



Health Policy Brief

Ohio and the ACA

A closer look at health insurance marketplace premiums and enrollment

Introduction

The ACA was signed into law in March 2010, creating new health insurance options for Ohioans. The law created health insurance marketplaces for consumers to check eligibility, shop for, and purchase subsidized private health insurance coverage. It also provided increased federal funding for the expansion of Medicaid eligibility.

After two years of new private health insurance coverage options and eligibility under the ACA, Ohio's marketplace enrollment lags behind other states. As of June 2015, the state's enrollment represented only about 20% of the estimated potential market size for marketplace coverage.¹ Compared to all other states and the District of Columbia, Ohio ranks 47th in percent of estimated potential market enrolled.

After two open enrollment periods and with the third open enrollment period approaching (November 1, 2015 – January 31, 2016), questions around Ohio's low marketplace take-up rate remain. This publication takes a closer look at premium price, a contributing factor to enrollment trends, and examines the following questions:

- What is Ohio's take-up rate and how does it compare to other states?
- What is the impact of price on consumer enrollment?
- What are Ohio's average premium prices and how do they compare with other states?
- What factors contribute to premium prices?

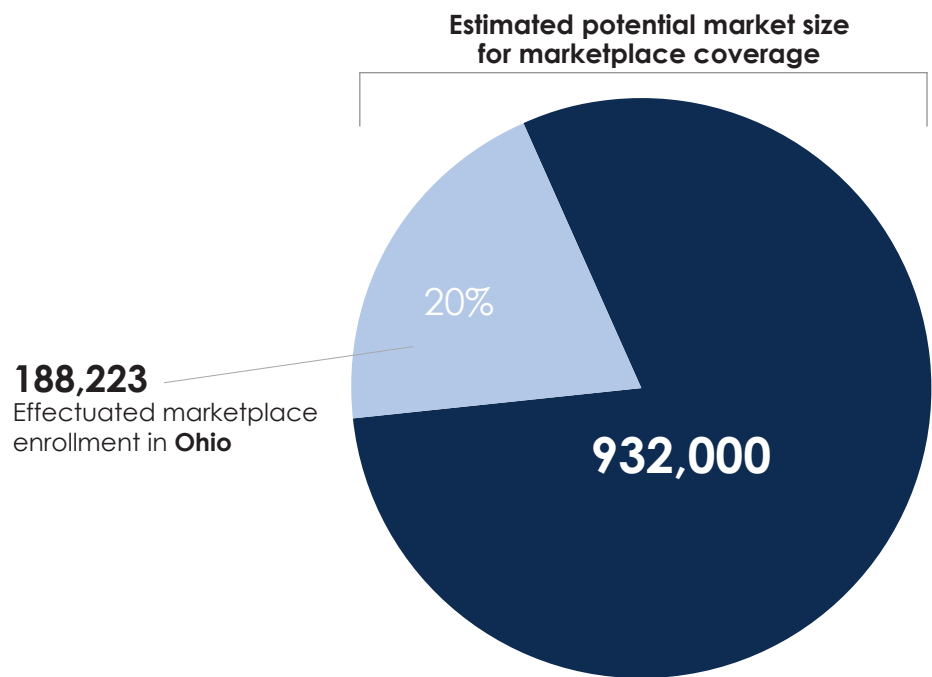
National landscape

The implementation of the ACA's health insurance reforms has varied among states with respect to marketplace structures and decisions on expansion of Medicaid eligibility. As of August 2015, there are 14 state-based marketplaces, 3 federally-supported marketplaces, 7 state-partnership marketplaces, and 27 federally-facilitated marketplaces (FFM). As a result of a 2012 Supreme Court ruling making the expansion of Medicaid optional rather than required, 31 states adopted Medicaid expansion as of August 2015.

Ohio landscape

As a federally-facilitated marketplace state, Ohio consumers use HealthCare.gov to purchase health insurance on the federal exchange. As a plan management partnership state, the Ohio Department of Insurance (ODI) performs

Figure 1. Ohio marketplace enrollment, as of June 2015



Source: Kaiser Family Foundation

Ohio at a Glance

- Federally-facilitated marketplace state (consumers use healthcare.gov)
- Implemented Medicaid expansion
- 16 insurers offering plans on the exchange for 2015 coverage
- Average premium price for a marketplace plan in Ohio in 2015 was \$389
- More than 234,000 Ohioans selected a marketplace plan in the second open enrollment period
- More than 621,000 Ohioans with Medicaid expansion coverage by August 2015

insurance regulatory functions, such as overseeing the certification of qualified health plans (QHPs). Additionally, ODI continues to collect and analyze information on plan rates, covered benefits, cost-sharing requirements, plan compliance, consumer complaints, technical assistance, and other related duties. However, the federal government has final authority to approve QHPs.

