

healthpolicybrief



A closer look at the impact of federal reform on Ohio insurance markets

Introduction

The Ohio Department of Insurance recently posted a report analyzing the impact of national health reform – specifically the Affordable Care Act (ACA) – on Ohio's consumers, businesses and insurance market.

Prepared by Milliman, Inc., “**Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange,**” was commissioned to assist Ohio officials in planning for the design and implementation of a federally mandated American Health Benefit Exchange. The report focuses on ACA changes regarding overall issuance of health insurance coverage, covered benefits, premium rating and underwriting, carrier regulation, as well as the expansion of Medicaid. Specifically, the report considers the key questions of:

- “**To what extent are current markets going to be impacted?**”
- “**What will the Ohio insurance market look like in 2014 and beyond?**”¹

As the report notes, it is important to keep in mind that exact impacts cannot be known. Further, projections in the report may change as new information becomes available and final rules are promulgated. Nevertheless, taken as a whole, the report provides a detailed look at how Ohio's insurance market may look in 2014, when most of the ACA changes will be implemented, and in 2017, a “mature year.”²

Select key findings

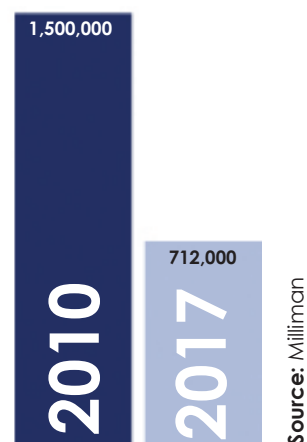
Nearly 800,000 currently uninsured Ohioans may gain health coverage by 2017, although the number could range from a low of 500,000 to a high of one million.³ This represents a 53% drop in uninsured from nearly 1.5 million in 2010 to 712,000. By comparison, some national studies estimate the number of uninsured Americans may drop by 56%⁴ or as much as 78%⁵; and at least one national study estimates Ohio's uninsured population will drop by 65%.⁶ The actual number of uninsured who gain coverage will depend upon a range of factors such as the effectiveness and aggressiveness of outreach and enrollment efforts and individual response to the individual mandate.

About 35% of the uninsured will gain coverage through the individual health insurance market and about 62% will gain coverage through Medicaid.⁷

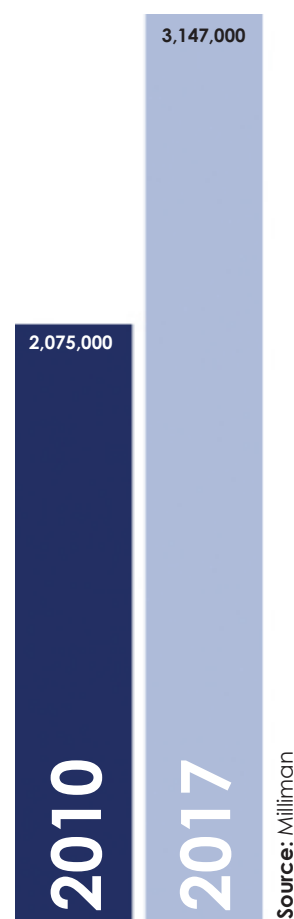
This is because the population with incomes up to 138% of the Federal Poverty Level (FPL) – the new Medicaid eligibility level starting in 2014 – has both the highest uninsured rate and the lowest rate of employer-sponsored coverage.⁸

The uninsured with the lowest incomes are expected to have the highest insurance take-up rates, due to the Medicaid expansion and availability of premium and cost-sharing subsidies through the exchange. Insurance take-up rates are projected to decrease as household income increases.⁹

Projected Ohio uninsured rate



Projected enrollment in Ohio Medicaid



All markets will experience significant change starting in 2014. However, the individual health insurance market, Medicaid, and uninsured markets will experience the greatest impact.¹⁰

