

Private Health Insurance Basics 2016

Current policy issues impacting the private health insurance market

What's inside?

High deductible health plans • Paying for value • Network adequacy and transparency • Risk programs • Mergers and consolidations

Policy issues related to health insurance coverage and affordability are primarily driven by rising healthcare costs, changes in market competition and implementation of Affordable Care Act (ACA) reforms. This fact sheet outlines policy issues impacting the private health insurance market, including affordability and access to coverage.

Affordability of non-group (individual/family) coverage

Affordability of health insurance coverage remains a concern for many consumers. A 2015 survey of uninsured consumers found that 79 percent of people who shopped for health insurance coverage decided they could not afford a plan after considering monthly premiums, deductibles, co-payments and co-insurance.¹ Early information on 2017 premiums in the U.S. indicates that health insurance premium rates will increase for coverage in 2017 and premium increases for plans offered on the ACA health insurance marketplace will be larger than years past.²

Ohioans may see an average premium increase of 13 percent for non-group plans sold on the ACA marketplace.³ Subsidies available for marketplace plans may minimize the impact of these increases for some, but people ineligible for subsidies will likely absorb the full impact of these increases.

Proliferation of high deductible health plans

A growing number of U.S. consumers are enrolled in high deductible health plans (HDHPs) with a total of 19.7 million HDHP enrollees in 2015, up from 17.4 million in 2014.⁴ Moreover, average deductibles for employees with employer-sponsored health insurance (ESI) coverage in the U.S. have almost tripled in the past decade, jumping from \$584 in 2006 to \$1,478 in 2016.⁵

HDHPs have a higher deductible compared to a traditional health plan, but can typically be purchased for a lower monthly premium.⁶ With some exceptions, such as for preventive services, individuals enrolled in HDHPs are required to cover up to 100 percent of their healthcare costs up to a set limit before being able to receive the full benefits of their health insurance coverage.

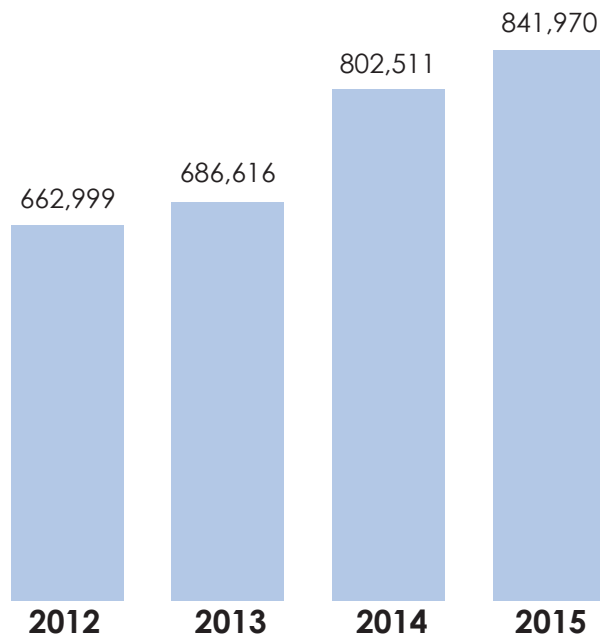
The impetus for the increase in HDHPs is two-fold. First, as healthcare costs have risen, health insurance issuers and employers have sought ways to reduce their financial liability. Second, increased cost-sharing is intended to direct a consumer towards more cost-effective utilization of healthcare services, including reducing excess utilization, seeking care in appropriate settings and improving personal health behaviors.

While a number of studies suggest that HDHPs are effective at both reducing cost and healthcare utilization, research also suggests that HDHP enrollees are more likely to delay or forgo necessary care.⁷ As a result, HDHPs could lead to greater utilization of high cost healthcare services in the long run.⁸ With deductibles increasing at a rate nearly six times faster than workers earnings from 2011 to 2016, there is also concern that HDHPs may disproportionately impact low-income individuals and families.⁹

Although about 40 percent of employees in Ohio with ESI coverage are in HDHPs, this percentage jumps to 61 percent for employees working in small companies with fewer than 50 employees.¹⁰ Compared to other states, Ohio had the fourth largest total HDHP enrollment with 841,970 enrollees in 2015, an increase of nearly 27 percent from 2012 (see Figure 1).¹¹

Ohio also experienced a sharp increase in HDHP enrollees from 2013 to 2014. This increase largely can be attributed to the establishment of the ACA health insurance marketplace (see **Private Health Insurance Basics fact sheet 4** for more information on the ACA marketplace). Almost 90 percent of

Figure 1. Ohioans in high deductible health plans, 2012-2015



Source: America's Health Insurance Plans Center for Policy and Research Census of Health Savings Account – High Deductible Health Plans

ACA marketplace enrollees nationally are in HDHPs.¹² However, cost-sharing subsidies may be available to reduce out-of-pocket costs for certain ACA marketplace enrollees.

