PCH 358 –private insurance

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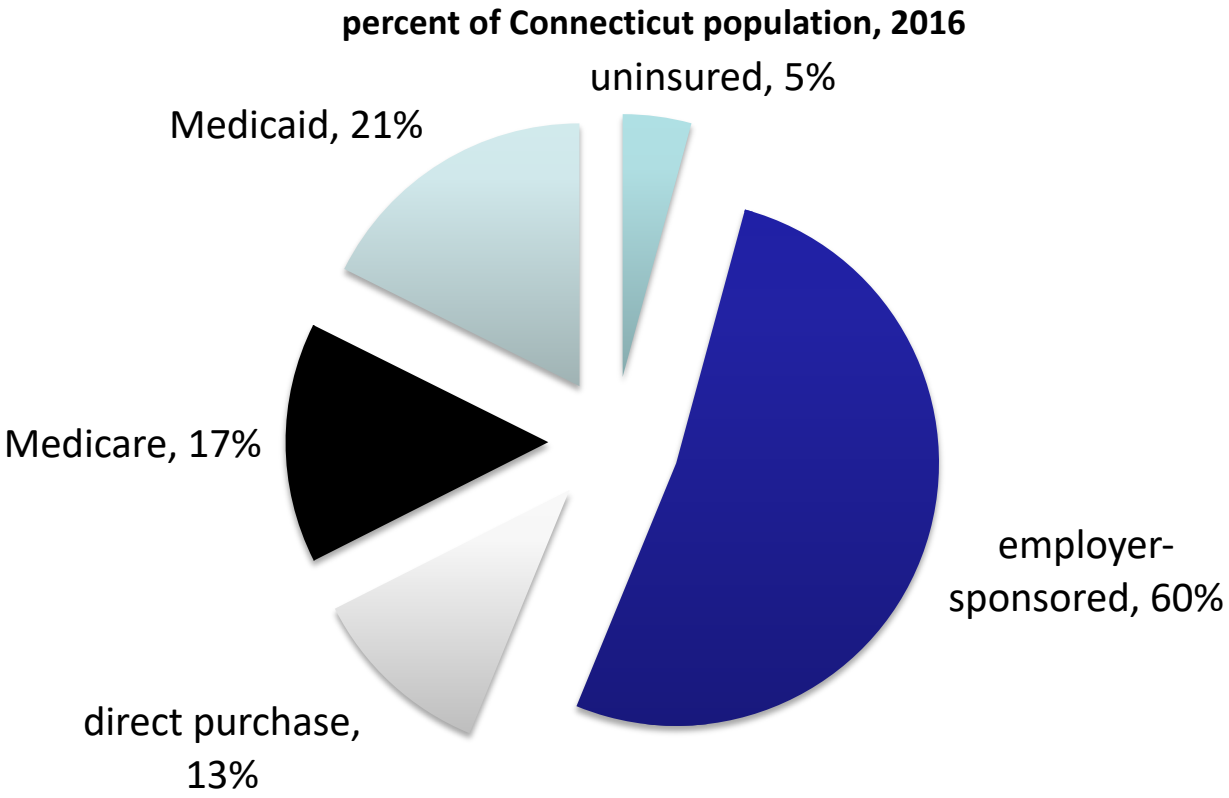
Spring 2018