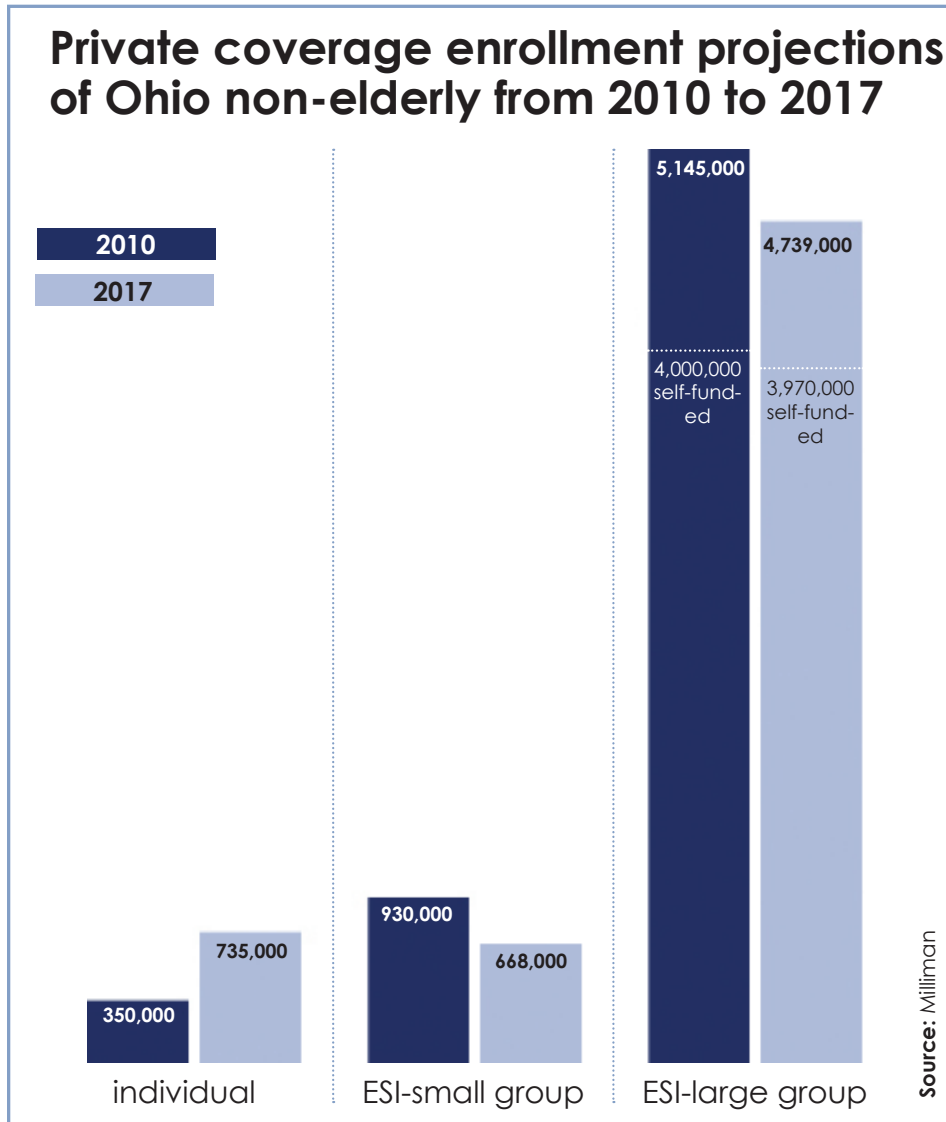
By 2017, the individual health insurance market may more than double in size to 735,000, adding 385,000. Much of this growth will come from the currently uninsured (289,000) who will enroll due to the individual mandate, guaranteed issue, and federal premium subsidies and cost-sharing subsidies.¹¹ In addition, a sizable portion is projected to be individuals who were previously enrolled in ESI coverage which will either be terminated or determined not to meet minimum requirements of covered benefits or affordability. Many of these will come from small employers that do not face a tax penalty for dropping or not offering coverage, generally offer lower benefit levels, and often require higher employee premium contributions.¹²

Because premium and cost-sharing subsidies are only available through the exchange, 71% of those in the individual health insurance market are expected to enroll through the exchange; 29% will enroll outside the exchange.¹³

By 2017, enrollment in Ohio Medicaid may grow by over one million.¹⁴ This is primarily driven by the ACA provision that expands Medicaid to all U.S. citizens or qualified legal aliens who are not eligible for Medicare, are under 65, and whose household incomes are up to 138% FPL.

