

Private health insurance basics 2016

Overview of private health insurance coverage

What's inside?

Purpose of health insurance • Ohio's coverage landscape • What it means to be uninsured • How health insurance works

What is health insurance?

Health insurance is a contract between an individual or group and a health insurance issuer (i.e. health plan issuer), where premium payments are made to the issuer in exchange for the issuer's payment of healthcare expenses for individuals covered by the issuer's health plan (also referred to as covered individuals or health plan enrollees). A health plan issuer is a licensed health insurance company that is subject to state insurance regulation.

Health insurance benefits can also be provided by employers to employees through a health benefit plan. An employer may contract with an insurance company to administer a health benefit plan, with the employer being responsible for paying an employee's healthcare claims (see **Private Health Insurance Basics fact sheet 5** for more information).

Purpose of health insurance

The primary function of health insurance is to transfer the risk of financial loss resulting from healthcare expenses to an insurer in exchange for a monthly premium.¹ Health insurance protects people against the uncertainty and high cost of healthcare expenses, making healthcare costs more predictable and limiting a person's out-of-pocket spending. Individuals with health insurance coverage are more likely to access needed care due to the reduced cost burden health insurance can provide.²

Private health insurance coverage

Private health insurance includes non-group (individual/family) and small or large group health coverage provided through an employer, another organization (such as an association or union) or purchased directly from a private insurance company. Private health insurance does not include federal, state or locally funded government programs such as Medicare, Medicaid and military or veteran coverage.

Health coverage landscape in Ohio

The private health insurance market is comprised of three segments: non-group (individual/family), small group and large group coverage.³ The small and large group market refers primarily to employer-sponsored health insurance coverage (ESI).

As of 2015, the majority of the state's population – nearly 6.6 million Ohioans (57.4 percent) – had private health insurance coverage either through non-group health insurance or through ESI (see Figure 1). About 4.2 million Ohioans (36.6 percent) had public health insurance coverage through Medicaid, Medicare or other government programs.⁴

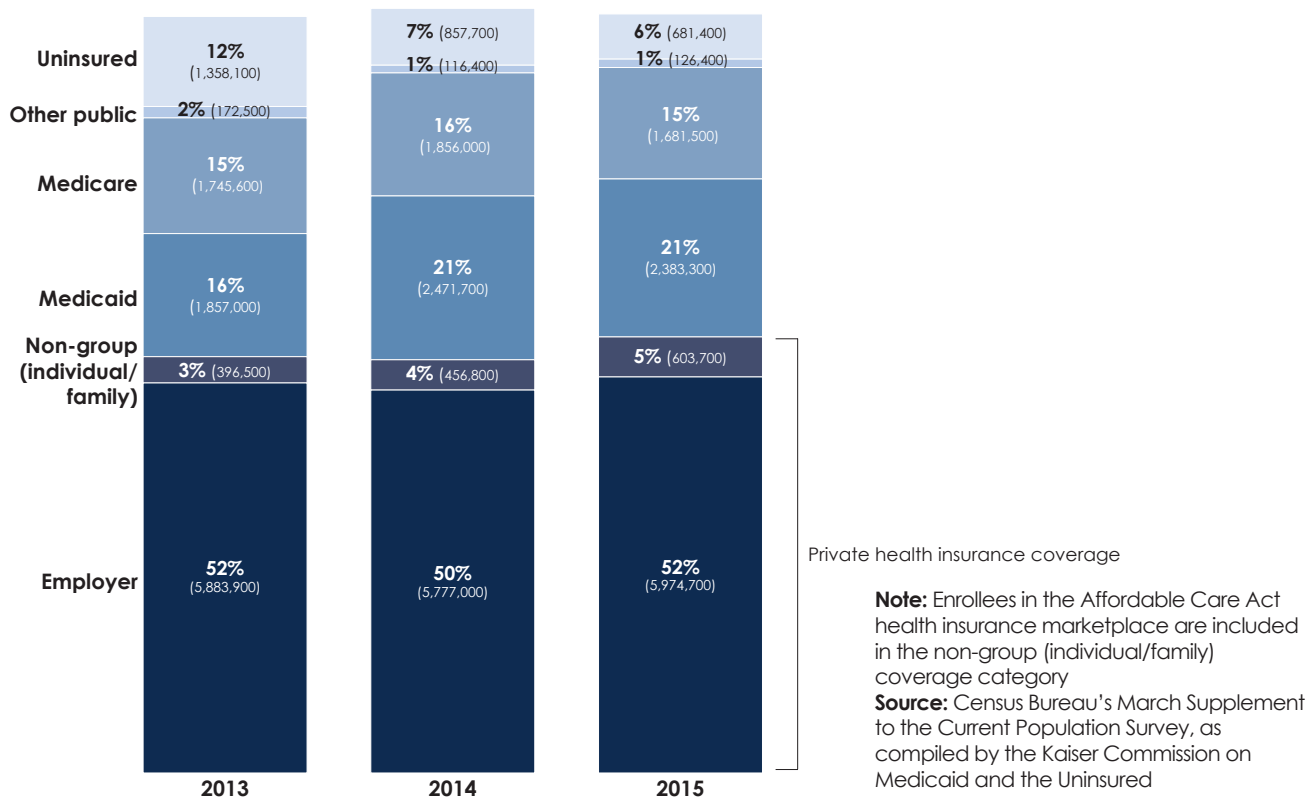
Six percent of Ohioans were uninsured in 2015. The number of uninsured Ohioans decreased by half from 2013 to 2015, falling from about 1.4 million Ohioans in 2013 to 681,400 Ohioans in 2015.⁵ The drop in the number of uninsured Ohioans between 2013 and 2015 was largely due to the extension of Medicaid eligibility to more Ohioans, with enrollment in Medicaid increasing 28 percent from 2013 to 2015.⁶

