

STUDY OF THE INDIVIDUAL AND GROUP HEALTH INSURANCE MARKETS IN OHIO

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Prepared for the Ohio Department of Insurance

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CONTENTS

- 1. Executive Summary 1
- 2. Introduction 4
- 3. Data Sources and Reliance 5
- 4. Overview of Ohio’s Health Insurance Markets 7
- 5. Ohio’s Individual Market 10
 - Competitive Landscape 10
 - Characteristics of Individual Market Enrollees 14
- 6. Ohio’s Group Markets 22
 - Overview of the Group Markets 22
 - Small Group Market and Competitive Landscape 24
 - Characteristics of Small Group Market Enrollees 27
 - Large Group Market and Competitive Landscape 30
 - Characteristics of Large Group Market Enrollees 32
- 7. Enrollment in Government Programs 35
 - Medicaid 35
 - Medicare 36
 - Other Government 37
- 8. Ohio’s Uninsured Population 38
 - Number of Uninsured Residents and the Uninsured Rate 38
 - Characteristics of the Uninsured Population 39
- 9. Distribution and Use 43

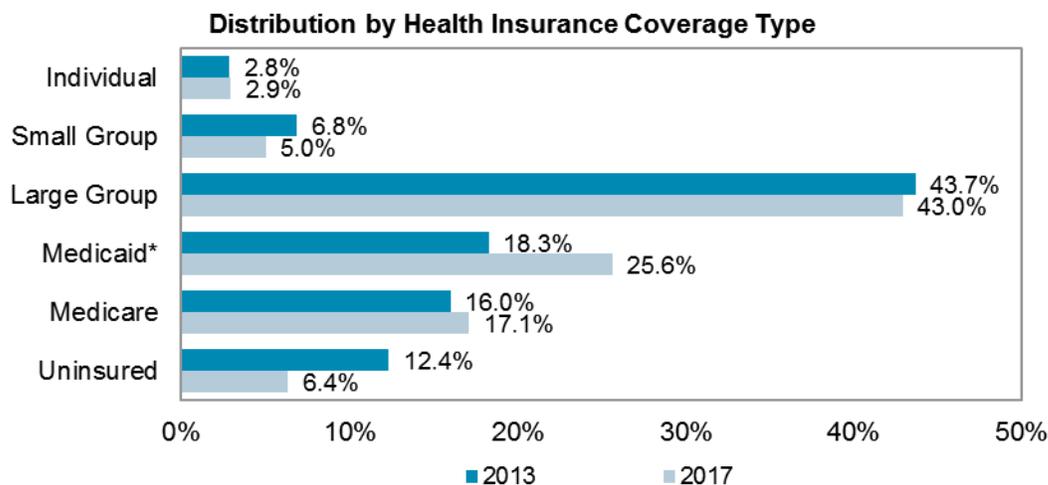
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Executive Summary

Oliver Wyman Actuarial Consulting, Inc. was engaged by the Ohio Department of Insurance to perform an assessment of its health insurance markets. This included an analysis of how the markets have changed since the implementation of the Affordable Care Act (ACA), including various characteristics of the populations enrolled in the individual and group markets, and the uninsured.

To conduct our analyses, we relied on numerous data sources, both as a basis for our estimates and our conclusions. These sources included information provided by insurers participating in Ohio's health insurance markets, annual statutory financial statements, reports from the Ohio Department of Medicaid, and other publicly available data such as the U.S. Census Bureau's American Community Survey and Current Population Survey, data from the Medical Expenditure Panel Survey, and other data from the Centers for Medicare and Medicaid Services.

Passage of the ACA brought about significant reforms to these markets. Key changes include the introduction of guaranteed issue of coverage, premium tax credits for low income individuals, adjusted community rating rules, mandates that individuals maintain coverage and large employers provide coverage to their employees, and the expansion of Medicaid to individuals with incomes below 138% FPL. These reforms led to a change in enrollment in most markets, both in terms of the number of people and the demographic and sociographic mix of the populations. The following chart summarizes the overall distribution of the populations enrolled in each health insurance market in Ohio in 2013 and 2017.



The market reforms under the ACA increased access to health insurance coverage, which resulted in a decrease in Ohio's uninsured rate from 12.4% in 2013 to 6.4% in 2017. The reduction in the uninsured rate was driven by Ohio's decision to expand Medicaid to cover most adults with incomes under 138% of the federal poverty level (FPL) and the introduction of premium tax credits to other low income individuals. The largest decrease in the number of uninsured was observed for the 25-

34 year old age range, likely driven by a combination of both the ACA's provision that allows individuals to remain covered under their parents insurance until age 26, and the expansion of Medicaid to cover childless adults with incomes up to 138% FPL. Roughly one-third of those that remain uninsured have family incomes below 138% FPL and likely could enroll in Medicaid at no cost.

Enrollment in the Ohio individual market increased from 329,000 enrollees in 2013 to 399,000 enrollees in 2015, before declining back to 342,000 enrollees in 2017. Enrollees with incomes below 400% FPL receiving premium tax credits comprised roughly 58% of the ACA individual market in 2017, with almost two-thirds of the market enrolled in silver plans. Most of the remaining ACA individual enrollees were enrolled in bronze plans. The individual market aged between 2015 and 2017, driven by an increase in age of non-ACA enrollees. However, ACA individual market enrollees were roughly two years older than non-ACA individual market enrollees. The older age of the ACA market is likely a result of restrictions on age rating factors and premium tax credits tied solely to income resulting in significant premium discounts for older individuals.

An increase in the average morbidity of the individual market and phasing out of the transitional reinsurance program has led to insurers needing to raise premium rates in excess of trend. Issuers observed loss ratios in excess of 90% between 2014 and 2016 and experienced underwriting margins of -5.1%, -9.7% and -2.9% for 2014, 2015, and 2016, respectively. Given these poor financial results, it is not surprising several major insurers either exited the ACA individual market entirely or reduced their service areas significantly in recent years. In 2016, consumers purchasing coverage through the Exchange had at least five insurers to choose from in every county. However, in 2018 consumers in 42, mostly rural, counties had only one insurer to choose from, while consumers in the 46 remaining counties had an average of two to three insurers to choose from. As a result, the market share of the top five insurers increased from 75% in 2015 to almost 90% in 2017, with the top three insurers representing over 75% of the entire individual market in 2017.

The ACA's impact on Ohio's group markets was much less pronounced than the individual market, particularly for the large group market. While the small group market is required to adhere to the same adjusted community rating rules, metallic level requirements, and EHB requirements that apply in the individual market, the large group market is not. The ACA also introduced an employer mandate to offer affordable coverage to employees. However, this requirement does not apply to small groups.

A majority of Ohio's employers with 100 or more employees offered health insurance coverage in 2013 and continued to do so in 2016, with the employer offer rate for groups with 50 to 99 employees increasing from 73% to 85% during this period. The employer offer rate for employers with fewer than 50 employees is significantly lower, likely due in part to the fact that the employer mandate does not apply to groups with fewer than 50 employees.

Enrollment in the Ohio small group market decreased from 792,000 in 2013 to 583,000 in 2017, with 57% of enrollees remaining in a non-ACA plan in 2017. A portion of the enrollment decrease is likely attributed to the ACA, as the introduction of premium tax credits in the individual market and the expansion of Medicaid may have introduced lower cost options for many small groups and their employees. Financial performance for the small group market was relatively stable between 2013 and 2016. Average premiums in the fully-insured market increased between 4% and 6% per year over this period, with loss ratios between 78% and 79% and underwriting gains of approximately

4% being observed. The average age of the small group market was relatively stable with benefit richness decreasing slightly.

Despite a slight decrease in enrollment in 2014, total enrollment in the large group market did not change materially between 2013 and 2017. Enrollment in fully-insured plans decreased over this period but was offset by an increase in enrollment in self-insured plans. The financial performance for the fully-insured large group market exhibited some volatility with a 78.3% loss ratio observed in 2015 followed by an 84.6% loss ratio in 2016. However, underwriting gains were observed in each 2015 and 2016. Medical loss ratio requirements of 85% in the large group market likely led to the observed average rate increase of only 3% in 2016, as carriers allowed the loss ratio to increase in order to reduce exposure to premium rebates.

Unlike the individual market, the competitive environment has been relatively stable in the group markets with few insurers exiting the market or reducing their service area. In both the small group and large group fully-insured markets 90% of enrollment is concentrated in the top five insurers, with 80% of enrollment in the top three.

Enrollment in Ohio's Medicaid program has increased substantially since 2013, driven by Ohio's decision to expand Medicaid in accordance with the ACA for the childless adult population. As a result, over 700,000 additional individuals were enrolled in Medicaid in 2017 relative to 2013. In 2017, approximately 86% of Medicaid enrollees were enrolled in a managed care plan, up from 80% in 2013. A majority of the increase was due to the introduction of MyCare in 2014.

Finally, the aggregate number of individuals enrolled in Medicare (traditional Medicare and Medicare Advantage combined) has increased in Ohio, consistent with trends observed nationwide as more and more baby boomers become eligible for Medicare. A decline in Medicare Advantage plans was observed in 2016, primarily driven by the Ohio Public Employees Retirement System's decision to no longer solely offer Medicare Advantage plans and instead offer enrollees the ability to purchase coverage, including Medigap and Medicare supplement policies, through a private exchange. However, enrollment in Medicare Advantage plans increased in 2017 relative to 2016.

2

Introduction

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) was engaged by the Ohio Department of Insurance (ODI) to perform an assessment of the current state of the individual, group, and uninsured markets. In the following sections, we provide a general overview of Ohio's health insurance markets, including the uninsured. Where possible, we provide context regarding the impact of known future changes that could impact the markets. Below is a summary of the information presented:

- For the commercial (i.e., individual and group markets) and uninsured markets, we analyze various characteristics associated with the populations enrolled in each market, including the demographic, socioeconomic, and geographic profiles of each market.
- For the commercial markets, we provide a detailed view of recent changes in enrollment and the competitive landscape. Additionally, we present key financial metrics to highlight the financial performance of the fully-insured market segments.
- For the individual and small group markets, we provide additional detailed information pertaining to ACA enrollees, including information related to average benefit levels, select risk characteristics, and various financial assistance metrics.
- For the group markets, we also provide an overview of recent changes in employer offer rates and employee take-up rates.

For our analysis, we relied on a wide range of data and other sources of information as described throughout this report. This includes information received from insurers currently or recently offering health insurance coverage in Ohio. Though we have reviewed the data for reasonableness and consistency, we have not independently audited or otherwise verified this data. Our review of the data may not reveal errors or imperfections, and we have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information are inaccurate or incomplete, our findings and conclusions may need to be revised. All estimates are based on information and data available as of January 8, 2018.

Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute for, legal advice. Accordingly, Oliver Wyman recommends that ODI secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

3

Data Sources and Reliance

We reviewed information from a variety of sources in assessing the current state of Ohio’s health insurance markets. This information includes reports from the Ohio Department of Medicaid, data from the Centers for Medicare and Medicaid Services (CMS), data from the U.S. Census Bureau’s American Community Survey (ACS) and Current Population Survey (CPS), data from the Medical Expenditure Panel Survey (MEPS), annual statutory financial statements of insurers issuing policies in Ohio, and various other sources.

Additionally, a data call was sent to a majority of insurers offering coverage in the individual and/or group markets in Ohio to collect detailed information pertaining to individual and employer-based market enrollees. These data included membership and claims information for the time period beginning January 2015 and ending July 2017, and provided insight into various aspects of the corresponding populations, such as the distribution of individuals enrolled in metallic plans and non-metallic plans (i.e., plans that are not compliant with the ACA, also known as non-ACA plans¹), by cost-sharing reduction (CSR) variant, etc.

The data collected also included “outbound” reports associated with the federal transitional reinsurance and risk adjustment programs. Insurers in Ohio are required to upload enrollment and claims data to External Data Gathering Environment (EDGE) servers. These “outbound” reports summarize information pertaining to each insurer’s ACA population.

It is important to note that the information from the data call served as the primary basis for any 2017 population estimates. A description of the data sources used in analyzing each insurance market is summarized in the sections that follow.

- Fully insured enrollment and market share estimates were based on information from the insurer data call responses and the Supplemental Health Care Exhibits (SHCEs). Information from MEPS, in conjunction with information from the SHCEs, was used to estimate enrollment in self-insured plans.
- The financial performance of the fully insured markets was based on data from the SHCEs and CMS’ Medical Loss Ratio (MLR) data. This data was compared to information from the insurer data call responses for consistency.
- The average rate change for 2017 was estimated based on information from the insurer data call responses and represents the average change in premium rates per-member-per-month (PMPM) relative to 2016, including changes in the overall demographic mix. The projected rate change for 2018 ACA enrollees was estimated using information provided by ODI and represents the average rate change that was approved with ODI. In determining the appropriate

¹ Non-ACA plans refer to grandfathered benefit plans (i.e., health plans in effect prior to when the ACA was signed into law, or March 23, 2010) and transitional benefit plans (i.e., non-grandfathered health plans that were in effect on October 1, 2013)

rate change in the individual market for 2018, adjustments were made to account for the premium load associated with Exchange silver plans to account for the lack of CSR funding.

- Exchange participation was determined using QHP Landscape files published on Healthcare.gov, and information provided by ODI.
- Average benefit levels and the demographic mix of individual market enrollees were estimated using information from the insurer data call responses. For the individual market, this information was compared to information from CMS' open enrollment reports for consistency, where appropriate.
- The distribution of ACA-compliant individual market enrollees by Federal Poverty Level (FPL) was estimated using information from the insurer data call responses, CMS' open enrollment reports, and actuarial judgment. Due to the lack of available information, actuarial judgment was used to assess the distribution of enrollees by FPL for individuals who enrolled in individual market coverage outside of the Exchange, including individuals enrolled in non-ACA plans. Additional summaries pertaining to individuals enrolled in ACA-compliant coverage, including average advanced premium tax credit amounts (APTCs), were based on information from the insurer data call responses, MLR data, and CMS' open enrollment reports.
- EDGE server outbound reports were used to determine the prevalence of specific medical condition categories for ACA enrollees.
- The Agency for Health Care Research and Quality's MEPS data was used to assess the general characteristics of the employer group market. MEPS identifies key statistics for the group employer market by state, including employer offer rates and employee take-up rates. All statistics from the MEPS data are available by various group sizes.
- The distribution of group market enrollees by income was estimated using data from ACS.
- Medicaid and CHIP enrollment were estimated using publicly available case load reports published by the Ohio Department of Medicaid.² This information was compared to Medicaid enrollment information published by CMS.
- Medicare enrollment was estimated using the data from the Medicare Enrollment Dashboard published by CMS.³ The estimates include individuals enrolled in fee-for-service (FFS) Medicare and Medicare Advantage coverages. Adjustments were made to remove individuals who are dually enrolled in both Medicare and Medicaid.
- The other government category consists of non-elderly individuals enrolled in health care coverage offered by local, state, and federal government entities, including individuals covered under TRICARE. ACS data was used to estimate the proportion of the population enrolled in the other government category.
- The number of uninsured individuals was estimated using information from ACS and other publicly available survey data (e.g., Gallup, Kaiser Family Foundation, etc.).
- 2016 ACS data serves as the basis for any additional statistics regarding the uninsured population (e.g., demographic information).

