Ohio Progress Report

STATE ACTIONS PROTECTING PATIENTS IN THE EXCHANGE

OVERVIEW

States vary in terms of the patient-centeredness of their health insurance markets. While federal rules set minimum requirements for consumer protections, some states have taken extra steps to make their markets more patient-focused. This Progress Report measures a state across five principles to assess how well its insurance market is designed to meet the needs of people with chronic diseases and disabilities.

FIVE PATIENT-FOCUSED PRINCIPLES

NON-DISCRIMINATION

To ensure cost sharing and other plan designs do not discriminate or impede access to care.

- ◐ No state action to limit discrimination.
- ◐ Four unique platinum offerings in the 2015 exchange.
- ◐ No state action on provider network requirements.
- ● The premium for the 2nd lowest cost silver plan is 1% lower in 2015 than it was in 2014.[2]

For non-discrimination metrics, relative to other states, Ohio is an

TRANSPARENCY

To promote better consumer access to information about covered services and costs in exchange plans.

- ◐ HealthCare.gov links to external provider networks and formularies and also allows consumers to filter search results. However, the website lacks a formulary search tool, a provider search tool, and calculators to help estimate tax credit or out-of-pocket expense amounts.
- ◐ No state action regarding contracting requirements for plan information transparency.

For transparency metrics, relative to other states, Ohio is a

OHIO HIGHLIGHTS

Ohio's exchange is regulated by the federal government and operates through HealthCare.gov.

In the 2014 plan year, 154,700 Ohioans selected an exchange plan through HealthCare.gov. About 17% of Ohio residents who are eligible for exchange coverage enrolled in an exchange plan in 2014.[1]

Ohio expanded Medicaid, effective January 1, 2014.

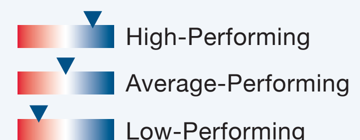
PROGRESS LEGEND

This report measures states using two methods of evaluation:

First, the report measures a state's performance on a series of metrics related to the five principles.

- ● Beneficial for Patients
- ◐ Neutral for Patients
- ● Negative for Patients

Second, the report compares a state's aggregate performance on all metrics within each principle to other states' performance on these same metrics.



STATE OVERSIGHT

To ensure all health insurance exchange plans meet applicable requirements.

- ◐ Passive purchasing—the state does not actively negotiate with plans to participate in the exchange.
- ◐ No state action regarding contracting requirements for exchange participation.
- ● Its effective rate review program allows the state to manage premium increases.[3]
- ● Sixteen carriers in the 2015 exchange.

For state-oversight metrics, relative to other states, Ohio is an

Average-Performing State

UNIFORMITY

To create standards to make it easier for patients to understand and compare exchange plans.

- ◐ No state action to standardize benefit designs.
- ● The quality rating system planned by the federal government for use on HealthCare.gov will show ratings for the 2017 plan year.
- ◐ No state action on standardized display of plan information.

For uniformity metrics, relative to other states, Ohio is an

Average-Performing State

CONTINUITY OF CARE

To broaden sources of coverage and protect patients transitioning between plans.

- ◐ No state action on continuity-of-care requirements.[4]
- ● Ohio expanded Medicaid, which now covers an estimated 526,000 people in the state.

For continuity-of-care metrics, relative to other states, Ohio is an

Average-Performing State

A MORE PATIENT-FOCUSED OHIO MARKETPLACE

Ohio has not exercised its full authority to regulate the exchange to promote patient protections. Ohio's reliance on the federal government to run the exchange reduces the state's influence over its own health insurance market. Ohio would have more control over exchange plans if the state opted to create a state-based exchange. Ohio has yet to establish standards that would increase transparency or uniformity, protect patients from discrimination, or develop continuity-of-care requirements to help patients maintain access to care. Under a different operational model, Ohio also could become an active purchaser. The state has few platinum plans, which limits options for the people who would benefit the most—those with chronic conditions and disabilities.

METHODOLOGY

Data by Avalere Health as of January 1, 2015. Avalere maintains a proprietary database of state policy developments for all 50 states and DC. Avalere also used key resources from publicly available websites, cited where applicable. Avalere conducted a focused review of state exchange insurance markets; this assessment is not intended to be a comprehensive review of state insurance markets. Avalere only included finalized actions established in the state, and did not include proposed measures or actions.

For definitions of key terms, see the National Health Council's Putting Patients First® glossary.

1 Kaiser Family Foundation, "Estimated Number of Individuals Eligible for Financial Assistance through the Marketplaces," November, 2014, accessed via: http://kff.org/other/state-indicator/estimated-number-of-individuals-eligible-for-premium-tax-credits-through-the-marketplaces/
2 Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces," January 06, 2015, accessed via: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/
3 The Center for Consumer Information & Insurance Oversight, "State Effective Rate Review Programs," April 16, 2014, accessed via: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html
4 Families USA, "Standards for Health Insurance Provider Networks: Examples from the States," November 2014, accessed via: http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf