



Private Health Insurance Basics

2017 update

Current policy issues impacting the individual health insurance market in Ohio

Introduction

The Health Policy Institute of Ohio released its latest edition of Private Health Insurance Basics as a series of six fact sheets in October 2016. This fact sheet serves as an addendum to the original series, giving policymakers and stakeholders updated information on the most relevant policy issues related to the individual private health insurance market.

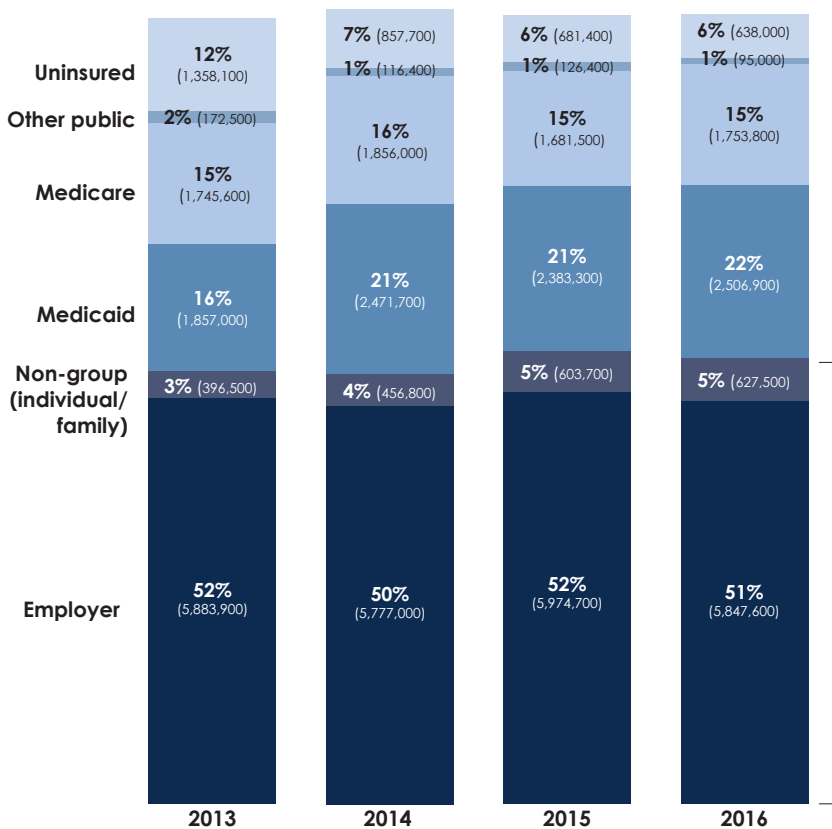
The individual (also known as non-group) insurance market has been the focus of significant attention since the passage of the Affordable Care Act (ACA). The percentage of Ohioans that purchase health insurance coverage on the individual market has increased by two percentage points since 2013 (see figure 1), but remains low relative to other sources

of coverage. The impact of potential policy changes on the availability, cost and quality of coverage could be substantial for the more than 600,000 Ohioans who purchase coverage through the individual market.

Background

In 2016, an estimated 5 percent of Ohioans, or about 627,500 people¹, had individual health insurance coverage. About 240,000 Ohioans, about 2 percent of the population, purchased that coverage on the marketplace created by the ACA.² Eighty-nine percent of Ohioans were enrolled in either employer-sponsored private health insurance or public coverage (including Medicaid and Medicare) and about 6 percent were uninsured (see figure 1).

