## Health Insurance Marketplaces: Issuer Participation and Premium Trends in Rural Places, 2018

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### Purpose

Since 2014, when the Health Insurance Marketplaces (HIMs) authorized by the Patient Protection and Affordable Care Act (PPACA) were implemented, considerable premium changes have been observed in the marketplaces across the 50 states and the District of Columbia. This policy brief assesses the changes in average HIM plan premiums from 2014 to 2018, before accounting for subsidies, with an emphasis on the widening variation across rural and urban places, providing information during Congressional debates on the future of the program.

### Key Findings

- Insurance issuers reduced HIM participation across both rural and urban places (with 1.7 and 2.2 issuers, respectively), both in states that expanded Medicaid under the PPACA and in non-expansion states.
- The average adjusted premium (before premium subsidy) continues to rise across all of the above categories, and the gap has widened between the 32 Medicaid expansion and 19 non-expansion states. Average premiums in rural counties are higher than average premiums in urban counties in both expansion and non-expansion states (by $43 per month and $27 per month, respectively).
- Prior trends of lower premium changes at greater population densities are no longer observed in the 2018 data.
- In 2018, 1,581 counties (52 perent) have one participating insurance issuer. Nationwide, 42 percent of all urban counties and 55 percent of all rural counties only have one issuer.

### Introduction

HIMs are in their fifth year, operating in a political environment that challenges their structure and viability, making their future uncertain. We analyzed data describing issuer participation and premiums charged at the county level across the United States from 2014-18 and investigated trends to understand the impact of the uncertain political environment, and to suggest policies that may improve options for rural consumers in the individual marketplace.

> **Analysis of published premiums, even with our adjustments, is only one element of an analysis of affordability. Individual and family eligibility for subsidies and cost-sharing reductions will significantly impact whether potential HIM consumers find plans affordable. Median incomes in rural counties average $41,240, compared to $48,124 in urban counties, meaning that higher subsidies are available to rural consumers.**

## Methods

We analyzed data for all insurance plans in states operating either Federally Facilitated Marketplaces (FFMs) (including Partnership Marketplaces [PMs]) or State-Based Marketplaces (SBMs) in 2018. Data on FFMs and PMs and on SBMs operating with federal support[1] are from comprehensive county-level files available from the Centers for Medicare & Medicaid Services.[2] Data on available plans from the remaining 13 SBMs were obtained from state insurance commissions and from shopping states' online consumer portals. All monthly premiums reported here are for 27-year-old individuals (the standard reported by the federal government for FFMs) who do not use tobacco; premiums typically increase by age and by tobacco use status. We created an overall average premium for each county by normalizing all other metal levels of coverage to an equivalent cost for a silver plan, using the "actuarial value" corresponding to each metal level, and we performed cost-of-living adjustments.[3]

When comparing urban and rural areas, we used county-level averages, defining urban and rural by the standard Urban Influence Code definitions.[4] In some comparisons, we zoomed out to the rating-area level, which can be as small as a single county or as large as a small state. Many rating areas are a contiguous mixture of metropolitan, micropolitan, and non-core counties, making it difficult to systematically characterize them as rural or urban. In the rating-area level analysis, we used population density as a measure of population dispersion that could be related to decisions to set premiums, and also as a proxy indicator of ruralness of the rating area.

## Results

Using methods the RUPRI Center has used in previous analyses,[3] we report growth of average second-lowest silver plan premiums – because this is the anchor that determines the size of subsidies – at various rating area population densities. Figure 1 shows that from 2014-2017, premium growth tended to be lower in rating areas with greater population density (persons per square mile of land area). We previously explained this trend as a result, in part, of reduced competition in rural areas, which in turn comes from smaller risk pools and more risk to an issuer of outlier claims. However, the 2017-2018 data depart from this trend, showing increases of 33 percent and higher across all categories.