² <http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/CaseloadReports.aspx>

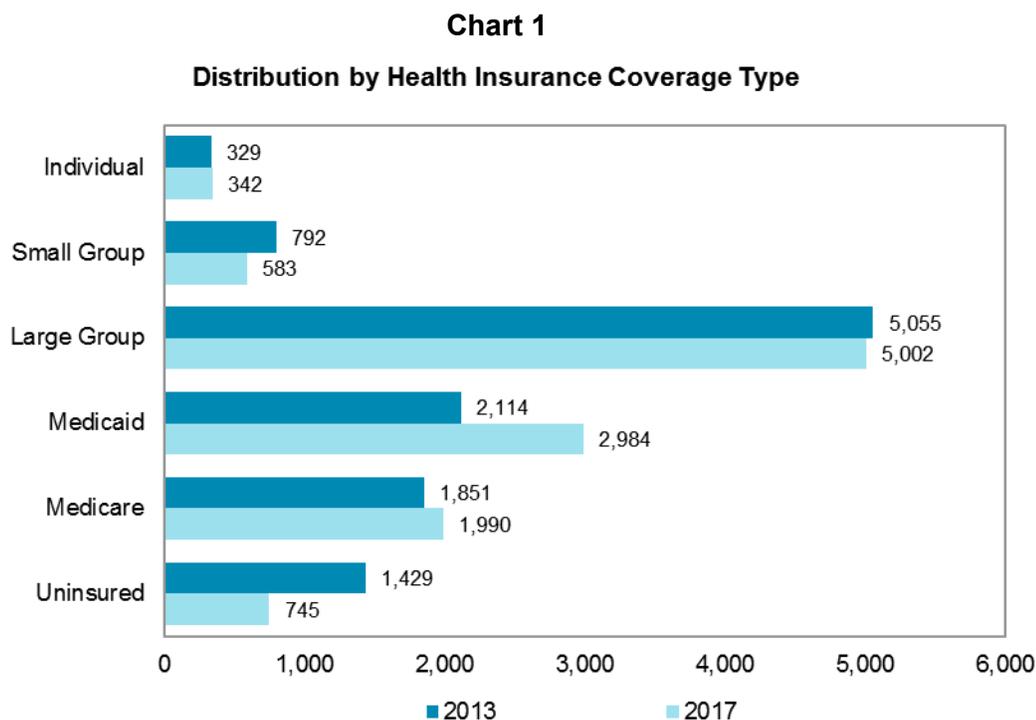
³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>

4

Overview of Ohio’s Health Insurance Markets

Ohio’s health insurance markets have changed significantly over the course of the last several years since the implementation of the ACA. The individual market has experienced the most significant changes, with the introduction of guaranteed issue of coverage, premium tax credits, adjusted community rating rules, and the individual mandate. The Medicaid market also has been impacted since Ohio elected to expand Medicaid to cover most individuals with incomes below 138% FPL. The changes to the individual and Medicaid markets, combined with the lack of a mandate requiring that small employers offer coverage, has resulted in alternate avenues for employees of small employers to seek health insurance coverage. The large group market has been somewhat immune to the changes under the ACA relative to the other commercial markets given the comprehensive nature and prior availability of large group employer coverage.

Chart 1 summarizes enrollment by health insurance market in 2013 and in 2017.



Sources: Insurer data call responses, MLR reporting data, and SHCEs

Significant enrollment changes occurred with the Medicaid and uninsured segments. Key takeaways include:

- In 2013, prior to implementation of the most significant market reforms under the ACA, Ohio's uninsured rate was 12.4%, which was lower than the nationwide average of 14.4%.⁴
- In 2017, Ohio's uninsured rate fell to 6.4%, well below the nationwide uninsured rate of 12.4% observed in 2016.⁵ Please note, the National Health Interview Survey has not been released for 2017.
- A majority of the decrease in the uninsured rate in Ohio was attributed to Ohio electing to expand Medicaid to cover most adults with family incomes under 138% FPL. Prior to 2014, only a portion of adults with incomes below 90% FPL were eligible for Medicaid. Children who reside in households with family incomes below 206% FPL were already covered under the Ohio Healthy Start program, the State's Children's Health Insurance Program (CHIP).⁶

Enrollment in the individual market in Ohio increased modestly from 329,000 enrollees in 2013 to 342,000 enrollees in 2017, but with the introduction of guaranteed issue and the elimination of high risk pools in 2014, the risk profile of individual market enrollees has changed significantly. Individual market enrollees in 2017 were less healthy and older relative to 2013 individual market enrollees. Additionally, while not shown in Chart 1, individual market membership peaked in 2015 at 399,000 enrollees and subsequently decreased in 2016 and 2017. Since 2016, the competitive landscape has changed significantly in Ohio's individual market with several major insurers, including Anthem and Aetna, either exiting the individual market entirely or reducing their service area significantly. Additionally, narrow provider network products have become more prevalent, which likely has had an adverse impact on enrollment in the individual market.

In the Ohio small group market, enrollment decreased by over 200,000 enrollees from 792,000 in 2013 to 583,000 in 2017. Nationwide, small group enrollment has been decreasing over the course of the last several years as fewer small group employers offer coverage. Small employers are exempt from the employer mandate, and the presence of guaranteed issue and premium tax credits in the individual market provide some small group employees and their families with a more affordable option for accessing health insurance coverage. However, enrollment in small group self-funded products in Ohio increased by over 50,000 enrollees since 2013 to 131,000 enrollees in 2017 as small employers seek more innovative options for providing health insurance coverage.

On November 14, 2013, the Center for Consumer Information and Insurance Oversight announced the introduction of transitional policies, which initially allowed insurers to renew in-force individual and small group non-grandfathered policies through the end of October 2014, despite the coverage not being compliant with the ACA.⁷ Ohio chose to adopt the transitional policy, and the transitional policy was subsequently extended through the end of 2018.⁸ Approximately 57% of small group

⁴ National Health Interview Survey Release Program - 2013

⁵ National Health Interview Survey Release Program - 2016

⁶ <http://www.medicaid.ohio.gov/FOROHIOANS/Programs/ChildrenFamiliesandWomen.aspx>

⁷ <https://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>

⁸ http://www.insurance.ohio.gov/Legal/Bulletins/Documents/Bulletin_2013-01.pdf

enrollees in Ohio had transitional coverage in 2017 compared to 26% of individual market enrollees. The presence of transitional policies has allowed some consumers in the individual and small group markets to maintain health insurance coverage that is more affordable, relative to ACA-compliant coverage that is offered.

Large group enrollment in Ohio remained relatively steady between 2013 and 2017, despite the introduction of the employer mandate. Most large employers offered coverage prior to the introduction of the ACA, but it should be noted that the proportion of employers with 51 to 99 employees offering health insurance coverage has increased since 2013.

Medicare enrollment in Ohio increased by 139,000 enrollees, from 1,851,000 enrollees in 2013 to 1,990,000 enrollees in 2017. The growth in Medicare enrollment is consistent with the overall aging of the population.

As noted earlier, the uninsured rate in Ohio was lower than the uninsured rate nationwide in 2016. However, our analysis shows that the uninsured rate in Ohio increased in 2017 relative to 2016 as enrollment in the individual and small group markets continued to decline. ACA individual market enrollees faced significant rate increases in 2018 due to poor experience associated with ACA individual market enrollees. Additionally, On-exchange silver plans included an additional load due to the lack of CSR funding. Beginning in 2019, individuals who elect to be uninsured will no longer face a tax penalty as a result of the Tax Cuts and Jobs Act of 2017. These items indicate that the markets will continue to evolve in the very near future, and suggest that the uninsured rate in Ohio will likely continue to increase in both 2018 and 2019.

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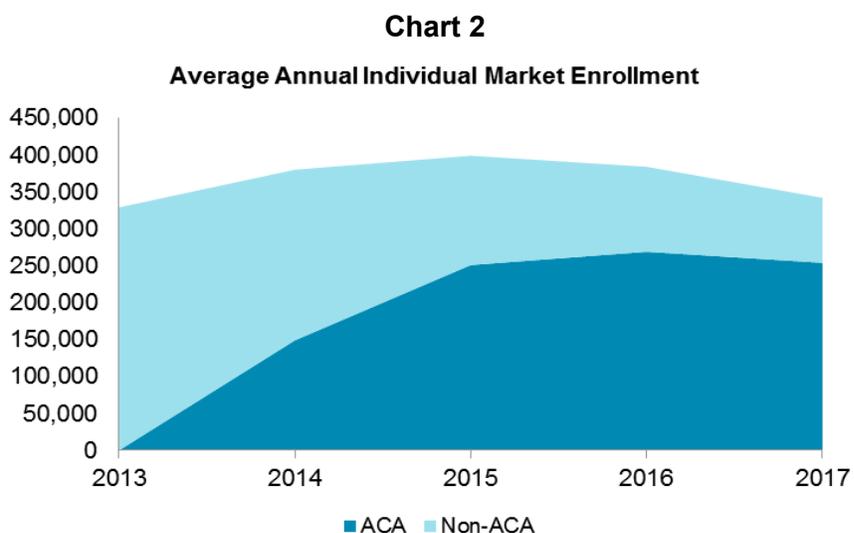
Ohio's Individual Market

The Ohio individual market experienced several significant changes starting in 2014 due to implementation of the ACA. Guaranteed issue, premium tax credits, essential health benefits (EHBs), and an individual mandate were introduced, and insurers were required to adhere to new adjusted community rating restrictions and actuarial value requirements (e.g., metallic levels). Relative to a study ODI completed in 2011,⁹ growth in the individual market as a result of the implementation of the ACA has not materialized as expected. Additionally, claim costs have been higher than expected, resulting in significant losses for insurers' individual market business.

In this section we examine the current state of Ohio's individual market. We first present individual market enrollment by plan type, market share for the top five insurers, the overall financial performance of the market, and Exchange participation. We then analyze various characteristics of Ohio individual market enrollees (e.g., demographic mix, average benefit levels, etc.) to help understand the population that has taken up coverage in the individual market and how it has changed in recent years.

Competitive Landscape

The Ohio individual market has evolved over the course of the last five years. As shown in Chart 2, enrollment in the individual market increased 21% between 2013 and 2015 from 329,000 enrollees to 399,000 enrollees, respectively. However, the individual market subsequently contracted by 15,000 enrollees in 2016, driven by a reduction of 33,000 individuals enrolled in transitional and grandfathered plans (collectively referred to as non-ACA plans).



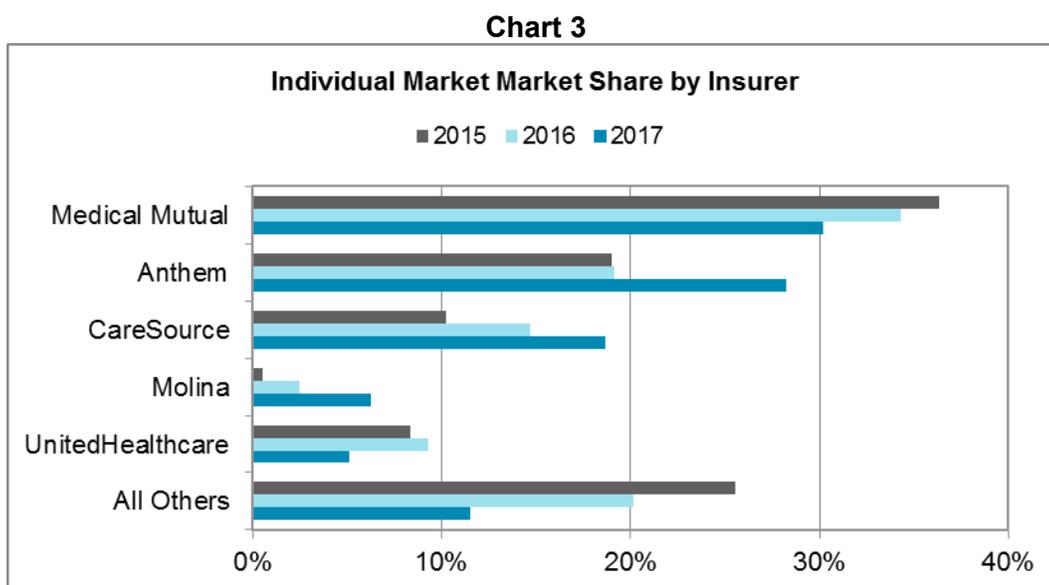
Sources: Insurer data call responses, MLR reporting data, and SHCEs

⁹ https://www.insurance.ohio.gov/Consumer/Documents/Milliman_Report.pdf

The non-ACA market segment has been a closed block since the end of 2013, so a contraction of the non-ACA market segment is expected as individuals gradually lapse coverage for a variety of reasons (e.g., individuals become eligible for employer sponsored coverage, Medicaid, or Medicare). Emerging 2017 data shows the individual market continued to contract in 2017, with both the ACA and non-ACA market segments experiencing a reduction in enrollment.

Market Share by Insurer

Chart 3 summarizes the market share for the top five insurers in Ohio’s individual market by year for 2015 through 2017.¹⁰



Sources: Insurer data call responses, MLR reporting data, and SHCEs

Medical Mutual remained the largest individual market insurer in 2017, but the organization’s market share has declined steadily since 2015; Anthem, CareSource, and Molina all gained market share in 2017. Collectively, the market share of the top five insurers increased from 75% in 2015 to almost 90% in 2017, with the top three insurers representing over 75% of the individual market in 2017. Please note, market share estimates are shown at the parent company level with Medical Mutual and UnitedHealthcare representing multiple insuring entities.

Financial Performance

Table 1 summarizes recent financial performance of individual market insurers. Underwriting losses were observed in the individual market between 2014 and 2016. In 2014 when the most significant provisions of the ACA were implemented, average paid claim costs PMPM increased 53.0%, while average premiums PMPM only increased 28.5%. Between 2014 and 2016 the traditional loss ratio consistently exceeded 90% but improved slightly in 2016 as the increase in claim costs PMPM

¹⁰ Top five insurers were identified based on insurers with the greatest membership in 2017, as reported in the insurer data call responses.

moderated.¹¹ It is important to note that a portion of the increase in claims and premiums shown in Table 1 for 2015 and 2016 is due to the phase out of the federal transitional reinsurance program.

Table 1

Financial Performance by Year for Individual Market Insurers					
Year	Membership (in 1,000s)	Loss Ratio	Underwriting Gain/Loss	Year over Year Change	
				Claims PMPM	Premium PMPM
2013	329	79.0%	1.5%		
2014	380	94.1%	-5.1%	53.0%	28.5%
2015	399	95.8%	-9.7%	15.7%	13.6%
2016	384	92.4%	-2.9%	8.5%	12.5%

Sources: Insurer data call, responses, MLR reporting data, and SHCEs

Based on information included in the insurer data call, average individual market premiums increased about 9.0% in 2017. Given the lack of available claims data for all of 2017, it is not clear how claim costs PMPM will ultimately change in 2017 relative to 2016. An analysis completed by ODI suggests average premiums for Exchange plans will increase approximately 34% in 2018. However, 11% of the rate increase is due to the lack of CSR funding that has been built into the premium for silver plans sold through the exchange.¹² Therefore, assuming individuals that are not eligible for APTCs purchase silver plans sold outside of the exchange that do not include this load, or purchase plans at other metal levels, we estimate they may experience an average rate increase closer to 21%. Information to determine the average rate change for non-ACA in 2018 plans was not available.

Insurer Participation in the Individual Market

Insurer participation in Ohio's Exchange has been among the highest in the nation since the inception of Exchanges, but similar to nationwide trends, insurer participation in Ohio's Exchange decreased starting in 2016. In 2016, HealthSpan sold its insurance operations to Medical Mutual, InHealth, a health insurance co-op formed under the ACA, became insolvent, and UnitedHealthcare exited the ACA individual market.^{13, 14} In 2017, Aetna and Humana announced their intention to exit the ACA individual market at the end of 2017.^{15, 16} Additionally, Anthem, the second largest insurer in the Ohio individual market, announced it would withdraw from Ohio's Exchange at the end of 2017 and reduce its service area to just one county, displacing a large number of individual market

¹¹ Traditional loss ratios are calculated as incurred claims PMPM (adjusted for recoveries under the transitional reinsurance program) divided by earned premiums PMPM.

¹² <http://insurance.ohio.gov/Consumer/Pages/Exchange%20Overview.aspx>

¹³ <http://www.insurance.ohio.gov/Newsroom/Pages/05262016InHealth.aspx>

¹⁴ <https://www.medmutual.com/About-Medical-Mutual/Newsroom/2016/March/Medical-Mutual-of-Ohio-Acquires-HealthSpan-Insurance-Business.aspx>

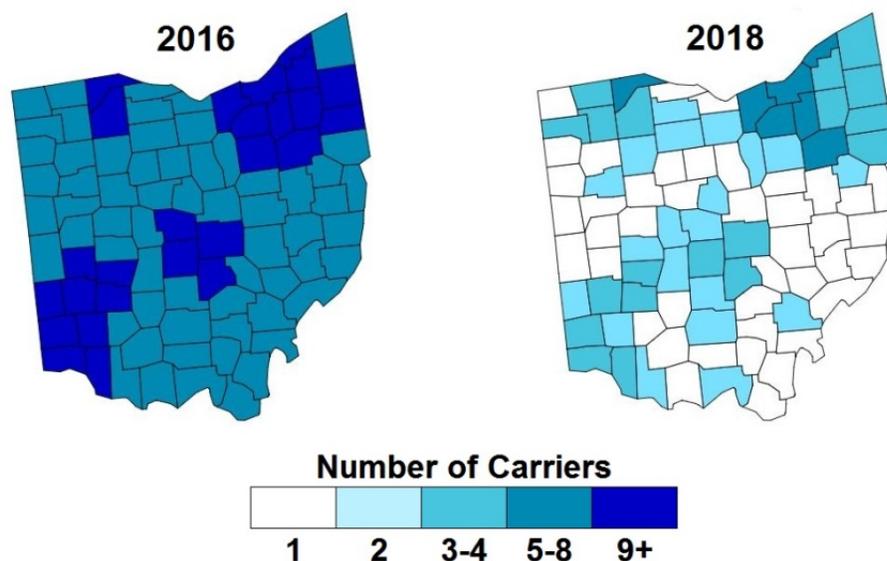
¹⁵ <http://press.humana.com/press-release/current-releases/humana-continues-build-upon-proven-strategy-following-termination-mer>

¹⁶ <https://www.aetna.com/plan-info/individual/health-plans/2017/ohio.html>

enrollees.¹⁷ The recent financial performance of the individual market segment combined with previous uncertainty associated with the funding of CSR payments and future market reforms are often reasons cited by insurers for exiting the Exchanges, or the individual ACA market all together.

