



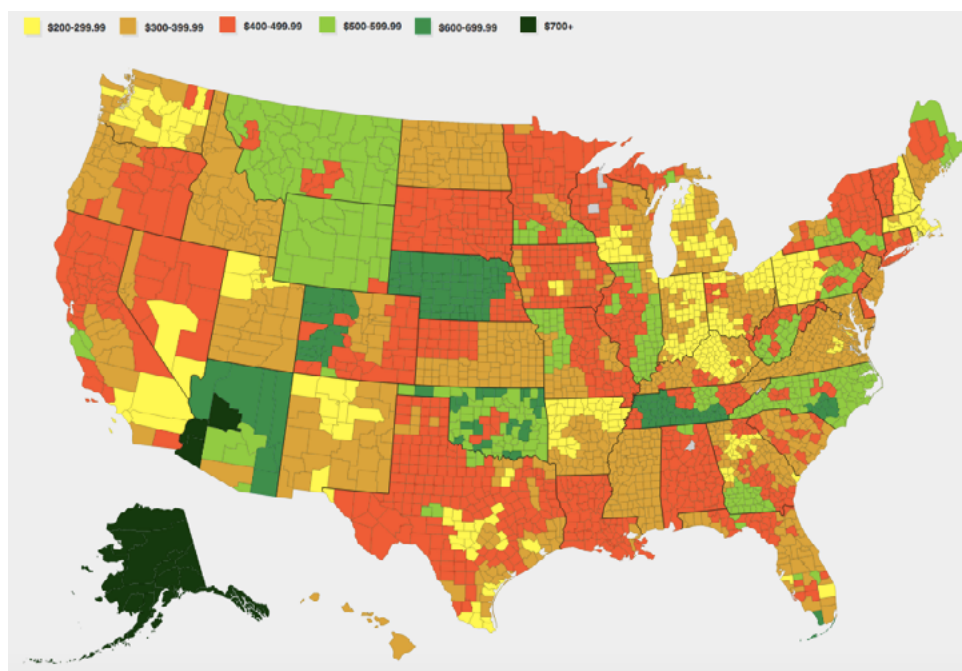
Health Care is Local: Impact of Income and Geography on Premiums and Premium Support

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The American Health Care Act (AHCA) proposes a significant change in how and to whom premium tax credits are dispersed, proposing a flat rate adjusted only by age. The Affordable Care Act (ACA) bases its premium tax credit calculation on three factors: age, income and local cost of insurance premiums. While there has been extensive discussion of the impact of eliminating premium support based on consumers' income, there has been relatively little on what happens when credits are not adjusted based on where a consumer lives. By failing to account for local variation, a premium tax credit structure could lead to significant increases in premiums and out-of-pocket costs paid by consumers while also potentially reducing plan availability for those who live in relatively high cost and rural areas of each state.

This issue brief provides an overview of the context and potential impact of changing the health insurance premium tax credit structure from one that factors for age, income, and local premium costs to one that considers only age. The brief underscores that, while cost variation is often framed as comparing costs between states, in reality costs vary widely within state borders leading to large differences in insurance premiums and out-of-pocket spending. An accompanying [State Chart Book](#), leveraging data available from the Kaiser Family Foundation¹, further illustrates estimated variation in premiums, premium spending by consumers, and estimated tax credits organized by state and select counties. The analysis illustrates predicted differences between the ACA and AHCA's tax credit structures in 2020, showing stark examples of potential differences in consumer premium spending.

Map 1. Health Insurance Marketplace Second Lowest Cost Silver Plan, Monthly Premium by County, 2017 (Calculated for 40-year old individual, non-smoker)



Source: <http://nashp.org/health-insurance-marketplace-second-lowest-cost-silver-plan-by-county-2017/>

What is Geographic Rating?