Forty-seven percent of the new enrollment in Medicaid will come from the uninsured population; 45% will come from the ESI market; and the balance from the individual market.¹⁵ As noted earlier, actual enrollment will depend upon the effectiveness and aggressiveness of outreach and enrollment efforts.

The federal government will pay 100% of the cost of those newly eligible for Medicaid for the years 2014-2016. The federal share will then decrease annually and level off at 90% in 2020 and beyond. It is estimated that 69% of those who enroll in Medicaid in 2014 and beyond will be newly eligible.¹⁶ Others who are currently eligible but not enrolled in



Medicaid also will enroll after 2014 due to increased awareness regarding their eligibility and the ACA requirement that all have health insurance. The standard federal match rate will apply to these individuals, estimated to be 31% of new Medicaid enrollees.

The majority of non-elderly Ohioans will continue to be covered through employer-sponsored insurance (ESI). However, the rate of ESI coverage is projected to drop from the current rate of nearly 61% to 54% in 2017,¹⁷ continuing the trend of ESI erosion in Ohio dating back to at least 2003/2004.¹⁸

The enrollment estimates across insurance markets reflect a scenario in which Ohio does not implement the Basic Health Plan (BHP) option. The report estimates that if Ohio chooses to implement a BHP, exchange enrollment may drop by 30-40%.¹⁹ This is due to the ACA provision that individuals eligible for the BHP cannot join the exchange and receive subsidies.

Rates

The ACA impact on premium rates will be shaped by changes in covered benefits, rating rules, carrier regulations and issuing of health insurance in the ESI and individual markets. The study provides estimated overall premium rate impact in the individual, ESI-small group, and ESI-large group markets. Overall, the report projects **greater premium increases in the individual insurance market and more limited increases in the ESI-small group and ESI-large group markets**, due to several factors, including²⁰:

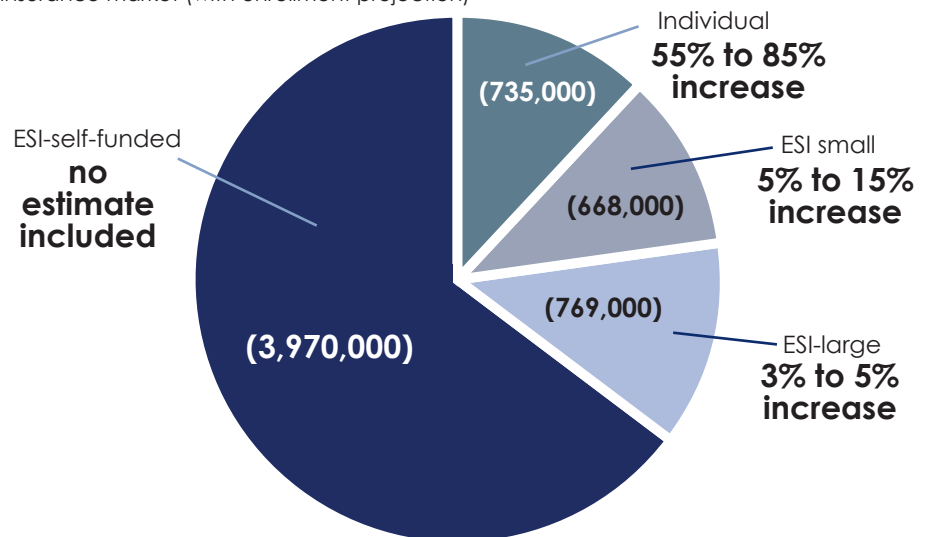
- **Covered benefit requirements:** Generally, the individual market will have to do more to meet the minimum essential benefits requirements, relative to the ESI markets. As a result, average benefit coverage levels in the individual market will be comparable to the small group market. This, combined with premium and cost-sharing subsidies, may help the rising number of Americans who are underinsured—people who have health insurance but have plans with inadequate coverage that leave them exposed to unaffordable medical costs.²¹
- **Higher levels of coverage:** The combination of premium subsidies and adjusted community rating may allow individuals with pre-existing conditions and chronic illnesses to purchase a higher level of coverage than in the current health insurance market.
- **Greater health needs:** Those enrolling in the individual market are projected to have greater health needs compared to the current health insurance populations.