The first open enrollment period for coverage on the health insurance marketplace was October 1, 2013 to March 31, 2014. The second open enrollment period was November 15, 2014 to February 15, 2015, with a special enrollment period March 15 to April 30 for tax season.

Ohio is also a Medicaid expansion state. Medicaid coverage for people with incomes up to 138% of the federal poverty level began on January 1, 2014.

Ohio marketplace and Medicaid enrollment

Nationally, 11.7 million Americans selected plans through the Health Insurance Marketplace during the second open enrollment period for 2015 coverage. During that time frame, 234,341 Ohioans selected a marketplace plan.

On March 31, 2015, about 10.2 million consumers nationally had “effectuated” coverage, meaning individuals paid for coverage and had an active policy. Ohio’s effectuated enrollment was 188,223.

Ohio’s marketplace effectuated enrollment represents only about 20% of the estimated potential market size for marketplace coverage.² Compared to all other states and the District of Columbia, Ohio ranks 47th in percent of estimated potential market enrolled.³

While there are many factors to consider when comparing take-up rates, it is clear that enrollment in Ohio has occurred at a slower pace than similar states in the region. For example, Pennsylvania saw 48% and Michigan saw 43% of its eligible population enroll. Both of these states border Ohio in the Midwest, have similar population sizes and are federally-facilitated marketplace states that have implemented Medicaid expansion.

By August 2015, more than 621,000 Ohioans had coverage through the new Medicaid eligibility category (Group VIII).⁴ Medicaid expansion enrollment has significantly outpaced the administration’s estimates and has contributed to a decrease in the uninsured rate statewide.

Despite robust Medicaid expansion enrollment, there is a large portion of Ohio’s population that is still without insurance coverage. Analysis of take-up rates nationwide shows that states with Medicaid expansion did not have significantly lower marketplace enrollment than non-expansion states.

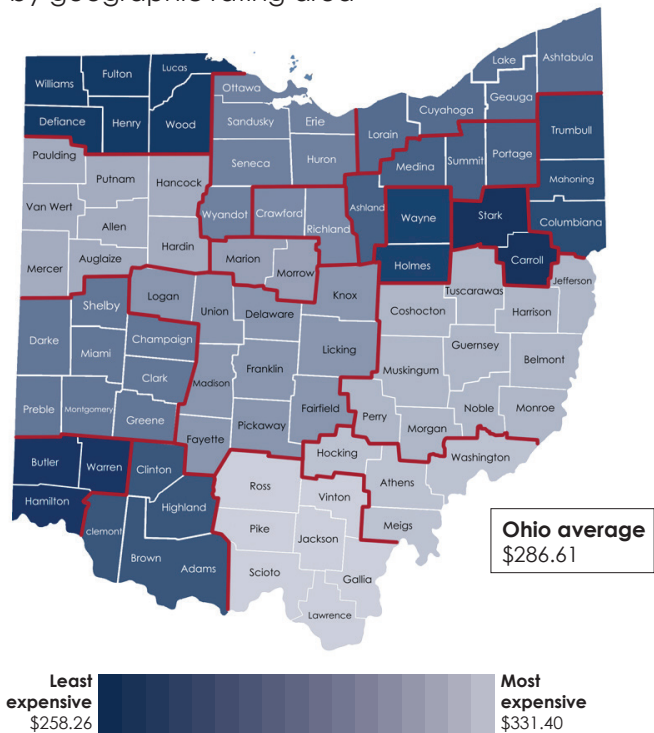
Impact of price on consumer enrollment

Analysis of the first and second health insurance marketplace open enrollment periods has shown that price is a significant factor in a consumer’s decision to purchase health insurance coverage. During the first and second enrollment periods, Ohio’s premium prices on the federally facilitated marketplace (FFM) were higher than the FFM state average both before and after the application of subsidies (see “Premiums” section below).