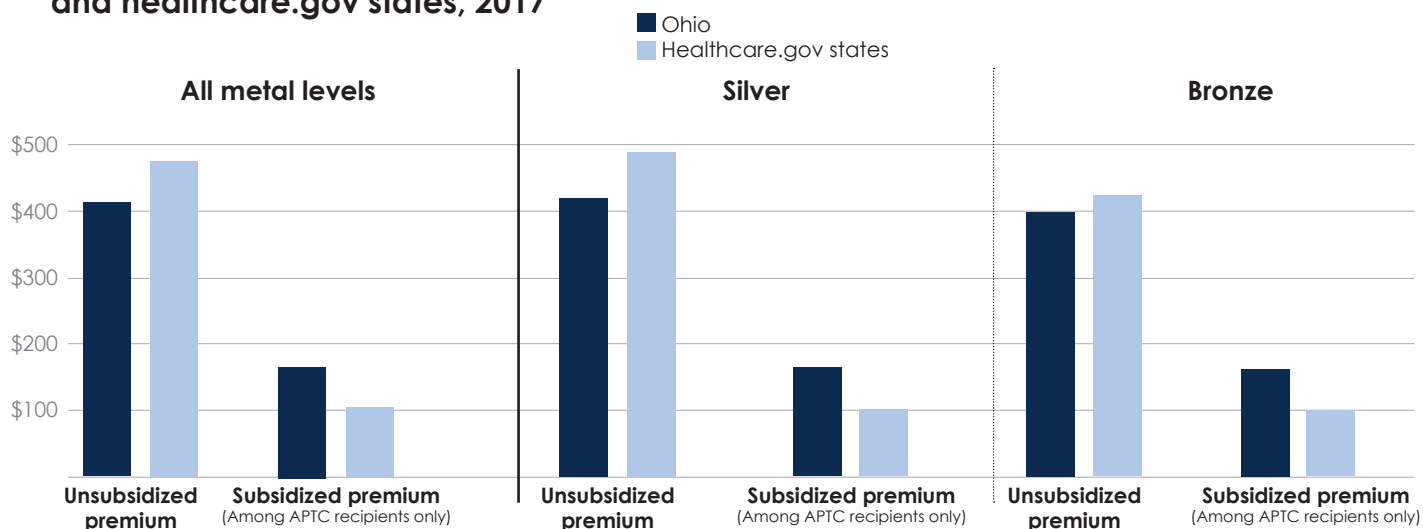
Figure 1. Health insurance coverage for Ohioans, 2013 through 2016



Private health insurance coverage

Note: Enrollees in the Affordable Care Act health insurance marketplace are included in the non-group (individual/family) coverage category
Source: Census Bureau's March Supplement to the Current Population Survey, as compiled by the Kaiser Commission on Medicaid and the Uninsured

Figure 2. Unsubsidized and subsidized ACA marketplace premiums by metal level, Ohio and healthcare.gov states, 2017



Source: HPIO analysis of Centers for Medicare and Medicaid Services, 2017 Marketplace Open Enrollment Period Public Use Files.

Purchasing individual health insurance coverage

People who need individual health insurance coverage may purchase “on-exchange” products using the federally-facilitated health insurance marketplace (FFM) created by the ACA or they may purchase “off-exchange” products from agents or brokers or directly from insurers. In 2017, 238,843 Ohioans purchased insurance on the ACA marketplace, down from 243,715 in 2016.³

Current and expected trends in premium price increases

The Ohio Department of Insurance (ODI) approves rate changes for health insurance sold on the individual and small group market in Ohio. According to [information posted on ODI’s website](#), premiums on Ohio’s ACA marketplace will increase by an average of 34 percent for plan year 2018 (see figure 2 for average premiums for the 2017 plan year).⁴ Defunding of CSR payments is among the reasons cited for large premium increases in 2018.⁵ ODI estimates that about 11 percent of the projected increase in Ohio’s overall marketplace premiums is attributable to defunding of CSR payments to insurers.⁶