CT coverage, 2016

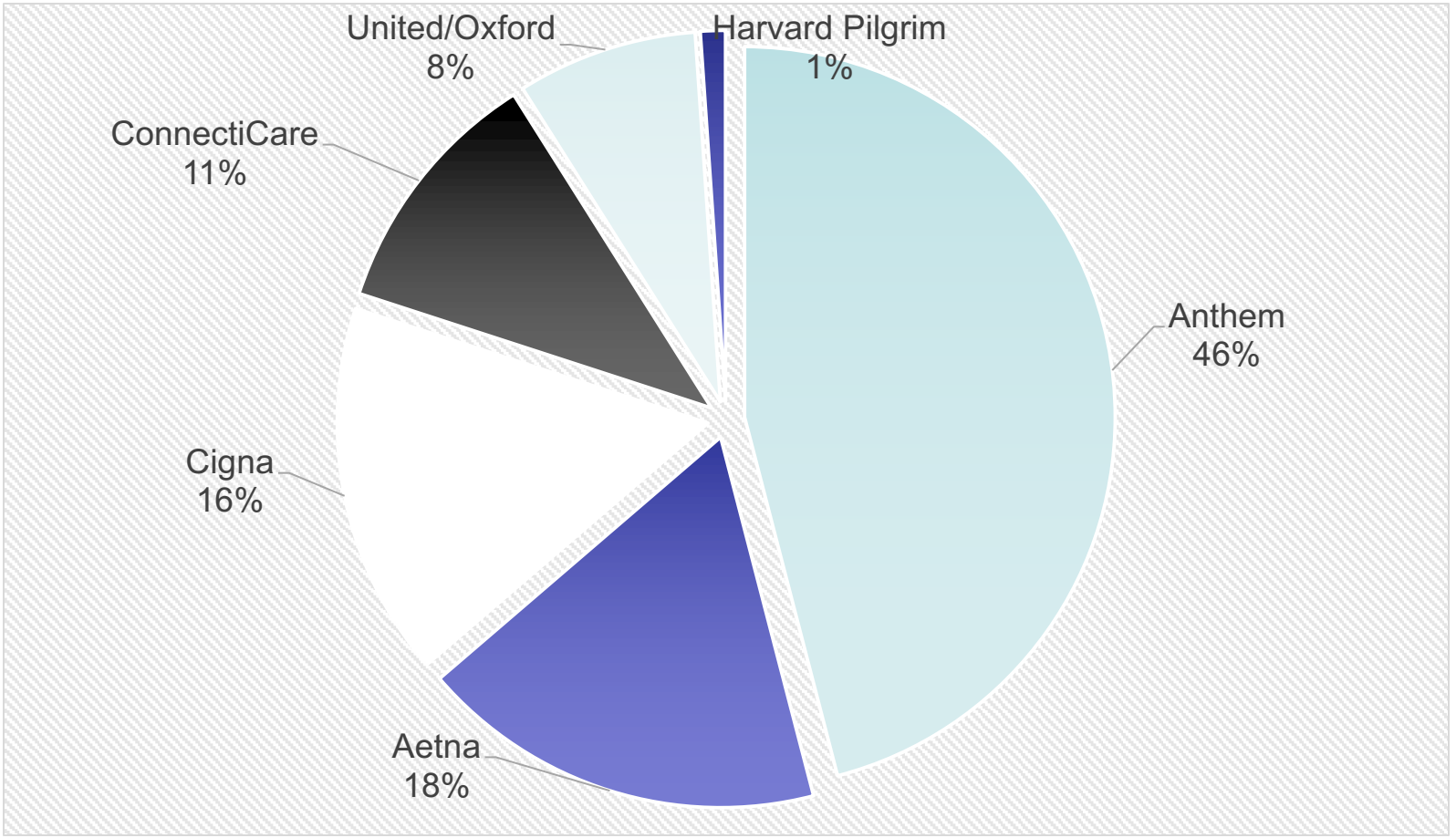


Source: 2017 US Census

Terms – private insurance

- Adverse selection, death spiral
- Medical underwriting
- Pre-existing medical condition
- Community rating, rate bands
- Gatekeeping
- Free riders
- Moral hazard
- Medical loss ratio