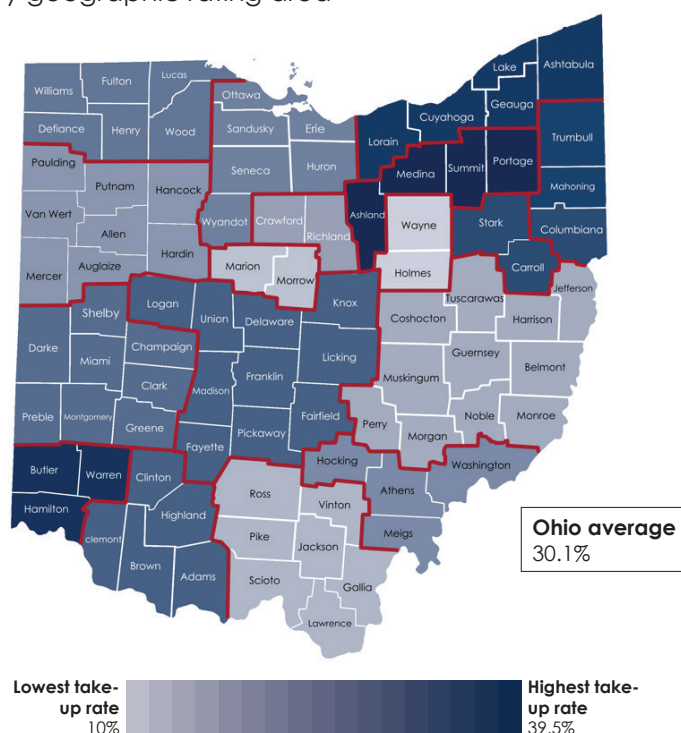
According to results from the Urban Institute’s Health Reform Monitoring Survey (HRMS), financial barriers were the most frequently cited reason that uninsured adults who visited the health insurance marketplace did not enroll. Unaffordable costs were mentioned by 58% of such respondents.⁵

Figure 2. Marketplace premium and take-up rates, by rating areas

Average premium for a 27 year old, 2015
by geographic rating area



Actual take-up rate, 2015
by geographic rating area



One potential explanation for this trend is that consumers are unaware of financial assistance options, such as premium tax credits or cost-sharing subsidies. However, the HRMS survey also found that unfamiliarity with financial assistance was not the main reason consumers found coverage unaffordable.

While consumer assistance and outreach, along with increased awareness of the availability of financial assistance, may encourage some uninsured consumers to enroll, evidence indicates that cost remains a deterrent to many.

Premiums

Prior to the 2014 implementation of the health insurance marketplace, the average monthly premium in Ohio's private individual insurance market was \$222, below the national average of \$235 and the 17th lowest in the country.⁶

During the 2015 open enrollment period, Ohio's average monthly premium on the exchange was \$389 across all age groups.⁷ Also, 24 of the 38 states using the HealthCare.gov enrollment platform had pre-subsidy premiums lower than those in Ohio.⁸

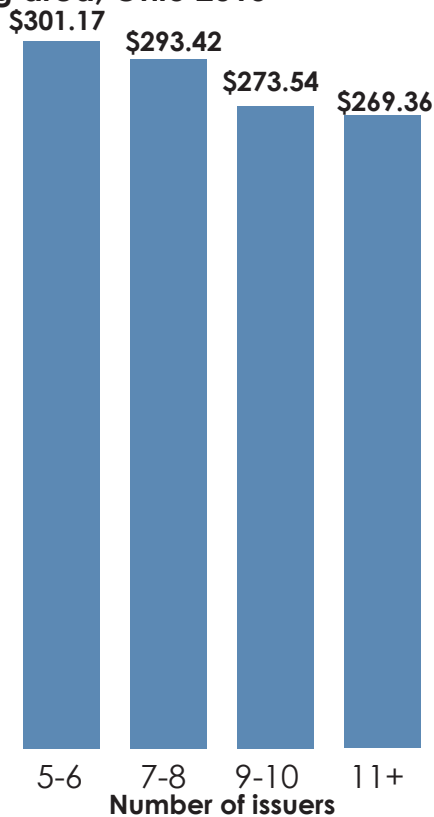
After the application of Advance Premium Tax Credit (APTC) subsidies, only one state, New Jersey, had higher average premiums than Ohio. Ohio's post-APTC average premium in 2015 was \$145, compared to an average of \$101 among all states using the HealthCare.gov platform.⁹ For an explanation of APTC, see "Tax credit" section on page 5.