What does it mean to be uninsured?

Uninsured individuals have no health insurance coverage and are often billed higher charges for the healthcare services they receive. As a result, uninsured individuals are at greater risk for medical bankruptcy than those who are insured.⁷ People who are uninsured may delay or forgo needed care (see Figure 2), receive care at hospital emergency departments, rely on limited services from free clinics and federally qualified health centers or experience severe financial hardship from medical debt.⁸

Certain federal and state laws, including the Emergency Medical Treatment and Labor Act (or EMTALA) and the Disproportionate Share Hospital (DSH) program (administered as the Hospital Care Assurance Program in Ohio), ensure that people with low incomes receive emergency and critical healthcare services regardless of ability to pay.⁹ However, these laws do not provide health

Figure 1. Health insurance coverage for Ohioans, 2013 through 2015



insurance coverage and do not guarantee access to follow-up care, primary care, specialty care, preventive services or ongoing prescription drug access. Also, DSH program payments were reduced as part of reforms introduced through the Affordable Care Act (ACA) in anticipation of more people gaining coverage.

Why are people uninsured after the Affordable Care Act?

The ACA was designed to reduce the percent of people who are uninsured through the extension of Medicaid eligibility and the availability of subsidized coverage for certain individuals through ACA health insurance marketplaces (see **Private Health Insurance Basics fact sheet 4** for more information on the ACA health insurance marketplace).¹⁰ However, the ACA was not designed to provide universal health insurance coverage and does not extend federally-funded or subsidized coverage to certain groups, such as undocumented immigrants.¹¹ The high costs of health insurance coverage and not being eligible to receive subsidized or public health insurance coverage are often cited as reasons for why people remain uninsured.¹²

What does it mean to be underinsured?

People who are insured but have high out-of-pocket costs relative to their income or ability to pay are considered underinsured. People who are underinsured are at risk of accumulating medical debt or forgoing necessary care because of cost.¹³ The Commonwealth Fund estimated that 31 million insured adults in the U.S. (23 percent of adults younger than 65) were underinsured in 2014.¹⁴

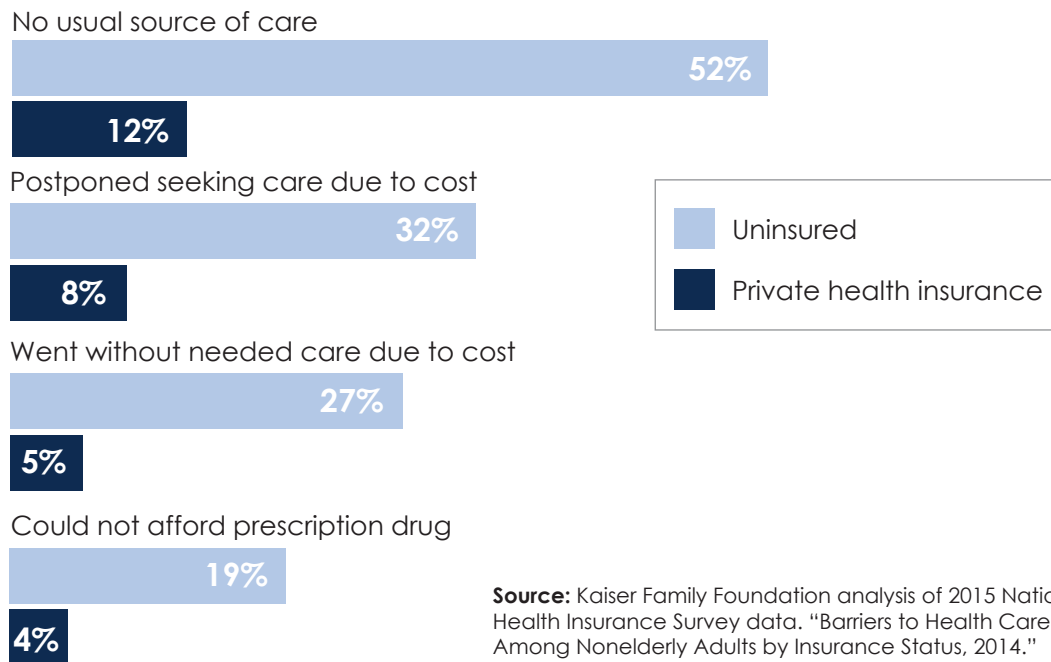
How does health insurance work?

