RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Nonmetropolitan Premiums, Issuer Participation, and Enrollment in Health Insurance Marketplaces in 2022

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Purpose

Since the inception of the Health Insurance Marketplaces (HIMs) in 2014 following the passage of the Affordable Care Act, significant premium variation has been observed in HIMs across the 50 states and the District of Columbia, and between metropolitan and nonmetropolitan places. This policy brief describes differences in unsubsidized and net-of-subsidy premiums between nonmetropolitan and metropolitan counties in plan design and availability in 2022. Consistent with previous reports of HIM activity, we report enrollment-weighted plan selection by metal level and premiums paid by number of issuers and by Medicaid expansion status.

Key Findings

- Average premium costs in 2022 for consumers without subsidies were highest in noncore counties at $720 per month, compared to $686 in micropolitan counties and $643 in metropolitan counties.

- However, the average net monthly premium actually paid by consumers (across both subsidized and unsubsidized groups) was highest in metropolitan counties at $131, compared to $120 in micropolitan counties and $112 in noncore counties. Net premiums among those receiving a subsidy were highest in metropolitan counties at $93, followed by micropolitan counties at $84, and noncore counties at $79. These trends may be due in part to rural/urban differences in the income distributions of potential HIM consumers.

- In the 158 (18.4 percent) metropolitan counties with fewer than three issuers, unsubsidized monthly premiums averaged $746 in counties with one issuer and $694 in counties with two issuers. In comparison, in the 302 nonmetropolitan counties (19.0 percent) that had fewer than three issuers, unsubsidized premiums averaged $936 in counties with one issuer and $783 in counties with two issuers.

- In nonmetropolitan counties, overall average net premiums and net premiums among those receiving a subsidy were approximately $39 and $27 lower, respectively, in nonexpansion than expansion states, which is similar to the pattern in metropolitan counties. These differences arise largely because the population with incomes between 100 percent and 138 percent of FPL, who are covered by Medicaid in expansion states, is eligible for the highest subsidies in the HIMs. This indicates disparities *within* rural America as opposed to contributing to rural/urban disparities.

Background

Early work by the RUPRI Center on HIMs examined premiums, county-level enrollment, and local HIM characteristics in nonmetropolitan areas.[1,2,3,4] Although several policy changes have

occurred that may have affected these results, which we described in more recent work,[5] the HIMs from 2018 to 2022 in nonmetropolitan areas have not yet been studied thoroughly. We found in that work that the number of plan options available in nonmetropolitan areas has significantly increased, suggesting that more nonmetropolitan residents may now benefit from more robust marketplace participation. With the average number of issuers in nonmetropolitan counties ranging from 2.79 plans in 2014 to a low of 2.04 plans in 2017 and up to 3.07 plans in 2022, there has been a net increase in offerings in nonmetropolitan areas from 2014 to 2022. The impact of this change in the number of issuers may, due to increased competition, be expected to have limited the growth of unsubsidized and subsidized (net) premiums, and the variety of options available across the U.S. may affect rates and hence contribute to geographic differences.