Within Ohio, premiums varied across rating areas and counties. For a 27-year-old seeking insurance on the exchange during the second open enrollment period, the average pre-APTC premium varied from a high of \$335 in Hocking County to a low of \$249 in Hamilton County. Counties within rating areas tended to have similar average premiums; however, because not all plans are offered in all parts of a rating area, there was still variation among monthly premium averages by as much as \$35 within a rating area. For an explanation of rating areas, see box on page 6.

Factors affecting premium prices

Premium variance was associated with a number of factors across Ohio rating areas and counties, including the number of issuers, hospitals, and other providers in an area, and population density and demographics.

Figure 3. **Average monthly premium (27-year-old) by number of issuers in rating area, Ohio 2015¹⁰**



Number of issuers

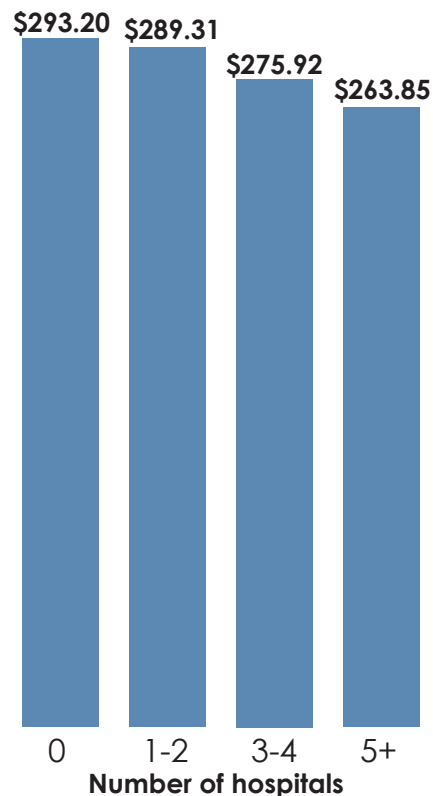
Areas with a higher number of issuers tended to have lower average premiums and higher take-up rates. Rating areas with eleven or more carriers had the lowest premiums, with an average premium of \$269 for a 27-year-old. Rating areas with only five or six issuers had the highest premiums, averaging \$301 (see Figure 3).

Provider presence

Counties with more hospitals had significantly lower premiums than those with few or no hospitals.¹¹ The twelve Ohio counties with no hospital had an average premium of \$293; counties with five or more hospitals had an average premium of \$264. Premiums in counties with only one or two hospitals looked similar to no-hospital counties, averaging \$289.

The ratio of residents-to-primary care physicians (PCP ratio) was also correlated with the average premium in an area. Areas with fewer primary care physicians per resident had higher average premiums overall. Lower numbers of hospitals and providers may be

Figure 4. **Average monthly premium (27-year-old) by number of hospitals in county, Ohio 2015¹²**



a factor driving up premiums in these areas because insurers have diminished negotiating power in rate setting discussions.

Population density and demographics

Across Ohio, counties with greater rural density (percent of population living in a rural area) had significantly higher premiums and lower take-up rates compared to more urban areas. Overall, 22.1% of Ohioans live in rural areas.¹³ Counties with lower than average rural density had average premiums of \$267, while counties with rural density twice the state rate or higher had average premiums of \$293. Appalachian counties had the highest premiums, averaging just over \$300.¹⁴ Rural areas in Ohio tend to have fewer providers and hospitals than more urban areas, which may contribute to higher premium levels, perhaps due to these providers and hospitals having greater bargaining power when negotiating reimbursement rates with insurers. Rural areas in Ohio also tend to have older populations and higher smoking rates, both factors that contribute to premium prices (see page 5).

Both rural and nonrural areas with higher rates of poverty also had higher average premiums. Because insurers can vary plan premiums based on an enrollee's age (See "Other factors in premium pricing" below), areas with older populations may have higher average premiums than areas with younger demographics.

Premium increases

Each year, insurers submit rate increase proposals to state or federal regulators for approval. Anticipated rate increases for 2016 exchange plans vary widely by state. Some states have experienced rate increase requests over 40%. States whose regulators actively negotiate participation and prices with insurers are likely to see smaller health insurance rate increases than other states, such as 4% in California.¹⁵

In Ohio, the Ohio Department of Insurance reviews rates proposed by insurers. Rate increase requests for 2016 varied from a low of approximately 3% to a high of 14.5%.¹⁶ While only two of the 16 carriers offering plans in the state requested double digit price increases, these carriers, Medical Mutual and Aetna, hold a significant market share across Ohio rating areas.¹⁷

Proposed rate increases apply to pre-subsidy premiums. As a result, consumers would see changes in their post-subsidy premiums, based on how subsidies are calculated and plan availability.