As seen below in Figure 1, consumers purchasing coverage through the Exchange in 2016 had at least five insurers to choose from in every county, with most consumers having an average of six or seven insurers. In 2018, consumers in 42 of Ohio’s 88 counties had only one insurer to choose coverage from through the Exchange; these counties tend to represent more rural regions of the state. Consumers residing in the 46 remaining counties in Ohio will have an average of two to three insurers to choose coverage from through the Exchange. Approximately 78.8% of ACA individual market enrollees purchased coverage through the Exchange in 2017, up from 72.0% in 2016.

Figure 1
Average Number of Insurers Offering Coverage by County



Sources: CMS open enrollment reports and information supplied by ODI

With a decrease in the number of insurers offering coverage through the Exchange, consumers are left with fewer plan offerings and limited in-network provider options. No insurers offered platinum level coverage in the individual market in 2017, and in 20 counties only one gold plan option was available through the Exchange. In 2018, consumers in six counties will only have two plans (one silver and one gold plan) available to them through the Exchange.

Insurer Provider Network

Most individual market insurers utilized narrow provider networks to obtain more favorable provider reimbursement rates. In 2017, Anthem was the only Exchange insurer offering an open access provider network product across the state, and while there were other insurers offering open access provider network products, the service areas of those insurers were limited. With Anthem’s

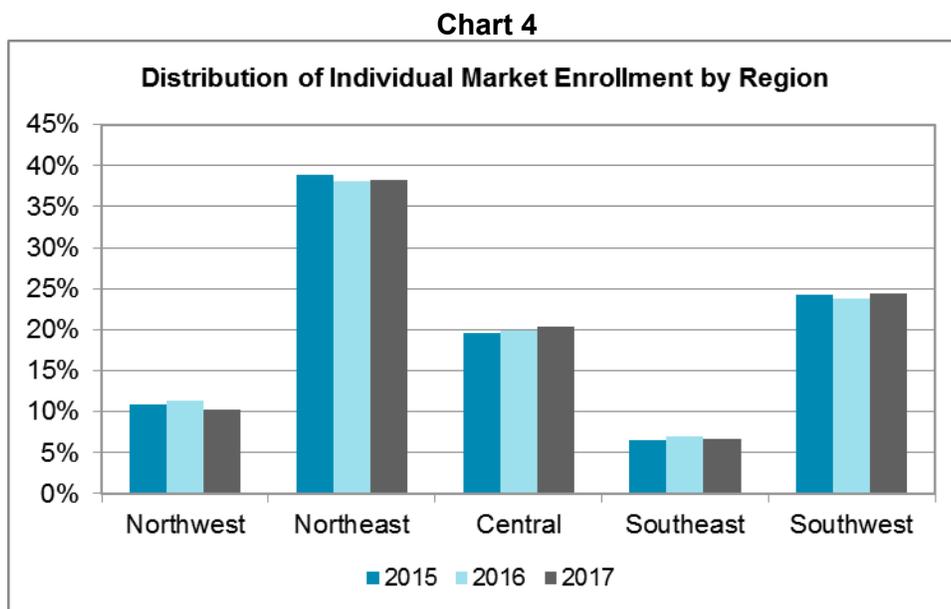
¹⁷ “Anthem Pulling Out of Ohio Health Care Exchange.” Dayton Business Journal, 6 June 2017, <https://www.bizjournals.com/dayton/news/2017/06/06/anthem-pulling-out-of-ohio-health-care-exchange.html>

announcement that it will not offer coverage through the Exchange in 2018, a significant number of enrollees may have needed to find a new primary care physician due to a change in provider network. While there are several factors influencing the overall dynamics in the individual market, the lack of consumer choice may have contributed to the reduction in ACA individual market enrollment in 2017. Given additional insurers are exiting the market in 2018, further contraction of the individual market is possible in 2018.

Characteristics of Individual Market Enrollees

Geographic Characteristics

Chart 4 summarizes the distribution of all individual market enrollees in Ohio by region.¹⁸ A majority of individual market enrollees are located in the northeast portion of the state, consistent with the overall distribution of Ohio's population in general. Since 2015, the distribution of individual market enrollees by region has not changed significantly, despite limited consumer choice in the Exchange in parts of the state in 2017. While not evident when examining Chart 4, little change in the overall distribution is observed between 2015 and 2017 when also examining the enrollment separately for the ACA and non-ACA markets.



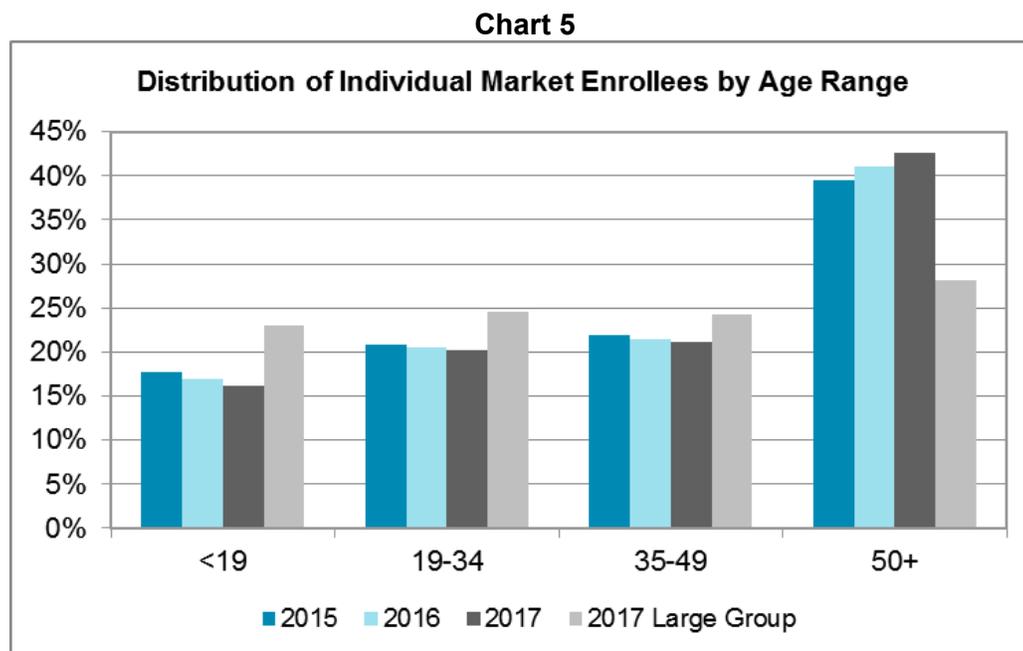
Source: Insurer data call responses

Age Characteristics

Chart 5 summarizes the distribution of individual market enrollees by age group, alongside the distribution of 2017 large group market enrollees for comparative purposes. Individual market enrollees are significantly older than 2017 large group market enrollees, with approximately 43% of

¹⁸ Each region is defined using the Ohio Geographic Rating Areas for ACA plans. The northwest region is defined as geographic rating areas 1, 2, and 6. The northeast region is defined as geographic rating areas 11, 12, 13, 14, and 15. The central region is defined as geographic rating areas 7, 8, and 9. The southeast region is defined as geographic rating areas 10, 16, and 17. The southwest region is defined as geographic rating areas 3, 4, and 5.

2017 individual market enrollees being age 50 or older, compared to 28% of large group market enrollees. Chart 5 also demonstrates that the individual market population is aging, with the average age of individual market enrollees increasing from 39.5 in 2015 to 40.8 in 2017.



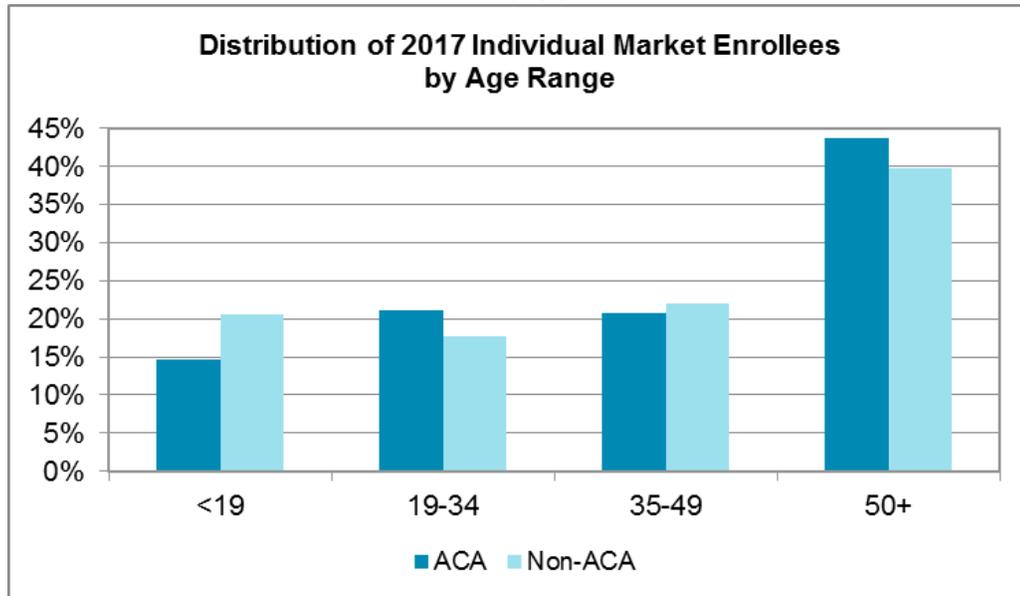
Source: Insurer data call responses

The rate of aging observed in the individual market is greater than the rate of aging observed in the general population. An aging risk pool typically exerts upward pressure on claim costs, resulting in higher premium rates, all else equal.

Chart 6 shows the age distribution of 2017 individual market enrollees, split by plan type (i.e., ACA and non-ACA). ACA enrollees are older than non-ACA with an average age of 41.3 compared to 39.2, respectively. The average age of those enrolled in the ACA individual market has remained relatively stable over the period of 2015 through 2017. However, the average age of non-ACA individual market enrollees has increased. Therefore, the contraction in the size of the non-ACA market, combined with an increase in average age of non-ACA enrollees, has led to the observed increase in the average age of the overall individual market shown in Chart 5 above.

A lower proportion of children are covered under ACA plans relative to non-ACA plans. While not shown, information from the insurer data call shows 53.5% of ACA individual market enrollees in 2017 were female compared to 47.0% of non-ACA individual market enrollees being female. The difference in demographic mix between ACA and non-ACA enrollees is likely driven by the presence of unisex rates and a 3:1 age rating limitation in the ACA market.

Chart 6

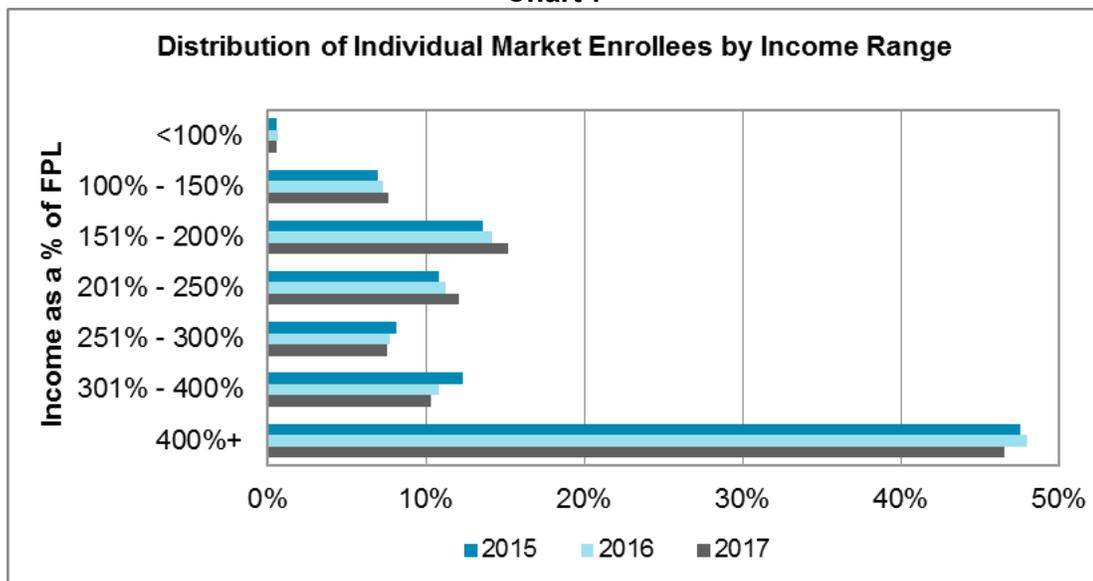


Source: Insurer data call responses

Income Based Characteristics

The distribution of individual market enrollees by income range in relation to FPL is shown in Chart 7. The proportion of individual market enrollees has shifted over the period from 2015 to 2017, resulting in greater concentration at incomes at or below 250% FPL. This trend is being driven in part by an increase in the overall proportion of the individual market population enrolled in ACA plans.

Chart 7



Sources: CMS open enrollment reports, ACS, and actuarial judgment

Non-ACA enrollees on average have higher incomes compared to ACA enrollees as the presence of premium tax credits through the Exchange encourages non-ACA enrollees with incomes at or below 400% FPL to switch to ACA coverage. Since individuals with incomes above 400% FPL are not eligible for premium tax credits, they may be more sensitive to large premium rate changes since they will bear the full burden of any rate increase, while most enrollees with incomes below 400% FPL may only experience a rate increase that is consistent with wage growth. Given this phenomenon, as premiums rise individuals with incomes above 400% FPL are more likely to become uninsured or seek coverage through another avenue (e.g., the group markets).

Table 2 provides an overview of the proportion of ACA individual market enrollees with incomes at or below 400% FPL (i.e., the APTC-eligible population).

Table 2

Summary of APTC Statistics			
	2015	2016	2017
Percent of ACA individual Market with Incomes <400% FPL	70.1%	68.4%	69.0%
Percent of ACA Individual Market Receiving APTCs	57.7%	56.5%	57.8%
Average APTC for Individuals Receiving APTCs PMPM	\$253.01	\$250.00	\$265.36

Sources: Insurer data call responses and open enrollment reports

Approximately 70% of ACA individual market enrollees had incomes at or below 400% FPL in 2017. However, only 58% of the ACA individual market population received APTCs. A portion of enrollees with incomes at or below 400% FPL did not qualify for APTCs since market premiums for the second lowest cost silver plan for their age did not exceed the required subsidized premium levels for their income level. Additionally, some individuals enrolling through ACA coverage outside of the Exchange were likely not aware they were eligible for APTCs if they had enrolled through the Exchange. While the average APTC amount for individuals receiving APTCs decreased slightly in 2016, the average amount increased in 2017. Please note, the average APTC amounts shown have not been normalized for changes in age, benefits, or income mix among APTC-eligible enrollees.

Given the reduction in ACA enrollment in 2017, we would have expected the non-subsidized ACA individual market population to drop coverage first (i.e., mostly individuals with incomes above 400% FPL), since most of the subsidized population is largely sheltered from large rate increases other than for changes in overall inflation levels.¹⁹ However, the 2017 membership data shows fewer individuals eligible for premium tax credits enrolled in coverage through the individual market coverage in 2017. The reduction in subsidized membership is likely, at least in part, due to fewer plan and provider network options being available through the Exchange.