Data and Methods

Using the Robert Wood Johnson Foundation's HIX Compare data[6] on 2022 HIM premiums and enrollment counts by county, we assigned metropolitan status based on Urban Influence Codes.[7] We calculated the number of unique issuers in each county. Where enrollment data were available (in the 33 states where marketplaces are federally facilitated), we calculated averages across metropolitan and nonmetropolitan areas for pre-subsidy premiums, post-subsidy premiums, distribution of plan enrollment by metal level, and cost-sharing reduction (CSR) status. Silver CSR plans are available at three cost-sharing levels to those with very low incomes (100 to 250 percent of the Federal Poverty Level [FPL]) and offer lower copays, deductibles, and out-of-pocket maximum costs to the beneficiary. In general, subsidies are available to people aged 18 to 64 whose incomes are between 100 and 400 percent of FPL, or 138 to 400 percent of FPL in Medicaid expansion states, on a sliding scale. They are calculated as the amount needed for an individual to purchase the second-lowest silver plan available in the county without exceeding a defined percent of total income; thus subsidies vary by county, by age, and by exact income. We extended the metal-level and CSR analyses to estimate the typical "actuarial value" received by metropolitan and nonmetropolitan HIMs consumers by applying the percentages stipulated in the law to the enrollment totals calculated.[8] We used metropolitan status and information tracked by the Kaiser Family Foundation on Medicaid expansion status over time to further analyze premium data.
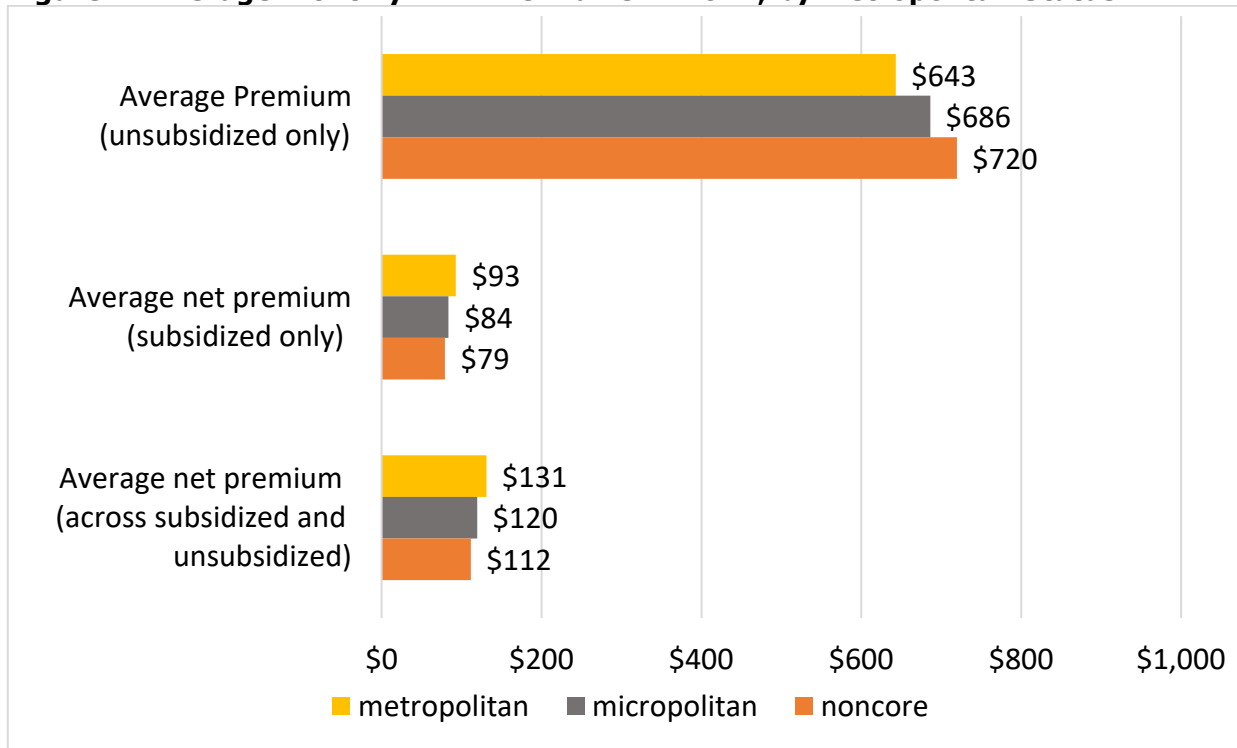
Public Use Microdata Sample (PUMS) data from the 2017-2021 five-year American Community Survey were used to estimate the proportion of individuals across income-to-poverty brackets that were potential consumers of the HIMs. We identified those who reported that they had neither a disability nor health insurance through Medicare; Medicaid, Medical Assistance, or any kind of government-assistance plan; TRICARE or other military health care; Department of Veterans Affairs; Indian Health Service; or an employer or union.

