

That improvement was mainly driven by changes in the share of counties with only one insurer. In 2018, there were 1,613 counties that had only one insurer. By this year, 556 of those counties had gained a second insurer, and another 870 counties had gained two or more insurers. During the same period, 20 counties went from two insurers to one. The net result is that this year only 207 counties have a single insurer offering exchange coverage.

Patterns of Insurer Exchange Participation

The increase in insurer exchange participation resulted from a combination of insurers expanding into additional states and insurers returning to states they had previously exited.

Two newer insurers—Oscar Health and Bright Health—are notable for their business strategy of offering coverage only within selected local markets.

Oscar Health first offered exchange coverage in 2014 in New York City, while Bright Health started in 2017 by offering exchange coverage in seven Colorado counties encompassing the cities of Boulder, Colorado Springs, and Denver. In subsequent years, both insurers expanded into more metropolitan areas in more states. For plan year 2022, Oscar offers coverage in 21 states while Bright offers coverage in 15 states. Yet, Oscar and Bright only offer coverage in select counties within those states—except for Nebraska, where both companies offer coverage statewide, and New Mexico, where True Health New Mexico (which Bright acquired last year) operates statewide. However, Bright just announced that it will discontinue coverage in New Mexico and five other states next year.[1]

The behavior of larger, more established insurers is illustrated by how two of them—Aetna (now a subsidiary of CVS Health) and United Healthcare—have responded over time. Aetna offered exchange coverage in 17 states in 2014 and 2015, but by 2018 had exited all of them. After a four-year absence, the company resumed coverage in eight of those states for plan year 2022. Similarly, United Healthcare offered exchange coverage in 34 states in 2015, but by 2018 had exited all but three of them and offered coverage in only four states in 2019 and 2020. Since then, United has returned to more states—a total of 10 in 2021 and 18 in 2022.

Market Stabilization

The rebound in insurer competition reflects actions by Trump Administration officials to stabilize the exchange market.

Specifically, the Trump Administration closed regulatory loopholes that some medical providers and enrollees had used to "game" the system and saddle insurers with significant losses. In turn, those losses

1. Bright intends to exit the individual market in Illinois, New Mexico, Oklahoma, South Carolina, Utah, and Virginia next year. See news release, "Bright Health Group Continues to Drive Focus on Consumer Retail Markets with Fully Aligned Model," Bright Health Group, April 14, 2022, https://investors.brighthealthgroup.com/news/news-details/2022/Bright-Health-Group-Continues-to-Drive-Focus-on-Consumer-Retail-Markets-with-Fully-Aligned-Model/default.aspx (accessed May 10, 2022).

were factors that contributed to escalating premiums and insurers exiting the market. The Administration also revised other regulations to provide states and insurers with more flexibility to accommodate local circumstances.

Another move by the Trump Administration was to eliminate the payment to insurers of separate "cost-sharing reduction" subsidies. Congress never appropriated funding for those separate payments and their elimination forced insurers to include those costs in their base premiums for silver plans.[2] That made the true cost of silver plans transparent, but also increased the ACA's "premium tax credits," which are pegged to the second-lowest-cost silver plan available to the subsidy-eligible enrollee. Thus, for subsidized enrollees—who overwhelmingly choose silver plans—the increase in premiums was offset by an increase in subsidies, while premiums for other plans were unaffected by the change.

In addition, the Trump Administration approved "Section 1332" waivers in 15 states, which gave those states regulatory relief from some of Obamacare's mandates in order to better align existing federal subsidy dollars with enrollee need using state-based "reinsurance" programs. As a result, insurers in those states were able to maintain, or even reduce, premiums. That particularly benefited unsubsidized exchange customers.[3]

New Regulations Could Reduce Choice and Competition

On May 6, the Department of Health and Human Services (HHS) published the finalized version of its "HHS Notice of Benefit and Payment Parameters for 2023" rule.[4] Each year, HHS issues this omnibus rule, consisting mainly of technical changes and updates to various Obamacare requirements that insurers need to account for when designing their product offerings for the next plan year.

In its proposed version of the rule for plan year 2023, the Biden Administration also included several provisions that either reverse regulatory

2. Doug Badger, "How Lawmakers Should Deal with Obamacare Cost-Sharing-Reduction Payments," Heritage Foundation *Issue Brief* No. 4797, December 18, 2017, https://www.heritage.org/sites/default/files/2017-12/IB4797.pdf.
3. Center for Medicare and Medicaid Services, "Section 1332: State Innovation Waivers," https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (accessed March 1, 2022). See also Doug Badger, "How Health Care Premiums Are Declining in States That Seek Relief from Obamacare's Mandates," Heritage Foundation *Issue Brief* No. 4990, August 13, 2019, https://www.heritage.org/sites/default/files/2019-08/IB4990.pdf, and Doug Badger and Edmund F. Haislmaier, "State Innovation: The Key to Affordable Health Care Choices," Heritage Foundation *Backgrounder* No. 3354, September 27, 2018, https://www.heritage.org/sites/default/files/2018-09/BG3354_2.pdf.
4. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," Final Rule, *Federal Register*, Vol. 87, No. 88 (May 6, 2022), pp. 27208–27393, https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf (accessed May 10, 2022).

improvements made by the Trump Administration or impose additional requirements on insurers.[5] Most of those changes remain in the final version of the rule. Consequently, the Biden Administration now risks replicating the premium escalation and insurer exits that characterized the exchanges from 2016 to 2018.