CT insurer market share 2016



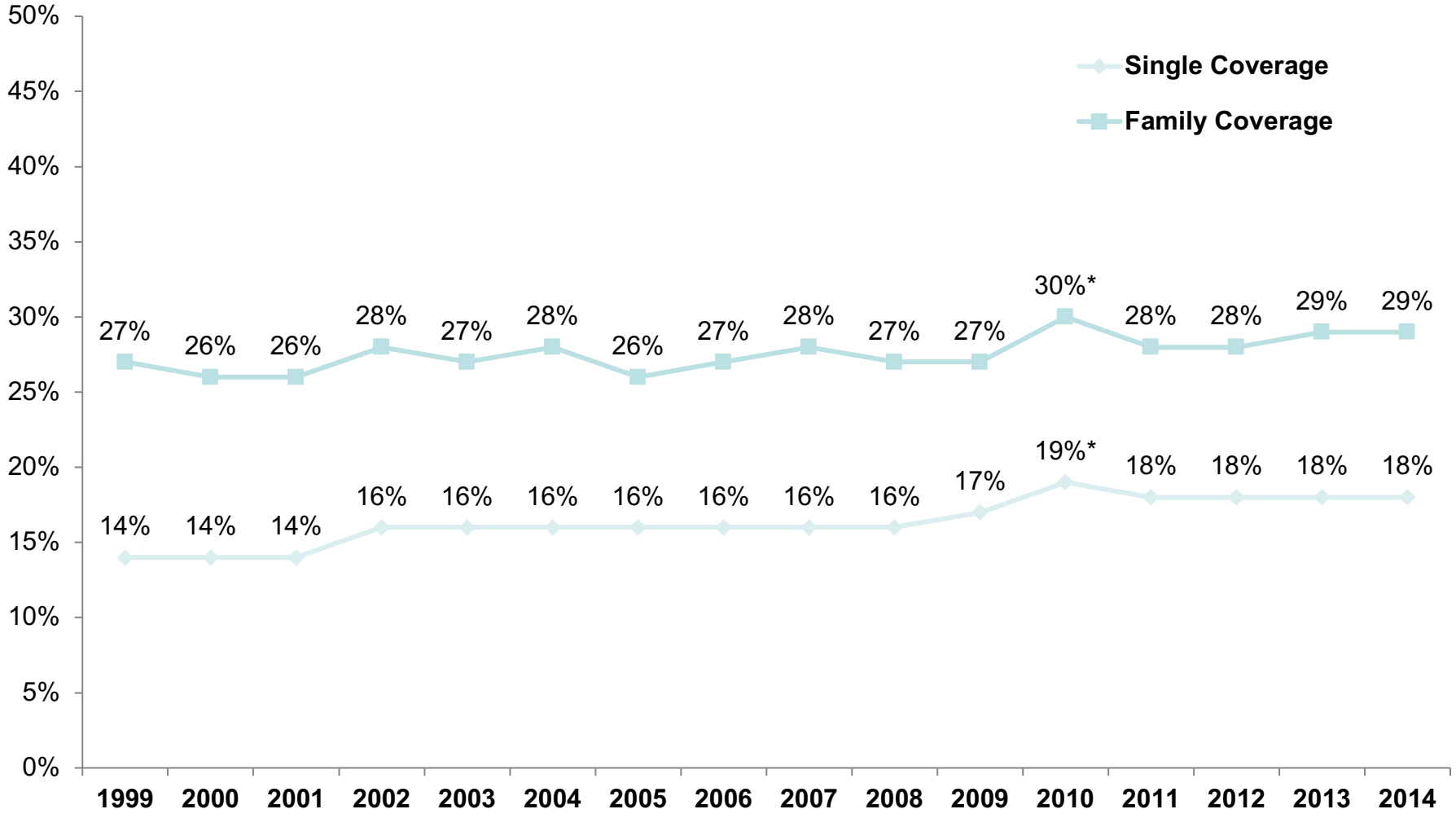
How does private health insurance work?

- Employer pays set monthly premiums to insurance company for each eligible employee
- Consumer pays copayments, premiums, coinsurance, and deductible
- Insurance company pays medical costs to provider after consumer pays his share
- Regulated by state Dept of Insurance
- Some coverage mandates in CT law
- Some consumer protections in CT law, particularly for small businesses
- ACA adds more consumer protections, finance controls

Consumer payments

- Premiums – monthly payments, usually deducted from paycheck, pay whether or not you get sick
- Copayments – flat fee paid to provider for each service, preventive care is now exempt
- Coinsurance -- % of treatment cost paid to provider
- Deductible – set amount paid by patient before insurance pays anything

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2014



* Estimate is statistically different from estimate for the previous year shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014.

