The Committee on Energy and Commerce, Subcommittee on Health
Summary of Statement of Mary Taylor,
Ohio Lt. Governor and Department of Insurance Director
Washington, District of Columbia
April 3, 2013

Mr. Chairman and distinguished members of the committee, I will provide testimony regarding Ohio's experience with high risk pools as created under the Affordable Care Act (ACA). I will discuss state regulatory authority, the impacts of the ACA in Ohio, issues our Department had with the ACA high risk pool program and concerns we have with the ACA moving forward.

States have regulated insurance for decades based on the specific needs of their populations. Over the years Ohio has taken advantage of state regulated insurance in order to address our individual market and our consumers. Unfortunately, states will no longer have the ability to make decisions based on the needs of their consumers and their job creators.

Prior to the ACA, states took very different paths in addressing the health care needs of their citizens. Ohio's ACA created high risk pool caused regulatory problems and confusion that resulted in disagreements between Ohio and the federal government.

The conflicts led to disagreements on rates for the program and eventually a lawsuit over consumer eligibility for the program. Based on the experiences that we had with the federal government overseeing the high risk pool, we fear that similar problems will arise as the ACA is fully implemented.

The Committee on Energy and Commerce, Subcommittee on Health

Statement of Mary Taylor,

Ohio Lt. Governor and Department of Insurance Director

Washington, District of Columbia

April 3, 2013

Mr. Chairman and distinguished members of the committee, thank you for the opportunity to testify this afternoon. My name is Mary Taylor and I am Ohio's Lt. Governor and also the Director of the Ohio Department of Insurance. I appreciate the opportunity to testify before you today regarding Ohio's experience with the high risk pool program under the Affordable Care Act (ACA).

States have regulated insurance for decades based on the specific needs of their populations, economies and insurance markets. Nationally, all insurance commissioners are members of the National Association of Insurance Commissioners (NAIC) which is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and the five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory supervision to ensure fair oversight of the insurance industry and consistent consumer protections. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

Over the past 60 years, under the leadership of many different administrations, our Department has managed and regulated a competitive insurance market for consumers and job creators. Our efforts have helped us achieve better choice and pricing not just for health insurance, but across all lines of insurance. We take great pride in these accomplishments and attribute our success to the professional and experienced staff we have working on behalf of all Ohioans.

The mission of the Department of Insurance is to provide consumer protection through education and fair but vigilant regulation while promoting a stable and competitive environment for insurers. We consider consumer protection our primary function.

Our Department's Product Regulation and Actuarial Service division is charged with reviewing premium rates and contracts to ensure they adhere to state laws and regulations, and providing guidance to the industry and legislature on insurance issues. Along with policy and rate review, the division also licenses multiple employer trusts, alliances and health insuring corporations and accredits independent review organizations. Our Department's Market Conduct Division works to investigate and oversee insurer conduct in the marketplace. In addition, our Consumer Services Division assists consumers who have questions about their insurance policies, the claims process, and filing complaints when necessary. Finally, our Risk Assessment Division closely monitors the financial condition of insurance companies doing business in Ohio by conducting in-house analyses of financial statements, overseeing insurers'

statutory and solvency compliance on an ongoing basis and conducting periodic on-site examinations.

The Department of Insurance leverages these divisions, and others, to review all insurance products sold in Ohio, ensure the premium rates are actuarially justified, adequate, and non-discriminatory and assist consumers. Overall, our Department ensures companies are solvent while monitoring their conduct in order to protect consumers from practices that do not meet the highest standards.

Our department oversees 250 Ohio based insurance companies, 205,000 licensed insurance agents and agencies, verifies $485 million in premium tax collected by the state and operates a number of consumer service programs that helped Ohioans save $24.4 million in 2012. The $58.7 billion of premium written in Ohio by the 1,636 insurance companies licensed to sell in our state make Ohio the seventh largest insurance market based on premium in the United States and the 22nd largest in the world.

