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A TALE OF TWO STATES: INSURANCE PREMIUMS IN BORDER COUNTIES OF NEBRASKA AND IOWA¹

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KEY POINTS

— Nebraska's decision not to expand their Medicaid program as allowed under the Affordable Care Act has contributed to higher health insurance premiums compared to Iowa in border counties.

— For three hypothetical household scenarios, Nebraska border counties had higher average monthly health insurance premiums in the Bronze, Silver, and Gold health plan levels. Only in the Platinum health plan level did Iowa border counties have higher average health insurance premiums. Rates were pre-premium assistance tax credits.

— Average health insurance premiums in Nebraska border counties in the Bronze, Silver, and Gold levels were up to 4.2 percent greater than the average monthly premiums in Iowa border counties.

— Because of higher premiums in Nebraska, consumers in Nebraska bordering counties pay

more annually for their health insurance: up to over \$200 annually for Bronze plans, nearly \$200 annually for Silver plans, and nearly \$600 annually for Gold plans.

— States' decisions whether to expand their Medicaid program as allowed under the Affordable Care Act change the pool of consumers purchasing health insurance in the individual market through the health insurance marketplace. States not expanding Medicaid (like Nebraska) force lower-income consumers, who are generally less healthy, to purchase insurance through the health insurance marketplace, thus increasing premiums.

— The cost variations for Bronze and Silver plans are important because those are the plans most people are purchasing on the health insurance marketplace, particularly lower- and middle-income consumers. Individuals and families that have access to expanded Medicaid in Iowa are left without that option in Nebraska. Their only options are to purchase higher cost insurance or be uninsured.

¹ A special acknowledgment to Citizen Action of Wisconsin for the title (*A Tale of Two States: Why Wisconsin's Health Insurance Individual Marketplace Premiums are Dramatically Higher than Minnesota's*, October 2013).

INTRODUCTION AND STATE MEDICAID EXPANSION DECISIONS

The 10 Nebraska counties and the six Iowa counties along the Missouri River that form the state border have numerous similarities. These bordering counties form the core of two major metropolitan areas – Omaha, Nebraska, and Sioux City, Iowa. Outside of the metropolitan areas these counties are rural, made up of small towns and farms. Demographics across the state border are similar. These counties share common backgrounds and history and have common economic environments.

Like all states, Nebraska and Iowa had opportunities to institute specific public policy in response to the Patient Protection and Affordable Care Act (ACA). Both states elected to not develop their health insurance marketplace, rather electing that their citizens would use the federal health insurance marketplace (what became healthcare.gov). Both states initially decided not to expand their Medicaid programs as allowed under the ACA and a United States Supreme Court ruling. Eventually, Iowa developed and adopted the Iowa Health and Wellness Plan, a hybrid approach that creates a new public health care program for individuals earning up to 100 percent of the federal poverty level and fully subsidizes the purchase of private insurance for those making up to 138 percent. The U.S. Department of Health and Human Services approved the waiver needed for the program in December 2013.

Nebraska has yet to expand the state’s Medicaid program as allowed under the ACA or adopt a hybrid plan (commonly known as “premium assistance”). In 2013 the Nebraska Legislature failed to enact LB 577, a “pure” Medicaid expansion, and in 2014 the Nebraska Legislature filibustered and prevented LB 887 (the Wellness in Nebraska Act, a bill modeled after the Iowa law) from coming to a vote. This represents the primary ACA policy difference between the neighboring states. Because of these policy choices by the two states, neighbors or family members who may live only a few miles from each other but with similar circumstances may be eligible for health care coverage that exists in Iowa but not in Nebraska.

This report seeks to determine if this policy difference between the two states affects health insurance premiums in individual market plans available on the federal health insurance marketplace, and, if so, by how much.

WOULD STATE MEDICAL EXPENDITURES CAUSE A DIFFERENCE IN HEALTH INSURANCE PREMIUMS?

Medical costs are responsible for 75 percent to 85 percent of health insurance premiums in the individual health insurance market.² Thus, if there were major differences in medical expenditures between Nebraska and Iowa health insurance premiums in the individual market could be affected.

However, medical expenditures in Nebraska and Iowa are virtually the same. The most recent data show that there is only a \$127 annual per capita difference in health care expenditures between the two states, with Nebraska having 1.8 percent higher per capita annual expenditures.³

MEDICAID EXPANSION AND DIFFERENCES IN HEALTH INSURANCE PREMIUMS

State decisions on whether to expand Medicaid under the Affordable Care Act could explain part of any disparity in individual market premium rates among two states. A state electing not to expand their Medicaid program pursuant to the Affordable Care Act changes the insurance pool in the health insurance marketplaces. The result for a non-expansion state is that more lower income consumers, often in poorer health, are pushed into the marketplace, changing the makeup of the insurance pool and creating a pool that would be different had the state expanded Medicaid as allowed.⁴

Research has shown that differences in populations eligible to purchase health insurance on a health insurance marketplace have sig-

2 Citizen Action of Wisconsin, 2013.

3 “Health Care Expenditures per Capita by State of Residence.” Kaiser Family Foundation, 2014.; “Health Care Expenditures per Capita by Service by State of Residence,” Kaiser Family Foundation, 2014.

4 Citizen Action of Wisconsin, 2013.

nificant effects on premiums. The Rand Corporation found that a state decision not to expand Medicaid and to reject federal funding to expand a state’s Medicaid program under the ACA will increase premiums an estimated 8-10 percent in the individual market.⁵

Reasons offered for this estimate are that lower-income individuals eligible for the Medicaid expansion (those generally with incomes between 100 and 138 percent of the federal poverty level) tend to be less healthy, thus having higher health spending than those with higher incomes. Health status, while no longer a disqualifying circumstance for health insurance under the ACA, and health care spending would be factored into premium underwriting and rates for health plans offered in the health insurance marketplaces.⁶

Rand also finds the structure of insurance and tax credit assistance changes the health insurance marketplace pool and insurance premiums. As health insurance marketplace tax credits become available to lower-income individuals, the average health of the marketplace pool declines slightly, thus increasing premiums.⁷ Further, Rand found that the cost structure of Medicaid versus marketplace plans changes the health status of the marketplace pool. With Medicaid generally free and with marketplace health plans requiring some level of consumer contribution, the “population of individuals who opt to enroll in the exchanges if Medicaid becomes unavailable tends to be slightly less healthy than the full population of individuals eligible for subsidies.”⁸

Therefore, the population of low-income Nebraskans forced to purchase health insurance in the marketplace because of the state’s decision not to expand Medicaid as allowed under the ACA is the population that will contribute to higher premiums for the health insurance marketplace pool.

METHODOLOGY

This report examined monthly premiums (before tax credits) for all health plans available on healthcare.gov – the federal health insurance marketplace for both Iowa and Nebraska – at all four insurance levels (Bronze, Silver, Gold, and Platinum) for the 10 Nebraska counties and the six Iowa counties along the Missouri River that form the state border. All available health plans to consumers in both states at the four levels were averaged and compared.

Three hypothetical consumer structures were used to gather health plan data. Those structures were:

— 30 year old single, no children, \$28,000 annual income, nonsmoker, no employer-sponsored insurance

— 40 year old couple (two 40 year olds in household), two children (12 and 10), \$60,000 annual income⁹, nonsmoker, no employer-sponsored insurance

— 60 year old couple (two 60 year olds in household), no children under 26, \$60,000 annual income, nonsmoker, no employer-sponsored insurance

There are two caveats to these scenarios. First, since monthly premium comparisons were before premium tax credits, the annual incomes in the scenarios did not influence the figures used for comparison. Second, because of Iowa Medicaid and Children’s Health Insurance Program rules and the possible eligibility of the children in the second family, healthcare.gov for Iowa stated “the plans and prices you’ll see won’t count people who are eligible for Medicaid or CHIP.” The children were not included in the Iowa premiums for this family. Therefore, data for both states becomes for a two 40 year person household (without children) to develop comparable data.

5 Eibner, C. et.al. *The Affordable Care Act and Health Insurance Markets*. 2013. Santa Monica, CA: Rand Corporation.

6 Rand, p. 33.

7 *Id.*

8 *Id.*

9 \$60,000 is an approximation of the median household income for two wage earners in both states.

RESULTS

Results of the review of the comparable health plans available on healthcare.gov for neighboring counties in both states are outlined below. It is fair to point out that these are average premium costs before the premium assistance

tax credits; premium assistance tax credits are based on individual factors such as income, actual premium costs may be lower, and the variations presented below may be different for some consumers.

CONSUMER STRUCTURE #1

30 year old single, no children, \$28,000 annual income, nonsmoker, no employer-sponsored insurance (pre-premium assistance tax credit)

Average Monthly Premium; Pct. Difference	Bronze	Silver	Gold	Platinum
Nebraska	\$217.53; 4.0%	\$265.23; 1.1%	\$330.20; 2.2%	\$330.20
Iowa	\$209.07	\$262.44	\$297.80	\$360.89; 9.3%

AVERAGE ANNUAL COST DIFFERENCE

Bronze: Nebraska \$101.52
Silver: Nebraska \$33.48
Gold: Nebraska \$78.84
Platinum: Iowa \$368.28

CONSUMER STRUCTURE #2

40 year old couple, two children (12 and 10), \$60,000 annual income, nonsmoker, no employer-sponsored insurance (pre-premium assistance tax credit)