Cost-sharing reductions

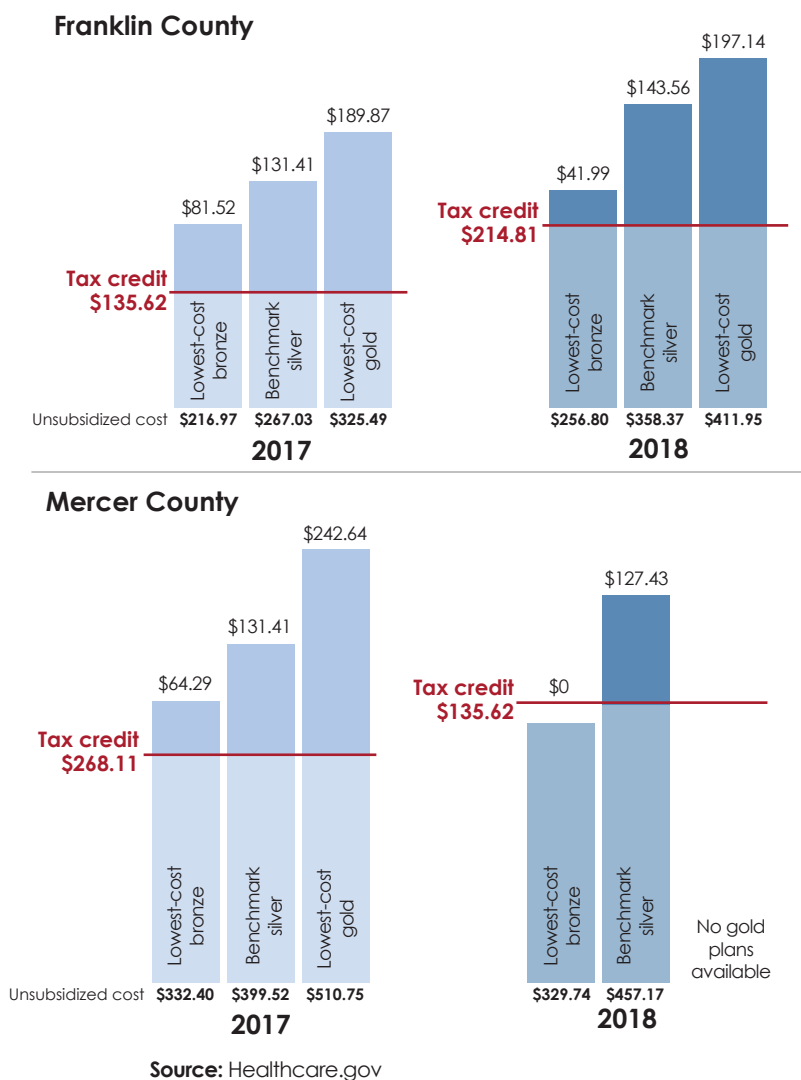
People with incomes at or below 250 percent of the federal poverty level (FPL) can qualify for CSRs to lower out-of-pocket costs associated with silver plans purchased on the ACA marketplace.⁷ Since 2014, when the ACA marketplace opened, the federal government has reimbursed the cost of CSR to insurers, although some have challenged the legality of those reimbursements. Under current law, insurers must honor CSRs for those who are eligible, even if the federal government does not continue to reimburse.⁹

Advanced premium tax credit (APTC) eligibility and marketplace purchasing power

Ohio households with incomes between 138 and 400 percent FPL are potentially eligible for advanced premium tax credits (APTC) to reduce monthly premiums for health insurance purchased on the ACA marketplace. However, in some Ohio counties, households with incomes below 400 percent FPL were not eligible for tax credits in 2017 as a consequence of how the credits are calculated. This occurred when the second lowest cost silver plan available in the county was considered to be affordable relative to household income. If the benchmark silver-level plan increases more than other metal levels in 2018 — as is likely to happen if CSR reimbursements are cut-off — these consumers and others that receive subsidies will be eligible for larger APTC, and therefore, have greater purchasing power in the marketplace for bronze and gold plans (see figure 3).⁸

In 2014, the House of Representatives [filed a lawsuit — now on appeal — alleging that CSR payments are illegal](#) because Congress did not appropriate funds.¹⁰ On Oct. 12, 2017, the White House announced that it will stop making CSR reimbursement payments to insurers. Immediately following the announcement, 18 state attorneys general sued the Trump Administration, alleging that the CSR payments are required by the ACA and that no congressional appropriation is necessary. The states also asked a federal court to issue an injunction requiring the Trump administration to continue issuing CSR payments while the case is litigated. This request was denied on October 25.¹¹