Other factors in premium pricing

Under the ACA, insurance companies can vary plan premium prices by only four factors¹⁸: tobacco use, geographic location (rating areas), enrollee age, and number of enrollees on plan (i.e. individual vs. family plan).

Tobacco surcharge

Under the ACA, insurers can charge tobacco users a surcharge that is up to 50% higher than the premium for a non-smoker purchasing the same plan. According to a 2014 study looking at 35 states and the District of Columbia, Ohio was one of only eight states with median tobacco surcharges at or above 25% for plans on the exchange.¹⁹

Some states have capped tobacco surcharges below the 50% federal allowance, decreasing

premium disparity. Six states and the District of Columbia prohibit tobacco surcharges altogether on individual plans and one state prohibits tobacco surcharges for marketplace coverage only.²⁰ Ohio does not prevent or limit insurers from applying the federal maximum allowable surcharge for tobacco use.

The cigarette smoking rate in Ohio is 23.4%, well above the national rate of 19.9%.²¹ As a result, Ohioans may experience higher effective premiums than consumers in other states with similar tobacco surcharge policies. High tobacco surcharges may deter enrollment and decrease access to cessation services.²² The ACA requires health plans to cover tobacco cessation services without cost sharing in most cases.

Rating areas

Ohio chose not use the default rating area structure proposed by the Centers for Medicare and Medicaid Services (CMS), instead structuring its rating areas based on county. This structure resulted in urban and rural counties grouped together into one rating area. Research on the first open enrollment period found that states with rating area structures that mixed urban and rural areas had higher average premiums than those structures using MSA+1 or Whole State design.²³ For more on rating areas, see page 6.

Other factors affecting cost

Tax credits

Advanced Premium Tax Credits (APTCs) are federal tax credits provided to eligible individuals and used to lower monthly premium costs. The amount of APTC available to an individual or family is based on their annual income compared to the Federal Poverty Level (FPL), with those with lower incomes qualifying for higher APTCs.

APTCs vary by rating area (see "What is a Rating Area" on page 6). The APTC for a rating area is calculated based on the second lowest cost silver plan (SLCSP) available during the given enrollment period.

While insurers must charge the same premium for a given plan within a rating area, they are not required to offer that plan in all parts of a rating area. Plan service areas can be zip code based, while APTCs are rating area based. Consequently, people in some parts of a rating

What is a rating area?

Rating areas are geographic regions defined by each state which all issuers must use for setting premium rates. Premiums for the same plan must be uniformly set within a rating area, but may vary from one rating area to another.²⁵ APTCs are also calculated and applied by rating area. However, insurers are not required to offer all plans in all parts of a rating area. Ohio's 88 counties were grouped into 17 rating areas.

What are the potential rating area designs?

MSA+1 – Groups each metropolitan statistical area (MSA) into its own rating area, and all non-metropolitan areas (or rural counties) in the state into a single rating area (+1). This is considered the default design. Proposals for other designs had to be submitted for CMS approval.

Individual counties – Each individual county is its own rating area.

Whole State – The entire state is considered one rating area.

Other methods – Some states created other rating structures, such as grouping three-digit ZIP codes or by dividing and grouping rating areas along county lines, as Ohio did.

area may have access only to higher premium plans, yet may not receive a tax credit sufficient to offset these higher premiums. This issue is more pronounced in rating areas with a mix of urban and rural segments (see Rating Areas section).

Additionally, if the SLCSP in an area is only slightly more expensive than other plans, such as bronze plans, then the subsidy will not go as far to reduce the out-of-pocket cost of plans. An analysis of Kaiser Family Foundation premium data showed that areas with bigger differences between the price of the average silver versus bronze plan had lower average post-subsidy premiums than those areas where silver and bronze plans were closer in price.²⁴

Deductibles

Areas with lower average premiums tended to have higher average deductibles. Although the monthly cost of these plans may be more affordable to consumers, HDHP can mean large out-of-pocket expenses for enrollees when they access health care.