Specifically, the following four Biden Administration regulatory changes have the greatest potential to increase premiums and reduce insurer competition:

1) Reinstating a Loophole that Enables Enrollees to Skip Paying Premiums. The ACA requires insurers to issue coverage to all qualified applicants. It also provides a three-month grace period for non-payment of premiums by subsidized purchasers in the exchanges. In contrast, unsubsidized buyers (both on and off the exchanges) are subject to state laws—which in most states provide a standard one-month grace period. The interaction of those two ACA provisions creates a perverse incentive for some enrollees to avoid paying past-due premiums when re-enrolling—even in the same plan with the same insurer.

The Trump Administration addressed that problem by issuing regulations clarifying that insurers could delay the effective date of new coverage until any past-due premiums the applicant owed the insurer for the previous plan year were paid up.[6] The Biden Administration's new rule reverses that policy, on the grounds that it creates "barriers to health coverage," and argues that insurers can instead "pursue other mechanisms to collect past-due premiums."[7]

The problem with that argument is that the "other mechanisms"—such as hiring debt collectors or obtaining court orders—are cumbersome, time consuming, less effective, and could cost more than the amount owed.

In commenting on this provision in the proposed rule, the American Academy of Actuaries expressed "strong concerns about the potential impact to health plans and rates for other plan participants that could arise from members gaming the system if CMS [Centers for Medicare and Medicaid Services] finalizes the proposal to allow past-due premiums to be forgiven for re-enrolling members." The Academy went on to note that "this proposal may *adversely affect premiums,*

5. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," Proposed Rule, *Federal Register*, Vol. 87, No. 3 (January 5, 2022), pp. 584–728, https://www.govinfo.gov/content/pkg/FR-2022-01-05/pdf/2021-28317.pdf (accessed March 1, 2022).
6. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; Market Stabilization," Final Rule, *Federal Register*, Vol. 82, No. 73 (April 18, 2017), pp. 18346–18382, https://www.govinfo.gov/content/pkg/FR-2017-04-18/pdf/2017-07712.pdf (accessed March 1, 2022).
7. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," Final Rule, pp. 27218–27219.

as premiums for all members would have to increase to offset the increased bad debt assumed by issuers." (Emphasis in original.) The Academy further stated that premium increases "could be in the range of 0.3% to more than 3%," that the "expected rate of disenrollment would increase," that the "required premium load would increase at an even higher rate as the amount of unpaid premiums increases are compounded by decreases in paid premiums," and that it could also "reduce access if issuers exit the market."[8]

The same concerns and objections were echoed in comments submitted by the Accreditation Association for Ambulatory Health Care as well as those from several insurers.[9] Molina Healthcare estimated that the effect "could equate to 4%–7% of annual premium on average, which will encourage even more nonpayment of premiums." Molina went on to point out:

> The policy could also increase adverse selection as typically the healthiest members would most likely stop paying premiums thus reducing the funds available to issuers to cover costs for sicker members. The financial exposure associated with this proposal could also extend to providers, who would be left without proper payment as the grace period claims payment provisions would activate due to a member's nonpayment of premiums in the last quarter of the benefit year. CMS should encourage year-round insurance coverage and not introduce a large loophole which will degrade program integrity, incentivize fraud, waste, and abuse, and increase costs, adversely impacting coverage affordability especially, and unfairly, for those consumers who play by the rules and make their premium payments.[10]

8. American Academy of Actuaries, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 26, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0225 (accessed March 1, 2022).
9. "Restricting the ability for issuers to collect premiums owed and forcing insurers to either pay the costs and fees associated with collection efforts or write-off the amount owed heightens the risk for either increased consumer cost as issuers will likely pass down these costs as rates increase or, alternatively, insurer collapse." Accreditation Association for Ambulatory Health Care, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0265 (accessed March 1, 2022). "The ability of issuers to attribute a premium payment made for new coverage to any past-due premiums owed incentivizes the maintenance of continuous coverage, controls against potential adverse selection and contributes to the overall stability of the Marketplaces. Altering the current interpretation of guaranteed availability could increase instances of uncollected or written off premiums, the costs of which are ultimately borne by other individual consumers, the majority of whom are themselves in need of financial assistance to purchase coverage." UPMC Health Plan, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0161 (accessed March 1, 2022). "This proposed change could negatively affect overall coverage affordability, as the debts owed will have to be absorbed across the markets." United Healthcare, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0220 (accessed March 1, 2022).
10. Molina Healthcare, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0161 (accessed March 1, 2022).

The response of the Biden HHS was to downplay and dismiss these concerns and simply adopt its proposed changes in the final rule.[11] Thus, under the amended regulations, an insurer will now be deemed to be in violation of Obamacare's guaranteed issue of coverage requirement (and consequently subject to fines and other enforcement actions) if the insurer refuses to issue coverage to an applicant due to the applicant's "failure to pay premium owed under a prior policy, certificate, or contract of insurance, including by attributing payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance."[12]

2) Eliminating Verification Requirements for many Special Enrollment Periods (SEPs)—Encouraging More People to Forego Buying Coverage Until They Need Medical Care. The ACA requires insurers to issue coverage to all qualified applicants during an annual open enrollment period, and during SEPs outside open season for individuals experiencing a "qualifying life event"—such as getting married, losing employer coverage, or moving to another state. Those provisions were designed to balance enabling sick individuals to get coverage with the necessity of discouraging healthy individuals from waiting until they expect to require medical care before buying coverage—behavior which could cause the market to collapse. While the basic regulatory design was the same as that applied to the employer-group-coverage market, which has long had guaranteed issue of coverage, for plans sold through the Obamacare exchanges Congress expanded the number and type of qualifying events that trigger an SEP.[13]

Initially, the Obama Administration relied mainly on applicants self-attesting that they qualified for an SEP and required little or no documentation to support assertions of eligibility. As insurers reported disproportionately high claims costs for SEP enrollees, the Obama Administration began to require more verification, and the Trump Administration expanded those requirements.[14] The Biden Administration is now eliminating pre-enrollment verification for most SEPs in the 30 states whose

11. "Some commenters suggested that the provision will lead to higher costs for issuers and result in higher premiums for consumers. One commenter speculated that the increase in premiums could range from 0.3 percent to more than 3 percent. A few commenters also stated that the proposed rule will reduce access to coverage if issuers exit the market. A few commenters stated that the proposed rule could negatively affect risk pools.... We disagree that this rule is likely to result in an increase in premiums, have a negative financial impact on issuers or providers, or cause issuers to exit the market." Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," Final Rule, p. 27370.
12. New subsection (i) under 45 Code of Federal Regulations § 147.104, and ibid., p. 27386.
13. Healthcare.gov, "Getting Health Coverage Outside Open Enrollment," https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ (accessed March 1, 2022).
14. Center for the American Experiment, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0196 (accessed March 1, 2022).

exchanges are federally run and will allow state-run exchanges to determine for themselves the extent to which they will verify SEP applications.

The American Academy of Actuaries noted that "[l]ess restrictive SEP enforcement mechanisms have the potential to worsen the risk profile."[15] The trade association America's Health Insurance Plans (AHIP) also opposed this change, stating that:

> SEP pre-enrollment verification promotes a stable risk pool and reduces the negative impact of the abuse of SEPs. We are concerned that removing SEP pre-enrollment verification, together with recent policy changes including a longer open enrollment period and continuous enrollment for individuals with incomes under 150 percent of the federal poverty level, will have the cumulative impact of destabilizing the individual market risk pool and raise premiums. Instead, HHS should prioritize policies that encourage 12 months of continuous coverage.[16]

United Healthcare, Cigna, and the Blue Cross Blue Shield Association cited similar concerns in their comments opposing this change.[17]

Notwithstanding those concerns, the Biden Administration adopted this proposed change in the final rule. Consequently, starting next year, the federally run exchanges will conduct verifications only for applicants who claim loss of other "minimum essential coverage" as the reason for their SEP eligibility.

3) Imposing More Detailed Federal "Network Adequacy" Regulations that Could Make It Harder for Insurers to Offer Plans in Rural Counties. Obamacare's statutory language is vague and aspirational with respect to the provider networks of plans sold on the exchanges. The law simply instructs the Secretary of HHS to "establish criteria" for certifying plans to be offered on the exchanges and enumerates eight parameters—the second of which reads, "ensure a sufficient choice of providers."[18]

15. American Academy of Actuaries, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule.
16. America's Health Insurance Plans, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0279 (accessed March 1, 2022).
17. "Cigna has concerns about the potential increase in fraudulent activity as a result of this change and recommends CMS consider alternatives to scaling back the SEP verification process that would strike a balance between maintaining a stable risk pool and lowering barriers to coverage." Cigna, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0213 (accessed March 1, 2022). "Just as verifying eligibility for subsidies protects the integrity of the program, SEP verification helps ensure consumers are not enrolled and receiving subsidies inappropriately. It also helps maintain a balanced risk pool by deterring consumers from enrolling only when they become sick or injured." Blue Cross Blue Shield Association, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0222 (accessed March 1, 2022). "Removing this checkpoint could potentially result in adverse selection and the sort of gaming behavior that can increase costs for all consumers in the market." United Healthcare, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule.
18. Public Law 111–148 § 1311(c)(1).

Given that state health insurance laws typically include "network adequacy" standards for managed care plans, the Obama and Trump Administrations mainly relied on those state laws when approving plans to be offered on the federally run exchanges. The Biden Administration has now amended the regulations to impose new federal "time and distance standards" (starting in 2023) on providers in 34 different medical specialties and "appointment wait time standards" (starting in 2024) on facilities offering any of 11 different specialty services.[19] Furthermore, the new regulations stipulate that any insurer seeking to offer a plan that does not meet the new standards will be required to include with its application a "written justification" for "how the plan's provider network provides an adequate level of service for enrollees and how the plan's provider network will be strengthened and brought closer to compliance with the network adequacy standards prior to the start of the plan year."

These new regulations could adversely affect insurer choice and competition, particularly in rural areas with fewer providers. If insurers are unable to meet the requirements, or obtain exemptions, rural counties would likely have fewer insurers offering coverage and only more expensive non-network plan options.

AHIP and several insurers, as well as the Kansas Insurance Department—which predicts that between 54 and 60 of that state's 105 counties could be adversely affected—submitted comments objecting to these additional requirements.[20]

Those commentors all asserted that existing state regulations are the best way to ensure that network adequacy standards appropriately account for local circumstances. As CVS Health put it, "There is no consumer benefit by adding a federal layer of regulation to an already functioning state regulatory environment."[21]

4) Requiring Insurers to Offer Government-Designed "Standard" Plans. Under the Biden Administration's new regulations, starting in 2023, if an insurer participating in a federally run exchange offers a "non-standardized" plan, it will be required to also offer a "standardized plan" in the

19. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," Final Rule, pp. 27325 and 27326, Tables 14 and 15.

20. Kansas Insurance Department, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0155 (accessed March 1, 2022). "Health plans located in a rural setting are better equipped to engage with state regulators regarding their networks. For example, in rural North Dakota and South Dakota, there may be a perceived network gap for a particular specialty provider. What may not be clear to the Department, though, is that [that] particular part of the state is not able to support such a specialty provider due to its remote characteristics." Sanford Health Plan, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0185 (accessed March 1, 2022).

21. CVS Health, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0198 (accessed March 1, 2022).

same service area, at the same metal level and with the same network type as the non-standard plan.

The final rule sets forth the specifications for those standardized plans in two tables.[22]

The rationale offered by the Biden Administration is that "the significant increase of plan offerings available on the Exchanges over the last several plan years" could result in consumers experiencing "choice paralysis."[23]

However, as one insurer pointed out: "The proposed rule would have the unintended effect of producing more, not fewer, products to the market and thus would exacerbate the issue identified by CMS."[24] Other commentors echoed that observation.[25]

The American Academy of Actuaries cautioned that "adding more plans to a crowded marketplace will not make purchasing easier, even if these plans are standardized. Instead, the additional offerings may add to the confusion, particularly as it is likely the standardized plan options may not meet the needs of some consumers."[26]

Even a provider group, the Federation of American Hospitals, weighed in against the idea, stating:

> We do not agree with CMS's concern that the number of plan options has risen along with rising Exchange enrollment. On the contrary, we believe that the increasing number of plan choices indicate an increasingly robust market where issuers and providers have the flexibility to innovate, and consumers are able to enjoy a wide range of options.[27]

Another telling indicator was this observation by the Blue Cross Blue Shield Association: "We also would note that the proposed standardized plans represent benefit designs that are not commonly seen in the market."[28]

22. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," Final Rule, pp. 27314 and 27315, Tables 12 and 13.
23. Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023," Proposed Rule, p. 673.
24. Sanford Health Plan, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule.
25. America's Health Insurance Plans, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule; UPMC Health Plan, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule; Cigna, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule; Blue Cross Blue Shield Association, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule; and Molina Healthcare, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule.
26. American Academy of Actuaries, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule.
27. Federation of American Hospitals, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule, January 27, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0169 (accessed March 1, 2022).
28. Blue Cross Blue Shield Association, comments on the 2023 Notice of Benefit and Payment Parameters Proposed Rule.

That is an understated way of pointing out that the government-designed plans are likely to be unappealing to many consumers.

In responding to these comments, HHS admitted that "standardized plan option requirements could potentially increase the total number of plan offerings," but encouraged insurers "to modify their existing non-standardized plan offerings...to conform with the cost-sharing parameters of the standardized plan options" as a way to "reduce the risk of choice overload."

In sum, the Biden Administration thinks that the problem with Obamacare is that it offers too many different insurance plans, and that the solution is for insurance companies to offer plans designed by the government—and preferably only such plans. Implementing these new requirements will likely further disincentivize insurer participation in the Obamacare exchanges.

Conclusion

As the Obamacare exchange market has stabilized over the past four years, more insurers have resumed, or expanded, their offering of exchange coverage. While insurer competition is still far below pre-ACA levels at both the state and county levels, insurer choice and competition in the Obamacare exchanges for 2022 is roughly back to where it stood in 2015—before large and escalating losses prompted numerous insurers to exit the exchanges.

The Biden Administration's new regulations now threaten to reverse much of that progress. They could significantly reduce insurer choice and competition in the exchanges and increase premiums for individuals and taxpayers who subsidize these costs.

Edmund F. Haislmaier is the Preston A. Wells, Jr., Senior Research Fellow in the Center for Health and Welfare Policy at The Heritage Foundation.

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 1 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
Alabama	Blue Cross and Blue Shield of Alabama	Blue Cross and Blue Shield of Alabama
	Bright Health, Inc.	Bright Health Insurance Company
	UnitedHealth Group, Inc.	UnitedHealthcare
Alaska	Oregon Dental Service	Moda
	Premera	Premera Blue Cross Blue Shield of Alaska
Arizona	Blue Cross Blue Shield of Arizona, Inc.	Blue Cross Blue Shield of Arizona, Inc.
	Bright Health, Inc.	Bright HealthCare from Bright Health Company of Arizona
	Centene Corporation	Ambetter from Arizona Complete Health
	Cigna Corporation	Cigna HealthCare of Arizona, Inc.
	CVS Health Corporation	Banner Health and Aetna Health Plan, Inc.
	Medica Holding Company	Medica
	Oscar Health, Inc.	Oscar Health Plan, Inc.
	UnitedHealth Group, Inc.	UnitedHealthcare
Arkansas	Centene Corporation	Ambetter from Arkansas Health & Wellness, QC Life and Health, QCA Health Plan
	USAble Mutual Insurance Company	USAble Mutual Insurance Company, Health Advantage
	Oscar Health, Inc.	Oscar Insurance Company
California	Anthem, Inc.	Anthem Blue Cross of California
	Blue Shield of California	Blue Shield of California
	Bright Health, Inc.	Bright HealthCare
	Centene Corporation	Health Net of California, Inc., Health Net Life Insurance Company
	Chinese Hospital Association	Chinese Community Health Plan
	Kaiser Permanente	Kaiser Permanente
	Local Initiative Health Authority for Los Angeles County	L.A. Care Health Plan
	Molina Healthcare, Inc.	Molina Healthcare
	Oscar Health, Inc.	Oscar Health Plan of California
	Sharp HealthCare	Sharp Health Plan
	Santa Clara County	Valley Health Plan
	Western Health Advantage	Western Health Advantage
Colorado	Anthem, Inc.	HMO Colorado, Inc.
	Bright Health, Inc.	Bright Health Insurance Company
	Cigna Corporation	Cigna Health and Life Insurance Co.
	Denver Health and Hospital Authority	Denver Health Medical Plan, Inc.
	Friday Health Plans, Inc.	Friday Health Plans
	Kaiser Permanente	Kaiser Foundation Health Plan of Colorado
	Oscar Health, Inc.	Oscar Insurance Company
	UnitedHealth Group, Inc.	Rocky Mountain Health Maintenance Organization, Inc.
Connecticut	Anthem, Inc.	Anthem Blue Cross Blue Shield
	EmblemHealth, Inc.	ConnectiCare Benefits, Inc., ConnectiCare Insurance Company

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 2 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
Delaware	Highmark, Inc.	Highmark Blue Cross Blue Shield Delaware
D.C.	CareFirst, Inc.	CareFirst
	Kaiser Permanente	Kaiser
Florida	Bright Health, Inc.	Bright HealthCare
	Centene Corporation	Ambetter from Sunshine Health
	Cigna Corporation	Cigna Healthcare
	CVS Health Corporation	Aetna CVS Health
	GuideWell Mutual Holding Corporation	Florida Blue, Florida Blue HMO, Florida Health Care Plans, Capital Health Plan
	Health First, Inc.	Health First Commercial Plans, Inc.
	Molina Healthcare, Inc.	Molina Healthcare
	Oscar Health, Inc.	Oscar Insurance Company of Florida
	SantaFe HealthCare, Inc.	AvMed
	UnitedHealth Group, Inc.	UnitedHealthcare
Georgia	Anthem, Inc.	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
	Bright Health, Inc.	Bright HealthCare
	CareSource	CareSource
	Centene Corporation	Ambetter from Peach State Health Plan
	Cigna Corporation	Cigna HealthCare of Georgia, Inc.
	CVS Health Corporation	Aetna CVS Health
	Friday Health Plans, Inc.	Friday Health Plans
	Health One Alliance, LLC	Alliant Health Plans
	Kaiser Permanente	Kaiser Permanente
	Oscar Health, Inc.	Oscar Health Plan of Georgia
	UnitedHealth Group, Inc.	UnitedHealthcare
Hawaii	Hawaii Medical Service Association	HMSA
	Kaiser Permanente	Kaiser Permanente
Idaho	Blue Cross of Idaho Health Service, Inc.	Blue Cross of Idaho Health Services
	Cambia Health Solutions, Inc.	Regence BlueShield of Idaho
	Intermountain Health Care, Inc.	SelectHealth
	Molina Healthcare, Inc.	Molina Healthcare
	Montana Health Cooperative	Mountain Health CO-OP
	PacificSource Health Plans	PacificSource Health Plans
Illinois	Bright Health, Inc.	Bright HealthCare
	Carle Foundation	Health Alliance
	Centene Corporation	Ambetter of Illinois
	Cigna Corporation	Cigna Healthcare
	Health Care Service Corporation	Blue Cross and Blue Shield of Illinois
	Mercy Health Corporation	MercyCare Health Plans
	Molina Healthcare, Inc.	Molina Healthcare