Proportions were estimated at the State-Public Use Microdata Area (PUMA) level. PUMAs are nonoverlapping areas that partition each state into geographic units containing approximately 100,000 people. Income-to-poverty brackets were defined as less than 138 percent of FPL, 138 through 250 percent of FPL, 251 through 400 percent of FPL, and greater than 400 percent of FPL. We created four PUMA categories by cross-walking census tracts to PUMAs. We then computed the percentage of the population of each PUMA that is nonmetropolitan, according to Rural Urban Commuting Area definitions, and then divided PUMAs into groups with less than or equal to 25 percent, greater than 25 up to 50 percent, greater than 50 up to 75 percent, and above 75 percent of the population living in a nonmetro area. We calculated the size of the potential HIM market by income bracket using these groups.

Results

Figure 1 shows that average unsubsidized premium costs were highest in noncore counties at $720 per month, compared to $686 in micropolitan counties and $643 in metropolitan counties. However, the average net premium actually paid across all consumers, accounting for subsidies, was highest in the metro region at $131, compared to $120 in micropolitan counties and $112 in noncore counties. (These differences occur because not all consumers receive a subsidy and subsidies are variable across individuals by county, by age, and by income.)

Figure 1. Average monthly HIM Premiums in 2022, by Metropolitan Status

Average Premium (unsubsidized only): metropolitan $643, micropolitan $686, noncore $720

Average net premium (subsidized only): metropolitan $93, micropolitan $84, noncore $79

Average net premium (across subsidized and unsubsidized): metropolitan $131, micropolitan $120, noncore $112

Legend: metropolitan, micropolitan, noncore

Similarly, net premiums among just those receiving a subsidy were highest in metropolitan counties, at $93 per month, followed by micropolitan counties at $84 and noncore counties at $79. These differences are likely due in part to differences in the income distribution of the potential HIM consumers in urban vs. rural places. As Figure 2 shows, the share of this population who qualify for the most significant subsidies increases as PUMAs become more rural: only 38.0 percent of the population in the most urban quartile falls into the 138 percent to 400 percent FPL range, whereas 45.1 percent of the most rural quartile does. There are also more people below 138 percent FPL, some of whom would be eligible for HIMs in non-expansion states.

Figure 2. Potential HIM Consumers' Incomes Relative to FPL by Urban/Rural Quartile of PUMA

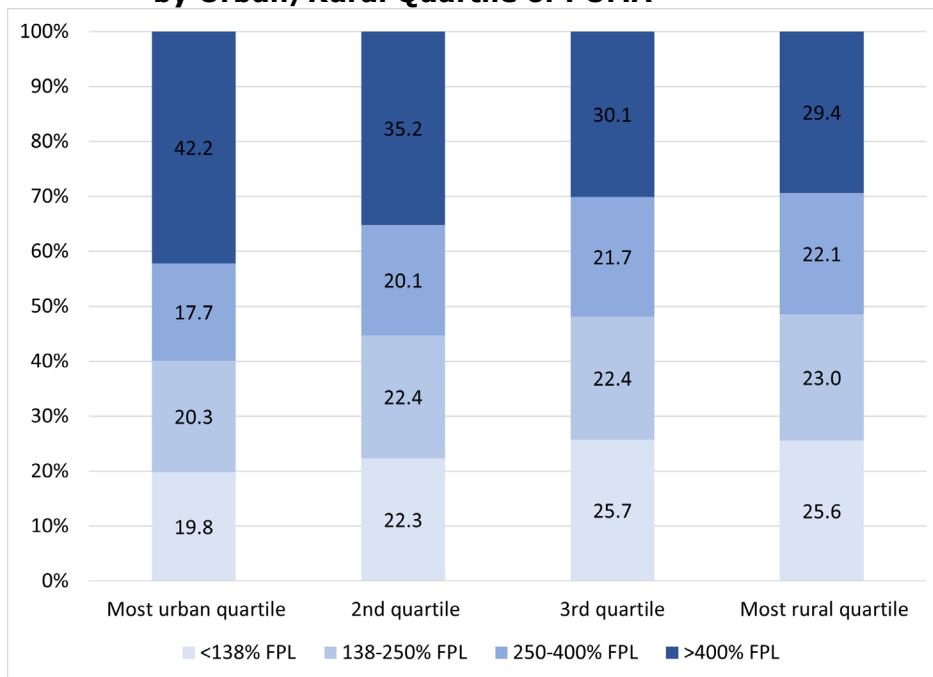|	Most urban quartile	2nd quartile	3rd quartile	Most rural quartile
>400% FPL	42.2	35.2	30.1	29.4
250-400% FPL	17.7	20.1	21.7	22.1
138-250% FPL	20.3	22.4	22.4	23.0
<138% FPL	19.8	22.3	25.7	25.6