Figure 1. Second-Lowest Silver Adjusted Premium Increases, by Population Density of Rating Area
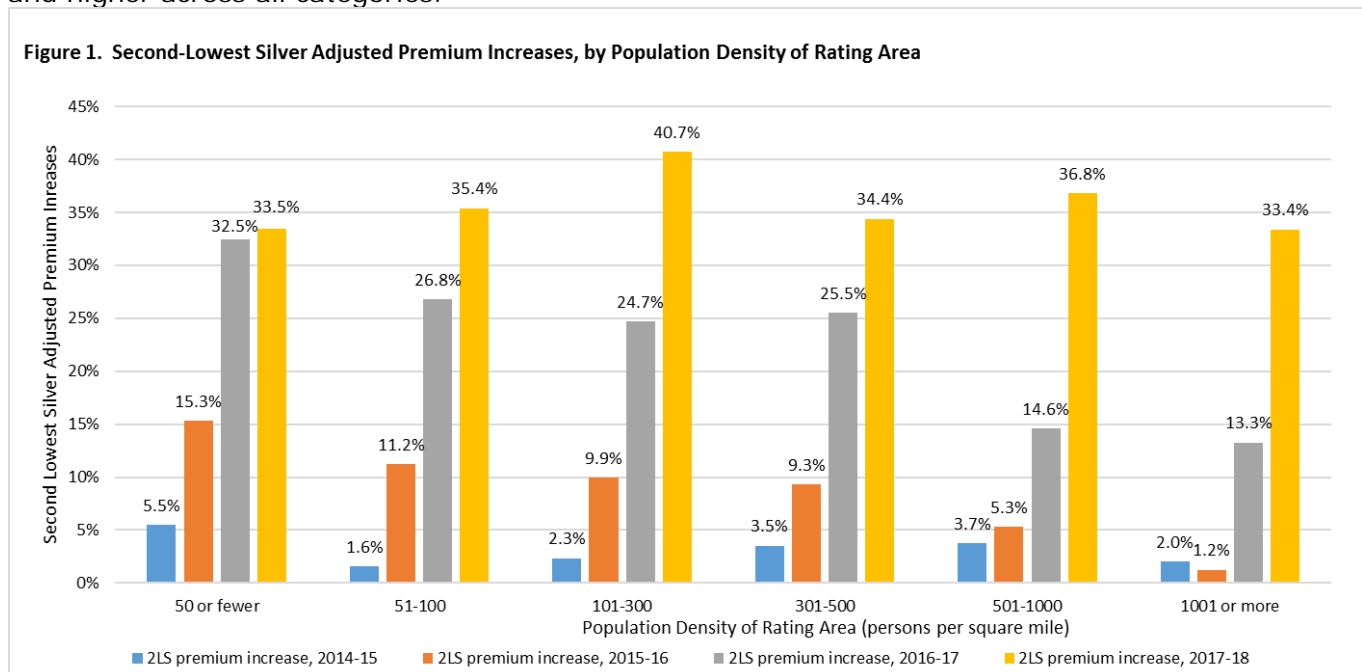
Previous RUPRI research suggests that at least three firms in an insurance market are needed to create a competitive environment that will in turn hold premiums down.[5] In addition to our findings on premium increases, we also found that some issuers dropped out of HIMs or reduced their service areas in 2018 across both Medicaid expansion states and non-Medicaid expansion states. Lower firm participation in non-expansion states has been observed each year. In 2018, 65 percent

of rural counties in non-expansion states have just one participating firm, compared to 43 percent of rural counties in expansion states (Figure 2). Overall in 2018, expansion states average 2.3 participating firms, compared to 1.5 in non-expansion states, while urban counties average of 2.2 issuers participating, compared to 1.7 in rural counties (not shown in figure). However, the urban/rural differential is greater among counties in expansion states.

Rural and urban counties without Medicaid expansion had higher monthly premiums (in general) than rural and urban places with Medicaid expansion. Average adjusted premiums were approximately $55 higher (12.5 percent) in rural areas of non-expansion states than in expansion states and approximately $70 higher (15 percent) in urban areas (Figure 3). Gaps have widened significantly since 2014.