Consumer price and quality tools

Access to healthcare price and quality information can assist consumers, particularly those enrolled in HDHPs, to make informed decisions about where to seek affordable care. In addition, having price information prior to receiving services allows consumers to plan appropriately for future financial outlays rather than being surprised by unexpected medical bills. According to a 2015 TransUnion Healthcare survey, 80 percent of respondents said that upfront cost estimates are a factor in choosing a provider, and 79 percent said they were more likely to pay their bills if they received a price estimate prior to receiving care.¹³

A growing number of health plans are

Thresholds for high deductible health plans and health savings accounts

The point at which a health plan becomes an HDHP is set by federal statute¹⁴ and the Internal Revenue Service (IRS) issues an annual instruction that adjusts the deductible and HDHP out-of-pocket spending limits based on inflation (see thresholds below).¹⁵

To help consumers pay for out-of-pocket healthcare costs not covered under a HDHP, HDHPs are often paired with health savings accounts (HSAs) or other medical care reimbursement accounts. HSAs are savings accounts that enable 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.¹⁶ If unused, HSA funds roll over from year to year and can earn interest.¹⁷ Employers and insured individuals may both contribute to an HSA, but the IRS sets limits on how much can be contributed to the account each year.

High deductible health plan and health savings account thresholds, 2016 and 2017

	2016	2017
Individual or "self-only" coverage		
HDHP minimum annual deductible	\$1,300	\$1,300
HDHP maximum annual out-of-pocket spending limit	\$6,550	\$6,550
HSA maximum annual contribution limit	\$3,350	\$3,400
Family coverage		
HDHP minimum annual deductible	\$2,600	\$2,600
HDHP maximum annual out-of-pocket spending limit	\$13,100	\$13,100
HSA maximum annual contribution limit	\$6,750	\$6,750

Source: Internal Revenue Service, Rev. Proc. 2016-28 and Rev. Proc. 2015-30

developing tools that can help consumers navigate healthcare prices and provider quality. However, there are often limitations to the tools provided:

- **Few “shoppable services”:** Shopping around for care may only be practical in the case of discretionary services such as imaging, elective procedures and non-emergent services.
- **Prices are not specific enough:** The majority of published prices in existing transparency tools are an average price for the standard consumer. Such prices generally do not account for confidential, negotiated rates between insurers and providers. Likewise, published prices may not reflect total costs or out-of-pocket costs that are specific to a consumer’s particular health plan design.
- **Narrow networks:** The trend toward narrow provider networks impacts the utility of transparent price data by limiting the consumer’s options of providers.

For more information on healthcare data transparency, see HPIO’s [Healthcare Data Transparency Basics 2016](#).

Paying for value

U.S. health care is built on a fee-for-service (FFS) system, where a provider is paid for each specific service delivered to a patient. FFS often incentivizes the delivery of a greater volume of services to patients, without accounting for efficiency, cost or quality of care. Health insurers are increasingly turning to new methods of paying for “value” in health care which incentivize providers to control costs and improve quality of care and health outcomes. For more information on value-based payment mechanisms, see HPIO’s [Beyond Medical Care Fact Sheet: Paying for value over volume through payment reform](#).

The federal Center for Medicare and Medicaid Innovation awarded Ohio a \$75 million State Innovation Model (SIM) implementation grant in 2014. Led by the Governor’s Office of Health Transformation, the focus of the SIM is to align healthcare payments with desired health outcomes. SIM funds are being used to develop a Comprehensive Primary Care program for Ohio, as well as episode-based payment models for various clinical conditions, working in partnership with health insurers, providers and other public and private health stakeholders.

Value-based insurance design

Another common mechanism used by insurers to improve health outcomes and contain costs is value-based insurance design (V-Bid). V-Bid refers to health insurance benefit designs that remove the financial barriers consumers may face in receiving necessary, high-value clinical services.¹⁸ V-Bid aligns consumer out-of-pocket spending with the value of clinical services received – driven by reviews of evidence-based research and data.¹⁹

Health plans that incorporate V-Bid often cover preventive and wellness visits and treatments, as well as medications needed to manage chronic conditions, at low or no cost to the consumer. Conversely, consumer cost-sharing is higher on services that are identified as providing low or no value, or where the evidence of effectiveness is unclear. By directing consumers to “higher-value” and cost-effective clinical services and reducing utilization of unnecessary or ineffective services, health insurers will save money and improve individual health.²⁰ V-Bid principles can also be applied to HDHPs and be implemented in conjunction with payment reform strategies to achieve healthcare value.²¹

Ohio’s Comprehensive Primary Care program (CPC)

A patient-centered medical home (PCMH) is a team-based model for care delivery that includes comprehensive management of a patient’s health needs through improved care coordination. Ohio’s CPC program is designed to increase access to PCMH and pay for value by financially rewarding primary care practices that keep people healthy and hold down the total cost of care. In Ohio, to qualify for incentive payments, participating providers must meet activity, efficiency, clinical quality and total cost of care measures.