Legend: <138% FPL, 138-250% FPL, 250-400% FPL, >400% FPL

Figure 3 shows that just 158 metropolitan counties (18.4 percent) have fewer than three firms participating, with unsubsidized premiums averaging $746 per month in counties with one issuer and $694 per month in counties with two issuers. In comparison, 302 nonmetropolitan counties (19.0 percent) had fewer than three firms participating, with unsubsidized premiums averaging $936 per month in counties with one issuer and $783 per month in counties with two issuers. A sharp decline is observed when a county has at least three or four issuers in both county types.

Although unsubsidized premiums are slightly higher in nonmetropolitan counties (controlling for the number of issuers), it is important to note that the net-of-subsidy premiums are very similar across metropolitan and nonmetropolitan counties. In fact, both measures—the average net premium paid and the average net premium among those receiving a subsidy—are sometimes lower in nonmetropolitan counties than in metropolitan counties.

Figure 3. HIM Premiums by Issuer Participation by Metro vs. Nonmetro County Status
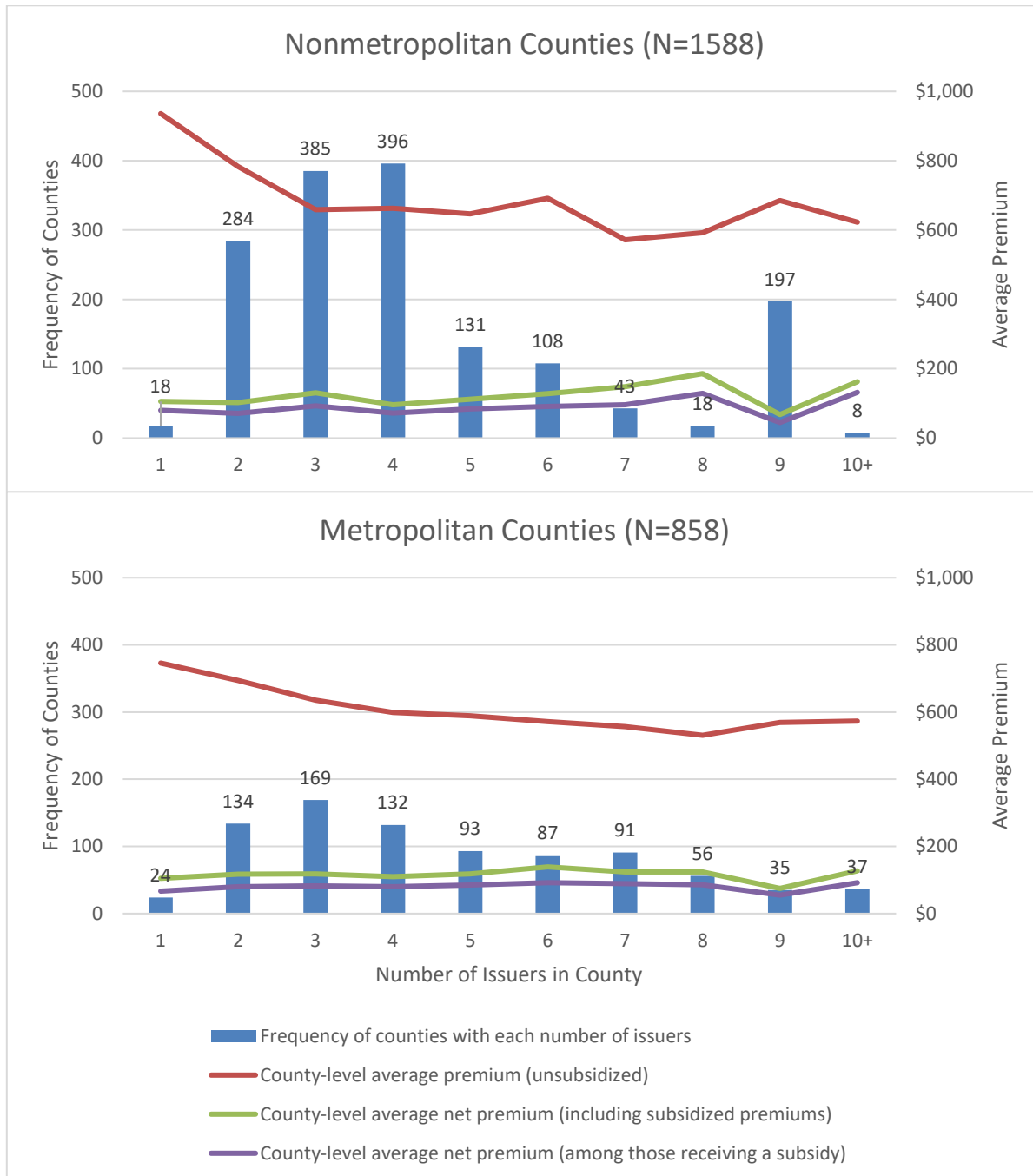
The estimates of the potential HIM market by county (analyzed by income above) were also used to estimate the share of this consumer group actually enrolled in HIMs. Figure 4 shows that this rate was very similar across geography, with 4.6 percent of the estimated potential HIM consumers in metropolitan areas enrolling, compared to 4.2 percent in micropolitan counties and 4.8 percent in noncore counties.