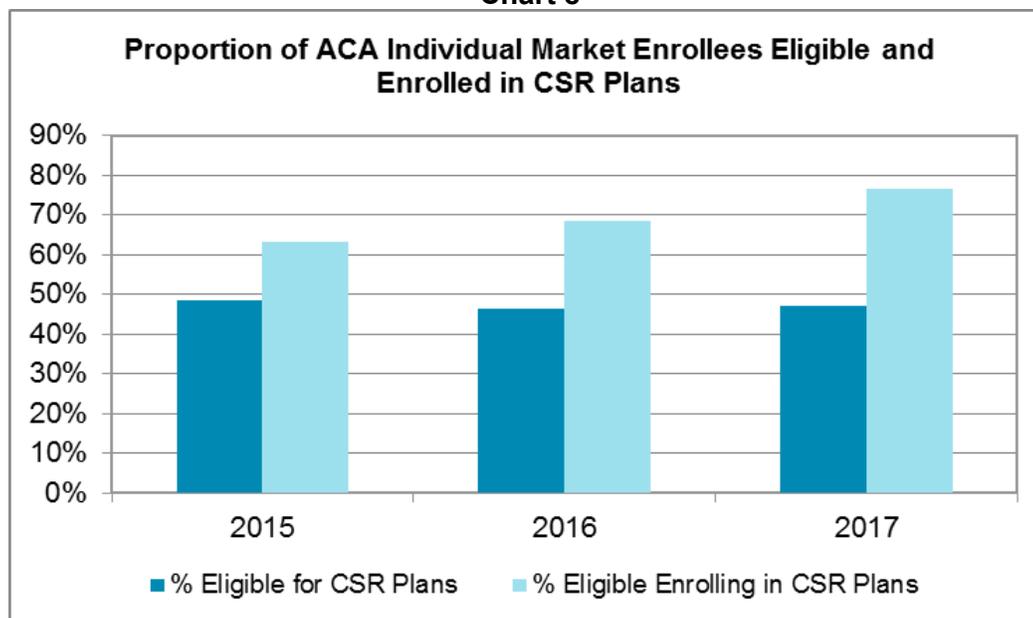
Individuals with incomes under 250% FPL are eligible to enroll in a silver plan CSR variant²⁰ through the Exchange, although they may choose to enroll any other non-catastrophic plan available through the Exchange. As shown below in Chart 8, the proportion of individuals eligible to

¹⁹ The subsidized premium an individual is required to pay can change from year to year due to changes in income in relation to FPL or the required percentage of income individuals are required to pay at different FPL levels.

²⁰ Silver CSR variant plans are provide reduced cost sharing for silver coverage

enroll in CSR plans (roughly 50%) remained steady between 2015 and 2017, but of those eligible to enroll in CSR plans the proportion that actually enrolled in CSR plans increased significantly, from 63% in 2015 to 77% in 2017. A majority of the remaining individuals with incomes under 250% FPL likely chose to buy down to bronze-level coverage, accepting higher cost sharing requirements in exchange for lower monthly premiums.

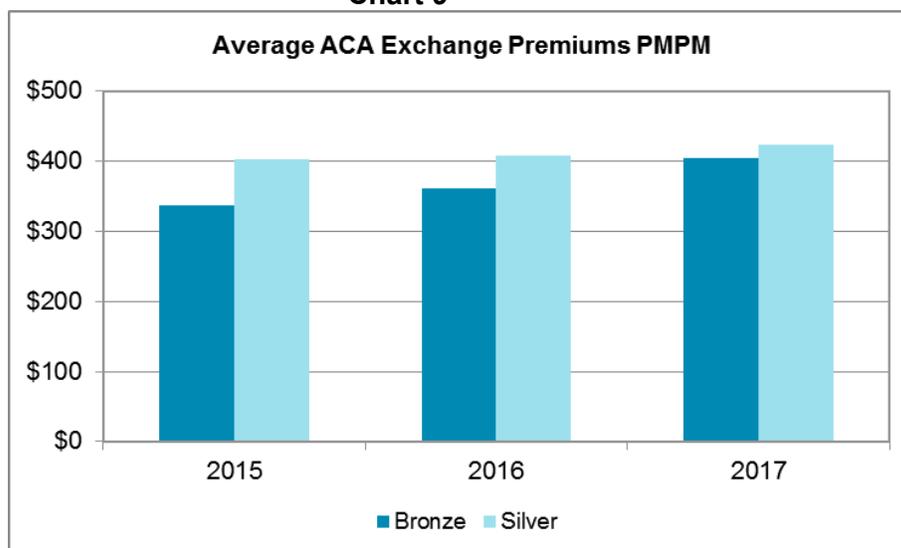
Chart 8



Sources: Insurer data call responses and open enrollment reports

Multiple items are likely influencing the recent increase in the proportion of CSR eligible enrollees taking up coverage in CSR plans. Chart 9 shows average premiums PMPM for bronze and silver plans offered through the Exchange. The average premium PMPM for bronze plans increased at a faster rate compared to the average premium PMPM for silver plans between 2015 and 2017. Changes in demographic and geographic mix underlying these average premiums are not known. To the extent changes in demographic and geographic mix do not account for all of the rate compression that occurred between the average bronze and silver premiums it could have led to some individuals losing access to no-cost or low-cost bronze coverage as their premium tax credits became less valuable in relation to bronze premiums (i.e., if premiums for bronze plans increase faster than the change in APTCs, bronze coverage becomes more expensive to an individual eligible for premium tax credits, all else equal). As bronze coverage becomes more expensive, some individuals may view the silver CSR variant plans to be more valuable given the lower member cost-sharing levels associated with those plans relative to bronze plans.

Chart 9



Sources: Insurer data call responses and open enrollment reports

Note: Premiums are not normalized for differences in age and geography

Benefit Characteristics

Table 3 summarizes the distribution of ACA individual market enrollees by metal level for 2015 through 2017. The distribution of enrollees by metal level shifted between 2015 and 2017 with a greater proportion of enrollees selecting silver-level coverage in 2017 relative to 2015, and reductions in enrollment at all other metal levels.

Table 3

Distribution of ACA Individual Market Enrollees by Metal Level			
	2015	2016	2017
Catastrophic	1.4%	1.4%	1.0%
Bronze	34.0%	36.0%	31.4%
Silver	53.3%	55.3%	62.6%
<i>Base Silver</i>	22.7%	23.6%	26.6%
<i>73% CSR Silver</i>	6.9%	8.2%	10.3%
<i>87% CSR Silver</i>	15.0%	15.0%	16.6%
<i>94% CSR Silver</i>	8.7%	8.5%	9.1%
Gold	9.7%	7.1%	5.0%
Platinum	1.6%	0.3%	0.0%

Sources: Insurer data call responses and open enrollment reports

With fewer insurers offering coverage in the individual market and through the Exchange, the number of plans available to consumers has decreased significantly. The median number of plans offered to consumers within a given county through the Exchange dropped from 70 in 2016 to 31 in 2017. Platinum coverage was offered statewide through the Exchange in 2015, limited to only seven counties in 2016, and no insurers offered platinum coverage in 2017. The median number of gold plans offered to consumers through the Exchange dropped from 15 in 2016 to 4 in 2017.

Limited consumer choice within certain metal levels may be influencing the overall distribution of enrollment by metal level (e.g., significantly fewer gold plan options may be leading to lower enrollment in gold plans).

Benefit levels for non-ACA enrollees are more difficult to characterize since there are no “metallic” requirements. Using the ratio of paid claims to allowed claims (paid-to-allowed ratio) as a metric to assess the differences in the richness of coverage between ACA and non-ACA enrollees, the proportion of allowed claim costs paid by insurers is lower for non-ACA enrollees compared to ACA enrollees (i.e., average member cost sharing for non-ACA enrollees relative to their allowed claims is higher for non-ACA enrollees compared to ACA enrollees), as shown in Table 4. It is important to note that non-ACA plans in the individual market also generally cover fewer services relative to ACA plans since non-ACA plans are not required to cover the ACA’s ten essential health benefit categories (EHBs). For example, some non-ACA individual market plans may not provide coverage for maternity services.

Table 4

Paid-to-Allowed Ratios by Plan Type		
Plan Type	2015	2016
ACA	73.7%	74.3%
Non-ACA	70.7%	70.9%

Source: Insurer data call responses

Morbidity Characteristics

Prior to 2014, the average morbidity of individual market enrollees was lower than that of the small and large group enrollees. Since the introduction of guaranteed issue in the individual market in 2014, individuals who were not previously able to access health insurance coverage in the individual market (e.g., individuals that could not pass underwriting), including high-risk pool enrollees, began enrolling in the individual market. Since many new individual market enrollees were in much poorer health than pre-ACA individual market enrollees, the average morbidity in the individual market increased.

Table 5 summarizes our best estimate of the average morbidity in the 2016 individual and small group fully-insured markets, relative to the 2016 fully-insured large group market. Allowed claims PMPM for 2016 enrollees were normalized to account for differences in age and gender, benefit levels, and provider networks. We note that we did not have all of the information necessary to also normalize allowed claims PMPM for differences in the geographic mix in each market. Therefore, any differences in allowed cost due to differences in geographic mix are underlying our estimate of morbidity differences.

The age and gender adjustment accounts for differences in demographic mix between the markets, with a “1.0” factor representing the average claim cost for a 40 year old male. The induced demand adjustment accounts for differences in utilization of services due to differences in member cost-sharing levels. The network adjustment reflects the impact narrow networks have on claim costs. Narrow networks are more prevalent in the ACA individual market relative to the group markets. We assumed nearly half of all 2016 individual market enrollees and one quarter of all small group market enrollees, including non-ACA enrollees, were enrolled in a narrow network product, and that narrow networks reduced claim costs by 10%.

Based on the analysis described, we estimate that enrollees in the total individual market could have an average morbidity that is approximately one percent higher than large group fully-insured enrollees. Small group fully-insured enrollees have an average morbidity that is roughly the same as large group enrollees.

Table 5

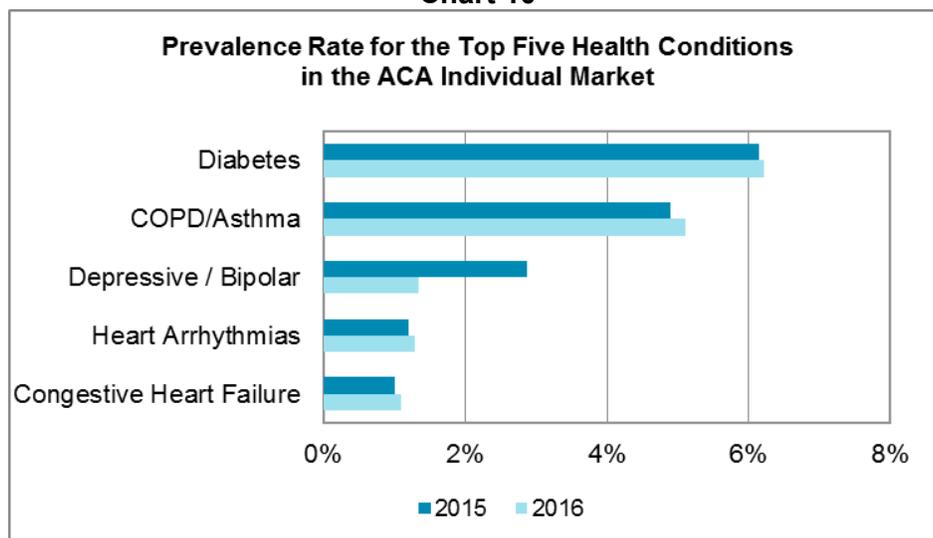
Relative Morbidity of the Commercial Markets - 2016						
Market	A	B	C	D	=A/B/C/D	Morbidity Relative to Large Group
	Allowed Claims PMPM	Adjustment Factors			Normalized Claims PMPM	
		Age/Gender	Induced Demand	Network		
Individual	\$459.53	1.549	1.046	0.950	\$306.66	1.013
Small Group	\$425.40	1.374	1.073	0.975	\$288.69	1.005
Large Group	\$440.68	1.376	1.086	1.000	\$294.72	N/A

Sources: Insurer data call

Information regarding the types of health conditions associated with individual market enrollees is limited. We received outbound reports from the EDGE server risk adjustment and reinsurance processes, but this information only provides insight into the health conditions associated with ACA individual market enrollees. No comparable information is available for non-ACA enrollees. Chart 10 summarizes the five health conditions most prevalent in the ACA individual market enrollees, using CMS' hierarchical condition categories for diagnostic classification (HCCs).

Diabetes and chronic obstructive pulmonary disease/asthma (COPD/asthma) are the most prevalent health conditions among ACA individual market enrollees. The data shows approximately 20% of ACA individual market enrollees in 2016 had at least one HCC, with roughly 6% having two or more. It should be noted that while Chart 10 shows a noticeable decrease in the proportion of enrollees with depressive or bipolar disorders in 2016. This decrease is driven by a change in the definition of depressive and bipolar disorders.

Chart 10



Source: EDGE server outbound reports

6

Ohio's Group Markets

The ACA's impact on Ohio's group markets was much less pronounced than for the individual market, particularly for the large group market. Some of the largest changes from the ACA that affected both the small and large group markets included capping member out-of-pocket medical expenditures, the elimination of pre-existing condition exclusions, and the elimination of dollar caps on annual benefits. In the small group market, the ACA required insurers to adhere to the same adjusted community rating rules, metallic level requirements, and EHB requirements that apply in the individual market. However, unlike the individual market, guaranteed issue previously applied to the small group market prior to the passage of the ACA, dampening the impact of the changes mandated by the ACA relative to the individual market. In the large group market, the ACA introduced an employer mandate to offer affordable coverage; employers with fewer than 50 full-time equivalent employees are not subject to the employer mandate.

In this section we first examine the current state and recent trends in the Ohio employer group markets. We then analyze the small group employer market in more detail, including an overview of the competitive landscape and various characteristics of small group enrollees. Finally, we analyze the large group employer market in more detail, including an overview of the competitive landscape and various characteristics of large group enrollees. For our purposes, we define a small group employer as an employer with 50 or fewer employees and a large group employer as an employer with 51 or more employees, consistent with Ohio's definition of small and large group employers. Additionally, the analysis of the competitive landscape for both the small and large group markets is focused on fully-insured plans due to the lack of available data regarding self-funded plans.

Overview of the Group Markets

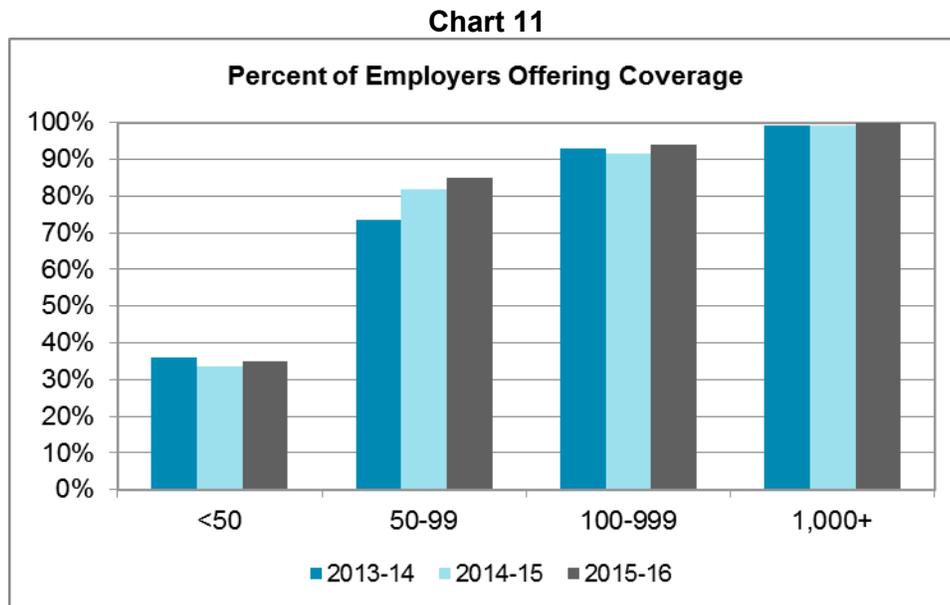
Employer Offer Rates

The ACA mandated employers with 50 or more full-time equivalent employees offer comprehensive, affordable health insurance coverage to full-time employees or pay a penalty starting in 2015.²¹ Chart 11 shows the proportion of employers offering coverage to employees, with two-year averages shown to reduce the volatility present in the data for smaller cohorts (e.g., employers with 50 to 99 employees). A majority of Ohio's employers with 100 or more employees offered health insurance coverage between 2013 and 2016. The employer offer rate for employers with 50 to 99 employees increased about ten percentage-points between the 2013-14 time period and the 2015-2016 time period.

The employer offer rate for employers with fewer than 50 employees has generally decreased since 2013 and is significantly lower relative to employers with 50 or more employees. This is likely due to the presence of various aspects of the ACA, such as the presence of guaranteed issue and

²¹ The employer mandate was initially delayed until 2015 for employers with 51 or more employees. However, for employers with 51 to 99 employees, the employer mandate was further delayed until 2016.

premium tax credits in the individual market, and the fact that the employer mandate does not apply to groups with fewer than 50 employees.