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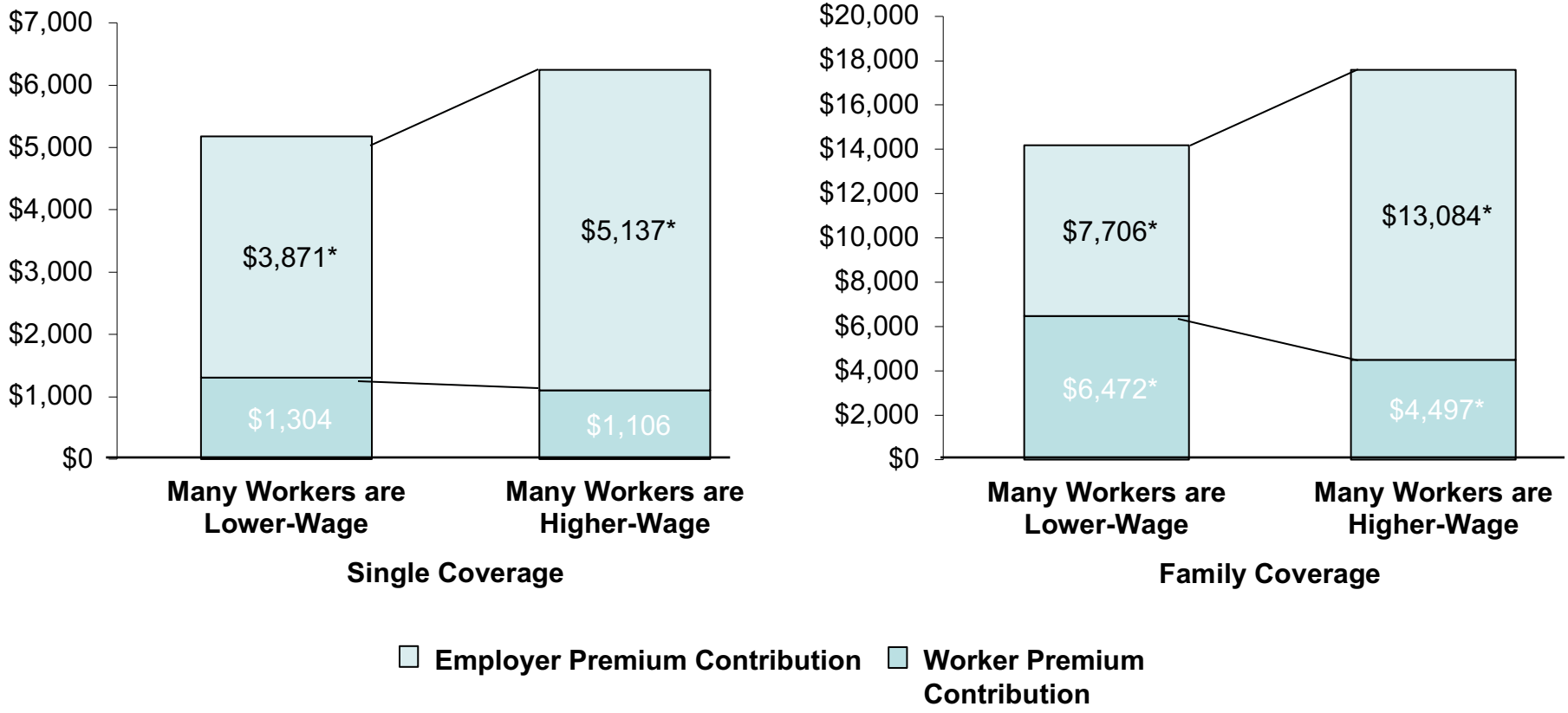
Average Worker and Employer Premium Contributions For Covered Workers at Higher- and Lower-Wage Firms, 2014



*Estimate for many workers are lower-wage is statistically different from estimate for many workers are higher-wage, within coverage type (p<.05).

NOTE: Firms with many lower-wage workers are ones where 35% or more of employees earn $23,000 or less. Firms with many higher-wage workers are ones where 35% or more of employees earn $57,000 or more. Wage cutoffs are the inflation adjusted- 25th and 75th percentile of national wages according to Bureau of Labor Statistics using data from the Occupational Employment Statistics (OES) (2012).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014. National Compensation Survey: Occupational Earnings in the United States, 2012. http://www.bls.gov/ncs/ocs/sp/nctb1489.pdf.

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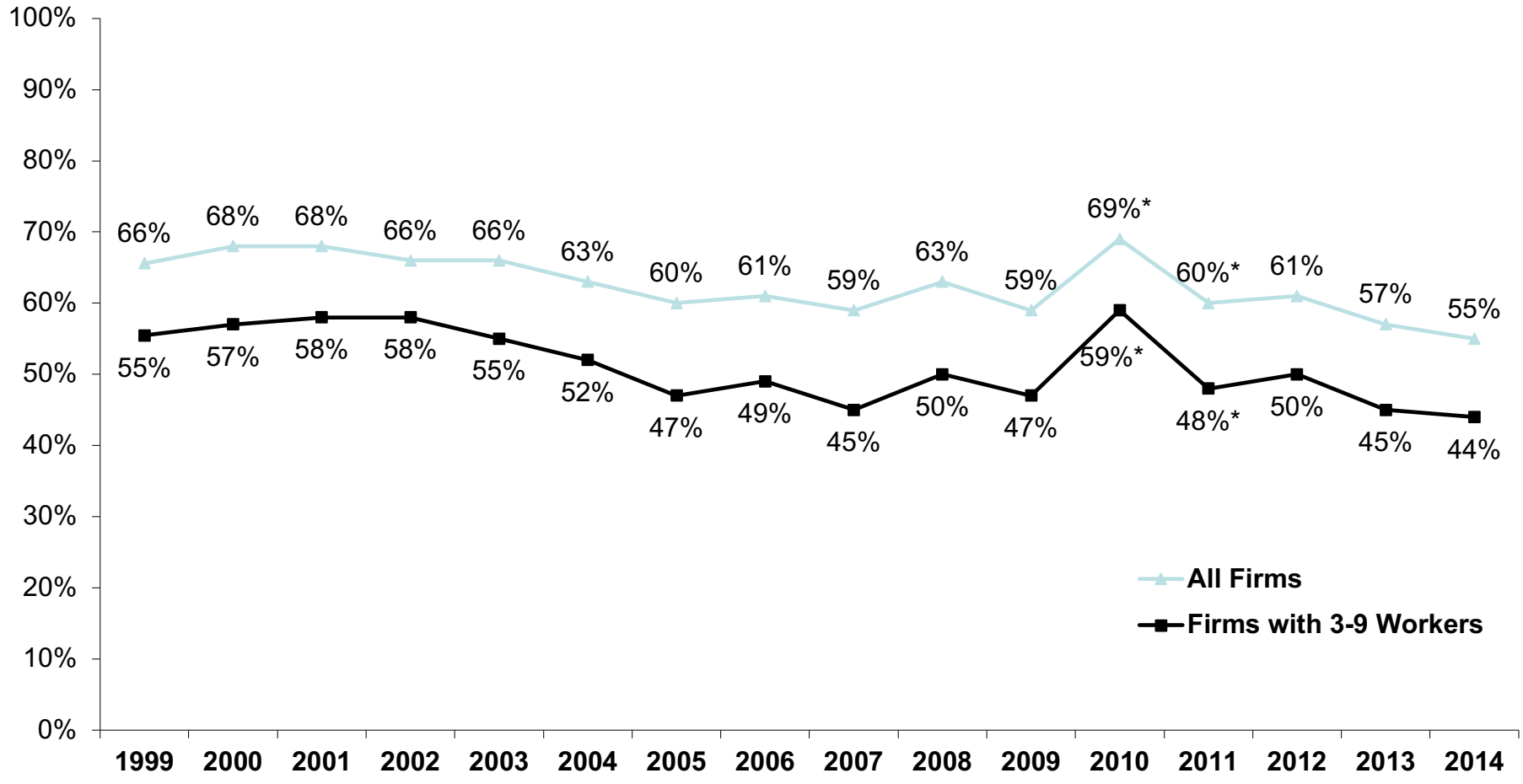
Percentage of All Firms Offering Health Benefits, 1999-2014



*Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. The percentage of firms offering health benefits is largely driven by small firms. The large increase in 2010 was primarily driven by a 12 percentage point increase in offering among firms with 3 to 9 workers. In 2011, 48% of firms with 3 to 9 employees offer health benefits, a level more consistent with levels from recent years other than 2010. The overall 2011 offer rate is consistent with the long term trend, indicating that the high 2010 offer rate may be an aberration.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014.

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How well does private health insurance work?