Those last two factors, as well as the possibility that employers with lower-than-average health care costs may choose to self-insure rather than subsidize less healthy groups in the risk pool, raise the risk of adverse selection.

The individual health insurance market premiums are estimated to increase by 55% to 85% above current market average rates,²² excluding the impact of medical inflation. Covered benefit requirements will account for between 20 – 30% of this rate increase.²³ It is important to understand that rate changes for particular individuals will vary significantly within the market. Males under age 35 in good health are likely

Projected private insurance premium increases by 2017*

by insurance market (with enrollment projection)



*excludes impacts of anticipated healthcare inflation. Individual premium projection excludes tax credit subsidies

Source: Milliman

to experience the largest increases; individuals with chronic illnesses or pre-existing conditions may have premium decreases relative to their current available coverage.²⁴ Comparing markets, premiums in the individual market are estimated to exceed premiums in the ESI-small group market by 8 to 12%, post-reform.²⁵

The estimated rate increases do not take into account premium subsidies or cost-sharing subsidies for those who meet income requirements. While the average total premium for those in the individual market may increase, the out-of-pocket cost for households eligible for the subsidies may decrease relative to today's market.²⁶

The ESI-small group market premiums are estimated to increase by 5% to 15% above current market average rates, and the ESI-large group market premiums by 3% to 5%, excluding the impact of medical inflation. The rate impact in ESI markets is less than in the individual market because of the minimal expansion of covered benefits and fewer changes to the risk pool.²⁷

When reviewing the rate impact by market, it is important to keep in mind the relative size of each market. While the individual market will experience the largest rate increase, it represents a small share of the market — 11% of privately insured, non-elderly Ohioans in 2017. The ESI small group market will be about 10%; the ESI large group market will be 12%; and the ESI self-funded will be 58%. (See graphic above.)

Premium and cost-sharing subsidies will drive enrollment in the exchange. In order to assure affordability, the ACA includes two types of subsidies,

each available only through the exchange:

- **Premium subsidies**, to offset the cost of insurance premiums, for consumers with incomes between 139% FPL and 400% FPL. Available as tax credits, the subsidies cap a household's premium contribution at a percentage of their household income, ranging from just over 3% for households with incomes at 139% FPL, to 9.5% for households with incomes at 300% - 400% FPL.²⁸ The report projects that "for households with incomes at 250% FPL or less, the required premium contribution in the exchange for family coverage may be less than the current typical employer plan contribution. However, for households with incomes above 250% FPL, a family's premium cost in the exchange will be greater than the average employer plan, assuming ESI is available."²⁹ Because the plans will vary according to the benefit tiers within the exchange, premiums paid by families will vary by benefit tier.
- **Cost-sharing subsidies**, to offset cost-sharing such as deductibles, copays, and coinsurance, for consumers with incomes up to 250% FPL. To receive the cost-sharing subsidy, consumers must purchase a plan in the silver level (the second lowest tier).³⁰ Silver level plans have an actuarial value of 70%, meaning that for a standard population, the plan will pay 70% of their health care expenses, while the enrollees themselves will pay 30% through cost-sharing. The cost-sharing subsidies increase the actuarial value of the silver plan to 94% for those with incomes up to 150% FPL; to 87% for those with incomes between 151-200% FPL; and to 73% for those with incomes between 201-250% FPL.³¹

Premium and cost-sharing subsidies are only available in the exchange. As a result, the report projects that 95% of individuals with household incomes between 139% and 200% FPL purchasing insurance in the individual market will purchase coverage through the exchange; this percentage will decrease slightly for those with incomes between 200-400% FPL. The report estimates significantly lower exchange enrollment for individuals with household income over 400% FPL due to the lack of subsidies.³²

As noted previously, 71% of the individual market is expected to enroll through the exchange and 29% outside the exchange.³³

Adverse selection

A key concern regarding exchanges is the potential for adverse selection, which occurs when less healthy people disproportionately enroll in a risk pool, leading to the possibility of unsustainability and failure. The report outlines four sources of adverse selection which Ohio should consider in the establishment and operation of an exchange:³³

2011 Federal Poverty Guidelines

(by household size)

	100%	138%	200%	250%	400%
1	\$10,890	\$15,028	\$21,780	\$27,225	\$43,560
2	\$14,710	\$20,230	\$29,420	\$36,775	\$58,840
3	\$18,530	\$25,571	\$37,060	\$46,325	\$74,120
4	\$22,350	\$30,843	\$44,700	\$55,875	\$89,400

Note: Annual guidelines for all states except Alaska, Hawaii and DC

source: Federal Register, Vol. 76, No. 13, January 20, 2011, pp. 3637-363

- **Individual enrollment:** Adverse selection related to enrollment occurs when individuals defer the purchase of insurance until it is needed.
- **Inside versus outside the exchange:** If there is large variation in rules outside the exchange versus inside the exchange, the market outside the exchange may have more flexibility to meet consumer needs. As a result, it may attract a larger share of those not eligible for subsidies and raise the risk for adverse selection.
- **Among health benefit plans and carriers within an exchange:** Individuals' income and health status likely will drive their choice of plans. Those with known health conditions are more likely to purchase plans with richer benefit coverage and could lead to adverse selection.
- **Insured versus self-funded plans:** As of 2014, health status rating will no longer be allowed. As a result, ESI-small groups with healthier populations may choose to self-insure rather than subsidize less healthy groups in the risk pool.

The ACA includes provisions aimed at minimizing adverse selection but these will not eliminate the possibility that it could still occur. (For example, see HPIO's Health Policy Brief, "Federal Rules for Establishing Health Insurance Exchanges," for proposed ACA rules on reinsurance, risk corridor and risk adjustment programs.) The report includes a number of additional policies that Ohio could consider in order to guard against adverse selection.³⁴

Viewing the Milliman report

The Ohio Department of Insurance has posted the Milliman report online at: <http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf>

Conclusion

This brief highlights just some of the key findings of the report. It is important that stakeholders review the entire report in order to understand the range of possible impacts the ACA will have on insurance markets in Ohio. And, as noted earlier, projections in the report may change as new information becomes available and final rules are promulgated.

As with other health policy issues, it is likely that people with differing perspectives will draw different conclusions. For example, some are concerned that the projected rate increases in the individual market are unsustainable. Others may conclude that on balance, the changes in the individual market will benefit consumers because they will gain more comprehensive benefits. Some see a sizable Medicaid expansion of Medicaid as an unsustainable mandate on states, while others see a sizable Medicaid expansion as an effective way to reduce uncompensated care and cost shifting.

Regardless of these differing perspectives, it is clear that the final impact on Ohio's insurance markets will depend upon both the ACA provisions themselves as well as the leadership, collaboration and key decisions that Ohio leaders and stakeholders pursue.