Insurance rating allows insurers to adjust premiums to reflect differences in the costs of care that vary by region, and for different age groups and populations. Historically the most significant “rating factor” has been health status or pre-existing conditions of insurance applicants. Under the ACA, however, a number of factors – such as prior health conditions – are not allowed to be used as a rating factor. In contrast, rating based on geography remains an allowable form of insurance rating.

The AHCA preserves regulation of geographic rating instituted under the Affordable Care Act which continues to provide states flexibility to define the number and borders of their geographic rating areas. However, it eliminates any adjustment to the tax credits to offset higher health care costs in different rating areas. The AHCA also continues the current policy that states may opt to essentially negate geographic rating by defining only a single rating area.² The majority of states opted to implement rating areas that aligned with methods used prior to passage of the Affordable Care Act, mostly based around counties.³ States have some discretion in the number of rating areas they apply. Seven states have a single rating area (DE, DC, HI, NH, NJ, RI, VT), while Florida has 67 (See Table 1).⁴

What Drives the Need for Geographic Rating?

Health care costs vary significantly by geography. Market realities prohibit the ability of insurers to remain competitive and sustainable in a regionally-based market without accounting for geographic factors. Specifically, insurers must have some capacity to respond to regional disparities in the underlying cost of health care generated by:

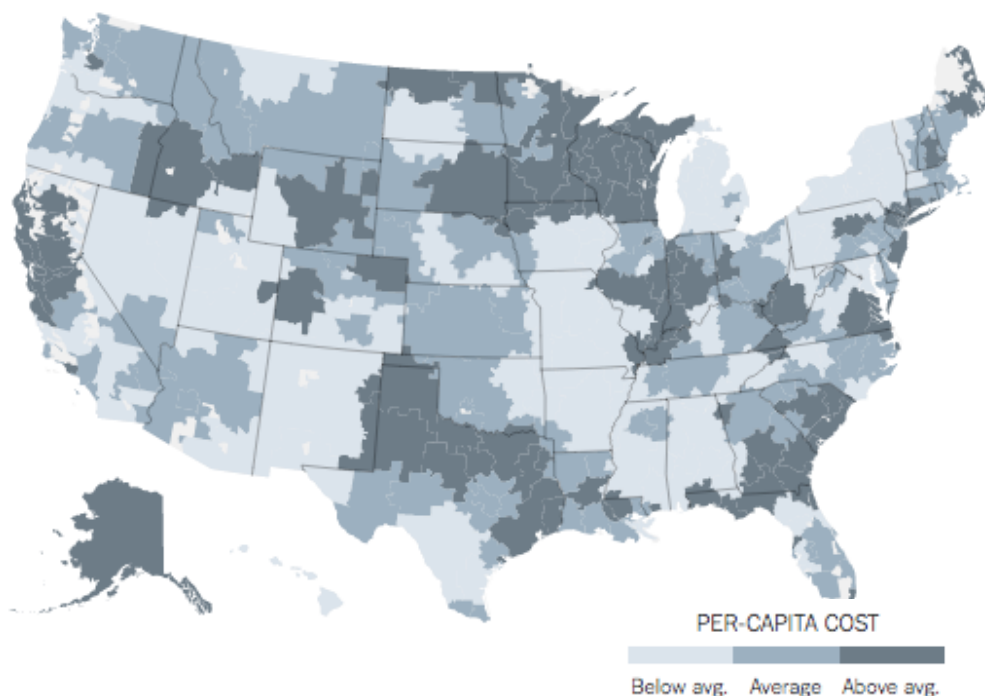
- Variation in the cost of services within and between regions.** Studies have documented wide variation in the cost of services, even when accounting for differences in income, demography and health status within regions.^{5,6} One likely driver is wide variation in the prices set for health care services (see map 2).^{7, 8, 9, 10} Price variation – both within and between regions – is especially problematic for private insurance, which, in contrast to Medicare and Medicaid, has an array of health plans with differing market position negotiating with an array of providers. One study of employer-sponsored insurance found that the price of knee replacement surgery could range from \$21,300 to \$45,000 depending the hospital used in New York City.¹¹ A comparison of pricing of procedures in California found that in the Bay Area, the negotiated rate paid by insurance plans for knee replacement surgery ranged from \$47,600 to \$74,700; while the difference in Los Angeles was from \$26,200 to \$43,800.¹² A Blue Cross Blue Shield Association study of non-Medicare members found that the cost of hip-replacements could range from \$11,327 to \$73,987 nationally.¹³

