Health Policy 201– private health insurance

Ellen Andrews, PhD
CT Health Policy Project
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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

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

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

CT average consumer costs

(2010)	CT	US
Single premium, employee share	23% $1,234	21% $1,021
Family premium, employee share	26% $3,824	27% $3,721
Copay doctor visit	$23.81	$22.82
Single deductible	$1,201	$1,025
Family deductible	$2,308	$1,975
Individual policy premium, monthly	$306	$215
Avg wait for employer coverage	7.6 weeks	8.0 weeks

Sources: 2010 MEPS, AHRZ, Kaiser Foundation State Health Facts

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

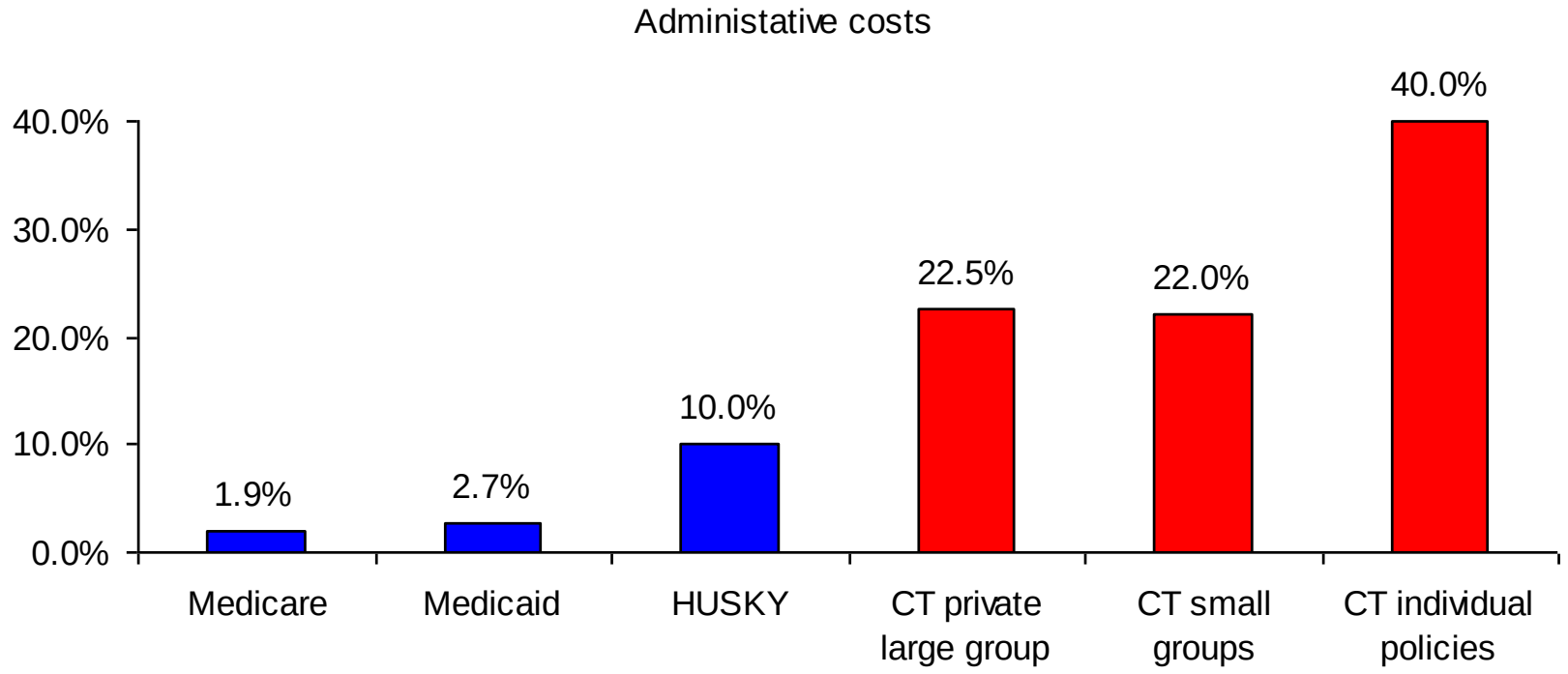
Terms

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

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



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
- 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 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
- Report cards
- Capitol reserves
- Scams

Insurance regulation

- Large groups generally self-insured, often unionized, good benefit packages
  - MLR typically 20%
  - Shared with employer
  - No CT state regulation
- Small groups – fully insured, 1 to 50 people in CT
  - Guaranteed issue and renewal
  - Modified community rating
  - MLR typically 25%
  - CT rate review only HMOs for small groups

Insurance regulation

- Individual
  - Medical underwriting – look back 12 months
  - MLR typically 30 to 50% and higher
  - Pre-existing condition exclusion 12 months
  - No rate review, no community rating
  - No guaranteed issue or renewal
  - ACA will change much of this
  - Small market now – 9.6% of CT residents
  - Will grow significantly with individual mandate

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

Trends

- Managed care
- Shifting more costs to employees
- Consumer directed health plans
- Disease management
- Personal responsibility incentives/penalties

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