Because of this regulatory environment, and the size of our market, Ohio has a very competitive health insurance market with numerous companies writing health insurance business from which Ohio consumers can choose. In order to determine the impacts of the ACA on Ohio's vibrant market, my department commissioned a report conducted by Milliman Inc. in 2011 that looked specifically at the Ohio insurance market pre-ACA and projected its impact on Ohio moving forward.

This report projected average premiums would increase in the individual market in Ohio between 55 percent and 85 percent. Specifically, Milliman projected a healthy young male in the individual market may experience a rate increase between 90 percent and 130 percent, but that a 60 year old with chronic health conditions may experience a premium decrease. In the small group market average premium increases were projected to be less dramatic at 5 percent to 15 percent overall. However, the report also projected the potential for significant rating variance in the small group market resulting in premium increases of up to 150 percent or a premium decreases of nearly 40 percent for groups at opposite ends of the current rating structure. Finally, the report noted that the previously outlined increases in premium do not account for medical trend, which Milliman noted has been rising 7 to 8 percent nationally.

In addition to significant changes to insurance premiums, the report projected a substantial shift in how people get their coverage. The individual market in Ohio is projected to more than double while employer sponsored insurance (ESI) in the small group market is projected to decrease by 28 percent. The report also projected changes to other ESI markets including a decrease to the large group market of 27 percent and the self-funded market of about 2 percent.

These impacts demonstrate concerning and, for many Ohioans, negative changes to our market in addition to the fact the law does little in the way of trying to actually reduce the underlying cost of care that has historically been driving the increasing cost of health insurance coverage.

Instead, the law exacerbates the cost by mandating additional benefits, levying additional taxes and fees on the health industry and adding more people into an already unsustainable system.

The ACA is a one-size-fits-all, national approach to health care that takes the flexibility away from states and is laden with very narrow and rigid regulations that will only further the problems in our system, not help alleviate them. Over the years Ohio has taken advantage of state regulated insurance – a right all other states have had prior to the ACA – in order to address our individual market and our consumers. Unfortunately states will no longer have the ability to make decisions based on the needs of their consumers and their job creators.

There are many examples demonstrating the extensive new red tape and regulatory impacts of the federal government's one-size-fits-all approach to health care. One example starting to receive national attention is the application process American consumers will have to go through in order to obtain health insurance through the exchanges. As drafted now, the application appears to be page after page of information consumers must provide concerning their eligibility to access coverage and their ability to qualify for tax credits and subsidies. The application will be burdensome to consumers and cannot be altered by states even though states have been regulating insurance for decades and may have better and more efficient solutions for helping consumers through the enrollment process.

Instead of facing such a centralized bureaucracy of health care, states should have the ability to evaluate the challenges facing their populations and implement more localized solutions. Prior

to the ACA, states took very different paths in addressing the health care needs of their citizens. One concept that has been around for years – and several states had been using to address the needs of their populations – is the high risk pool. Just like the exchange concept, both can be useful tools to address concerns about access to health insurance coverage, if done well.

Pre-ACA several states had high risk pools in place to address the needs of individuals with pre-existing conditions. However, implementing them as mandated in the ACA has been problematic and eventually bankrupted the program (as House leadership pointed out in the letter to President Obama dated March 5, 2013).

The ACA mandated high risk pool programs were often times just a heavy handed and bureaucratic extension of the federal government. The poor management of the program led to their unsustainability and, ultimately, the untimely decision to close enrollment in the program earlier this year.

Ohio's high risk pool was set-up being administered by an Ohio licensed private health insurer, but funded by the United States Department of Health and Human Services (HHS).
The Department of Insurance retained its general authority over the high risk pool, including the right to regulate the rates and resolve consumer appeals, in addition to general oversight of the high risk pool program.

HHS released a report for year-end 2012, which reported information on every state's enrollment, claims paid and administrative expenses. Based on the HHS reported information, the Ohio high risk pool program ranked in the top ten for lowest administrative expenses and was in the top five for highest number of enrollees. The findings of the report show the Ohio program has some of the largest enrollment for ACA required, state run high risk pools, while being among the lowest in administrative costs.

Even though the program administered by Ohio was among the most efficient and cost effective in the country, the overall set-up of the ACA mandated high risk pool program quickly caused problems and resulted in disagreements between the two agencies. The Department of Insurance's regulatory issues with HHS left the Ohio administrator caught in the middle between two regulators. In 2011, as required under Ohio law, the Ohio administrator submitted rates for the two high risk pool plans to our Department for review and approval. The submissions included rate increases for both plans being sold in the high risk pool – a 3 percent increase for the $2,500 deductible plan and a 17 percent increase for the $1,500 deductible plan.

As with all rates, our Department's staff reviewed these rate increases and believed them to be actuarially justified based on utilization and other factors pertaining to the experience of the group and approved the rates for use in Ohio. However, HHS refused to approve the rates and directed the Ohio administrator to artificially reduce the rate increase for the $1,500 deductible

plan. In addition, HHS directed the program to artificially inflate the rates for the $2,500 deductible plan, to further subsidize the lower deductible plan.

As a certified public accountant and an insurance regulator whose primary concern relates to company solvency, forcing a company to artificially restrict rates and artificially inflate others causes serious solvency concerns down the line and puts the company at risk to not be able to pay their obligated claims. State regulators of insurance generally do not allow companies to subsidize one pool of business with another. As regulators, we must ensure that each block of business is solvent on its own and charging appropriate rates. Without these assurances it can be difficult at best to get a true picture of the ability of a company to continue to adjudicate and pay enrollee's claims.

Eventually, HHS and the Department of Insurance were able to come to an agreement on rates that were acceptable to both parties, but this forced negotiation caused consumer confusion and pushed back renewal dates for the 2011-2012 policy year. Furthermore, the efforts of HHS to artificially manipulate rates, as well as several other changes HHS made related to the program, were a clear sign to the Department of Insurance the program would not be sustainable and would likely run out of funds before 2014.

Shortly after the problems with the rates were resolved, we began having eligibility disputes with HHS related to consumers with current or previous coverage applying for the high risk

pool. As the primary regulator, the Department of Insurance had the ability to make final determinations on eligibility appeals.

Our Department was reviewing eligibility appeals from Ohioans who had applied to the high risk pool program but had been determined ineligible by the Ohio administrator (in consultation with HHS). The Department of Insurance believed that these consumers in fact should be eligible because their previous coverage was not considered "creditable". However, HHS demanded the Ohio administrator ignore our Department's determination and instead follow HHS' directions.

Further, HHS forced the Ohio administrator to remove Ohio high risk pool members who had already been admitted to the program, in some cases for months, because it deemed their previous coverage "creditable." Ohioans who were clearly eligible for the high risk pool – according to our Department's review of their specific cases – were forced out of the program by HHS causing them to lose their only available source of coverage.

After protracted discussions between the Department of Insurance, the Ohio administrator, and HHS, it became clear that HHS would not recognize our Department's authority to make these determinations leading the Ohio administrator to file a lawsuit against both parties seeking clarification from the courts as to which party they were bound to follow. An agreement was eventually reached in which our Department's regulatory authority was upheld.

But this several month long ordeal demonstrated the federal government's propensity to overreach and disregard state regulation of insurance that resulted in harm to consumers in the process. Due to the nature of the consumers applying for coverage in the high risk pool – Ohioans with pre-existing conditions and in need of urgent medical attention – this dispute and subsequent litigation caused unnecessary confusion and concern for the Ohioans stuck in the middle.

While Ohio's high risk pool experience has come with challenges to say the least, we feel this tool – designed to help consumers find coverage they cannot secure anywhere else – is not without merit. However, as you seek to obtain additional funding to allow this program to continue to accept individuals through 2013, we encourage you to continue pressing for more flexibility and less red tape to ensure states are given the control they need to tailor this type of program to the needs of their citizens. Doing so would help consumers while avoiding some of the very issues that have plagued our high risk pool since 2011.

Based on the experiences that we had with the federal government overseeing the high risk pool, we fear that similar problems will arise as the ACA is fully implemented. We feel these fears are very real and pose a threat not just to regulation of health insurance in Ohio but across the country.