Figure 3. **Monthly premiums, after tax credits, for a 30-year-old man earning 200% FPL (\$24,120 a year), in Franklin and Mercer counties, 2017 and 2018**



According to rate filing forms,¹² defunding CSR payments was already factored into 2018 premium prices for silver-level plans in Ohio. People who are eligible for APTC — 75 percent of ACA marketplace enrollees in 2017 (see figure 4) — will not pay more out of pocket for coverage as a result of CSR payments being defunded. This is because APTCs are calculated based on a percentage of an eligible enrollee’s income rather than the actual cost of the coverage. In fact, the additional increase in premiums for silver-level plans will give most subsidized consumers larger tax credits, and therefore, greater purchasing power for plans in other metal levels (see figure 3). People who are not eligible for APTC will be exposed to the additional premium increase.

Individual mandate

The ACA mandates that individuals either have health insurance, qualify for a hardship exemption or pay a tax penalty — known as the individual shared responsibility payment or individual mandate.¹³ The individual mandate was designed to balance the risk pool in the individual market by requiring everyone, including people who are healthier, to purchase health insurance coverage or pay a tax penalty. If the individual mandate were not enforced or eliminated, premiums would likely increase because fewer healthy people would enroll in coverage.

On Jan. 20, 2017, President Trump signed an Executive Order that instructed executive agencies responsible for implementing the ACA to “waive, defer, grant exemptions from, or delay the implementation” of portions of the law that impose costs on states and/or individuals.¹⁴ Shortly after the Executive Order was signed, the [Internal Revenue Service \(IRS\) website](#) said that the agency would allow tax returns to be filed even if the filer did not answer questions about their health insurance coverage status on the return, but that current law still requires taxpayers to make the individual shared responsibility payment if it is owed.¹⁵

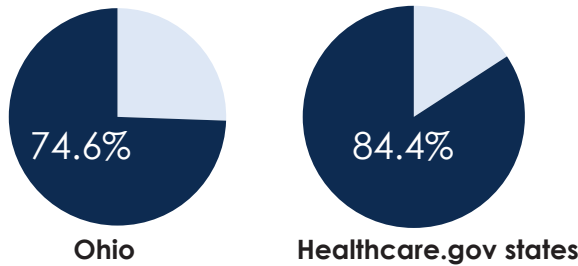
On Oct. 20, 2017, however, the IRS posted a new statement on its website stating that, “For the upcoming 2018 filing season, the IRS will not accept electronically filed tax returns where the taxpayer does not address the health coverage requirements of the Affordable Care Act.”¹⁶

During the Obama administration, a lengthy list of hardship exemptions was [posted on the IRS website](#), along with a required form. This list appears to be unchanged in 2017.

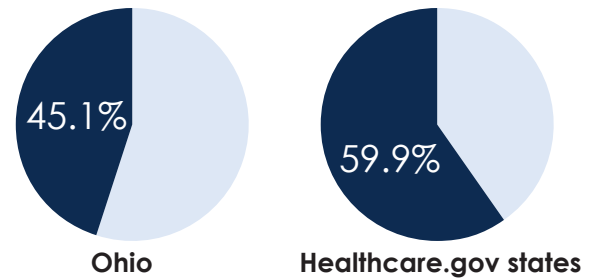
President Trump has indicated that he is still pressing Congress to repeal the individual mandate via legislation.

Figure 4. **ACA marketplace enrollment by financial assistance, Ohio and healthcare.gov states, 2017**

Percent of enrollees with advanced premium tax credit



Percent of enrollees with cost sharing reduction



Source: Centers for Medicare and Medicaid Services, 2017 Marketplace Open Enrollment Period Public Use Files.