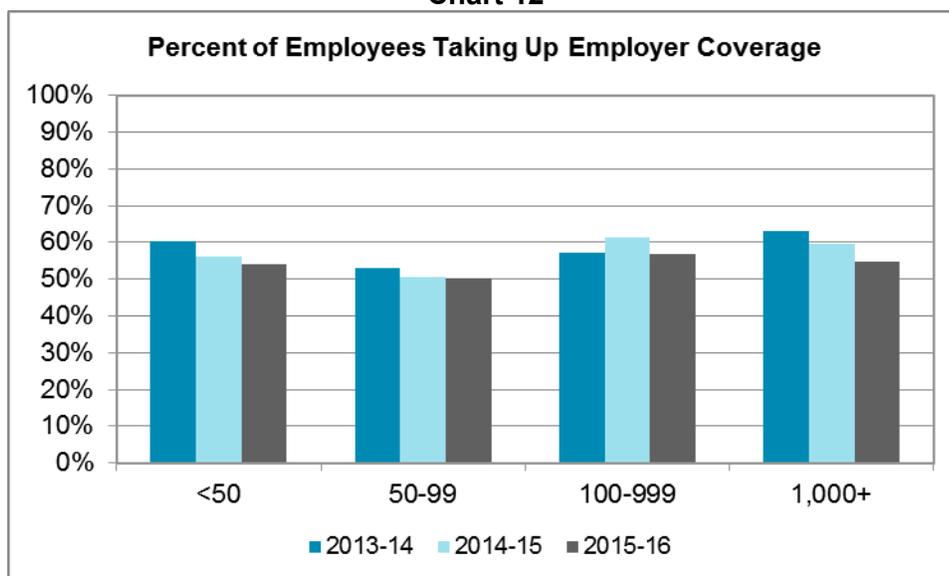
Source: MEPS

Employee Take-up Rates

Chart 12 shows the proportion of employees who take up health insurance coverage through their employer, among only those employers that offer health insurance coverage to their employees. The overall proportion of employees taking up coverage decreased for nearly all group sizes between 2013 and 2016, but the data shows the number of employees covered increased across all group sizes from 4.4 million in 2013 to 4.9 million in 2016. The decrease in the proportion of employees taking up coverage is most noticeable for employers with 50 or fewer employees and employers with 1,000 or more employees.

An analysis of the MEPS data shows a lower percentage of employees are eligible to enroll in group coverage, driven by a significant reduction in the number of part-time employees eligible for group coverage. However, the data also shows a lower percentage of eligible employees are electing to take up coverage. The reduction in the proportion of eligible employees electing to take up coverage may be attributable to an overall increase in employment levels as some newly hired individuals were already accessing group coverage through another member of the household (e.g., increased awareness of dependents staying on their parent’s policy through the age of 26). Additionally, a small portion of employees may now be accessing health insurance coverage through Medicaid as a result of changes in Medicaid eligibility in Ohio to now cover most individuals with household incomes below 138% FPL.

Chart 12



Source: MEPS

Small Group Market and Competitive Landscape

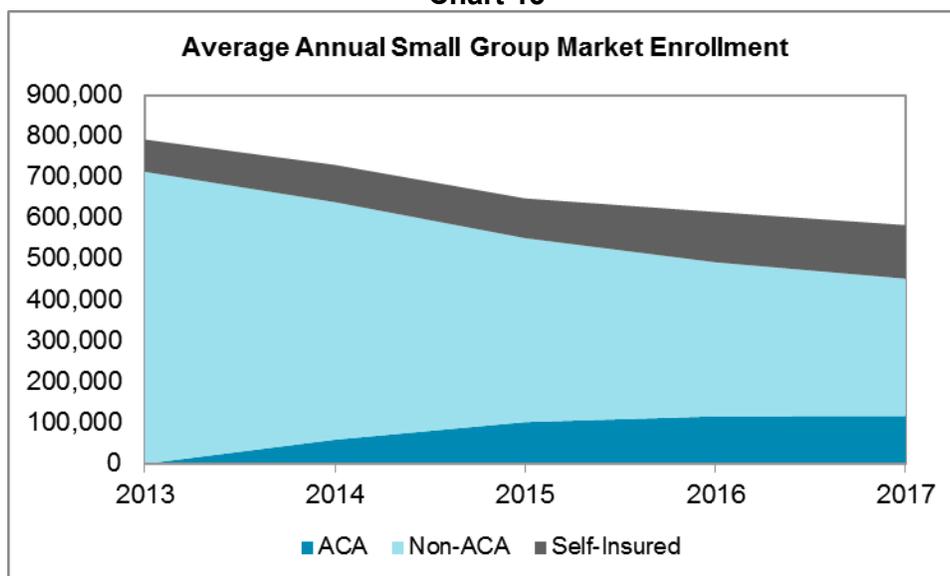
Enrollment in the Ohio small group market decreased each year between 2013 and 2017, a trend that has been observed nationwide. A portion of the decrease in small group enrollment is likely attributed to the ACA, given the introduction of guaranteed issue, premium tax credits in the individual market, and the expansion of Medicaid. However, nationwide enrollment in the small group market was decreasing prior to 2013. Despite the recent decline in overall enrollment, the small group competitive landscape and the characteristics of small group enrollees in Ohio have been relatively stable in recent years. For purposes of analyzing the small group market, government employees and their dependents were excluded from the small group market analysis. An analysis of government employees is included in Section 7.

Chart 13 shows enrollment in the small group market in Ohio decreased from 792,000 in 2013 to 583,000 in 2017, despite overall small group employment levels increasing 9.8% between 2013 and 2016.²² Nationwide, small group enrollment has been decreasing over the course of the last several years as fewer small group employers offer coverage. The decrease in enrollment in the small group market has been primarily driven by a decline in non-ACA enrollment, which is expected given it is a closed block of policies.

However, approximately 57% of Ohio small group enrollees were still enrolled in a non-ACA plan in 2017, with 85% of those enrollees being enrolled in a transitional plan. Enrollment in ACA plans increased between 2014 and 2015 but remained relatively flat in 2016 and 2017 with an overall increase of 1,000 enrollees to 117,000 in 2017. Enrollment in self-funded plans increased by over 50,000 enrollees since 2013, to 131,000 enrollees in 2017 as small employers seek more innovative options for providing health insurance coverage through the increased availability of small group self-funded products.

²² Based on an analysis of 2013 and 2016 Medical Expenditure Panel Survey (MEPS) data. 2017 MEPS data was not available at the time the report was completed.

Chart 13



Sources: Insurer data call responses, MLR reporting data, and SHCEs

The overall reduction in enrollment in the small group market is likely being driven by a number of factors. Small group employers are not subject to the employer mandate, and given the presence of guaranteed issue and premium tax credits in the individual market, some small employers may have determined their employees were better off receiving subsidized coverage through the Exchange in return for higher wages, using the cash savings associated with not providing health insurance coverage as a mechanism to fund increased wages. Additionally, the ACA's small employer tax credit was meant to encourage eligible employers with fewer than 25 full-time equivalent employees to offer coverage, but only a small portion of small employers have utilized the credit. Small employers view the administrative burdens and requirements associated with receiving the credit as outweighing the savings.²³

Average premiums for ACA plans are nearly 18% higher than non-ACA plans. If an employer currently enrolled in non-ACA coverage determines the non-ACA coverage is unaffordable upon renewal, seeking coverage in through an ACA plan may not be an alternative solution given the average premium differences between ACA and non-ACA coverage. Self-funding may not be a viable option for groups this size due to the additional administrative complexities and financial risks associated with self-funding.

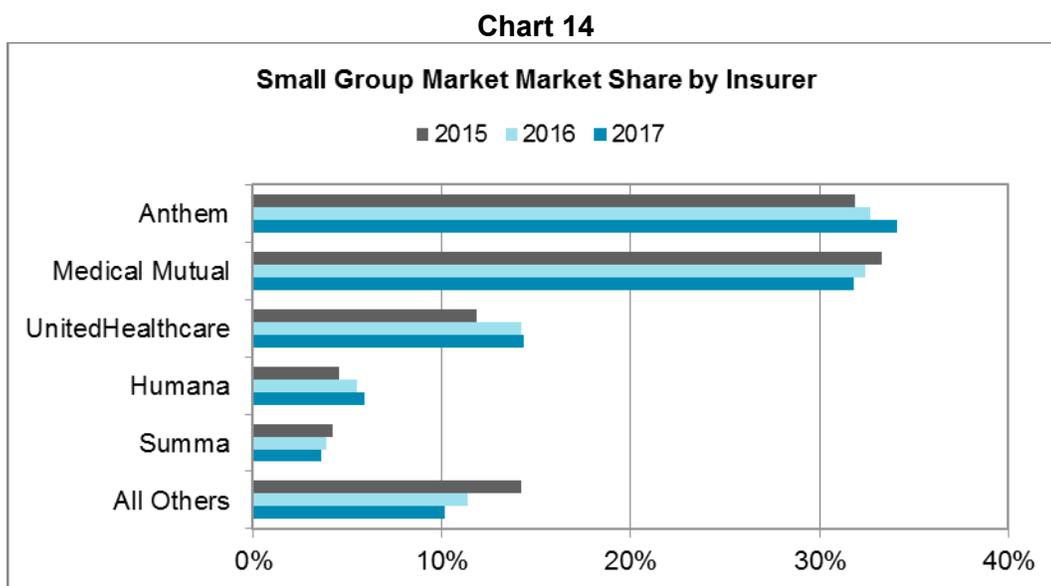
Market Share by Insurer

Chart 14 summarizes the market share for the top five health insurers in the Ohio fully-insured small group market by year for 2015 through 2017.²⁴ Overall, the competitive environment has been relatively stable in the small group market with few insurers exiting the market or reducing their service area. Anthem gained market share between 2015 and 2017 to become the largest insurer in

²³ <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/small-business-health-coverage.aspx>

²⁴ Top five insurers were identified based on insurers with the greatest membership in 2017, as reported in the insurer data call responses.

the fully-insured small group market. UnitedHealthcare and Humana also observed slight increases in market share. Medical Mutual lost market share between 2015 and 2017. Collectively, the market share of the top five insurers represents approximately 90% of the fully-insured small group market, with the top three insurers representing approximately 80% of the market.



Sources: Insurer data call responses, MLR reporting data, and SHCEs

Financial Performance

Table 6 summarizes recent financial performance of the fully-insured small group market across all insurers.

Table 6

Financial Performance by Year for the Fully-Insured Small Group Market

Financial Performance by Year for the Fully-Insured Small Group Market				Year over Year Change	
Year	Membership (in 1,000s)	Loss Ratio	Underwriting Gain/Loss	Claims PMPM	Premium PMPM
2013	713	78.7%	5.8%		
2014	639	78.8%	3.8%	4.6%	6.0%
2015	551	78.0%	3.9%	5.9%	5.8%
2016	492	78.2%	3.9%	3.0%	4.0%

Sources: Insurer data call responses, MLR reporting data, SHCEs, and MEPS

The financial performance was stable between 2013 and 2016. Loss ratios were similar for all four years, and insurers recorded an average underwriting gain of approximately 4%. Average claim costs increased between 3% and 6% per year, while average premiums increased between 4% and 6% per year. Based on information provided in the insurer data call responses, average premiums increased approximately 5.5% in 2017. ODI completed a preliminary analysis of the 2018 small group ACA rate filings, and average premiums for small group ACA plans are expected to increase

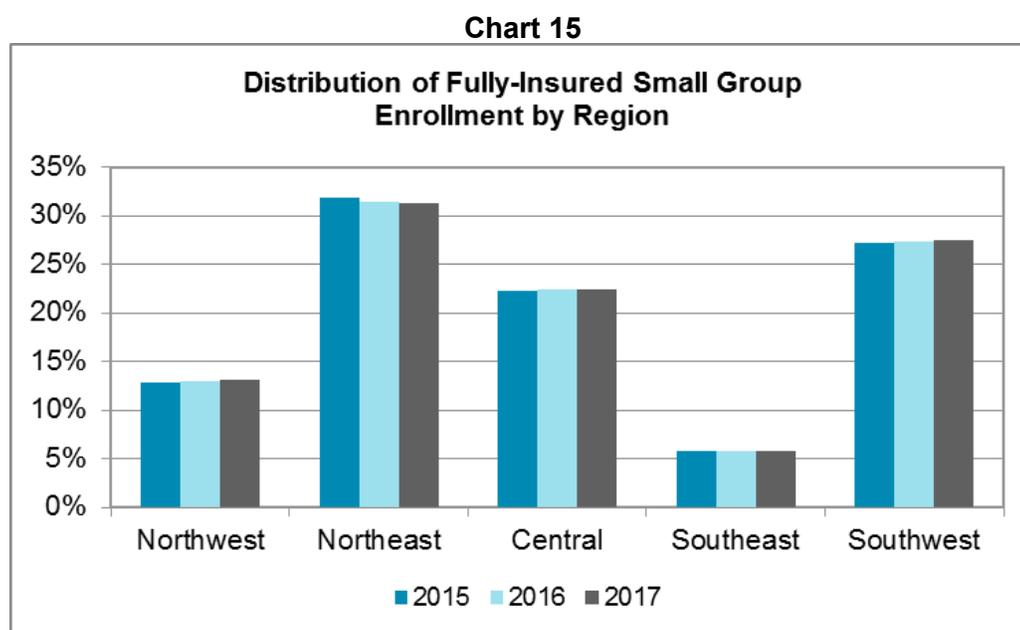
approximately 1% in 2018.²⁵ Information to determine the average rate change for non-ACA plans was not available.

It is important to note that for financial reporting purposes, insurers in Ohio were required to categorize the experience of all employers with 100 or fewer employees as small group for the years shown in Table 6. As a result, the information shown in Table 6 also includes the experience of employers with 51 to 100 employees. Approximately two-thirds of small group member months underlying the experience reported in the financial statements is attributed to employers with 50 or fewer employees. Additionally, the loss ratios produced using information from the insurer data call closely align with the loss ratios from the financial statement and MLR reporting data. As a result, we believe the financial statement and MLR reporting data serves as a good proxy for the financial performance of the fully-insured small group market.

Characteristics of Small Group Market Enrollees

Geographic Characteristics

Chart 15 summarizes the distribution of enrollees in Ohio’s fully-insured small group market by region.²⁶ Similar to the individual market, a majority of fully-insured small group enrollees are located in the northeast portion of the state, with the fewest located in the southeast region. The overall distribution of enrollees by region has not changed significantly since 2015.



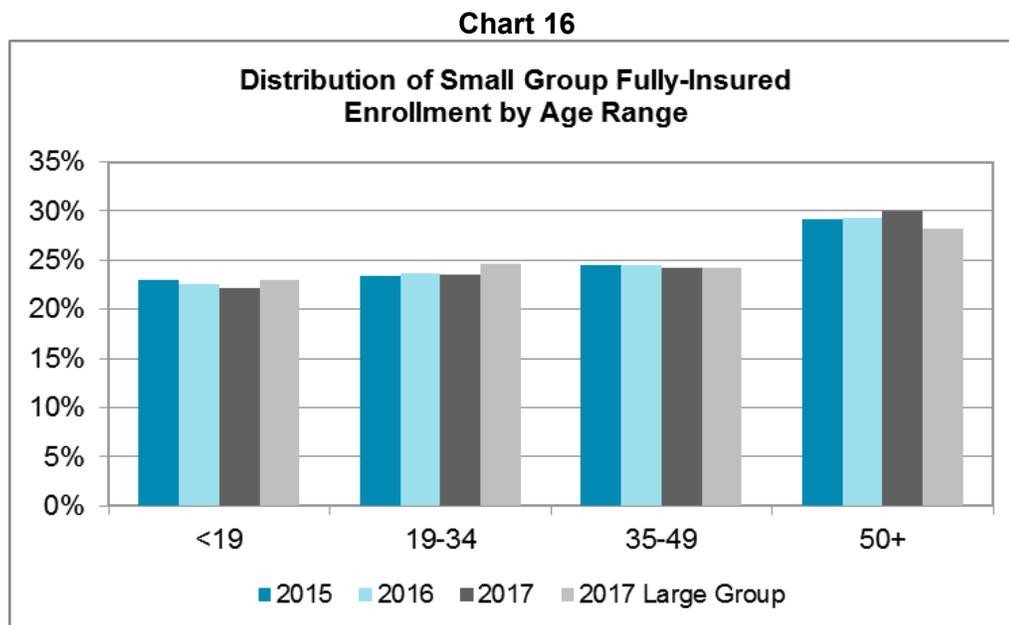
Source: Insurer data call responses

²⁵ <http://insurance.ohio.gov/Consumer/Pages/Exchange%20Overview.aspx>

²⁶ Each region is defined using the Ohio Geographic Rating Areas for ACA plans. The northwest region is defined as geographic rating areas 1, 2, and 6. The northeast region is defined as geographic rating areas 11, 12, 13, 14, and 15. The central region is defined as geographic rating areas 7, 8, and 9. The southeast region is defined as geographic rating areas 10, 16, and 17. The southwest region is defined as geographic rating areas 3, 4, and 5.