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 3 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
Illinois (cont.)	Oscar Health, Inc.	Oscar Health Plan, Inc.
	Medica Holding Company	WellFirst Health
	UnitedHealth Group, Inc.	UnitedHealthcare
	University Health Care, Inc.	Quartz
Indiana	Anthem, Inc.	Anthem Blue Cross and Blue Shield
	Ascension Care Management Holdings	US Health and Life
	CareSource	CareSource
	Centene Corporation	Ambetter from MHS
Iowa	Medica Holding Company	Medica Insurance Company
	Oscar Health, Inc.	Oscar Insurance Company
	Wellmark	Wellmark Health Plan of Iowa, Inc.
Kansas	Ascension Care Management Holdings	US Health and Life
	Blue Cross and Blue Shield of Kansas, Inc.	Blue Cross and Blue Shield of Kansas, Inc.
	Blue Cross and Blue Shield of Kansas City	Blue Cross and Blue Shield of Kansas City
	Centene Corporation	Ambetter from Sunflower Health Plan
	Cigna Corporation	Cigna Healthcare
	Medica Holding Company	Medica
	Oscar Health, Inc.	Oscar Insurance Company
Kentucky	Anthem, Inc.	Anthem Health Plans of KY (Anthem BCBS)
	CareSource	CareSource Kentucky Co.
	Centene Corporation	WellCare
	Molina Healthcare, Inc.	Molina Healthcare
Louisiana	Centene Corporation	Ambetter from Louisiana Healthcare Connections
	CHRISTUS Health	CHRISTUS Health Plan
	Louisiana Health Service & Indemnity Company	Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Vantage Health Plan
	UnitedHealth Group, Inc.	UnitedHealthcare
Maine	Anthem, Inc.	Anthem Blue Cross and Blue Shield
	Point32Health, Inc.	Harvard Pilgrim Health Care
	Maine Community Health Options	Community Health Options
Maryland	CareFirst, Inc.	CareFirst BlueCross BlueShield
	Kaiser Permanente	Kaiser Permanente
	UnitedHealth Group, Inc.	UnitedHealthcare
Massachusetts	Baystate Health	Health New England
	Blue Cross Blue Shield of Massachusetts	Blue Cross Blue Shield of Massachusetts
	BMC Health System, Inc.	Boston Medical Center HealthNet Plan

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 4 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
Massachusetts (cont.)	Fallon Community Health Plan, Inc.	Fallon Health
	Point32Health, Inc.	Harvard Pilgrim Health Care, Tufts Health Plan
	Mass General Brigham Incorporated	AllWays Health Partners
	UnitedHealth Group, Inc.	UnitedHealthcare
Michigan	Ascension Care Management Holdings	US Health and Life
	Blue Cross Blue Shield of Michigan Mutual Insurance Company	Blue Cross Blue Shield of Michigan Mutual Insurance Company, Blue Care Network of Michigan
	Centene Corporation	Ambetter from Meridian
	McLaren Health Care Corporation	McLaren Health Plan Community
	Molina Healthcare, Inc.	Molina Healthcare
	Oscar Health, Inc.	Oscar Insurance Company
	Sparrow Health System	Physicians Health Plan
	Spectrum Health System	Priority Health, Total Health Care USA, Inc.
	UnitedHealth Group, Inc.	UnitedHealthcare
Minnesota	Aware Integrated, Inc.	Blue Plus
	HealthPartners, Inc.	HealthPartners
	Medica Holding Company	Medica
	UCare Minnesota	UCare Minnesota
	University Health Care, Inc.	Quartz Health Plan
Mississippi	Centene Corporation	Ambetter from Magnolia Health
	Cigna Corporation	Cigna Healthcare
	Molina Healthcare, Inc.	Molina Healthcare
	Louisiana Health Service & Indemnity Company	Vantage Health Plan of Mississippi
Missouri	Anthem, Inc.	Healthy Alliance Life Co. (Anthem BCBS)
	Blue Cross and Blue Shield of Kansas City	Blue Cross and Blue Shield of Kansas City
	Centene Corporation	Ambetter from Home State Health
	Cigna Corporation	Cigna Healthcare
	Cox Health	Cox HealthPlans
	CVS Health Corporation	Aetna CVS Health
	Medica Holding Company	Medica, WellFirst Health
	Oscar Health, Inc.	Oscar Insurance Company
Montana	Health Care Service Corporation	Blue Cross and Blue Shield of Montana
	Montana Health Cooperative	Mountain Health CO-OP
	PacificSource Health Plans	PacificSource Health Plans
Nebraska	Bright Health, Inc.	Bright HealthCare
	Centene Corporation	Ambetter from Nebraska Total Care
	Medica Holding Company	Medica
	Oscar Health, Inc.	Oscar Insurance Company