States have traditionally regulated insurance and are well equipped to do so. We have appropriate regulatory processes in place to oversee insurer pricing, market conduct and

solvency. Just as with the high risk pool in Ohio, when a federal agency steps into a role in which they do not have experience or the expertise to properly understand the issue, it can have severe consequences for the market and consumers.

Knowing the challenges that lie ahead, I encourage members of Congress to continue working toward a better solution. For states like Ohio, better alternatives cannot come quickly enough. In the meantime, we will continue to focus our energy on areas of Ohio's health care system we can control. Our administration will continue our work to improve quality of care in Ohio, reduce costs, improve patient outcomes and truly reform Ohio's health care system. We have made significant progress over the past two years and feel it is essential to maintain our focus on moving Ohio forward.

Thank you for allowing me the opportunity to testify here today, and I am happy to answer any questions you may have.

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ATTACHMENT

Executive Summary of the Milliman Report dated August 31, 2011

Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange

August 31, 2011

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2. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), introduces significant changes in covered benefits, premium rating and underwriting, carrier regulation, and the overall issuance of health insurance coverage in the U.S. Certain changes have already occurred, while the majority of the impacts will begin on January 1, 2014. This is the date when all states must have both an individual market exchange and a Small Business Health Options Program (SHOP) exchange in operation, or default to a federally run exchange. This includes significant changes in the benefit offerings and underwriting of insurance policies both inside and outside these required exchanges.

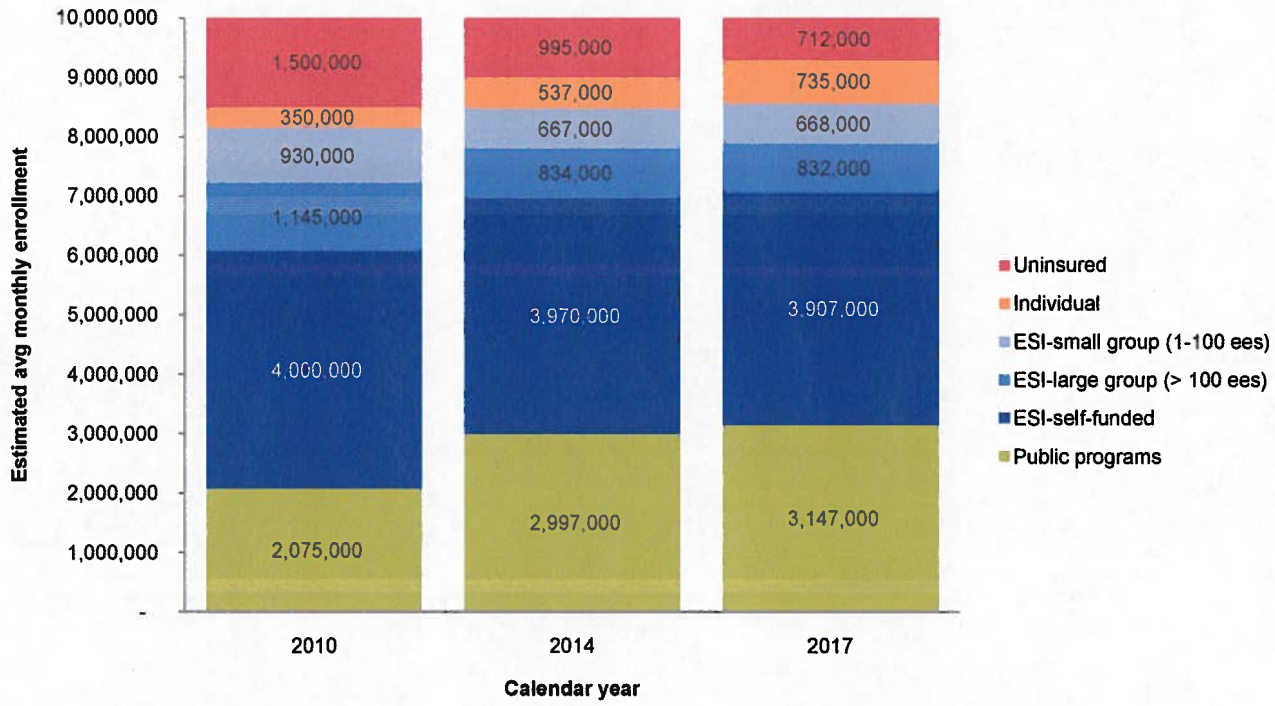
The primary ACA requirements for the commercial employer-sponsored (ESI)-small group and individual health insurance markets, both inside and outside the exchanges, include:

- Guaranteed issue of insurance coverage regardless of pre-existing medical conditions or health status
- Adjusted community rating with premium rate variations only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1)
- Premium rate consistency inside and outside the exchanges
- Ability of states to merge the ESI-small group and individual health insurance markets
- Ability of states to define small group up to 100 employees (mandatory by January 1, 2016)
- Definition and requirements for essential health benefits
- Individual tax penalty if not covered by minimum essential insurance coverage
- Employer tax penalty if not offering qualified insurance coverage (groups under 50 employees exempt)

The ACA also includes a significant expansion of the state Medicaid program to include all U.S. citizens and qualified legal aliens who are not eligible for Medicare, under age 65, and with household income up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard.

These changes are certain to impact the current source of health insurance coverage for a large number of Ohioans. The key question is, to what extent are the current markets going to be impacted? More specifically, what will the Ohio insurance market look like in 2014 and beyond? While the exact impacts are not known, this report used a model developed to illustrate the potential landscape of the Ohio insurance market in 2014 (initial year) and in 2017 (mature year). The estimates take into account the potential behavior of individuals and employers based on income level, age, and health status. Figure 2-1 illustrates the estimated changes in the source of coverage for 2010 to 2014 and 2017. It should be noted that these results assume that the state does not implement a Basic Health Program.

Figure 2-1: Ohio non-elderly covered lives by source of coverage – changes from 2010 to 2014 and 2017



The primary observations for calendar year 2017 (as compared to 2010) from the model results used to develop Figure 2-1 include:

- The individual health insurance market increases by approximately 110% or 390,000 lives
- The public programs increase by approximately 52% or 1,070,000 lives
- The ESI-small group market decreases by approximately (28%) or (260,000) lives
- The ESI-large group market decreases by approximately (27%) or (310,000) lives
- The ESI-self-funded market decreases by approximately (2%) or (90,000) lives
- The uninsured population decreases by approximately (53%) or (790,000) lives

The premium rates in the various markets are expected to react to the movement of individuals summarized above. This indicates that the model used to develop this report assumed that the healthcare cost of each individual is unique and that as they move to another market segment their associated costs go with them. The minimum benefit standards required in the ACA will also impact the premium rates to the extent they are higher standards than the current markets. Our analysis estimates that the premium rates may change as follows:

- Prior to the application of the premium tax credit subsidy, the individual health insurance market premiums are estimated to increase by 55% to 85% above current market average rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits. Current insured benefit expenses in the individual market are approximately 40% less than the ESI-small group market.[3] This is attributable to today's individual market having leaner covered benefits, such as the exclusion of maternity services, and a lower-cost population relative to the ESI markets.

It is estimated that the post-ACA individual market will have average benefit coverage levels more comparable to the small group market. It is also anticipated that this new individual market will be less healthy compared to the ESI market populations. For these reasons, premiums in the individual health insurance market post-ACA are estimated to be 8%-12% higher than the ESI-small group market, post ACA reforms.

- The ESI-small group market premiums are estimated to increase by 5% to 15% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the remaining ESI-small group market, ACA-imposed insurance carrier fees, and provider cost shifting from the public programs.

- The ESI-large group market premiums are estimated to increase by 3% to 5% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the ACA-imposed carrier fees and provider cost shifting from the public programs.