Executive actions change administration of the ACA

In early October 2017, President Trump said that he will use executive actions to introduce ACA reforms in the absence of a congressional plan to “repeal and replace” the law. The precedent for using executive authority to address policy concerns with the ACA was set by the previous administration. For example, President Obama expanded access to hardship exemptions in response to complaints from people who received ACA-related plan cancellation notices during the first open enrollment period.¹⁷

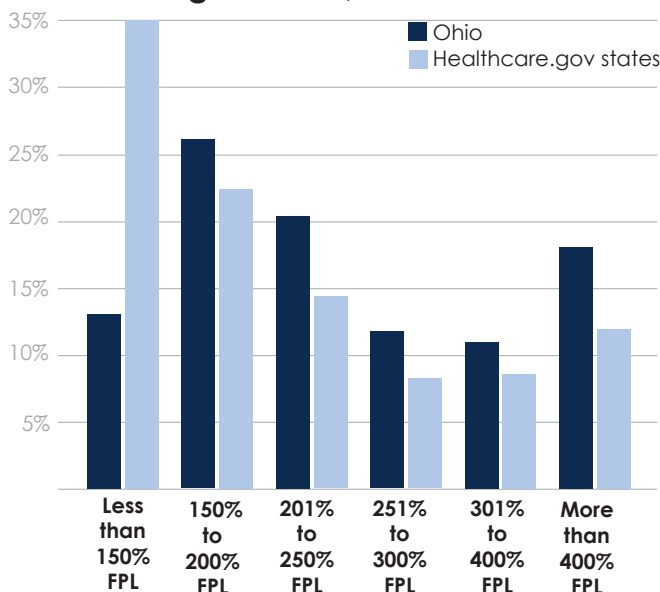
On Oct. 12, 2017, President Trump issued a **presidential memorandum** directing federal agencies, including the departments of Labor, Treasury and Health and Human Services, to consider changes to regulations with the intention of increasing “the healthcare choices

for millions of Americans, potentially allowing some employers to join together across state lines to offer coverage.”

According to the memorandum, proposals that agencies will be considering include:

- Broadening the interpretation of the Employee Retirement Income Security Act (ERISA) to allow more employers to participate in **association health plans**
- Expanding coverage through **short-term limited duration insurance** by making these policies renewable and increasing the length of time people can be covered by these plans. Regulations adopted under the Obama administration reduced the maximum allowable period of coverage from 12 to 3 months
- Changing existing regulations on **health reimbursement arrangements** (HRAs) — also known as health reimbursement accounts — to increase the ability of employers to offer HRAs and allow them to be used with non-group coverage

Figure 5. **Percent of ACA marketplace enrollment by income level, Ohio and healthcare.gov states, 2017**



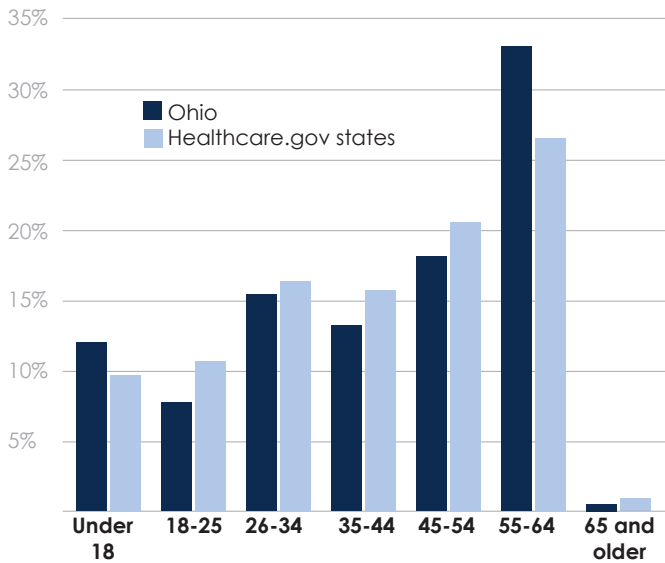
Source: Centers for Medicare and Medicaid Services, 2017 Marketplace Open Enrollment Period Public Use Files.