Age Characteristics

Chart 16 summarizes the distribution of fully-insured small group enrollees by age for 2015 through 2017 alongside the distribution of 2017 large group market enrollees for comparative purposes. Overall, the distribution of fully-insured small group enrollees by age did not change materially between 2015 and 2017 and is comparable to the distribution of large group fully-insured enrollees. The average age of the 2017 small group fully-insured enrollees is approximately 35.8, with ACA enrollees being slightly older than non-ACA enrollees (average age of 36.4 compared to 35.6, respectively). Additionally, information from the insurer data call shows that 48.4% of ACA enrollees are female compared to 45.3% of non-ACA enrollees being female. While the data underlying Chart 16 is based on small group fully-insured data, we believe this information is representative of the entire small group market. Demographic data of self-funded small group enrollees was not available.

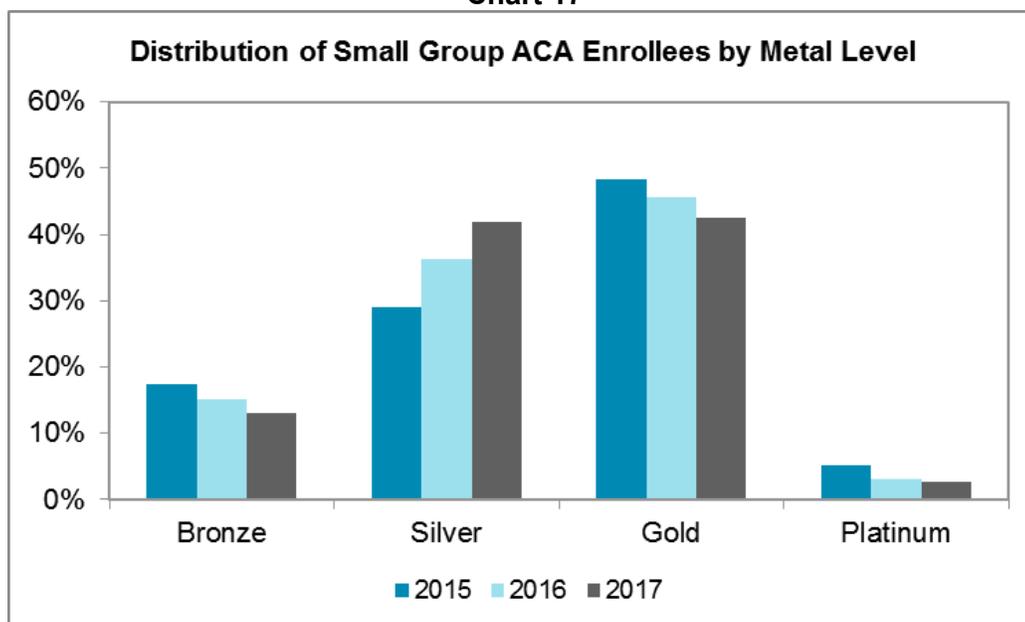


Source: Insurer data call responses

Benefit Characteristics

Chart 17 summarizes the distribution of ACA small group enrollees by metal level for 2015 through 2017. The distribution of enrollees by metal level shifted between 2015 and 2017 as a greater proportion of groups and individuals enrolled in silver coverage in 2017 relative to 2015. The proportion of enrollees in each of the other metal levels decreased between 2015 and 2017.

Chart 17



Source: Insurer data call responses

Benefit levels for non-ACA enrollees are more difficult to characterize since there are no “metallic” requirements. Using the paid-to-allowed ratio as a metric to assess differences in the richness of coverage between ACA and non-ACA enrollees, the proportion of allowed claim costs paid by insurers is lower for non-ACA enrollees compared to ACA enrollees (i.e., average member cost sharing for non-ACA enrollees relative to their allowed claims is higher for non-ACA enrollees) as shown in Table 7. While non-ACA plans in the small group market are not required to cover EHBs, non-ACA plans generally cover similar services as ACA plans, allowing for a better comparison of benefit levels between ACA and non-ACA plans than for the individual market.

Table 7

Paid-to-Allowed Ratios by Plan Type		
Plan Type	2015	2016
ACA	80.0%	79.6%
Non-ACA	78.6%	78.5%

Source: Insurer data call responses

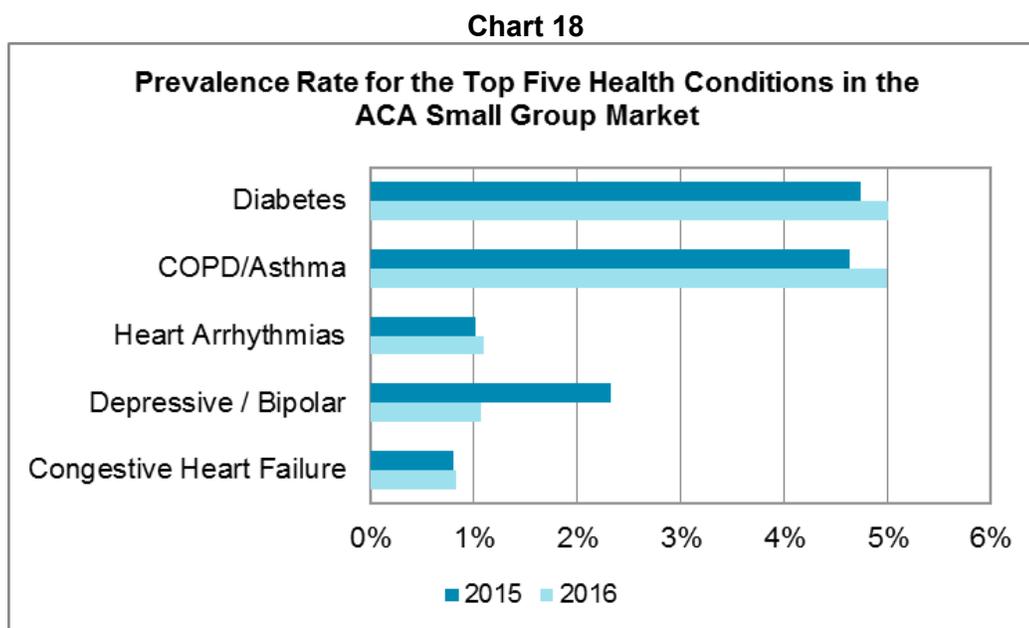
Morbidity Characteristics

Similar to the individual market, information regarding the types of health conditions associated with small group market enrollees is limited to ACA enrollees since data for non-ACA enrollees is not included in the EDGE server files. No comparable information was readily available for non-ACA enrollees.

Chart 18 summarizes the five health conditions most prevalent in the ACA small group market enrollees, using CMS’ hierarchical condition categories for diagnostic classification and the outbound reports from the EDGE server risk adjustment and reinsurance processes. Diabetes and chronic obstructive pulmonary disease/asthma (COPD/asthma) are the most prevalence health

conditions among ACA small group market enrollees, similar to ACA individual market enrollees. However, the overall prevalence of these conditions is lower among ACA small group enrollees relative to ACA individual market enrollees, likely due to the small group population having a more favorable demographic mix relative to individual market enrollees, and older adults being healthy enough to be actively employed full time.

It should be noted that while Chart 18 shows a noticeable decrease in the proportion of small group enrollees with depressive or bipolar disorders in 2016, this decrease is being driven by a change in the definition of depressive and bipolar disorders.



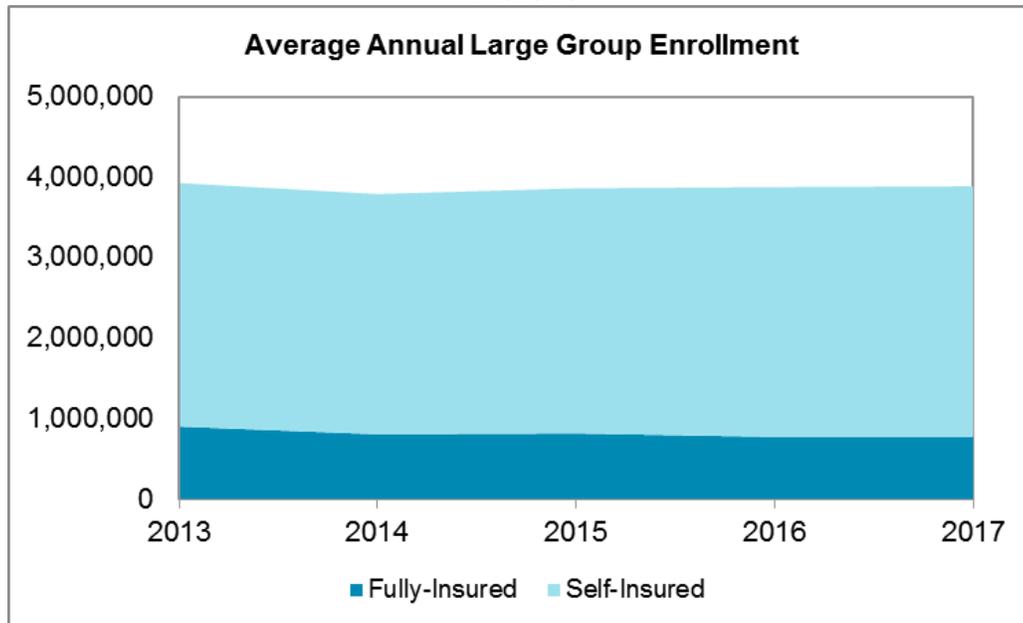
Source: EDGE server outbound reports

Large Group Market and Competitive Landscape

As noted earlier, the ACA's impact on the large group market was more moderate relative to its impact on the individual and small group markets. The employer mandate was one of the more significant provisions of the ACA that affected large group employers. However, most large group employers offered coverage to employees prior to the passage of the ACA. For purposes of analyzing the large group market in this section, government employees and their dependents were excluded from the large group market analysis, except where noted. An analysis of government employees is included in Section 7.

Chart 19 summarizes enrollment in the Ohio large group market. Despite a slight decrease in enrollment in 2014, total enrollment in the large group market did not change materially between 2013 and 2017. Enrollment in fully-insured plans decreased between 2013 and 2017, offset by an increase in enrollment in self-insured plans. Self-funding is prevalent in the large group market, and while self-funded groups are still required to comply with most of the benefit and cost-sharing requirements under the ACA, self-funded groups are exempt from some of the ACA's fees and taxes (i.e., the ACA's Health Insurance Providers Fee).

Chart 19

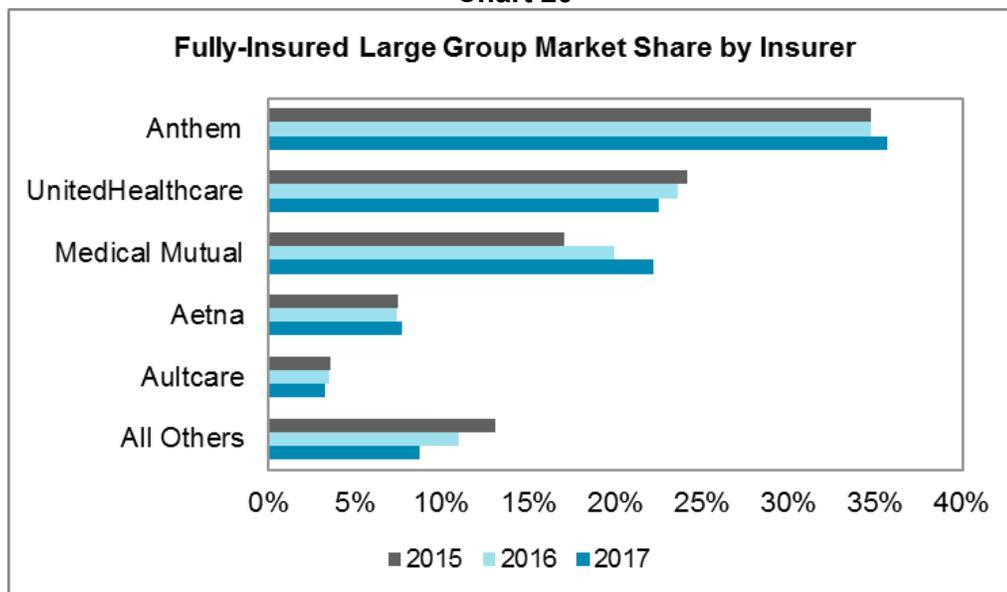


Sources: Insurer data call responses, MLR reporting data, SHCE, and MEPS

Market Share by Insurer

Chart 20 summarizes the market share of the top five health insurers in the Ohio fully-insured large group market (including government employees other than FEHBP) for 2015 through 2017.²⁷

Chart 20



Sources: Insurer data call responses, MLR reporting data, and SHCEs

²⁷ Top five insurers were identified based on insurers with the greatest membership in 2017, as reported in the insurer data call responses.

The competitive environment has not change significantly in recent years. Anthem is the largest insurer in the fully-insured large group market insuring roughly one-third of all enrollees, followed by UnitedHealthcare and Medical Mutual. Medical Mutual gained market share between 2015 and 2017, mostly at the expense of all other insurers not shown. Collectively, the market share of the top five insurers represented approximately 90% of the large group fully-insured market in 2017, with the top three insurers representing 80% of the market.

Financial Performance

Table 8 summarizes the financial performance of the Ohio fully-insured large group market (including government employees other than FEHBP) across all insurers. Loss ratios increased from 78.3% in 2015 to 84.6% in 2016, driven by a significant increase in claim costs PMPM combined with relatively low premium increases. This resulted in a smaller underwriting gain in 2016 relative to 2015. Based on information from the insurer data call responses, average premiums increased approximately 3.0% in 2016 and approximately 1.8% in 2017. The information to assess the average rate change in 2018 for the large group market was not available.

Table 8

Financial Performance by Year for the Fully-Insured Large Group Market					
				Year over Year Change	
Year	Membership (in 1,000s)	Loss Ratio	Underwriting Gain/Loss	Claims PMPM	Premium PMPM
2015	820	78.3%	8.2%		
2016	777	84.6%	3.2%	11.2%	3.0%

Sources: Insurer data call responses, MLR reporting data, SHCEs, and MEPS

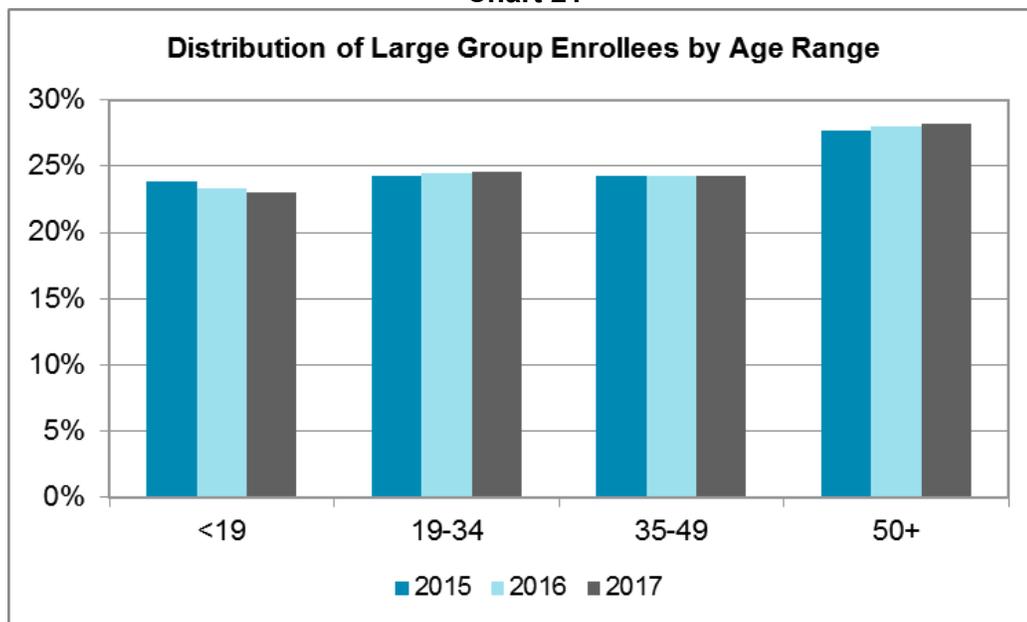
As noted earlier, for financial reporting purposes the experience of employers with 51 to 100 employees was reported as small group. Additionally, individuals enrolled in the federal employees health benefits program (FEHBP) are included in the financial results for the large group fully-insured market. Given the large size of each of these cohorts, and the unique characteristics of FEHBP enrollees, Table 8 relies on information provided through the insurer data call to calculate loss ratios and changes in premiums and claims PMPM. While our approach to summarizing the financial performance of the full-insured large group market is inconsistent relative to our reporting of the financial performance of the individual and small group markets, we believe our approach for the fully-insured non-government large group market produces a more accurate depiction of this market relative to the financial statement data.