- It should be noted that these increases will be in addition to regular expected healthcare inflation. The 2011 Milliman Medical Index reported 7% to 8% annual trends for the fourth year in a row.[1]

The premium change estimates illustrated above represent the estimated **average** premium impact to each of the market segments. It is important to note that individual policyholders and ESI-group policy premiums will have significant variability as a result of the ACA requirement for adjusted community rating (ACR). Individuals and smaller employers will observe the greatest impacts since they are more likely to be at one extreme or the other of the total current premium range (i.e. health status tier, age band, and gender category).

- In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a rate increase of between 90% and 130%. However, a 60 year old with chronic health conditions may experience a significant premium decrease.

- In the ESI-small group market, rating changes may result in a premium increase of 150% or a premium decrease of nearly 40% for groups at opposite ends of the current rating structure.

- Rate change variability attributable to ACR may result in healthier insured risks leaving the insured risk pool, while attracting a greater proportion of less healthy risks.

This estimated premium impact includes the combination of items impacting the entire market (such as minimum benefits and risk pool composition changes) as well as the items that mainly impact the lowest or highest extremes of the current premium range (such as restriction of age rating to a 3:1 ratio, removal of health status underwriting, and the elimination of gender rating). Similarly, individuals and ESI-small groups who consist of older ages, higher health risks, and higher female concentration will experience lower than average premium rate changes as a result of the subsidies created by ACR.

The changes which will result from to ACA will be significant. The task of implementing these regulations will require a significant amount of leadership and collaboration among the state, carriers, employers, consumers, brokers and agents, and providers. The key will be finding the issues that can be regulated by policy and using that authority to ensure as much market stability as possible through this period of change.

ATTACHMENT

Pre-Existing Condition

Insurance Plan Data

dated December 31, 2012

Pre-Existing Condition Insurance Plan Data as of December 31, 2012

The Affordable Care Act created the new Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to Americans denied coverage by private insurance companies because of a pre-existing condition. People living with conditions like diabetes, asthma, cancer, and HIV/AIDS have often been priced out of affordable health insurance options, and this has left millions without insurance.

PCIP is a temporary program that covers a broad range of health benefits and is designed as a bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. A range of professional, inpatient and drug treatments were provided to these individuals.

In 2014, all Americans – regardless of their health status – will have access to affordable coverage either through their employer or through new competitive marketplaces called Exchanges, and insurers will be prohibited from charging more or denying coverage to anyone based on the state of their health.

The PCIP program is administered by either the state or the federal government: 27 states have chosen to run their own programs, while 23 states and the District of Columbia elected to have their PCIP program administered by the federal government.

The PCIP program began accepting applications for enrollment in July 2010. Like private insurance plans, PCIP programs may incur expenses daily, but often do not submit claims for reimbursement until several weeks later. Accordingly, CCIIO will be posting data on a quarterly basis.

It is important to note that the PCIP interim final rule places a limit of 10 percent on administrative costs over the life of the program. HHS anticipates that our overall administrative costs will be at 10 percent or less over the life of the program, especially after one-time startup investments have been made. We continue to monitor these costs closely.

The chart below details reported expenditures paid as of December 31, 2012.[1]

[1] These figures reflect claims and administrative costs paid as of December 31, 2012 and do not reflect costs that are incurred but not reported.

State-run PCIP Expenditures by State

State Name	Enrollment as of December 31, 2012	Claims Paid as of December 31, 2012	Administrative Expenses Paid as of December 31, 2012	Expenditures Net of Premium Revenue as of December 31, 2012[2]
Alaska	45	$10,941,022	$759,095	$10,675,417
Arkansas	855	$12,107,536	$1,882,893	$10,279,752
California	15101	$446,930,880	$24,463,874	$415,847,028
Colorado	1331	$70,569,572	$3,030,334	$62,323,548
Connecticut[3]	577	$ 5,878,489	$1,669,592	$5,882,701
Illinois	3231	$79,224,278	$2,168,471	$63,672,037
Iowa	384	$12,241,308	$1,432,626	$10,985,986
Kansas	519	$24,763,688	$1,232,127	$22,612,656
Maine	48	$2,650,790	$64,376	$2,166,825
Maryland	1316	$28,055,806	$2,977,148	$25,745,115
Michigan	2040	$61,140,009	$2,091,275	$56,573,363
Missouri	2104	$53,496,193	$2,677,717	$46,618,679
Montana	333	$16,019,970	$1,047,718	$14,098,554
New Hampshire	662	$42,963,920	$1,276,387	$40,072,868
New Jersey	1363	$53,945,439	$1,183,450	$45,252,719
New Mexico	1398	$41,424,035	$1,929,526	$34,475,433
New York	5133	$141,947,406	$12,618,389	$128,019,638
North Carolina	5238	$40,354,000	$6,649,003	$25,446,090
Ohio	3333	$82,202,953	$2,567,154	$64,540,602
Oklahoma	952	$31,910,127	$1,826,898	$28,443,300
Oregon	1550	$75,560,690	$1,451,739	$60,247,598
Pennsylvania	6593	$103,867,537	$6,118,392	$77,070,945
Rhode Island	155	$7,164,815	$1,341,651	$7,002,801
South Dakota	191	$16,523,116	$462,809	$15,054,822
Utah	1248	$47,003,561	$963,151	$41,477,476
Washington	1013	$58,741,331	$2,836,958	$50,025,811
Wisconsin	2013	$21,682,406	$2,326,071	$14,916,985
TOTALS	**58,726**	**$1,589,310,877**	**$89,048,823**	**$1,379,528,747**

[2] PCIP members pay premiums. This premium revenue pays for some of the cost of the PCIP program. However, as a high risk pool, PCIP members incur expenses that exceed premiums paid. The $5 billion for the PCIP program covers the expenses in excess of premiums paid. The "expenditures net of premium revenue" equal the total expenses, claims and administrative, minus the total premium revenue.

[3] Connecticut's expenditure numbers (claims, administrative and expenditures net premium revenue) are through September 30 instead of December 31 because the state was unable to report complete data for the full quarter.

Federally-run PCIP Expenditures by State

State name	Enrollment as of December 31, 2012	Claims Paid as of December 31, 2012	Administrative Expenses Paid as of December 31, 2012[4]	Expenditures Net of Premium Revenue as of December 31, 2012[5]
Alabama	838	$22,033,383	N/A	N/A
Arizona	4628	$92,776,075	N/A	N/A
Delaware	302	$3,805,722	N/A	N/A
District of Columbia	81	$1,590,448	N/A	N/A
Florida	10635	$201,897,272	N/A	N/A
Georgia	3571	$78,351,726	N/A	N/A
Hawaii	151	$4,131,525	N/A	N/A
Idaho	791	$41,940,039	N/A	N/A
Indiana	1827	$36,160,193	N/A	N/A
Kentucky	1352	$18,627,492	N/A	N/A
Louisiana	1485	$21,032,061	N/A	N/A
Massachusetts[6]	17	$478,371	N/A	N/A
Minnesota	796	$12,134,933	N/A	N/A
Mississippi	347	$13,024,679	N/A	N/A
Nebraska	398	$13,599,247	N/A	N/A
Nevada	1320	$33,762,072	N/A	N/A
North Dakota	89	$3,277,834	N/A	N/A
South Carolina	1950	$45,097,307	N/A	N/A
Tennessee	1833	$41,205,235	N/A	N/A
Texas	9032	$363,560,460	N/A	N/A
Vermont	1	$135,875	N/A	N/A
Virginia	2521	$46,319,674	N/A	N/A
West Virginia	185	$3,762,422	N/A	N/A
Wyoming	284	$5,273,697	N/A	N/A
TOTALS	**44,434**	**$1,103,977,740**	**$87,752,491**[7]	**$1,026,762,600**

[4] Administrative expenses and expenditures net of premium revenue were not available for the federally-run states.

[5] Administrative expenses and expenditures net of premium revenue were not available for the federally-run states.

[6] Massachusetts and Vermont are guarantee issue states that have already implemented many of the broader market reforms included in the Affordable Care Act that take effect in 2014. Existing commercial plans offering guaranteed coverage at premiums comparable to PCIP are already available in both states.

[7] Figure does not reflect CCIIO administrative costs.