Until this presidential memorandum is interpreted by federal agencies and regulations are written and adopted, it is difficult to anticipate how it will impact Ohio’s health insurance marketplace. Some analysts think these proposals will change the makeup of ACA marketplace risk pools by offering younger and healthier consumers access to lower-cost plans that provide less comprehensive coverage.¹⁸ Consumers who elect to purchase ACA-compliant coverage may experience premium increases as risk pools become older and sicker.

ACA marketplace enrollment

Compared to others states that use healthcare.gov, fewer Ohioans are receiving APTC and CSR subsidies (see figure 4), due in part to expanded Medicaid eligibility. In states that did not accept federal funding to expand Medicaid eligibility, households with incomes between 100 percent and 138 percent FPL are eligible for subsidies to purchase insurance on the marketplace.

Figure 6. Percent of ACA marketplace enrollment by age, Ohio and healthcare.gov states, 2017



Source: Centers for Medicare and Medicaid Services, 2017 Marketplace Open Enrollment Period Public Use Files.

Ohioans with these incomes are enrolled in Medicaid if they meet other program eligibility criteria.

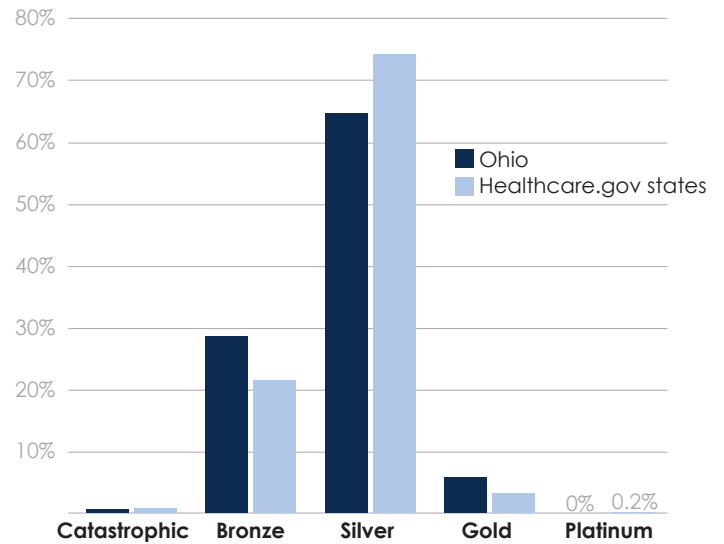
Expansion of Medicaid eligibility in Ohio may also explain why the proportion of Ohio marketplace enrollees with incomes between 100 and 150 percent FPL is 21.9 percentage points lower than the proportion for all healthcare.gov states (see figure 5).

Ohio's marketplace enrollment is similar to other healthcare.gov states in terms of age, with the notable exception of adults ages 55-64. One-third of Ohio's marketplace enrollees are aged 55-64, compared to about one-quarter of enrollees from other states (see figure 6).

Ohioans chose to enroll in bronze level plans at higher rates than other healthcare.gov states and in silver plans at lower rates (see figure 6). Lower enrollment in silver plans may be explained, in part, by lower levels of eligibility for CSR among Ohio marketplace enrollees. People must purchase a silver-level plan to be eligible for CSR.

Analysis of premium prices in Ohio's marketplace during 2017 reveals two issues that may have impacted marketplace enrollment. First, Ohioans were paying higher premiums after subsidies were applied than people in most other healthcare.gov states. This is counter intuitive

Figure 7. Percent of ACA marketplace enrollment by metal level, Ohio and healthcare.gov states, 2017



Source: Centers for Medicare and Medicaid Services, 2017 Marketplace Open Enrollment Period Public Use Files.