Ohio’s episode-based payment models

Ohio has developed a series of episode-based payment models designed to pay for value in outcomes and cost across an episode of care, including total joint replacement, perinatal and asthma acute exacerbation episodes. Episodes of care include all care related to a defined medical event. In Ohio, certain providers may

share in savings if their average costs for an episode of care are below a set benchmark and quality targets are met. Providers with average costs above an acceptable level may be penalized.

More information on Ohio's SIM initiatives can be found on the Governor's Office of Health Transformation [Engage Partners to Align Payment Innovation](#) page on their website.

Ensuring network adequacy and transparency

Regulation of network adequacy and transparency in the private health insurance market has traditionally been the role of state departments of insurance. However, under the ACA, health insurers must also comply with federal requirements related to network adequacy and transparency.²²

Network adequacy

Network adequacy refers to whether a health plan's network contains a sufficient number of primary and specialty care providers and facilities to ensure enrollees have reasonable, timely access to healthcare services covered by a health plan. Insurance companies generally contract with a network of providers in proximity to the communities where their enrollees live. Plans with broader networks typically have higher premiums, but provide greater choice to consumers in accessing healthcare providers. Establishing narrower or "skinny" provider networks is a common cost control mechanism implemented by insurers to keep plan costs down and offer lower premiums.²³

Qualified health plans (QHPs) sold on the ACA marketplace are required to "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."²⁴ The law does not provide specific metrics to define network adequacy. However, under the ACA, the Centers for Medicare and Medicaid Services (CMS) collect information about plan networks and verify that they provide "reasonable access" based on certain time and distance standards.²⁵ In draft rules for 2017, CMS encouraged states to adopt

standards proposed in the National Association of Insurance Commissioners Health Benefit Plan Network Access and Adequacy Model Act.²⁶ Another measure of network adequacy evaluated by CMS is the inclusion of essential community providers (ECP) within a health plan network. The ACA defines ECPs as providers who serve predominantly low-income, medically underserved populations based on federally-established ECP categories.²⁷ In 2017, 30 percent of ECPs in a plan's service area must be in a health plan's network or an insurer must demonstrate that in each area, they offered a contract to at least one ECP in each ECP category.²⁸

States have authority to add other categories of ECPs to the federally-designated list or implement higher standards than those developed by CMS.²⁹ Ohio law states that "a health insuring corporation shall, either directly or indirectly, enter into contracts for the provision of health care services with a sufficient number and types of providers and health care facilities to ensure that all covered healthcare services will be accessible to enrollees from a contracted provider or health care facility."³⁰ However, Ohio law does not specify or outline any additional criteria for measurement of network adequacy.

Network transparency

Network transparency ensures that consumers have clear, accurate and easily accessible information on providers within their health plan's network. Under the ACA, health insurers are required to display plan provider networks online and make hard copies of their directories available to consumers.³¹ However, insurers and providers may terminate contracts during the plan year, changing the plan's provider network. This can create confusion and disruption of care for consumers.

Under the ACA and Ohio law, QHPs are required to notify consumers 30 days before a provider they are seeing is no longer in-network. In certain severe circumstances, the ACA requires that plans pay for services provided by exiting providers as in-network services for 90 days after termination of their contract with the insurer or until treatment of the consumer is complete, whichever is shorter.³²

In early 2016, the Ohio Department of Insurance (ODI) enacted new requirements (outlined in Ohio Administrative Code 3901-8-16) to ensure that health plan network information is readily available to consumers. The new rule requires that health insurer directories contain up-to-date information about provider and network status for a health plan. In addition, upon termination of a network provider, a health insurer is required to:

- Provide notice to all plan enrollees who received services from the terminated provider within the past 12 months
- Update their directory before applying out-of-network cost-sharing to consumer claims³³

More information regarding the new rule can be found on ODI's [network transparency page](#) on its website.

Three R's of the Affordable Care Act

The ACA established risk adjustment, reinsurance and risk corridor programs ("three R's") to protect against the negative effects of both adverse selection and risk selection (see text box below) and to stabilize premiums across the private health insurance market (see Figure 2).