- Many CT residents are under insured
- Number going up

CT privately insured adults , out of pocket spending as % of household income						
	2001			2004		
	<5%	5-10%	>10%	<5%	5-10%	>10%
US	88.7	6.5	4.6	81.9	9.9	7.8
CT	91.8	4.7	3.3	84.4	7.2	7.6

Source: Blewett L, et al, Med Care Res Rev 66:167, 2009

Private Insurance only works with large and diverse pools

- Insurance costs are based on the health care needs of the people who are in the pool
- The larger and more diverse the pool, risk is spread over more people, and the lower the cost for everyone
- When healthy people are taken out of the pool, people with more health needs and risks are left, premiums get very expensive

Adverse Selection
Or
How a Death Spiral Happens

Insurance pools rely on a balance of mostly healthy members with a small minority of high utilizers

mostly healthy insurance pool

Insurance Pool

1 person @ $1million

+

1,000 people @$1,000 each

=$1 million

⬇

$ 2,000 each

less healthy pool

Insurance Pool

5 people @ $1million

=$5 million

+

1,000 people @$1,000 each

=$1 million

⬇

$ 6,000 each

half the healthy left the pool because the price spiked

Insurance Pool

5 people @ $1million

=$5 million

+

500 people @$1,000 each

=$500,000

$ 11,000 each

death spiral

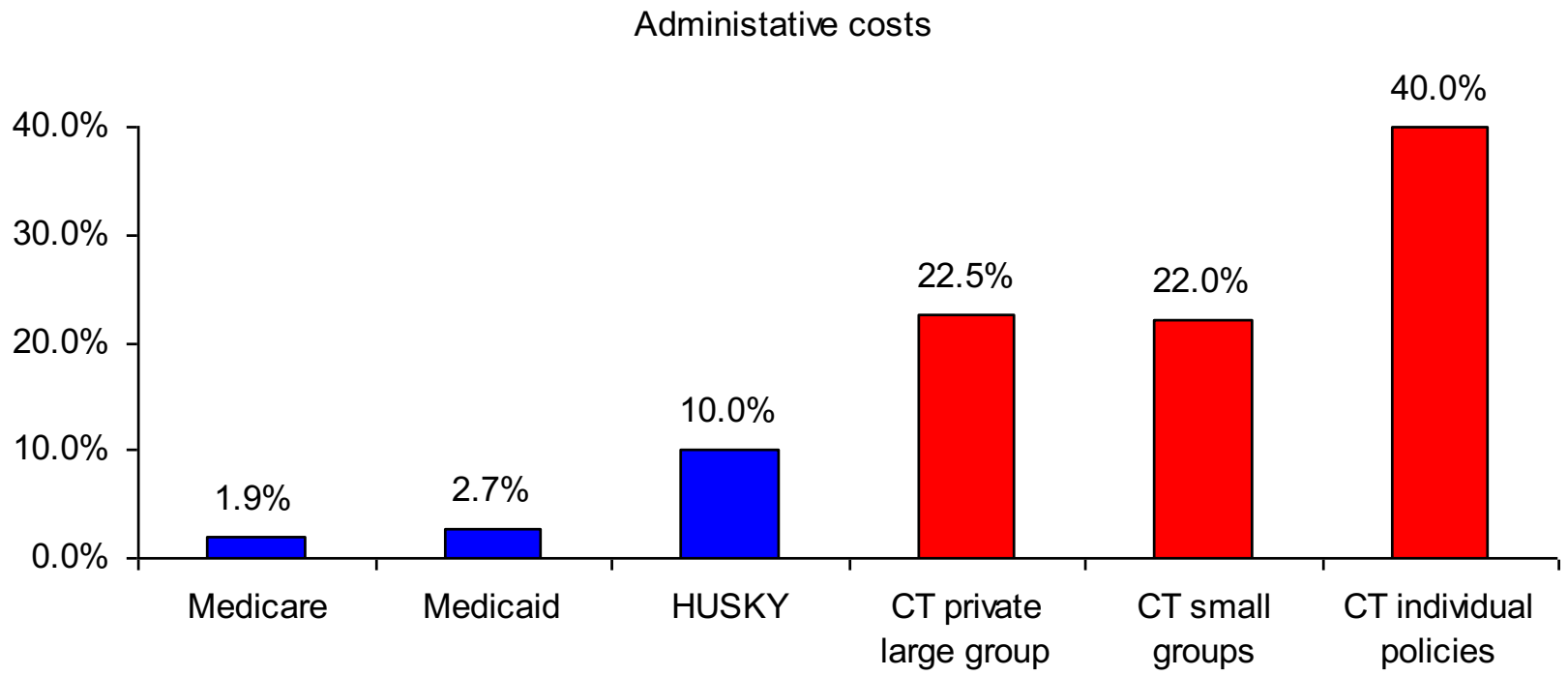
CT Charter Oak plan

- Real Death Spiral example
- Idea – health plan for uninsured
  - voluntary,
  - no pre-existing condition exclusion
  - Based on efficient HUSKY plans
- But attracted older, higher need people
- Premiums started at $257 pmpm 2008
- Up to $589 pmpm by March 2013
- Initially lots of interest
  - Max enrollment 14,579 May 2010
  - Down to 5,699 January 2013
  - Now it's gone