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 5 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
Nevada	Anthem, Inc.	HMO Colorado dba HMO Nevada
	Centene Corporation	SilverSummit Healthplan, Inc.
	CVS Health Corporation	Aetna Health of Utah, Inc.
	Friday Health Plans, Inc.	Friday Health Plans of Nevada, Inc.
	Intermountain Health Care, Inc.	SelectHealth
	Renown Health	Hometown Health Plan, Inc.
	UnitedHealth Group, Inc.	Health Plan of Nevada, Inc.
New Hampshire	Anthem, Inc.	Anthem Blue Cross and Blue Shield
	Centene Corporation	Ambetter from New Hampshire Healthy Families
	Point32Health, Inc.	Harvard Pilgrim Health Care
New Jersey	Horizon Blue Cross Blue Shield of New Jersey	Horizon Healthcare Services, Inc.
	Centene Corporation	Ambetter from WellCare of New Jersey
	Independence Health Group, Inc.	AmeriHealth HMO, Inc., AmeriHealth Insurance Company of New Jersey
	Oscar Health, Inc.	Oscar Garden State Insurance Corporation
New Mexico	Centene Corporation	Ambetter from Western Sky Community Care
	Bright Health, Inc.	True Health New Mexico
	Friday Health Plans, Inc.	Friday Health Plans
	Health Care Service Corporation	Blue Cross Blue Shield of New Mexico
	Molina Healthcare, Inc.	Molina Healthcare
	Southwest Health Foundation	Presbyterian Health Plan
New York	Anthem, Inc.	HealthPlus
	Capital District Physicians' Health Plan, Inc.	Capital District Physicians Health Plan
	EmblemHealth, Inc.	Health Insurance Plan of Greater New York
	Healthfirst PHSP, Inc.	Healthfirst New York
	Highmark, Inc.	Highmark BlueShield of Northeastern New York, Highmark BlueCross BlueShield of Western New York
	Independent Health Association, Inc.	Independent Health
	Lifetime Healthcare, Inc.	Excellus Blue Cross Blue Shield, Univera Healthcare
	Oscar Health, Inc.	Oscar Insurance
	MVP Health Care, Inc.	MVP Health Plan
	New York City Health and Hospitals Corporation	MetroPlus Health Plan
	Centene Corporation	Fidelis Care
	UnitedHealth Group, Inc.	United Healthcare
North Carolina	Blue Cross and Blue Shield of North Carolina	Blue Cross and Blue Shield of NC
	Bright Health, Inc.	Bright Health
	Centene Corporation	Ambetter of North Carolina, WellCare of North Carolina
	Cigna Corporation	Cigna Healthcare
	CVS Health Corporation	Aetna CVS Health
	Friday Health Plans, Inc.	Friday Health Plans

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 6 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
North Carolina (cont.)	Independence Health Group, Inc.	AmeriHealth Caritas Next
	Oscar Health, Inc.	Oscar Health Plan of North Carolina, Inc
	UnitedHealth Group, Inc.	UnitedHealthcare
North Dakota	Medica Holding Company	Medica
	Noridian Mutual Insurance Company	Blue Cross Blue Shield of North Dakota
	Sanford Health	Sanford Health Plan
Ohio	Anthem, Inc.	Anthem Blue Cross and Blue Shield
	Aultman Health Foundation	AultCare Insurance Company
	CareSource	CareSource
	Centene Corporation	Ambetter from Buckeye Health
	Medical Mutual of Ohio	MedMutual
	Molina Healthcare, Inc.	Molina Healthcare
	Oscar Health, Inc.	Oscar Insurance Corporation of Ohio, Oscar Health Insurance
	ProMedica Health System, Inc.	Paramount
	Summa Health System	SummaCare
Oklahoma	Bright Health, Inc.	Bright HealthCare
	Centene Corporation	Ambetter of Oklahoma
	Community Care Managed Healthcare Plans of Oklahoma, Inc.	CommunityCare
	Friday Health Plans, Inc.	Friday Health Plans
	Health Care Service Corporation	Blue Cross Blue Shield of Oklahoma
	Medica Holding Company	Medica Insurance Company
	Oscar Health, Inc.	Oscar Insurance Company
	UnitedHealth Group, Inc.	UnitedHealthcare
Oregon	Cambia Health Solutions, Inc.	BridgeSpan Health Company, Regence BlueCross BlueShield of Oregon
	Kaiser Permanente	Kaiser Permanente
	Oregon Dental Service	Moda Health Plan, Inc.
	PacificSource Health Plans	PacificSource Health Plans
	Providence Health & Services	Providence Health Plan
Pennsylvania	Capital BlueCross	Capital Advantage Assurance Company
	Centene Corporation	Pennsylvania Health & Wellness, Inc.
	Cigna Corporation	Cigna Health and Life Insurance Company
	Geisinger Health System Foundation	Geisinger Health Plan, Geisinger Quality Options
	Highmark, Inc.	Highmark, Inc., Highmark Benefits Group, Highmark Coverage Advantage, Inc.
	Independence Health Group, Inc.	QCC Insurance Company, Keystone Health Plan East
	Oscar Health, Inc.	Oscar Health Plan of PA
	University of Pittsburgh Medical Center	UPMC Health Coverage, Inc., UPMC Health Options, Inc.
Rhode Island	Blue Cross & Blue Shield of Rhode Island	Blue Cross & Blue Shield of Rhode Island
	Neighborhood Health Plan of Rhode Island, Inc.	Neighborhood Health Plan of Rhode Island

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 7 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
South Carolina	BlueCross BlueShield of South Carolina	BlueCross BlueShield of South Carolina
	Bright Health, Inc.	Bright HealthCare
	Centene Corporation	Ambetter from Absolute Total Care
	Molina Healthcare, Inc.	Molina Healthcare
South Dakota	Avera Health	Avera Health Plans
	Sanford Health	Sanford Health Plan
Tennessee	Blue Cross Blue Shield of Tennessee	BlueCross BlueShield of Tennessee
	Bright Health, Inc.	Bright HealthCare
	Centene Corporation	Ambetter of Tennessee
	Cigna Corporation	Cigna Healthcare
	Oscar Health, Inc.	Oscar Insurance Company
	UnitedHealth Group, Inc.	UnitedHealthcare
Texas	Baylor Scott & White Holdings	Scott and White Health Plan, FirstCare Health Plans
	Bexar County Hospital District	Community First
	Centene Corporation	Ambetter from Superior HealthPlan
	CHRISTUS Health	CHRISTUS Health Plan
	Harris County Hospital District	Community Health Choice
	CVS Health Corporation	Aetna Life Insurance Company
	Friday Health Plans, Inc.	Friday Health Plans
	Health Care Service Corporation	Blue Cross and Blue Shield of Texas
	Molina Healthcare, Inc.	Molina Healthcare
	Oregon Dental Service	Moda Health, Inc.
	Oscar Health, Inc.	Oscar Insurance Company
	Travis County Healthcare District	Sendero Health Plans
	UnitedHealth Group, Inc.	UnitedHealthcare
Utah	Bright Health, Inc.	Bright HealthCare
	Cambia Health Solutions, Inc.	BridgeSpan Health Company, Regence BlueCross BlueShield of Oregon
	Cigna Corporation	Cigna Healthcare
	Intermountain Health Care, Inc.	SelectHealth
	Molina Healthcare, Inc.	Molina Healthcare
	University of Utah	University of Utah Health Insurance Plans
Vermont	Blue Cross Blue Shield of Vermont	BlueCross BlueShield of Vermont
	MVP Health Care, Inc.	MVP Health Care
Virginia	Anthem, Inc.	HealthKeepers, Inc.
	Bright Health, Inc.	Bright HealthCare
	CareFirst, Inc.	CareFirst BlueCross BlueShield, CareFirst BlueChoice
	Piedmont Community Health Plan	Piedmont Community HealthCare HMO, Inc.
	Cigna Corporation	Cigna Health and Life Insurance Company
	CVS Health Corporation	Aetna Life Insurance Company
	Innovation Health Holdings, LLC	Innovation Health Plan, Inc.

APPENDIX TABLE 1

Health Insurers Participating in Exchanges in 2022, by State (Page 8 of 8)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and Subsidiaries)
Virginia (cont.)	Kaiser Permanente	Kaiser Permanente
	Oscar Health, Inc.	Oscar Insurance Company
	Sentara Healthcare, Inc.	Optima Health Plan
	UnitedHealth Group, Inc.	UnitedHealthcare
Washington	Cambia Health Solutions, Inc.	BridgeSpan, Regence BlueShield, Regence BlueCross BlueShield of Oregon
	Centene Corporation	Coordinated Care Company
	Community Health Network of Washington	Community Health Network of Washington
	Kaiser Permanente	Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington
	PacificSource Health Plans	PacificSource Health Plans
	Molina Healthcare, Inc.	Molina Healthcare of Washington
	Premera	Premera Blue Cross, LifeWise Health Plan of Washington
	UnitedHealth Group, Inc.	UnitedHealthCare of Oregon
West Virginia	CareSource	CareSource
	Highmark, Inc.	Highmark Blue Cross Blue Shield West Virginia
Wisconsin	Anthem, Inc.	Anthem Blue Cross and Blue Shield
	Aspirus, Inc.	Aspirus Health Plan
	Children's Hospital and Health System	Together with CCHP
	Common Ground Healthcare Cooperative	Common Ground Healthcare Cooperative
	Group Health Cooperative of South Central Wisconsin	Group Health Cooperative-SCW
	HealthPartners, Inc.	HealthPartners
	Mercy Health Corporation	MercyCare Health Plans
	Marshfield Clinic	Security Health Plan
	Medica Holding Company	Medica, Dean Health Plan
	Molina Healthcare, Inc.	Molina Healthcare
	Network Health, Inc.	Network Health
	UCare Minnesota	Quartz
	Wisconsin Physicians Service Ins. Corp.	WPS Health Plan
Wyoming	Blue Cross Blue Shield of Wyoming	Blue Cross Blue Shield of Wyoming
	Montana Health Cooperative	Mountain Health CO-OP

SOURCE: Data for the states using the federal exchange platform are from data.healthcare.gov. Data for the states and District of Columbia with a state-based exchange are from either the state's insurance department or the state's exchange.