The reinsurance and risk corridor programs are temporary programs that began in 2014 and will end in 2016. The risk adjustment program is intended to be a permanent program.

There have been concerns regarding the efficacy of the three R's since their implementation, particularly around the temporary nature of the reinsurance and risk corridor programs, the ability of the federal government to pay out all owed claims to health plans and sustainability of the risk adjustment program over the long-term. Specific concerns are outlined below:

- Ending the reinsurance program in 2016 is cited as a contributor to higher health insurance premiums and decreased issuer participation on the ACA marketplace in 2017 and beyond.³⁴

- In September 2016, CMS announced that it would not be able to pay risk corridor claims for 2015 because it would use all available funds to pay amounts owed on 2014 claims.³⁷ Several insurers filed a federal lawsuit for payment and CMS is working with the companies and the Justice Department to negotiate a settlement.³⁸
- Risk adjustment program payments to health insurance issuers for benefit year 2015 are being held (sequestered) by the federal government at a rate of 7 percent for fiscal year 2016.³⁹ The U.S. Department of Health and Human Services has indicated that risk adjustment payments sequestered in fiscal year 2016 "will become available for payment to issuers in fiscal year 2017 without further Congressional action."⁴⁰

In response to mounting concerns, CMS proposed significant changes to the risk adjustment program beginning in 2017.⁴¹ The proposed changes would add prescription drugs to the risk adjustment model, adjust payments for high- and low-risk enrollees and create a national risk adjustment program to compensate issuers for a portion of expenses incurred above \$2 million per enrollee, per year.⁴² CMS expects the proposed changes will help stabilize the ACA marketplaces, encouraging new and existing issuers to participate.

Mergers and consolidations across health insurers and providers

Following passage of the ACA, the number of mergers and consolidations by healthcare providers and insurers accelerated.⁴³ Health insurers claim that mergers will yield cost-savings that will be passed on to the consumer through "scale economies, negotiating leverage in hospital and physician contracting and diversification."⁴⁴ In response, to maintain leverage in rate negotiations with rapidly expanding health insurance companies and to improve performance in value-based payment models, providers are merging as well.⁴⁵

Adverse selection occurs when less healthy people disproportionately enroll in a health insurance plan.³⁵ Generally, this occurs because individuals with higher-than-average risk of needing health care are more likely to purchase health insurance than healthier individuals.

Risk selection occurs when insurers make their products less attractive to individuals with costly health conditions to avoid enrolling these individuals in their health plans.³⁶

Figure 2. Overview of the Affordable Care Act's (ACA) reinsurance, risk corridor and risk adjustment programs

Program	Purpose	Funding mechanism	Entities receiving payments	Timeframe
Risk adjustment	Protects against adverse selection and risk selection by spreading financial risk across non-group (individual/family) and small group markets, both inside and outside of the ACA marketplace	<ul style="list-style-type: none"> Funds are transferred from plans with low-risk enrollees to plans with high-risk enrollees Funds are collected from non-grandfathered plans inside and outside the ACA marketplace 	Non-grandfathered, non-group (individual/family) and small group plans offered inside and outside the ACA marketplace	Permanent
Reinsurance	Offsets risks associated with the potential for greater enrollment by high-cost enrollees and reduces the incentive for insurers to charge higher premiums due to this concern	<ul style="list-style-type: none"> Payment is provided to plans with higher-cost enrollees Funds are collected on a per capita basis from all health insurance issuers and self-funded group health plans 	Non-grandfathered plans in the non-group (individual/family) market that operate both inside and outside the ACA marketplace	2014-2016
Risk corridor	Stabilizes premiums and protects against inaccurate premium rate setting by health plan issuers	<ul style="list-style-type: none"> Health plan issuer losses and gains are limited to no more or less than set thresholds Plans with lower than expected claims are charged and plans with higher than expected claims receive payment; the Department of Health and Human Services is tasked with securing funding for outstanding claims 	Qualified health plans (plans eligible to be offered on the ACA marketplace)	2014-2016

Source: "Explaining Health Care Reform: Risk Adjustment, Reinsurance and Risk Corridors." Kaiser Family Foundation (2016)

The impact of these mergers and consolidations on health insurance coverage and affordability is not clear. However, recently proposed mergers of Aetna with Humana and Anthem with Cigna, four of the five largest health insurance companies in the nation, have drawn heavy scrutiny. The U.S. Department of Justice and state attorneys general, including Ohio, joined together in filing

lawsuits to block the mergers in July 2016.⁴⁶ The two merger challenges allege that the mergers would substantially decrease competition across markets, drive up costs for consumers and make it harder for healthcare providers to negotiate rates.⁴⁷ The suits will be heard later this year and decided in early 2017.

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