Figure 4. Percentage of Potential HIM Consumers Selecting Plans by Metropolitan Status
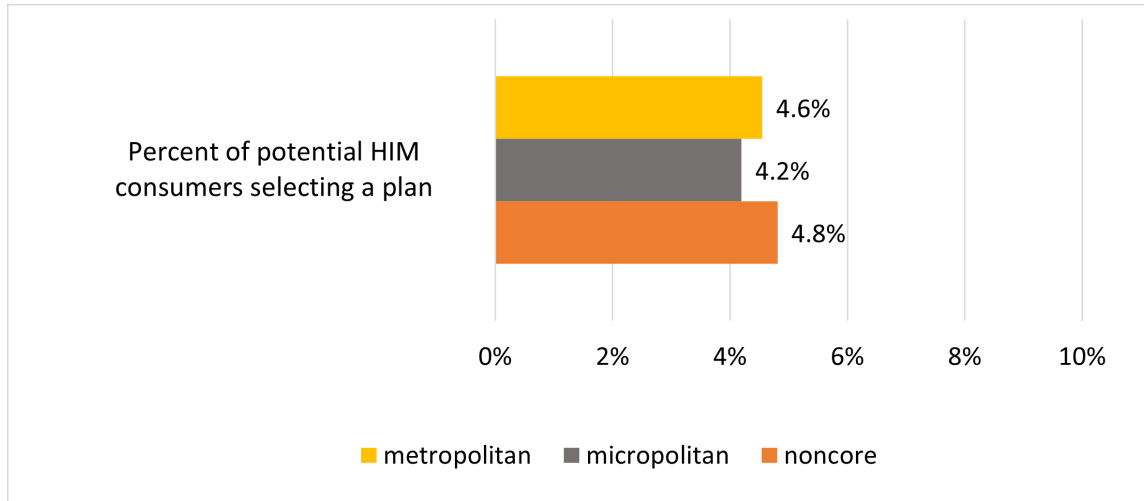
When examining plan selection, we found that patterns were fairly similar across metropolitan, micropolitan, and noncore counties (Figure 5); however, even small differences are significant because this analysis includes data on all of the millions of individuals enrolled. Most people selected silver plans, with bronze plans also being common, and relatively few people selected gold plans. Within the silver plan category, which contains standard plans and three levels of CSR plans corresponding to 100-150 percent, 150-200 percent, and 200-250 percent of FPL, it is important to note the share of people enrolled in the highest coverage (which is rated at 94 percent of actuarial value) versus lesser coverage levels. Actuarial value is the percent of total