An issuer or employer may pay all or a portion of a covered individual's healthcare expenses depending on a health plan's benefit structure. A health plan's benefit structure refers to the rules governing the type of services covered and the amount an insurer will pay for covered services. Benefit structures can vary greatly from one health plan to another.

Payment and cost-sharing

Insured consumers (and/or their employers) are required to make payments in exchange for health insurance coverage and may also be required to pay for a portion of the cost of healthcare services they receive, referred to as "cost-sharing." Common payment and cost-sharing arrangements are described on page 3.

Figure 2. **Barriers to health care by insurance status in the U.S., 2014**



Source: Kaiser Family Foundation analysis of 2015 National Health Insurance Survey data. "Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2014."

Premium: A set amount that must be paid in order to obtain health insurance coverage for a period of time. Premiums can be paid by the individual, their employer or both, and are generally paid at monthly, quarterly or annual intervals.

Deductible: A set amount that a consumer pays during a benefit period or plan year for covered services before the insurer begins to make payment toward those covered services. Some plans cover certain services (such as preventive services) before a deductible is applied. A health plan deductible does not refer to tax deductions.

High deductible health plan (HDHP): A health plan with a higher deductible which can typically be purchased for a lower monthly premium. The point at which a health plan becomes an HDHP is set by federal statute. The Internal Revenue Service issues an annual instruction that adjusts the deductible and HDHP annual out-of-pocket spending limits based on inflation.

Health savings accounts (HSAs): A savings account that enables consumers with HDHPs to pay for qualifying medical expenses with untaxed dollars. A consumer can place pre-tax money into an HSA and use those funds to pay towards deductibles, co-payments and other qualifying out-of-pocket medical expenses.

Co-payment: A flat rate dollar amount paid by a consumer directly to the provider at the time of receiving a covered healthcare service.

Co-insurance: A method of cost sharing in which the consumer is required to pay a defined percentage of their medical costs, often after their deductible has been met.

Out-of-pocket expenses: Healthcare expenses that a consumer pays out of his or her own pocket, such as deductibles, co-payments and co-insurance.

Out-of-pocket maximum: An annual limit that is set on consumer out-of-pocket spending after which an insurer is responsible for paying all claims for covered services under the health plan.

Self-pay rate: Consumers who are uninsured or obtain services that are not covered under their health plan are subject to a self-pay rate. Because insurance companies are able to negotiate rates with providers, self-pay rates are generally higher than health plan contracted rates.

Plan design

Provider networks are groups of healthcare providers contracted with to provide services under a health plan based on specified terms and negotiated rates. To control cost and quality, insurers may develop several different networks to be paired with the plans they sell. Consumers will generally pay less for healthcare services when they go to **in-network providers**. Services from **out-of-network providers** usually require higher cost-sharing.

Fee-for-service or indemnity plans: These plans allow plan enrollees greater choice in selecting providers and have fewer tools in place to restrict services and manage the cost of care for plan enrollees.

Managed care plans: These plans have various mechanisms in place to control the cost and delivery of healthcare services to plan enrollees including the use of provider networks.

Health maintenance organizations (HMOs): Referred to as health insuring corporations (HICs) in Ohio, individuals enrolled in an HMO are only covered for care if they see an in-network

provider. HMOs have no out-of-network benefit, meaning that the consumer must pay for 100 percent of the cost of care if they receive services from a provider not within the HMO's network. In some cases, consumers enrolled in HMOs are assigned to a primary care provider. In this situation, a specialist is seen only upon receiving a primary care doctor's referral.

Preferred provider organizations (PPOs): PPOs generally offer more flexibility than HMOs because they provide an out-of-network benefit. With an out-of-network benefit, the health plan issuer or employer will pay for part of the cost of care (subject to cost sharing and deductibles), but a consumer will generally pay more for out-of-network care than if they received care from an in-network provider. Consumers can also be subject to balance billing by out-of-network providers, which can be very expensive. Balance billing (also referred to as "surprise billing") occurs when out-of-network providers bill consumers directly for the difference between the self-pay rate and the contracted rate paid under the consumer's health plan.

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see other **Private Health Insurance Basics** fact sheets at

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