Characteristics of Large Group Market Enrollees

Age Characteristics

Chart 21 summarizes the distribution of large group enrollees (including government employees other than FEHBP) in Ohio by age for 2015 through 2017. The overall distribution of large enrollees by age did not change materially between 2015 and 2017, with the average age increasing from 34.8 in 2015 to 35.2 in 2017. While the data underlying Chart 21 is based on large group fully-insured data, we believe this information is representative of the entire large group market. Demographic data of large group self-funded enrollees was not available.

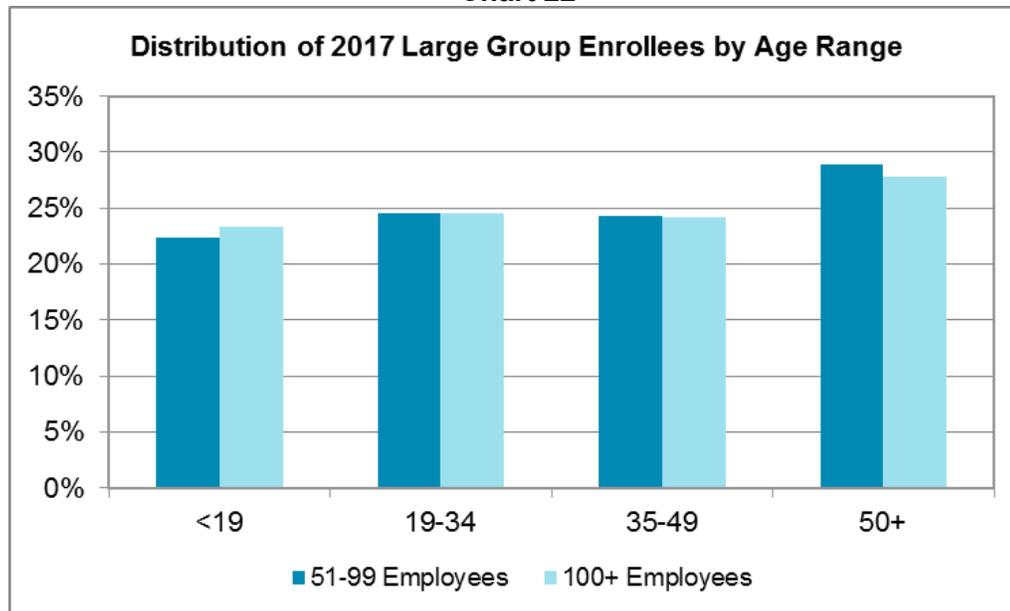
Chart 21



Source: Insurer data call responses

Further, Chart 22 shows little variation in the distribution of large group enrollees (including government employees other than FEHBP) by age for employers with 51 to 99 employees and employers with 100 or more employees in 2017. However, employers with 51 to 99 employees had a higher proportion of males enrolled (52.9%) versus employers with 100 or more employees (50.7%).

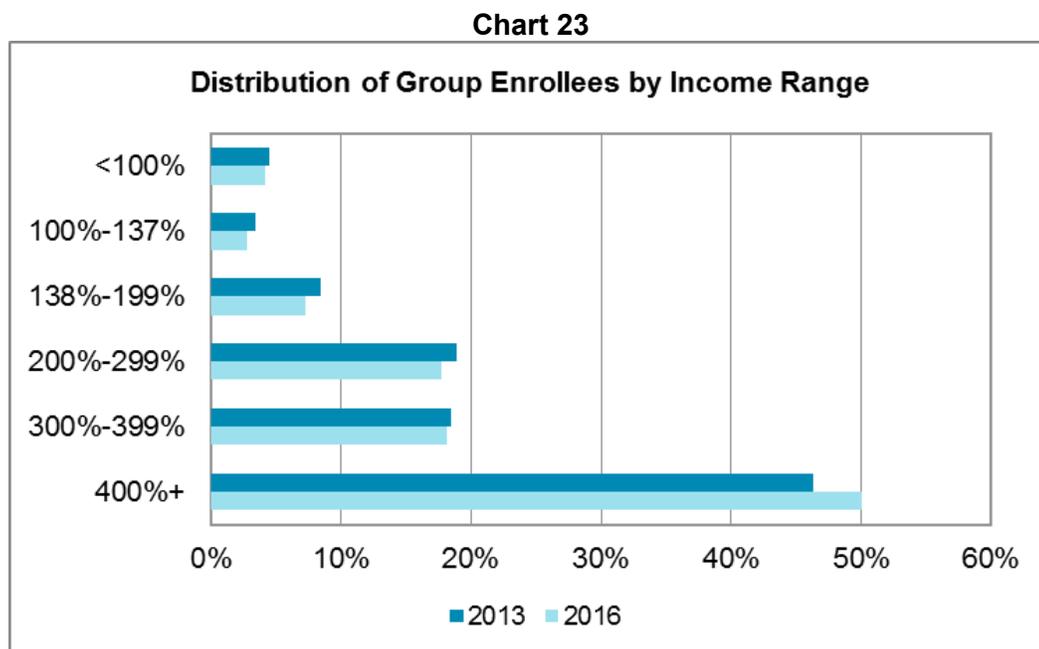
Chart 22



Source: Insurer data call responses

Income Based Characteristics

The distribution of group enrollees, including small group enrollees, by income range in relation to FPL for 2013 and 2016 is shown in Chart 23. The proportion of group market enrollees with incomes at or above 400% FPL increased between 2013 and 2016, while the distribution of enrollees at all other income ranges decreased slightly.



Source: ACS

This shift is likely due to the impact of two items. First, the individual mandate penalty amount increased as income increase. However, for some individuals in the lowest income ranges (e.g., individuals with incomes under 200% FPL), their employer coverage may have been deemed “unaffordable,” resulting in them taking up subsidized coverage in the individual market. Second, some small employers with low income employees may have dropped coverage. Since small employers are not subject to the employer mandate, they may have found that their employees are financially better off by accessing subsidized coverage in the individual market.

7

Enrollment in Government Programs

In this section, we examine enrollment in various government health care programs available to Ohio residents. We categorized enrollees into three broad programs: Medicaid, Medicare, and government employees and covered dependents. We first examine recent enrollment trends in Ohio's Medicaid programs, including the impact of Ohio's decision to expand Medicaid to cover most individuals with household incomes under 138% FPL. We then analyze recent enrollment trends for Medicare enrollees. Finally, we analyze recent enrollment trends for individuals covered under benefit plans offered by government entities.

It is important to note that Ohio does not have any federally recognized American Indian tribal entities, which means few Ohioans receive healthcare services through the Indian Health Service.

Medicaid

Ohio offers a variety of health insurance programs for low income residents. Below is a summary of the largest Medicaid programs providing full health care coverage to low income residents in Ohio.

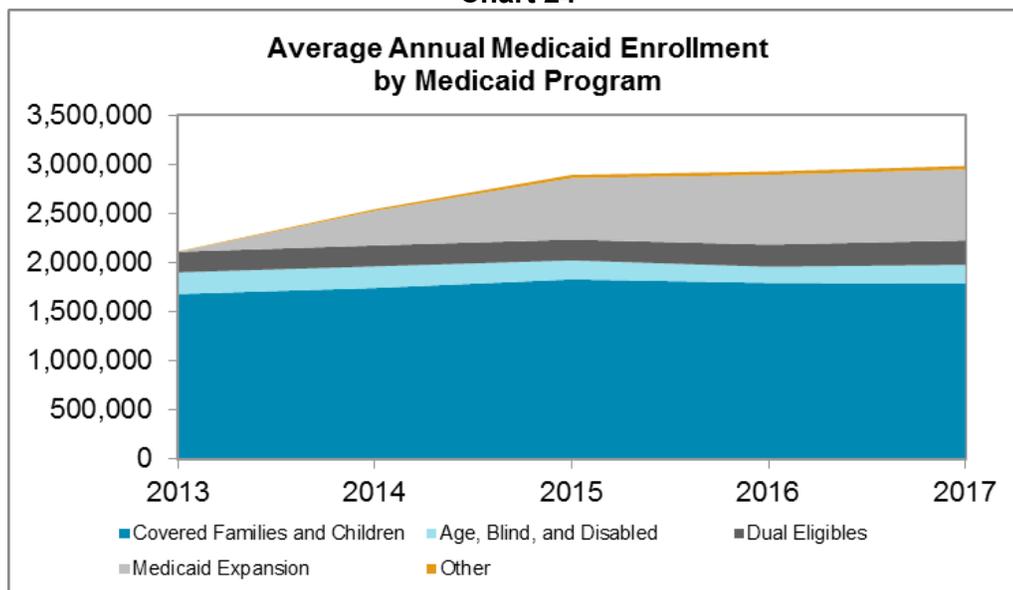
- **Ohio Healthy Start:** Provides health care coverage to uninsured individuals under the age of 19 with family incomes under 206% FPL, insured individuals under the age of 19 with family incomes under 156% FPL, and pregnant women with family incomes under 200% FPL.
- **Ohio Healthy Families:** Provides health care coverage to individuals with family incomes under 90% FPL who have at least one child under the age of 19 in the home.
- **Age, Blind, and Disabled:** Provides healthcare coverage to individuals who are age 65 or older, blind, or disabled and meet Medicaid income requirements. Coverage is provided for primary and acute care services as well as long-term care services.
- **MyCare Ohio:** Provides coordinated healthcare coverage to the state's low income seniors and individuals with disabilities who receive Medicare and Medicaid benefits (Medicaid-Medicare dual eligibles). MyCare Ohio began as one of the earliest Medicaid-Medicare dual eligible demonstration programs in the country and is only available in select counties. Approximately 42% of dual eligible enrollees participate in the MyCare Ohio program.
- **Medicaid Expansion:** Provides health care coverage to uninsured individuals with incomes under 138% FPL who do not qualify for any other Medicaid programs.

Enrollment in Ohio's Medicaid program has increased substantially since 2013, driven by Ohio's decision to expand Medicaid in accordance with the ACA for the childless adult population. Prior to 2014, the only non-disabled, non-elderly adults eligible for Medicaid were parents and caretakers with family incomes below 90% FPL and at least one child under the age of 19 in the home, and pregnant women with income at or below 200% FPL. In 2014, Ohio elected to expand Medicaid eligibility to essentially include all adults with incomes under 138% who did not qualify for any other Medicaid program, in accordance with the Medicaid expansion provision of the ACA.

As a result, an over 700,000 additional individuals qualified for Medicaid in 2017. Chart 24 below summarizes the enrollment by Medicaid program for individuals receiving full Medicaid benefits.

Please note, Covered Families and Children includes individuals enrolled in Ohio Healthy Start and Ohio Healthy Families. Additionally, MyCare Ohio enrollees are included with dual eligibles.

Chart 24



Source: Ohio Department of Medicaid caseload reports

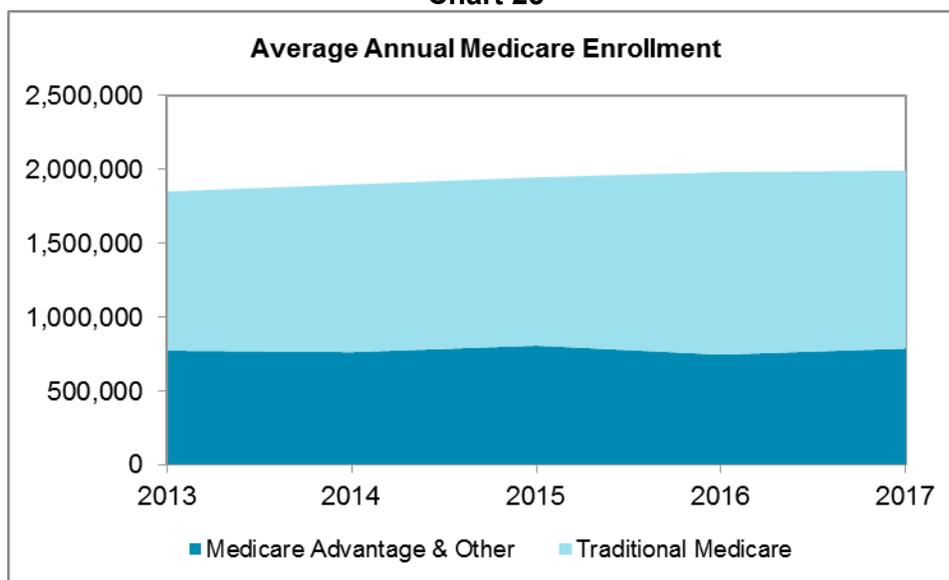
In 2017, approximately 86% of Medicaid enrollees were enrolled in a managed care plan, up from 80% in 2013. A majority of the increase in the proportion of individuals enrolled in a Medicaid managed care plan was due to the introduction of MyCare in 2014.

Medicare

As shown in Chart 25, the number of Ohioans enrolled in Medicare increased between 2013 and 2017 due to an overall aging of the population, with most of the increase occurring in Traditional Medicare (Medicare Fee-For-Service). Enrollment in Medicare Advantage and Other plans remained steady, despite a reduction in payments to insurers as prescribed by the ACA.

A decline in Medicare Advantage and Other plan enrollment was observed in 2016, primarily driven by the Ohio Public Employees Retirement System's decision to no longer solely offer Medicare Advantage plans and instead offer enrollees the ability to purchase coverage, including Medigap and Medicare supplement policies, through a private exchange. However, enrollment in Medicare Advantage plans increased in 2017 relative to 2016. Please note, dual eligible enrollees were excluded from the enrollment counts in Chart 25.

Chart 25

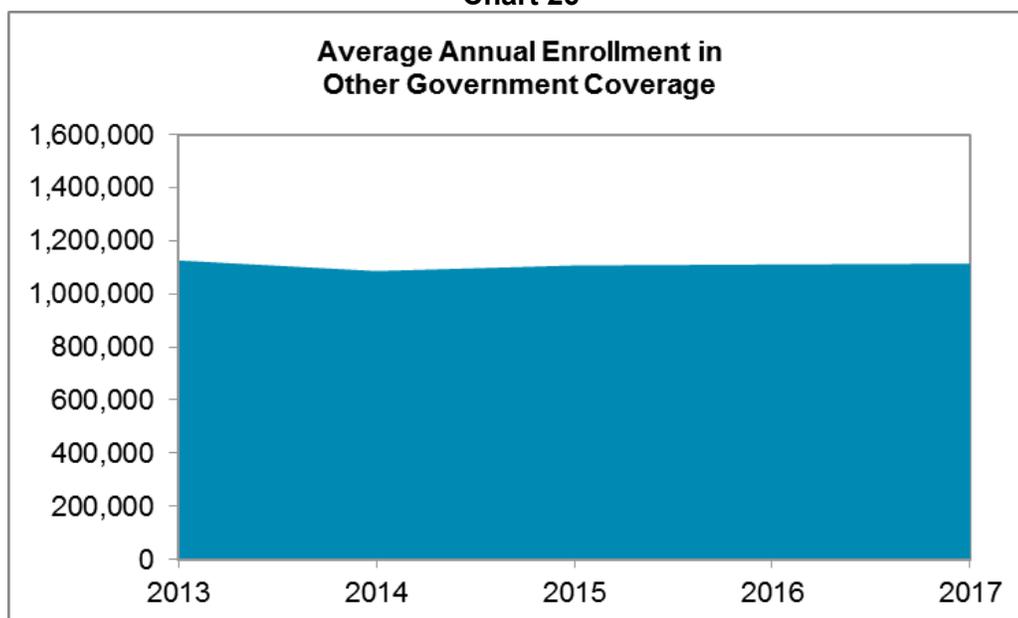


Sources: Medicare enrollment dashboard and Medicaid enrollment summary

Other Government

The other government category consists of non-elderly individuals enrolled in health care coverage offered by local, state, and federal government entities, including individuals covered under TRICARE. Chart 26 shows enrollment estimates by year for individuals in the other government category. While enrollment has fluctuated from year to year, enrollment has not changed materially between 2013 and 2017. Given the lack of available information, we are unable to provide a breakdown of enrollees by government jurisdiction (i.e., local, state, and federal entities).

Chart 26



Source: ACS

8

Ohio's Uninsured Population

In this section, we analyze Ohio's uninsured population. We first analyze changes in the number of uninsured individuals and the insured rate. We then analyze various characteristics of Ohio residents who are uninsured (e.g., demographic mix, socioeconomic mix, etc.).