Table 1. Number of Rating Areas by State

# of rating areas	States
1	DE, DC, HI, NH, NJ, RI, VT
2-5	AK, WY, ME, MD, MT, NV, ND, NE, NM, OK, SD, WA
6-10	AR, AZ, CO, CT, IA, ID, KS, KY, LA, MA, MN, MO, MS, NY, OR, TN, UT, PA,
11-15	WV, AL, VA, IL
16-20	GA, MI, NC, WI, IN, OH, CA
21+	TX (26), SC (46), FL (67)

- **Lack of provider competition.** Lack of provider competition in some geographic areas gives available providers market power to set rates for services. A study by the National Bureau of Economic Research found that prices charged by hospitals in monopoly markets was 15.3 percent higher than in markets with four or more hospitals.¹⁴
- **Lack of health plan competition.** In areas with more potential enrollment and higher interest by health plans to participate, there is more competition among health plans who seek lower rates and gain market share. Moreover, more enrollees means that health plans can spread risk across a greater population base, leading to reduced premiums.¹⁵
- **Prevalence of rural communities.** Health care costs are often notably higher in rural communities which experience all or some combination of the factors described above, especially lack of market competition from health plans and providers and challenges associated with unique health concerns of populations in these areas.^{16, 17, 18} Colorado, for example, has documented a nearly 36% differential in the annual cost of services for individuals in its “mountain communities” versus in the rating area including Boulder, its lowest-cost region¹⁹

Map 2. In-state variation of private insurance health insurance expenditures



Map based on employer sponsored health plan data collected from UnitedHealthCare, Aetna, and Humana by the Health Care Cost Institute. Data are estimated represent about 14 percent of the U.S. population.

Source: Kevin Quealy and Margot Sanger-Katz. “The Experts Were Wrong About the Best Places for Better Care and Cheaper Health Care.” The New York Times. Published December 15, 2015. Accessible here: <https://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html>

How does Geographic Rating Affect Premiums?

Geographic rating reflects differences in health care prices and thus allows large disparities in insurance premiums charged through the individual health insurance marketplaces. Effective geographic rating can provide incentives for insurers to enter markets where prices are higher and eligible populations more sparse, or bring greater competition into lower-cost, lower-risk regions of a state.

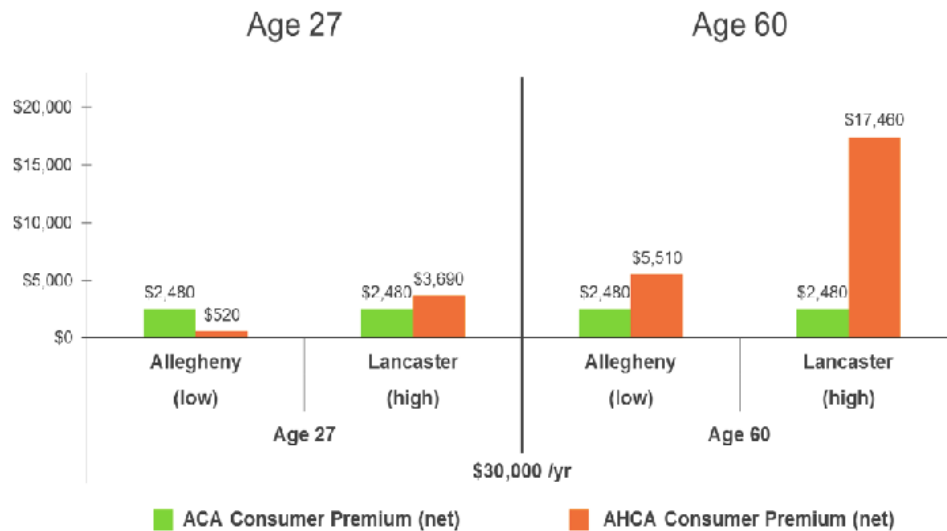
The gap between high- and low-cost regions is universal and exists in most states²¹, as detailed in the State Focus summaries. While some states have very large differentials – such as the seven states in which the highest cost regions are more than two times the costs of the lowest cost regions (AZ, FL, GA, IL, MI, PA, and TX) – in other states the costs may vary as little as ten percent between lowest and highest-cost regions.) (See Map 1).