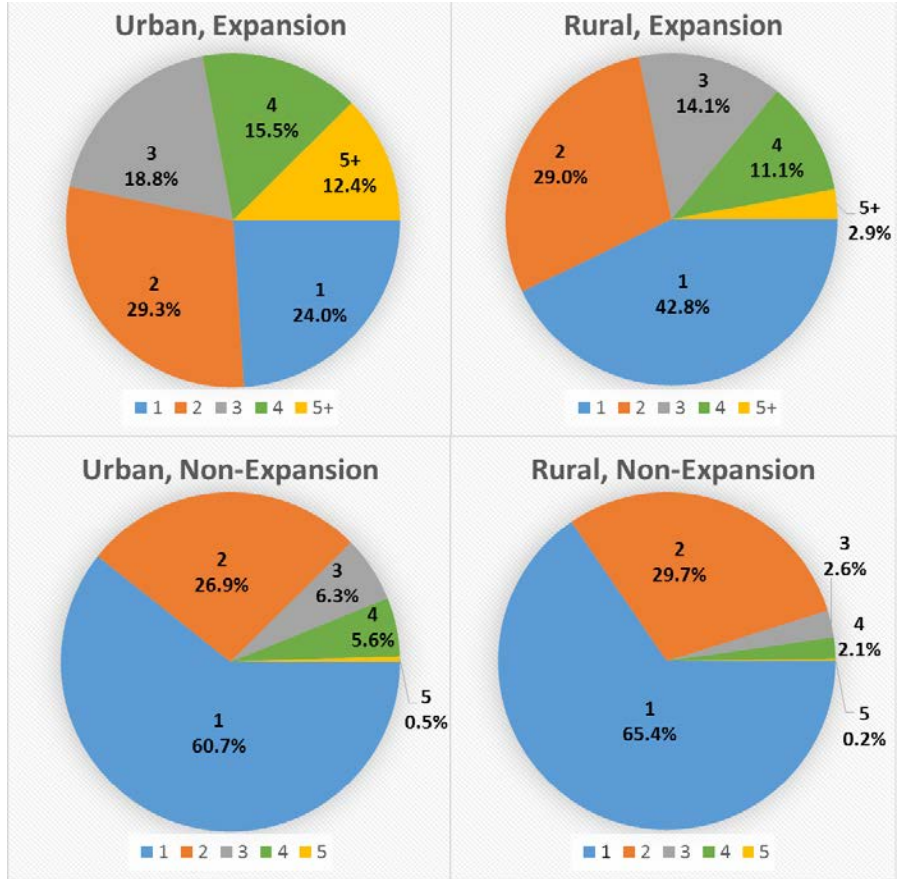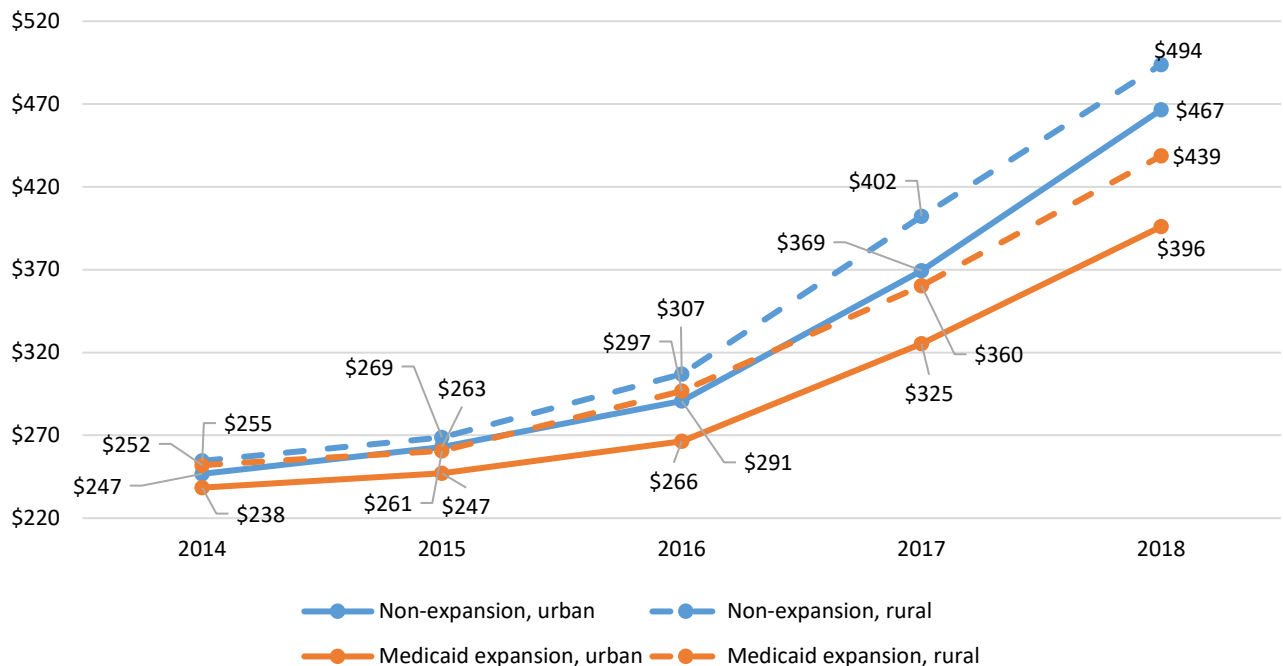**Figure 2. Distribution of Insurance Issuers by Percentage of Counties, Rurality, and Medicaid Expansion**