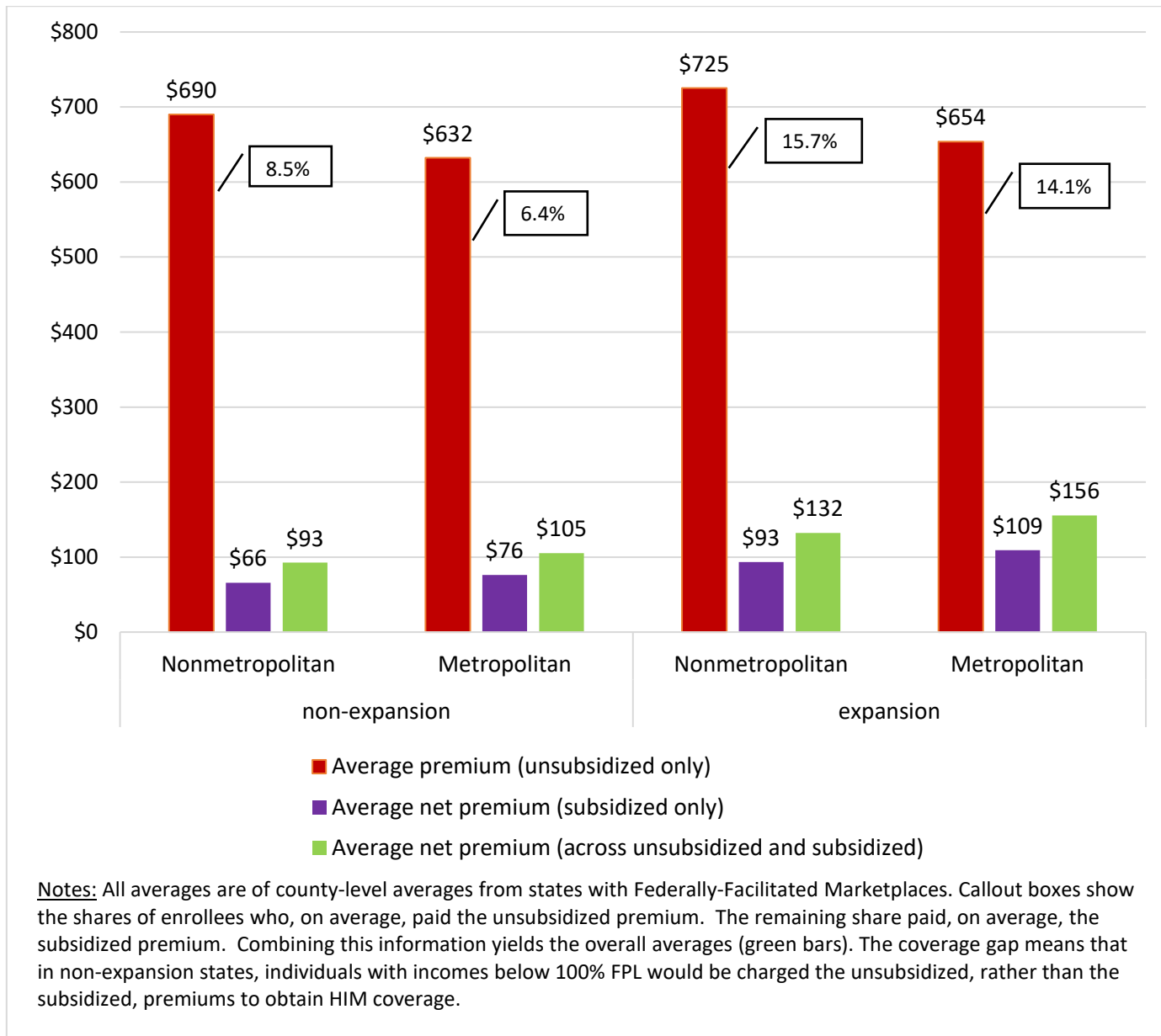**Figure 5. HIM Metal Level Selection by Metropolitan Status**
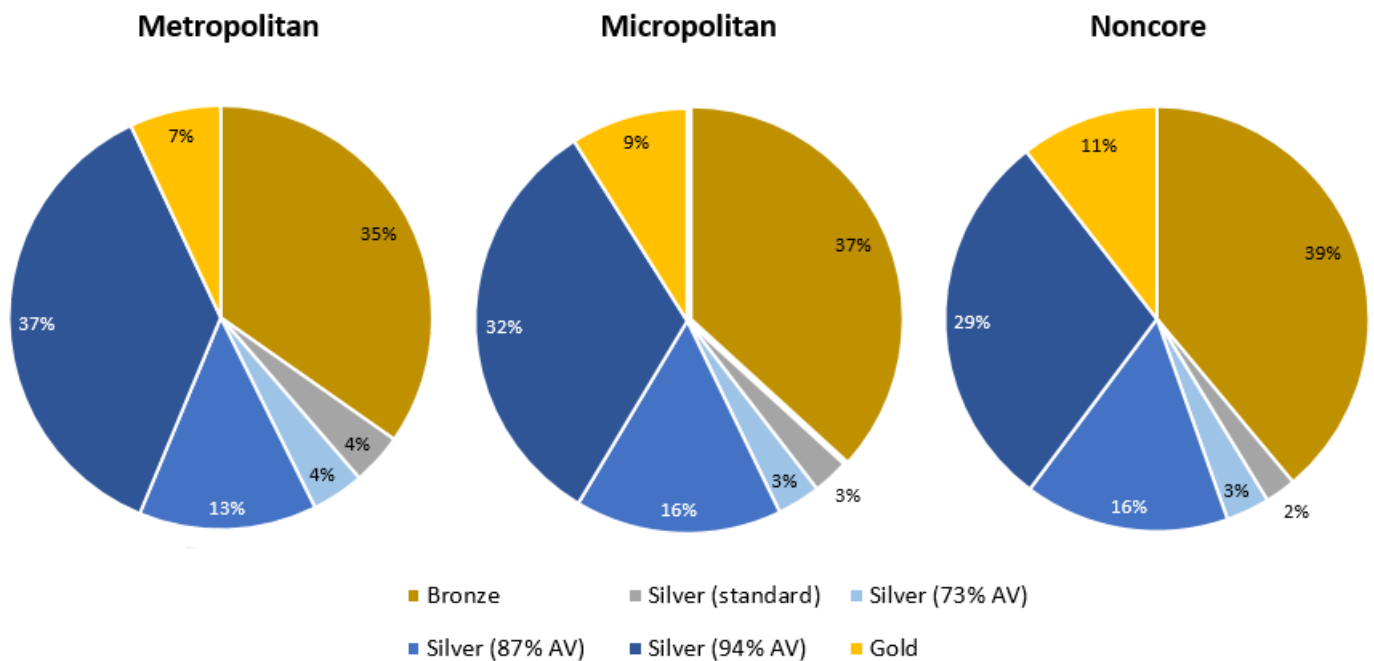
medical costs that the plan is expected to cover, on average. In metropolitan counties, 37 percent of people qualified for, and enrolled in, a plan with the highest level of actuarial value, i.e., they qualified for this highest-coverage plan type due to having an income between 100 and 150 percent of FPL. In contrast, only 32 percent and 29 percent of people in micropolitan and noncore counties, respectively, qualified for and enrolled in such a plan. Some consumers, especially those who don't qualify for a silver plan with higher actuarial value, apply the value of the subsidy to a gold or bronze plan instead. Applying it to a bronze plan can result in a very inexpensive, or even zero-premium, option for such consumers.