Health care is local and allowing health plans to develop regional pricing goes hand in hand with enabling them to develop products with networks tailored to regional markets. For example, health plans can offer products organized around local provider networks and targeted toward specific consumer needs. Health plans that chose to have a regional focus also may promote local efficiencies by concentrating negotiations and work toward a specific geographic area rather than expending resources to execute contracts statewide.

Mitigating the Effects of Geographic Disparities

Geographic rating allows health plans to charge consumers in high cost areas more than those in low cost areas. As a result, consumers receive disparate value from dollars spent toward health care, including insurance premiums. The ACA partially addressed this issue, by using the “second lowest Silver Plan” in the regions where eligible individuals live as a factor in determining the amount of premium tax credit received. In short, tax credits are adjusted to reflect areas with higher costs. The AHCA proposes a reduced and flat credit based on age. While this sets a national standard, this strategy means consumers in high-cost regions will experience higher costs. As illustrated by the State Chart Book, stark extremes could exist in changes to consumer premium spending between the AHCA’s tax credit methodology and that of the ACA. For example, a 27-year old making \$30,000 a year living in Lancaster County, Pennsylvania could expect to pay \$1,210 per year more for premiums under the AHCA as compared with the ACA, while a similar individual living in Allegheny County, Pennsylvania could expect to save \$1,960 per year in premium expenses under the AHCA. A 60-year old making \$30,000 could expect to spend \$3,030 more in Allegheny County and \$14,980 more in Lancaster County under the AHCA (See Chart 1).

Chart 1. Estimated Premium Cost to Consumer after Tax Credit under the ACA and AHCA in High and Low Cost Counties in Pennsylvania, 2020 (estimated for individual making \$30,000 per year)



Conclusion

Differences in health care costs, and insurer and provider competition drive regional variation in insurance premiums across and within states. Current law, through the ACA, accounts for these regional differences. Policymakers should carefully assess the impact of these differences as a key factor in analyzing proposals to change the ACA tax credit structure. Premium tax credit structures that do not account for regional premium variation will mitigate how effectively tax credits are able to improve affordability of insurance, especially for those in high-cost regions.

Endnotes

1. Kaiser Family Foundation, "Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps," Accessed on June 7, 2017. <http://www.kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/>
2. Rating areas may be set based on counties, three-digit zip-code, or Metropolitan Statistical Areas (MSAs) which are identified based on regions of high-population density. Seven states use the MSA method (TX, AL, VA, WY, ND, NM, OK), three use zip codes (AK, MA, NE), and one uses a combination method (CA).
3. New Jersey, for example, created a single rating area for its individual market pursuant to prevailing state law. Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market
4. The Center for Consumer Information and Insurance Oversight, "Market Rating Reforms: State Specific Geographic Rating Areas," Accessed on June 7, 2017 <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/state-gra.html>
5. Report findings state that even after accounting for differences in age, sex, health status, demography, and insurance markets, a large amount of geographic variation remains unexplained.
Institute of Medicine of the National Academies, "Variation in Health Care Spending; Target Decision Making, Not Geography," accessed on June 7, 2017 http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2013/Geographic-Variation2/geovariation_slides.pdf
6. Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care; Board of Health Care Services; Institute of Medicine. "Variation in Health Care Spending: Target Decision Making, Not Geography," accessed on June 7, 2017 <https://www.ncbi.nlm.nih.gov/books/NBK201643/>
7. Cooper, Z., Craig, S., Gaynor, M., Reenen, J., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," accessed on June 7, 2017 http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf
8. Newman, D., Parente, S., Barrette, E., Kennedy, K., "Prices for Common Medical Services Vary Substantially Among the Commercially Insured,"