Number of Uninsured Residents and the Uninsured Rate

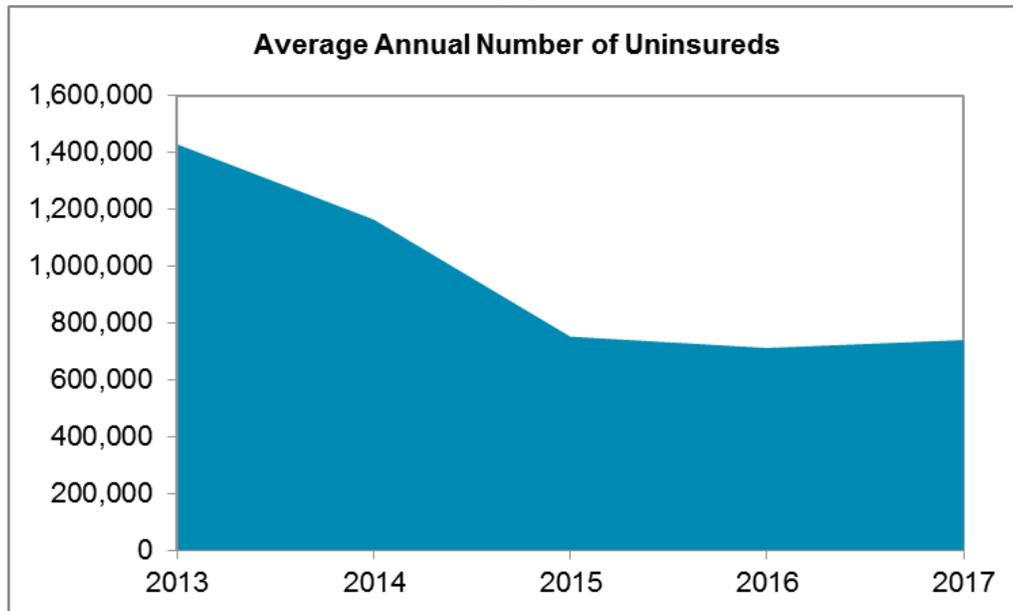
One of the main goals of the ACA was to expand access to affordable health insurance and reduce the uninsured rate. To do so, the ACA required guaranteed issue of coverage, expected states would expand Medicaid to cover all individuals with incomes below 138% FPL, introduced premium tax credits to make individual market coverage more affordable for lower income, non-Medicaid eligible individuals, and introduced tax penalties on most individuals who chose to remain uninsured or large employers who chose not to offer coverage to employees.

For Ohio, expanding Medicaid to cover all individuals with incomes below 138% FPL has resulted in a significant reduction in the number of uninsured individuals. Guaranteed issue of coverage, premium tax credits in the individual market and the individual and employer mandates have also contributed to fewer uninsured individuals, but to a much lesser degree.

Chart 27 summarizes the number of uninsured individuals over the period 2013 through 2017. The number of uninsured Ohioans has decreased from 1.43 million in 2013 to roughly 745,000 in 2017. This resulted in the overall uninsured rate of the population decreasing from 12.4% in 2013 to 6.4% in 2017.

It is important to note that the number of uninsured individuals increased by roughly 30,000 in 2017 relative to 2016, and may increase further in the near future as a result of both the significant rate increases that were implemented in the ACA individual market for 2018 and the elimination of the individual tax penalty for not having coverage starting in 2019.

Chart 27



Sources: National Health Interview Survey, Ohio Health Issues Poll, and other sources

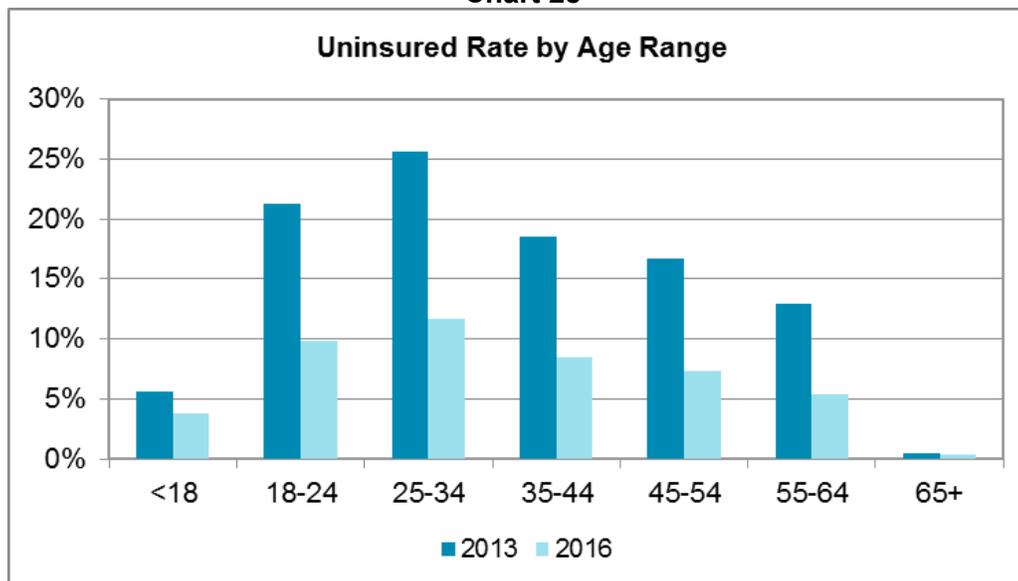
Characteristics of the Uninsured Population

The impact of the ACA was relatively uniform when comparing the 2016 uninsured rate by age range, income range, and work status to the corresponding 2013 cohort.

Age Characteristics

Chart 28 compares the uninsured rate by age range in 2013 and 2016.

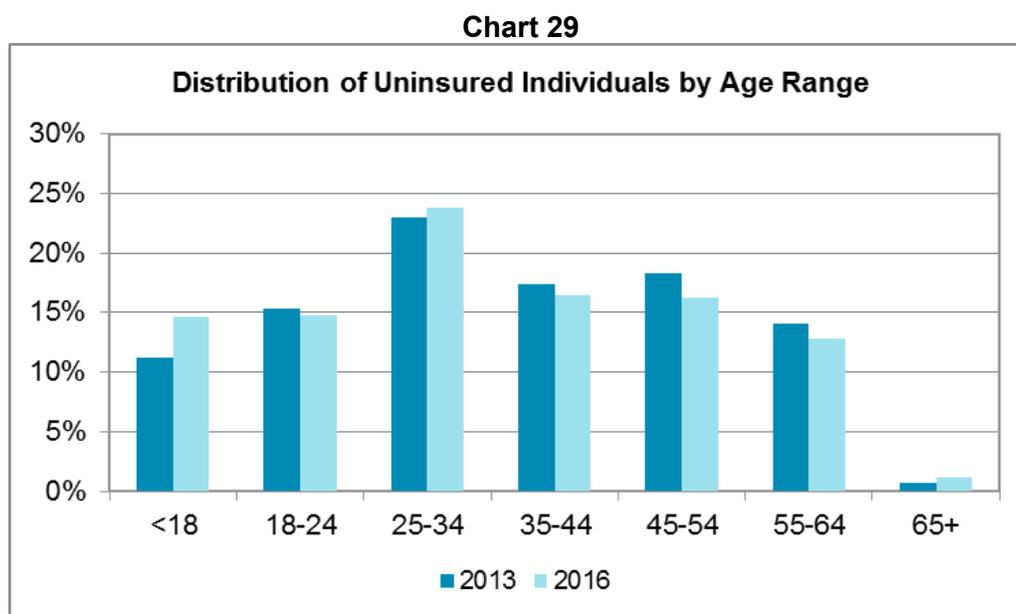
Chart 28



Source: ACS data summaries

The uninsured rate decreased for all age ranges, with the largest decrease observed for the 25-34 year old age range. The larger decrease in the number of individuals in this age range is likely driven by a combination of both the ACA's provision that allows individuals to remain covered under their parents insurance until age 26, and the expansion of Medicaid to cover childless adults with incomes up to 138% FPL. The change in the uninsured rate for individuals under the age of 18 was smaller than most other age ranges due to the presence of Ohio Healthy Start, the state's CHIP program being in place in 2013. The decrease in the uninsured rate for individuals age 65 or older was negligible since individuals are automatically enrolled in Medicare upon becoming eligible.

Chart 29 compares the distribution of uninsured individuals by age range in 2013 and 2016.



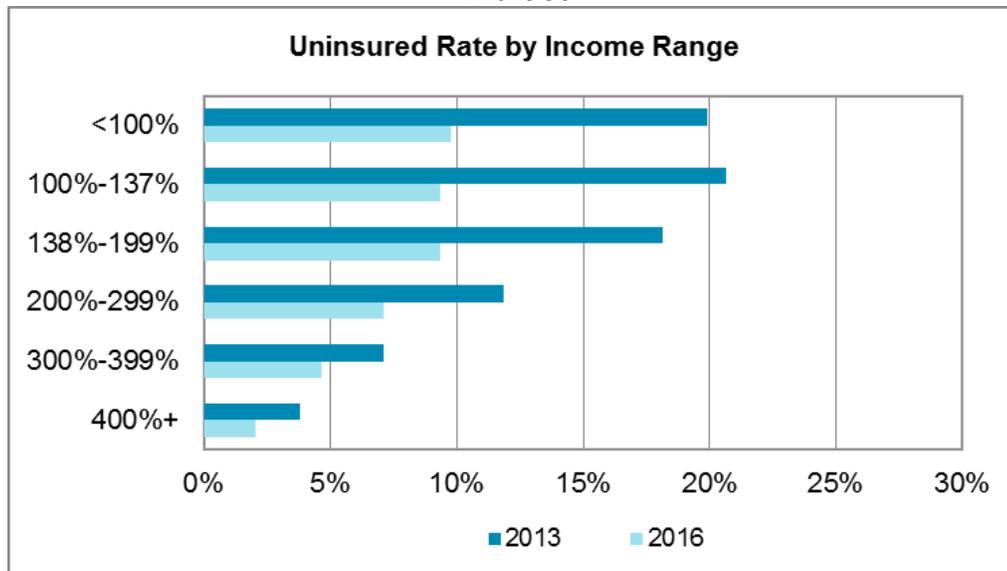
Source: ACS data summaries

Despite the significant decrease in the uninsured rate among individuals between the ages of 25 and 34, approximately one-fourth of all Ohioans that remained uninsured in 2016 were in this age range, a cohort sometimes referred to as the “young invincibles” (i.e., young, healthy individuals who utilize little healthcare). Minimizing the uninsured rate for the “young invincibles” may be critical for the continued viability of the Ohio individual market. It should be noted that the data shows approximately 57.7% of uninsured individuals were male in 2016, up from 54.0% in 2013.

Income Characteristics

Chart 30 compares the uninsured rate by family income range as a percent of FPL. A reduction in the uninsured rate was observed for all income ranges, with the lower income ranges experiencing the greatest improvement. The reduction in the uninsured rate for individuals with family incomes under 138% FPL was driven by the expansion of Medicaid eligibility, and the introduction of premium tax credits assisted in reducing the uninsured rate for individuals with family incomes between 138% and 399% FPL. The change in the uninsured rate was lowest for individuals with incomes at or above 400% FPL, since most of these individuals were previously enrolled in group health insurance in 2013.

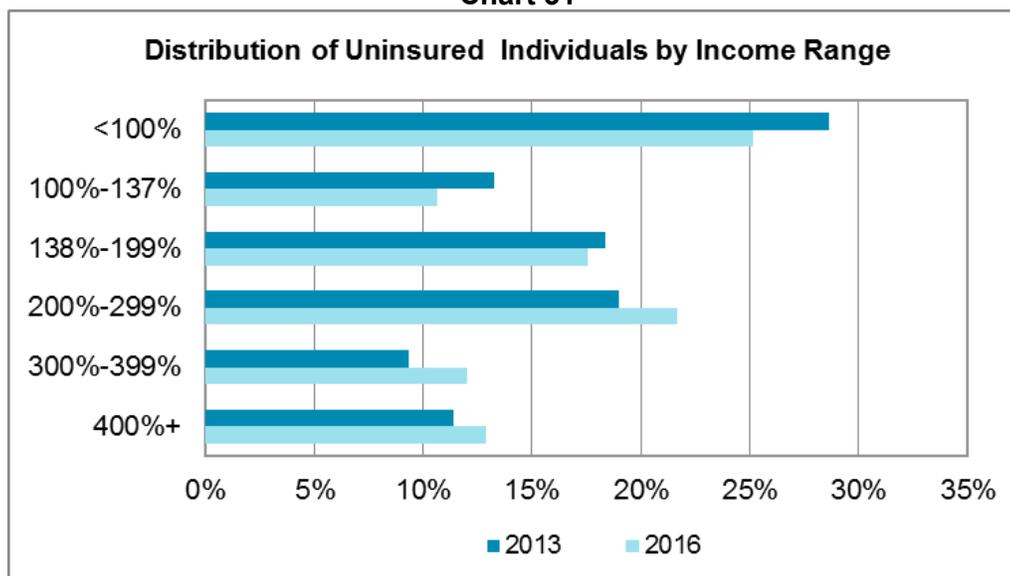
Chart 30



Source: ACS data summaries

Chart 31 shows that roughly one-third of all uninsured individuals in 2016 had family incomes below 138% FPL and likely could have enrolled in Medicaid at no cost. Another 15% of all uninsured individuals had family incomes between 138% and 199% FPL. This is noteworthy since individuals with incomes between 138% and 200% FPL who are eligible for APTCs are also eligible to enroll in CSR plans, which offer substantially richer benefits (i.e., lower cost sharing) relative to the base silver-level coverage, and in 2017 cap member premium contributions at 3.1% to 6.4% of family income, depending on family income and assuming individuals enroll in the second lowest-cost silver plan.

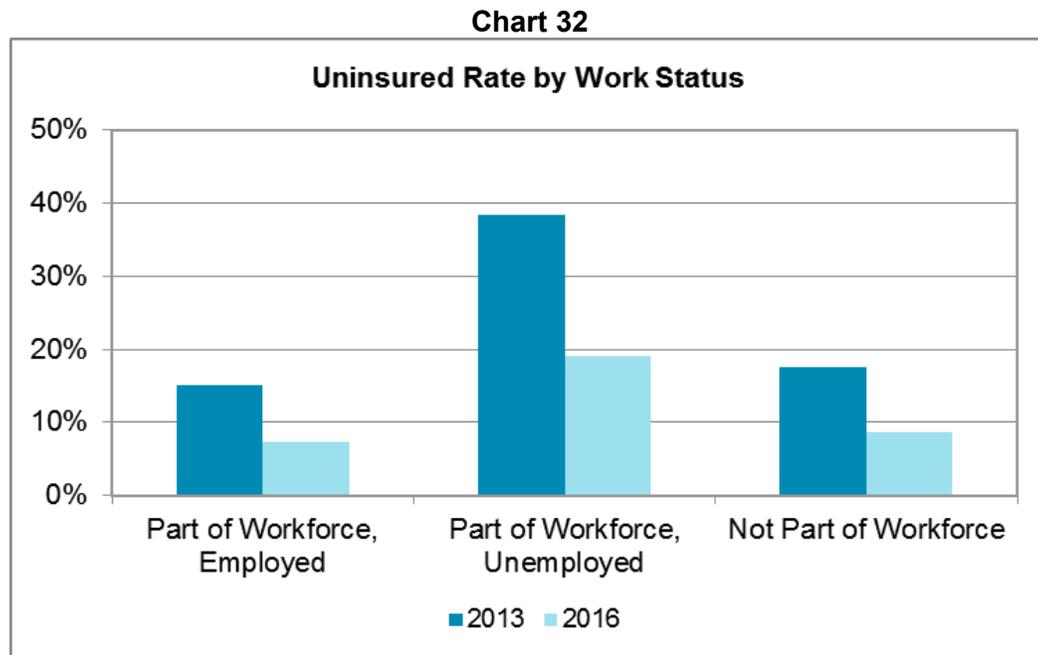
Chart 31



Source: ACS data summaries

Employment Characteristics

Chart 32 summarizes the uninsured rate by work status for individuals between the ages of 18 and 64. Individuals were categorized into three work status categories: part of the workforce and employed, part of the workforce but unemployed, and not part of the workforce. The uninsured rate across all three categories decreased from 2013 to 2016, with the uninsured rate for individuals in the workforce but unemployed experiencing the most significant decrease in the uninsured rate. This is likely a result of these individuals being eligible for Medicaid in 2016 but not eligible in 2013.



Source: ACS data summaries

9

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