**Figure 3. Rural and Urban Average Adjusted Premiums, 2014-2018, by Medicaid Expansion Status**

## Discussion

This brief examines 2018 HIM premium increases in both urban and rural areas in the context of prior data and relevant economic theory. As in past years, average firm participation is lower in rural places while average adjusted premiums are higher, again suggesting that for the individual insurance market to work well for rural populations, some policy changes are needed. Very high premium increases – no longer inversely related to rating area population density – may reflect the decision to end Federal cost-sharing reduction (CSR) payments. Many issuers anticipated that CSR payments might not continue, even though their legal obligation to provide CSR plans remains, so they factored their anticipated loss into their 2018 premiums.[6] Since the cost of such an adjustment is proportional to the population being covered, it is reasonable to expect that these costs would be uniformly distributed across population density categories and may have simply dominated the expected population density effect. If this is the case, i.e., that these results reflect a response to a one-time policy change, then in the future we may see a return to the prior trends. If not, policymakers may need to reconsider how to ensure that the individual market functions for rural consumers. Overall premium levels seem sensitive to the number of firms and to the need for three or more firms to ensure competition. However, in most rural areas, only one or two issuers are offering marketplace plans, a situation that also commonly occurs in Medicare Advantage and the Federal Employees Health Benefit Program. Thus, if choice is valued in and of itself, then incentives for firms to offer coverage in rural places may need to be considered, so that each consumer has a minimum of two or three issuers' plans from which to choose. If one affordable default choice is considered more important, regulations could be added to better incentivize the offering of a nationwide plan (as originally intended but not incentivized in the PPACA as a "multi-state plan" option) or a series of regional plans to attain this goal.

It is also important to note that the outcome envisioned by policymakers who created the PPACA, i.e., competitive marketplaces with robust participation and low premium growth, is somewhat closer to reality in states that have expanded their Medicaid programs as originally set forth in that legislation. This is likely due in part to the larger proportion of the potential HIM market in non-expansion states who are very near poverty (i.e., between 100 and 138 percent of the Federal Poverty Level [FPL], since this group is eligible for Medicaid in expansion states), and as such may be perceived as a more risky or high-need population which may discourage issuers from the market. Of course, there may also be a selection effect: states that chose to expand Medicaid may be different in other unobserved ways that also influence issuers' entry decisions.

In terms of premium growth, larger numbers of uninsured individuals in non-expansion states continue to seek care, which must be absorbed by other payers in the health care system.[7] If some of these costs are absorbed into HIM premiums, it makes sense that this would create an increasing differential over time, as we would expect a lag between the reduced uncompensated care costs and the restraining of HIM premiums in expansion states. In the first three years of expansion, states paid no matching dollars on their Medicaid expansion enrollees' claims, and in subsequent years the federal match does not fall below 90 percent. It is not surprising that this injection of federal dollars into the health care systems of these states helps contain costs in other parts of the system and continues to attract issuers. Going forward, states considering expanding and reforming Medicaid under waiver authority may be able to direct federal Medicaid dollars more intentionally (e.g., spending on population health, experimenting with value-based payment in their Medicaid managed care systems, creating a hybrid HIM/Medicaid model, etc.) in ways that could benefit rural populations more directly, while still receiving the flow of federal dollars that has been shown to attract HIM firm participation and contain growth of HIM premiums.

## Notes

[1] CMS.gov. September 2017. "State-based Exchanges" https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html.

[2] Healthcare.gov. August 2017. "2017 QHP Landscape Individual Market Medical Excel" https://data.healthcare.gov/browse?limitTo=blob

[3] For more details on our methodology, see "A Guide to Understanding the Variation in Premiums in Rural Health Insurance Marketplaces," 2014-5. Available at http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2014/Rural%20HIM.pdf

[4] USDA. October 2016. "Urban Influence Codes" http://www.ers.usda.gov/data-products/urban-influence-codes/

[5] "Health Insurance Marketplaces: Premium Trends in Rural Areas," May 2016. http://www.public-health.uiowa.edu/rupri/

[6] Kaiser Family Foundation. October 2017. "How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums" https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/on

[7] Kaiser Family Foundation. December 2017. "The Uninsured: A Primer – Key Facts about Health Insurance and the Uninsured Under the Affordable Care Act." https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/