Figure 8. Range of average advance premium tax credit (APTC), by number of insurers per county

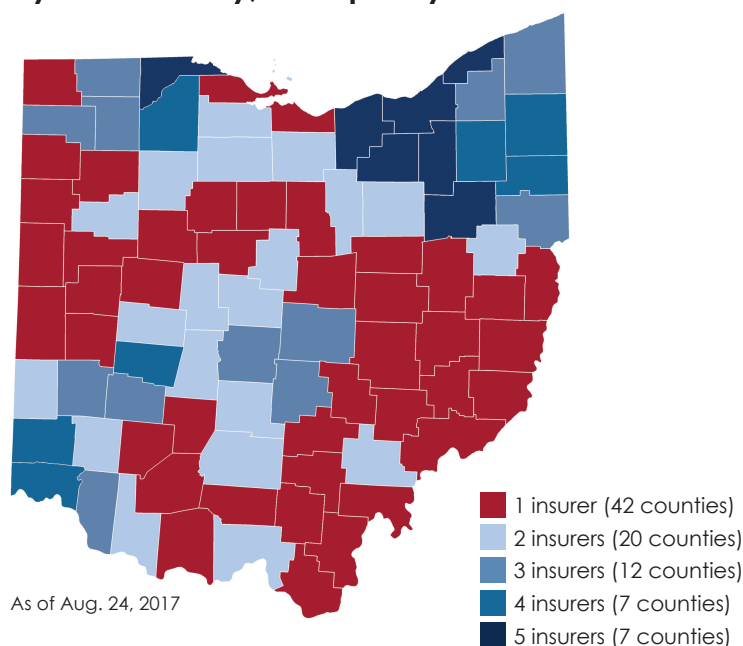
No. of insurers	Range of average APTC
1	\$317.89 – \$569.14
2	\$272.89 – \$478.76
3	\$224.79 – \$356.99
4	\$212.71 – \$280.51
5	\$198.25 – \$258.85
6	\$189.94 – \$237.31

Source: HPIO analysis of data from the Centers for Medicare and Medicaid Services

because unsubsidized premiums in Ohio were below average (see figure 2). Ohio's average monthly premium for bronze (\$162) and silver (\$164) level plans after applying APTC were 2nd and 3rd highest among healthcare.gov states, respectively. Second, the average APTC received by people in areas with greater insurer competition was lower than in counties with less competition (see figure 8).

As mentioned earlier in this brief, in some counties, individuals with incomes below 400 percent FPL were not eligible for tax credits because the second lowest cost silver plan in the county was considered to be affordable.

Figure 9. Number of ACA marketplace insurers by Ohio county, 2018 plan year



Source: Ohio Department of Insurance

Number of ACA marketplace plans offered

For the upcoming 2018 plan year, Ohio continues to see a reduction in the number of insurers that are offering plans in the ACA marketplace. General uncertainty in the marketplace is often cited by insurers that have chosen to withdraw from marketplaces before the 2018 plan year begins.

In 2016, Ohio ranked first among states using the federally facilitated marketplace in terms of the average number of insurers and qualified health plans (QHPs) per county, with an average of 81 QHPs and 10 insurers per county.¹⁹ In 2017, those averages dropped to 35 QHPs and less than 3 insurers per county.²⁰

According to ODI data, eight insurers have announced plans to sell health insurance products on the ACA marketplace in Ohio, compared to 11 in 2017 and 17 in 2016.²¹

The state also has seen an increase in the number of counties in which only one insurer is offering plans. In 2017, there were 20 counties in which only one insurer was offering plans.²² In 2018, 42 counties are expected to have one insurer (see Figure 9).²³

When Anthem announced earlier this year that it would no longer offer plans in Ohio's ACA marketplace, the state was left with 18 counties at risk of having no insurer in the marketplace.²⁴ However, by late August, other insurance companies agreed to offer plans in each of the effected counties.²⁵

Marketplace outreach

Ahead of the open enrollment period for the 2018 plan year, federal officials have announced several significant funding cuts that will impact efforts to enroll Ohioans in marketplace plans.

The ACA created a navigator program in which organizations are contracted to assist people with marketplace enrollment and conduct public education activities to raise awareness about the marketplace and also enroll eligible Ohioans in Medicaid. More information about navigator, certified application counselor and agent/brokers roles on Ohio's ACA marketplace is available on the [Ohio Department of Insurance website](#). The [Ohio legislature passed a law in 2013](#) that established a licensure process for Navigators and placed restrictions on some organizations from acting in this capacity. The legislation also established a training requirement for licensed insurance agents that wish to sell insurance on the marketplace.