- accessed on June 7, 2017 <http://content.healthaffairs.org/content/35/5/923.full?keytype=ref&siteid=healthaff&ijkey=YtK26xXyamaVQ>
9. Weinstein, J., Lurie, J., Olsen, P., et al., "United States' Trends and Regional Variation in Lumbar Spine Surgery: 1992-2003," accessed on June 7, 2017 <https://www.ncbi.nlm.nih.gov/pubmed/17077740>
 10. Skinner, J., Fisher, E., "Reflections on Geographic Variations in U.S. Health Care," accessed on June 7, 2017 http://www.dartmouthatlas.org/downloads/press/Skinner_Fisher_DA_05_10.pdf
 11. Quealy, K., Sanger-Katz, M., "The Experts Were Wrong about the Best Places for Better and Cheaper Health Care," accessed on June 7, 2017 <https://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html>
 12. Cost estimates available from California Healthcare Compare. Data accessible at: <http://www.consumerreports.org/cro/2015/09/about-california-healthcare-compare/index.htm>
 13. Blue Cross Blue Shield Association, "Blue Cross Blue Shield Association Study Reveals Extreme Cost Variations for Knee and Hip Replacement Surgeries," <https://www.bcbs.com/news/press-releases/blue-cross-blue-shield-association-study-reveals-extreme-cost-variations-knee>
 14. Study focused on claims for private employer-sponsored coverage. Cooper, Z., Craig, S., Gaynor, M., Reenen, J., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," accessed on June 7, 2017 http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf
 15. Barker, A., McBride, T., Kemper, L., Mueller, K., "Health Insurance Marketplaces: Early Findings on Changes in Plan Availability and Premiums in Rural Places, 2014-2015," accessed on June 7, 2017 <https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2015/Health%20Insurance%20Marketplaces.pdf>
 16. Rural Health Research Gateway. "Geographic Variation in Health Insurance Marketplaces: Rural and Urban Trends in Enrollment, Firm Participation, Premiums, and Cost Sharing in 2016," Presentation delivered on August 9, 2016. Accessible at: <https://www.ruralhealthresearch.org/webinars/geographic-variation-health-insurance-marketplace>
 17. National Advisory Committee on Rural Health and Human Services, "Affordable Care Act Plans and Premiums in Rural America," accessed on June 7, 2017 <https://www.hrsa.gov/advisorycommittees/rural/publications/plansruralamerica.pdf>
 18. National Association of Insurance Commissioners, "HCRAWG State Rate Review Subgroup Discussion Paper on Geographic Area Rating Factors." accessed on June 7, 2017 http://www.naic.org/documents/committees_b_ha_tf_related_docs_aca_rating.pdf
 19. Colorado Division of Insurance. "Single Geographic Rating Area Study," accessed on June 7, 2017 <https://drive.google.com/drive/folders/0BwguXutc4vbpZjg5a2hPUW0tbjg>
 20. Excluding states that use a single rating area for health insurance premiums.

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Acknowledgments:

These products were made possible through generous support from the Robert Wood Johnson Foundation. We are also grateful for the work of the Kaiser Family Foundation whose data we leveraged for this analysis (available at: <http://www.kff.org/interactive/tax-credits-under-the-affordable-care-act-vs-replacement-proposal-interactive-map/>). We send special thanks to the policy teams at Covered California for their analytic assistance, especially Isaac Menashe, Andrew Feher and Katie Ravel.

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