How insurers make money

- Collect premiums (and other revenue – i.e. drug rebates) into a pool
- Pay medical bills out of the pool (less consumer payments)
- Pay administrative costs
  - Includes disease management programs, care management, billing, CEO salaries, advertising, anti-fraud monitoring, negotiating with providers, prior authorization, etc.
- Rest is profit (margins)

Government programs are more efficient than private coverage
pre-ACA



Sources: CMS, DOI, DSS

How insurers make money

- Increase premiums
  - Premiums up 114% from 2000 to 2010
- Shift costs onto consumers
  - Consumer costs up 147% from 2000 to 2010
- Avoid high cost consumers – adverse selection
- Cut benefits
- Prior authorization, other barriers to accessing care
- Reducing options -- smaller provider panels, formularies
- Negotiating lower prices, paying late
- Shift to less expensive treatments, i.e. generics
- Consolidate the market through mergers
- Wellness plans

Insurance regulation

- Self insured – federal regulation only, through US Dept. of Labor, less strong regulation, generally large employers
- Fully insured – regulated by state insurance dept.s, small groups and individuals
- Mandates – state laws requiring coverage for certain benefits
- Rate review
- Medical loss ratio = % premiums spent on medical care
- Report cards
- Capitol reserves
- Scams

Insurance regulation

- Large groups generally self-insured, often unionized, good benefit packages
  - MLR limited to 15% under ACA
  - Shared with employer
  - No CT state regulation
- Small groups – fully insured, 1 to 50 people in CT
  - Guaranteed issue and renewal – CT law and ACA
  - Modified community rating
  - MLR limited to 20% by ACA
  - CT rate review only for small groups

Individual insurance regulation

- Pre-ACA
  - Medical underwriting – look back 12 months
  - MLR was typically 30 to 50% and higher
  - Pre-existing condition exclusion 12 months
  - No rate review, no community rating
  - No guaranteed issue or renewal
- Since ACA
  - No medical underwriting/pre-existing condition exclusion
  - MLR limited to 20%
  - Rates reviewed and adjusted by CID
  - Guaranteed issue and renewal

Mandates/Consumer protections

- 55 required benefits for coverage offered in CT
- State laws
- Not evaluated for cost effectiveness, often political, emotional
- Driven by narrow consumer groups & financial interests, opposed by insurers, conservatives
- CT number of mandates high among states
- Cost 18 to 22% of premiums
- Most mandated benefits are covered by large groups, not required to cover under law

Mandate examples

- Tumors and leukemia – costliest 3.7% of premiums
- Mental health
- Diabetes diagnosis and treatment
- Newborn coverage
- Cancer screenings
- Infertility
- Chiropractors
- Hearing aids for children
- Wigs for cancer patients
- Prescription contraceptives

HSAs and Consumer Directed health plans

What They Are
•A Health Savings Account is a tax-advantaged savings account for out-of-pocket health care costs usually coupled with a high-deductible health insurance plan

The Good News
•Tax-advantaged
•Usable for many medical expenses, including insurance plan deductibles
•Year to year carryover
•Employer to employer portability

The Bad News
•Consumers have to be very sophisticated to purchase health services – information is not readily available
•You have to earn enough to afford to save
•Attracts mostly healthy people, undermining the group health insurance pool
•Spending out of pocket is a disincentive to seek timely care

Trends

- Shifting financial risk to providers
- Pay for “quality”/ value
- Shifting more costs to consumers
- Consumer directed health plans will grow
- Personal responsibility incentives/penalties
- Value-based insurance design
- Expect continued erosion in employer-sponsored coverage
- Expect small growth in individual market
- Big Question – what President and Congress will do to stabilize the market