Average Monthly Premium; Pct. Difference	Bronze	Silver	Gold	Platinum
Nebraska	\$489.60; 4.2%	\$596.65; 2.7%	\$684.90; 1.3%	\$743.00
Iowa	\$470.05	\$580.80	\$676.40	\$814.17; 9.6%

AVERAGE ANNUAL COST DIFFERENCE

Bronze: Nebraska \$234.60
Silver: Nebraska \$190.20
Gold: Nebraska \$102.00
Platinum: Iowa \$854.04

CONSUMER STRUCTURE #3

60 year old couple, no children under 26, \$60,000 annual income, nonsmoker, no employer-sponsored insurance (pre-premium assistance tax credit)

Average Monthly Premium; Pct. Difference	Bronze	Silver	Gold	Platinum
Nebraska	\$1,039.04; 4.1%	\$1,266.65; 1.1%	\$1,455.18; 3.5%	\$1,577.20
Iowa	\$997.84	\$1,253.38	\$1,406.02	\$1,728.06; 9.6%

AVERAGE ANNUAL COST DIFFERENCE

Bronze: Nebraska \$494.40
Silver: Nebraska \$159.24
Gold: Nebraska \$589.92
Platinum: Iowa \$1,810.32

CONCLUSIONS AND IMPLICATIONS

In three of the four health plan levels (all except the Platinum level), Nebraskans in border counties have higher health insurance premiums than Iowans just across the border. In general, premium cost differences between the two states increase as consumers get older, and premium cost variations are greater for the lower level (Bronze and Silver) health plans. When age and health plan level are combined, the annual cost difference can be significant. For example, our hypothetical 60 year old Nebraska couple would pay nearly \$500 more annually for a Bronze plan.

The cost variations for Bronze and Silver plans are important because those are the plans most people are purchasing on the health insurance marketplace, particularly lower- and middle-income consumers. The most recent data from the U.S. Department of Health and Human Services show that 83 percent select a Bronze or Silver plan in the federal-facilitated health insurance marketplace (healthcare.gov, including Nebraska and Iowa; 16 percent select Bronze plans and 67 percent select Silver plans).¹⁰ Most border county Nebraskans, therefore, are selecting plans with the greatest cost variations compared to Iowa border county residents (our 60 year old couple selecting a Gold plan is the one exception).

While these cost variations do not reach the level of the Rand research estimates for a non-Medicaid expansion state, they do have significant consequences for lower-income residents in Nebraska bordering counties. Lower-income residents of border counties in Iowa without employer-sponsored health insurance can obtain health care coverage through the Iowa Health and Wellness Plan, Iowa's version of Medicaid expansion. But for Nebraska's decision not to expand their Medicaid program a similarly situated border resident Nebraskan could obtain coverage through something comparable. But now a similarly situated individual or family a few miles across the border in Nebraska is forced to attempt to purchase in the

health insurance marketplace individual market. These Nebraskans are forced to attempt to purchase health insurance that will cost up to several hundred dollars more per year, or likely be resigned to going without health insurance and risk the health and economic consequences that can entail.

The ACA was based, in part, on people below 138 percent of the poverty level receiving Medicaid coverage through states expanding their Medicaid programs. Therefore, the law does not allow premium tax credits for those below the poverty level (\$11,490 for an individual; \$19,530 for a family of three) even if their state elected not to expand their Medicaid program.

Eligibility for traditional Medicaid in Nebraska is limited. For parents of dependent children eligibility is limited to those below 55 percent of the poverty level. Other, non-disable adults are not eligible regardless of income. Many lower-income adults, including many in the border counties of the state, are forced into a "coverage gap" by Nebraska's refusal to expand their Medicaid program – they are not eligible for traditional Medicaid coverage, they may not be eligible for premium tax credits, they may be unable to afford the full cost of higher premiums, and they are likely without employer-sponsored insurance. The result is a continuation of uninsured status for many, primarily because of the state's refusal to adopt the ACA's Medicaid expansion.¹¹

Nebraska's decision not to expand Medicaid as allowed under the ACA has changed its health insurance marketplace pool. That changed pool has resulted in higher health insurance premiums for most Nebraskans. The decision has also left many lower-income Nebraskans in a "coverage gap." Because of the health insurance they buy in the individual market, lower- and middle-class Nebraskans may suffer some of the greatest consequences of this decision.

10 *Health Insurance Marketplace: March Enrollment Report, For the period: October 1, 2013 – March 1, 2014.* U.S. Department of Health and Human Services, March 11, 2014; state-by-state data is not available at this time.

11 The Kaiser Commission on Medicaid and the Uninsured. *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid.* October 2013.

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ABOUT THE CENTER FOR RURAL AFFAIRS

The Center for Rural Affairs is a private, non-profit organization with a mission to establish strong rural communities, social and economic justice, environmental stewardship, and genuine opportunity for all while engaging people in decisions that affect the quality of their lives and the future of their communities.



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