Questions for future analysis

As the implementation of the ACA continues in Ohio, questions remain regarding the impact of premium prices on insurance status and plan selection over time. Take-up rate and premium price data from the first two open enrollment

periods provides some insight into these issues, but additional research is necessary. Questions for future analysis related to enrollment and health insurance marketplace premiums include:

- How does the health status of the population contribute to healthcare costs and premium rates charged by insurers?
- What can claims data tell us about how the marketplace population utilizes healthcare. How does this affect premium prices in the individual market?
- Will early evidence of pent-up demand for healthcare services stabilize over time and lead to smaller increases in premium rates over time?
- What impact do narrow networks have on premium costs and access to care?
- How will Ohio's premium rates change over time as the implementation of the ACA continues and insurers and providers learn more about the marketplace population?
- What role can state insurance departments play in reviewing premium rates and controlling health insurance costs for consumers?
- What strategies can state-level policymakers use to ensure access to affordable health insurance?
- How can competition in the health insurance market lead to lower premium prices?
- What effect will the expiration of the reinsurance and risk corridor programs have on premium prices in future years?

Authors

Sarah Bollig Dorn, HPIO Health Policy Assistant

Stephanie Gilligan, HPIO Director of Access and Coverage Policy

Amy Rohling McGee, HPIO President

Policy Implications

Evaluate how premium tax credits are calculated. Premium tax credits are based on the second-lowest cost silver plan (SLCSP) available to an individual or family through their state's marketplace. A closer analysis of this methodology, along with marketplace plan offerings, could identify whether an alternative methodology could make plans more affordable for consumers. For example, a relatively inexpensive SLCSP could result in lower average premium tax credits, offering less flexibility to consumers who may want to select a more expensive plan that includes local hospitals or providers or other needed benefits. SLCSP premium calculations could also result in too much variation in price and affordability across rating areas. Since premium tax credits are based on rating area and plan offerings can vary based on zip code, residents in certain areas may only be eligible for plans with higher premiums, yet may not receive a tax credit sufficient to offset the higher premium. Further analysis could help identify whether an alternative rating area structure or method of calculating APTC could lead to more affordable premiums for residents.

Study the impact of eliminating or lowering the tobacco surcharge in Ohio. High tobacco surcharges can put health insurance plans out of financial reach for consumers, reducing access to cessation services and treatment. Surcharges disproportionately affect low-income individuals, who are more likely to be tobacco users. Currently nine states and D.C. have reduced or prohibited tobacco surcharges.²⁶

Examine the rate review process in Ohio. The ACA requires review of "unreasonable increases in premiums."²⁷ However, there is wide variation in state laws and practices, and opportunities exist to increase transparency. A more rigorous review and standards for insurance plans could ensure affordable rates for consumers. Some states with policies establishing greater rate review authority saw lower premiums in their individual markets.²⁸ New Mexico, for example, is a federally-facilitated marketplace state that made news for rejecting large Blue Cross Blue Shield rate increases for 2016 after what was described as the "most comprehensive review" the state department of insurance had undertaken in the past five years.²⁹ Some states have also provided consumers with better methods

for providing feedback on proposed rates. Oregon, for example, has instituted a public comment period for rate filings, contracted with a consumer advocacy group to weigh in on rate filings on behalf of consumers, and initiated public hearings.³⁰ However, reviewers must balance use of the rate review process to hold down consumer costs with encouraging insurer participation and competition in the marketplace.

Assess ways to integrate delivery system reform with affordable coverage. Increases in premium prices may be linked in part to increases in the cost of care. Therefore, opportunities may exist for state policymakers and other stakeholders to incorporate policy work on affordable coverage with broader strategies to address the rising costs of health care and delivery system reform. For example, testing new models of health care delivery and shifting from a volume-based payment system in healthcare to a value-based system may improve the affordability of insurance coverage if healthcare cost savings are passed on to the consumer. For more, see HPIO's **Paying for value over volume through payment reform** fact sheet.

Ensure adequate access to enrollment assistance. The ACA requires that consumers have access to assistance in understanding the options for healthcare coverage and on enrollment in the marketplace. Assistors can help consumers pick a plan that's most affordable and meets the healthcare needs of their family. Evidence from the first two open enrollment periods show that consumers want help in navigating the exchange and most would like to get help in-person.³¹ The Urban Institute found that consumers who gained coverage were more likely to have used direct assistance (in-person or call center) and less likely to seek information online than those who remained uninsured.³² Increased consumer assistance is especially important in rural areas and other regions of low enrollment, as these are often areas with high rates of uninsured residents. As a federally-facilitated state marketplace, Ohio received less federal funding for consumer assistance. However, opportunities exist for state policymakers to explore other sources of funding for consumer outreach and enrollment activities and platforms for sharing enrollment information and raising awareness of healthcare coverage options among consumers.

Notes

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