Notes

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3. Ibid., 6.
4. Buettgens, Matthew, Garrett, Bowen, and Holahan, John. December 2010. "America Under the Affordable Care Act." Accessed October 14, 2011. <http://www.rwjf.org/files/research/71555.pdf>.
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7. Milliman Client Report, 27. Additional calculations by Health Policy Institute of Ohio.
8. Ibid., 12.
9. Ibid., 29.
10. Ibid., 27.
11. Ibid.
12. Ibid.
13. Ibid. Additional calculations by Health Policy Institute of Ohio.
14. Ibid., 27.
15. Ibid. Additional calculations by Health Policy Institute of Ohio.
16. Governor's Office of Health Transformation press release. April 1, 2011. Accessed September 23, 2011. <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=dNq8RKQkLU%3D&tabid=40>.
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18. "Key Findings, 2010 Ohio Employer Health Survey." Ohio Colleges of Medicine, Government Resource Center. Accessed October 3, 2011. <http://ckm.osu.edu/sitetool/sites/ofhspublic/documents/keyfindings2010.pdf>.
19. Milliman Client Report, 48.
20. Milliman Client Report, 34-36. For a fuller discussion of factors impacting rates, see 34-42.
21. Schoen, Cathy, Doty, Michelle M., Robertson, Ruth H., and Collins, Sara R. "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent", Health Affairs, Sept. 2011 30 (9):1762-71. Access to full article: <http://content.healthaffairs.org/cgi/content/full/30/9/1762?ikey=hEO2tU8XwgcZ6&keytype=ref&siteid=healthaff>.
22. Milliman Client Report, 34.
23. Ibid., 35.
24. Ibid., 41.
25. Ibid., 34.
26. Ibid., 37.
27. Ibid.
28. Patient Protection and Affordable Care Act, section 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan. Available at <http://docs.house.gov/energycommerce/ppacacon.pdf>.
29. Milliman Client Report, 43.
30. Patient Protection and Affordable Care Act, section 1402. Reduced cost-sharing for individuals enrolling in qualified health plans. Available at <http://docs.house.gov/energycommerce/ppacacon.pdf>.
31. Ibid.
32. Milliman Client Report, 28.
33. Ibid., 29. Additional calculations by Health Policy Institute of Ohio.
34. Ibid., 63 – 66.
35. Ibid.

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Glossary

Affordable Care Act (ACA) – The federal health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Adverse Selection – People with a higher-than-average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Adjusted Community Rating – A rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders. Under health reform, beginning in 2014, health plans will be required to adopt adjusted community rating. Variations in premiums will only be allowed for differences in geography, family structure, age (limited to a 3 to 1 ratio) and tobacco use (limited to a 1.5 to 1 ratio).

American Health Benefit Exchange – Established in the ACA, to facilitate the purchase and sale of qualified health plans in the individual market in states. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education, and assist individuals with access to programs, premium assistance and cost-sharing reductions.

Basic Health Plan (BHP) – An ACA provision which permits states (effective January 1, 2014) to offer a BHP to certain uninsured individuals in lieu of those individuals' receiving federal subsidies to purchase health insurance through an exchange. To be eligible, individuals must: not be eligible for Medicaid or Medicare; and have income between 138% and 200% FPL for U.S. citizens, or below 133% for legal aliens.

Co-Insurance – A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Co-Payment – A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Deductible – A set amount of medical expenses a patient must pay before being eligible for benefits under an insurance program.

Essential Benefits/covered benefits – As specified in the ACA, plans in the health insurance exchange are required to offer coverage for "essential benefits" that must include: emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services (including pediatric oral and vision care).

Federal Poverty Level (FPL) – Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2011, the FPL for a family of four is \$22,350 (see chart on page 4).

Individual Mandate – The requirement that all individuals must obtain health care insurance or pay a penalty. The individual mandate will be in place by 2014, although some exceptions do apply (financial hardship, religious reasons). The penalty, in the form of a tax, will be \$95 per individual or up to 1% taxable income in 2014, whichever is lower. It increases to \$325 or up to 2% taxable income in 2015 and \$695 or up to 3% taxable income in 2016.

Individual health market – Health insurance coverage on an individual, not group, basis. The premium is usually higher for an individual health insurance plan than for a group policy.

Medicaid – A federally-aided, state-administered and jointly-funded health insurance program that provides medical benefits to qualified indigent or low-income persons in need of health and medical care. The program is subject to broad federal guidelines and states determine the benefits covered and methods of administration.

Pre-Existing Condition – A medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company.

Underinsured – People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

for a complete health policy glossary, visit
www.hpio.net/glossary





about hpio

The Health Policy Institute of Ohio is a 501(c)3 nonprofit organization that serves as Ohio's nonpartisan, independent source for forecasting health trends, analyzing key health issues, and communicating current research to policymakers, state agencies and other decision-makers.

HPIO informs health policy development through four strategic objectives:

- Achieving and Maintaining Health and Wellness for all Ohioans
- Ensuring Access to Care for all Ohioans
- Developing Tools for Improved Ohio Health System Data Transparency
- Aligning Public and Private Payments with Health Quality Outcomes

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