When people cannot access a CSR silver plan with higher actuarial value, what do they select instead? In noncore counties, more people chose bronze plans (39 percent, compared to 35 percent in metropolitan counties) and gold plans (11 percent, compared to 7 percent in metropolitan counties). This finding could be due to differences in the income distribution (as shown in Figure 2) coupled with the fact that subsidy levels are tied to the cost of the second-lowest standard silver plan but may be used toward any other type of plan. For individuals not eligible for any CSR plan (who have incomes above 250 percent of FPL), a subsidy may allow them to purchase a zero-premium bronze plan, or it provides a sizeable discount on the more comprehensive coverage of a gold plan. Figure 5 shows that in micropolitan and noncore counties, both of these responses occurred in an environment where fewer consumers were eligible for CSR silver plans than in metropolitan counties.

Figure 6 shows that the pattern of higher net-of-subsidy premiums in metropolitan counties is constant regardless of status of Medicaid expansion. It also shows that overall, people living in places without Medicaid expansion had, on average, lower monthly net premiums (green bars) than those in places with expanded Medicaid. In nonmetropolitan counties, overall average net premiums (green bars) and net premiums among those receiving a subsidy (purple bars) were approximately $39 and $27 lower, respectively, in nonexpansion than expansion states, which is similar to the pattern in metropolitan counties. As discussed below, these findings are directly related to the income levels of eligible and ineligible HIM consumers.

Averages of unsubsidized premiums (red bars) by Medicaid expansion status are not straightforward to interpret. While they too depend to some extent on the income levels of eligible and ineligible HIM consumers, other significant driving factors include the age of the consumer and, as shown in Figure 3, the competitive environment in the county of residence. The callout boxes in Figure 6 show that the share of HIM consumers paying the unsubsidized premium is much lower (8.5 percent in nonmetropolitan and 6.4 percent in metropolitan) in non-expansion locations than in those with Medicaid expansion.

Figure 6. Average HIM Premiums Paid by Metropolitan and Nonmetropolitan Consumers, by Medicaid Expansion and Subsidy Status, 2022

Notes: All averages are of county-level averages from states with Federally-Facilitated Marketplaces. Callout boxes show the shares of enrollees who, on average, paid the unsubsidized premium. The remaining share paid, on average, the subsidized premium. Combining this information yields the overall averages (green bars). The coverage gap means that in non-expansion states, individuals with incomes below 100% FPL would be charged the unsubsidized, rather than the subsidized, premiums to obtain HIM coverage.

Discussion

Compared with the metropolitan/nonmetropolitan differentials that initially characterized the HIMs, recent data show that many gaps have narrowed or disappeared. We found that nonmetropolitan residents paid, on average, lower premiums than metropolitan counterparts. This pattern was the same across states that expanded Medicaid and those that did not. Overall, the premiums paid by residents in non-expansion states were lower, indicating a higher level of enrollment in plans with low monthly premiums. This finding is likely a function of a higher percentage of those enrolling being the lowest eligible income categories (100 to 138 percent FPL), given that in expansion states households with incomes below 138 percent of FPL are enrolled in Medicaid.

Overall, nonmetropolitan people may derive more value from HIMs than metropolitan people, because they are less likely to have an offer of employer-sponsored insurance and tend to have lower incomes, which qualifies them for more sizable subsidies. The fact that the remaining nonexpansion states tend to be more nonmetropolitan adds to this phenomenon, since the group with incomes between 100 and 138 percent of FPL, who would otherwise be part of a Medicaid

expansion group, is instead heavily subsidized in HIMs and is eligible for high levels of CSRs. However, the tradeoff is that in nonexpansion states, significant coverage gaps remain for those with incomes below 100 percent FPL, since they will not qualify for their state's Medicaid program, and the HIMs are only available to those with incomes above 100 percent of FPL. Disparities in access to affordable insurance coverage exist across states, for both nonmetropolitan and metropoliltan households.

The early observation that at least three competing issuers are necessary to help contain premiums[1] continues to hold for the most recent data in both metropolitan and nonmetropolitan places. Nonmetropolitan places tend to have fewer issuers on average, as
well as more total counties with just one or two issuers, which presents two policy concerns: (1) the size of the subsidy borne by the federal government is greater than perhaps it could be, and (2) for higher-income nonmetropolitan individuals who do not qualify for subsidies, the HIM premiums are more likely to be unaffordable. This is a small group in percentage terms, but it represents a policy challenge that may disproportionately impact nonmetropolitan people and places.

While we did find evidence that, on average, the actuarial value of plan selections made by nonmetropolitan people may be slightly lower than that of metropolitan people, meaning that there is a slightly greater expected out-of-pocket cost for nonmetropolitan residents, these differences were small. This finding may be why we find similar HIM penetration rates across geography. Overall, as HIMs have matured and policies have shifted, nonmetropolitan people have benefitted. One caveat to this conclusion, however, is that this analysis does not consider network adequacy or access, so we cannot say definitively that the HIM products purchased by nonmetropolitan consumers are entirely equivalent to those purchased by metropolitan HIM consumers.

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