In September 2017, the U.S. Department of Health and Human Services (HHS) announced that it was cutting funding for Ohio's largest navigator grantee by 71 percent from \$1.7 million in 2017 to \$485,967 in 2018.²⁶ Shortly after the announcement, the Ohio Association of Foodbanks, which has served as the lead organization overseeing a statewide navigator consortium since 2013, announced that it was withdrawing from the navigator program.²⁷

In August 2017, the Centers for Medicare and Medicaid Services announced cuts to ACA

advertising by 90 percent, from \$100 million in 2016 to about \$10 million for the 2018 open enrollment period.²⁸

Federal state innovation waivers

Section 1332 of the ACA enables the secretaries of HHS and Treasury to waive certain requirements related to the private health insurance market and the employer and individual mandates starting in 2017.²⁹ These waivers are often referred to as 1332 or state innovation waivers. Examples of what can be included in a 1332 waiver are changes to essential health benefits, premium and cost-sharing subsidies and individual or employer mandates. The approval period for the waiver is five years, with potential renewals.

In December 2015, the Obama administration issued [guidance regarding 1332 waivers](#). This guidance limits the flexibility of states by putting clear parameters around what the federal government is willing to approve. Federal law also requires the waiver to be neutral to the federal budget.

According to federal law, the waiver must³⁰:

- Provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver
- Provide coverage to a comparable number of residents of the state as would be provided coverage absent a waiver

The Trump administration issued a letter to governors in March 2017 encouraging states to apply for state innovation waivers, particularly for high-risk pools or state-operated reinsurance.³¹ In May 2017, the federal government issued a checklist for states to use in submitting state innovation waiver applications.

As of Oct. 24, 2017, nine states — Alaska, Minnesota, Iowa, California, Hawaii, Vermont, Oklahoma, Massachusetts and Oregon — had submitted waiver applications and Oregon, Alaska, Hawaii and Minnesota's waivers had been approved.³² Oklahoma, California and Iowa have withdrawn their applications and Massachusetts and Vermont were deemed incomplete by CMS.³³

Ohio law enacted in 2015 requires the director of ODI to apply for a state innovation waiver that includes a waiver of both the individual and employer mandates.³⁴ The law states that “the application

shall provide for the establishment of a system that provides access to affordable health insurance coverage” for Ohioans. House Bill 49, the state budget bill, signed into law June 30, 2017, included a provision requiring the application to be submitted no later than Jan. 31, 2018.³⁵

In June 2017, ODI issued a [request for proposals](#) for actuarial analysis and application for a 1332 state innovation waiver. The department contracted with the firm Oliver Wyman for this work.

A key deliverable for the contract is an analysis of the individual and group insurance markets. A report, anticipated to be released during Fall 2017 will include demographic, health status and spending data as well as descriptions of the current:

- Individual health insurance market, including both on and off the federal exchange
- Small group market, including grandfathered, transitional and ACA compliant plans
- Large group and self-insured markets including grandfathered plans

The analysis of the small, large and self-insured group markets is expected to include data on the number of employers not offering health insurance and the number of people “pushed to the individual market because their employer does not offer healthcare.”³⁶

A public comment and hearing process will take place prior to submission of the waiver application. Oliver Wyman will identify programmatic and financing options, as well as conduct an actuarial analysis.

Conclusion

The individual insurance market has been the focus of significant attention since the passage of the ACA in 2010.

Although the percentage of Ohioans who purchase health insurance coverage on the individual market has increased by two percentage points since 2013, enrollment in individual insurance plans remains low relative to other sources of coverage. However, federal policy changes, general uncertainty, reduced outreach resources and potential future federal and state policy changes may impact the availability, cost and quality of coverage for the more than 600,000 Ohioans who purchase coverage through the individual market.

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Notes

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