

Ohio health insurance basics

October 2012

Why is health insurance important?

Health insurance fulfills a number of public policy objectives. Health insurance (1) enables consumers to share the risk of potentially high cost medical care with other consumers to prevent negative financial impact, (2) provides medical practitioners with a consistent source of payment, and (3) increases the likelihood that consumers will seek and receive needed and appropriate health care.¹ With health insurance, a contract is established between a consumer and an insurer where the consumer makes regular payments to the insurer in exchange for the insurer's agreement to pay all or a portion of the consumer's medical expenses for a specified period of time. Consumers enrolled in health insurance plans are referred to generally as enrollees or plan members. The type of services paid for and the amount an insurer agrees to pay in a health insurance plan is referred to as health care coverage. Health care coverage can vary significantly from plan policy to policy.

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Ohio health insurance at a glance

How do most Ohioans get insurance coverage?

5.8 million (51%)

Ohioans were covered by employer-sponsored insurance in 2011

Source: Kaiser Family Foundation State Health Facts



What types of employers offer coverage?

39%

Ohio small employers (less than 50 employees) offered coverage in 2011



97%

Ohio large employers (more than 50 employees) offered coverage in 2011



Source: Kaiser Family Foundation State Health Facts

Other sources of coverage

3.5 million

public health insurance (Medicaid, Medicare and other government programs)

1.5 million

uninsured

516,800

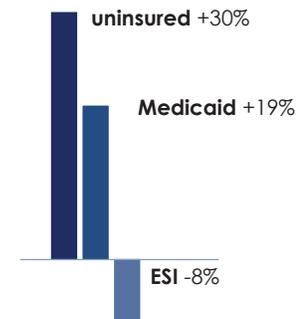
individual insurance plan



Source: Kaiser Family Foundation State Health Facts

Trends in coverage

From 2006-2007 to 2010-2011, Ohioans (ages 0-64) saw a **8%** drop in employer-sponsored (ESI) coverage, while the number of uninsured increased **30%** and the number enrolled in Medicaid increased **19%**.



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. Additional calculations by HPIO.

Public versus private health insurance

While this publication primarily covers information about private insurance, differentiating between public and private insurance coverage is important. Public health insurance coverage, offered to certain consumers that meet a defined set of eligibility requirements, refers to health plans funded by the federal, state or local government. Medicare, Medicaid, the Children's Health Insurance Program (CHIP), military health care, state and Indian Health Service plans are all examples of public health insurance.² Private health insurance includes group or individual health insurance plans that are provided to a consumer via an employer or union, or purchased by an individual from a private health insurance company.³

Employer-sponsored insurance coverage

Employer-sponsored insurance (ESI), private group health insurance coverage provided to employees by an employer or group of employers, is the number one source of health insurance coverage in the U.S. In some cases, employers extend ESI coverage to an employee's spouse and/or dependents.

ESI coverage is either fully insured or self-insured. If the coverage is fully insured, the employer purchases a plan from an insurance company that pays claims and bears risk. If the employer chooses to self-fund their ESI plan, the employer takes on the full risk of providing health insurance for their employees and is considered self-insured.⁴ Self-insured coverage is administered directly by an employer or through a contractual arrangement with a third-party administrator (TPA). A TPA assists the employer in tracking premiums, processing insurance claims and managing related plan paperwork.

Large employers are more likely to offer ESI than small employers. While almost all large businesses (50 or more workers) in the United States offer health insurance coverage to their employees (96.1 percent), the number of small businesses (less than 50 workers) offering coverage is just 39.1 percent, according to data from the Kaiser Family Foundation. The primary reason small firms do not offer health insurance coverage is the high cost of doing so.

In general, small employers face higher premiums for a number of reasons, including:

- More variable risk profiles (i.e. health risks are not spread across a large number of people)
- Higher employee turnover rates
- Higher rates of firm failure
- Higher rates of employees dropping in and out of coverage
- Higher administrative costs

Public Health Insurance Programs

Medicare

Medicare is a federally-run health insurance program that provides health insurance coverage for most seniors over the age of 65, certain individuals with disabilities under the age of 65 and certain individuals who have end stage renal disease (ESRD) or amyotrophic lateral sclerosis (Lou Gehrig's disease). The program is funded through employee payroll deductions.⁵

Medicaid

Medicaid is a jointly administered federal-state program that provides health and long-term care services to certain populations of low-income individuals as well as to aged, blind and disabled individuals meeting certain requirements.⁶ The federal government supports state administration by providing matching funds and establishing general programmatic guidelines. The **Children's Health Insurance Program (CHIP)** provides low-cost health insurance coverage for children in families with incomes too high to qualify for Medicaid, but that cannot afford private coverage.⁷ Ohio implemented CHIP as a Medicaid expansion, rather than as a separate program. Medicaid is the largest provider of coverage for children, with 38 percent of Ohio children covered in 2010. (For more information about Medicaid, see HPIO's *Medicaid Basics 2011*, <http://bit.ly/jYA32h>)

In addition, small-group employers may not qualify for coverage if a certain percentage of eligible employees do not enroll in the plan. Such practices protect insurers from “adverse selection.” Adverse selection occurs when the insured group consists of a disproportionate share of individuals who are in poor health and who incur higher medical costs.

Finally, unlike many large employers, most small employers do not have the option to self insure. For a small employer, self-insurance is a gamble, as even a limited number of high-cost claims could be financially devastating.

The role of agents and brokers

Agents and brokers play an important role in selling and implementing insurance contracts between individuals or employers/groups and insurance carriers. Services provided to consumers by agents and brokers can include shopping for plans among different insurance carriers, advising consumers on cost and coverage issues, and assisting with insurance-related problems.

Individual health insurance coverage

People who are unemployed, self-employed, work for companies that do not offer health insurance, or are unable to obtain insurance through a spouse or partner’s employer, may have the option to purchase coverage directly in the individual market. In 2011, 516,800 Ohioans were covered by individual plans.

Because people who buy coverage in the individual market must pay the full premium and are rated on the basis of their health or age, they often find that coverage is unaffordable.

In Ohio, those who previously had continuous group coverage for at least 18 months may convert group coverage to an individual plan with their former employer’s insurance company or apply for basic or standard individual coverage through any other insurer. In either case, the insurer must accept the application and cannot reject coverage due to health status.

Applicants for individual insurance who have had lapses in health coverage or have never been covered, may be denied coverage because of a pre-existing condition. In Ohio, people who have been denied coverage for a pre-existing condition have the option of seeking coverage through a process called open enrollment. Ohio insurance companies are required to hold open enrollment for a specified time period every year, and cannot deny an applicant coverage. However, the premiums tend to be even higher than those that are medically underwritten, and insurers are not required to take additional enrollees once the insurer has reached its statutorily required annual enrollment limit.

Beginning in 2014, the Affordable Care Act (ACA) calls for the following reforms to the individual health insurance market:

- Nondiscrimination based on health status
- Guaranteed issue and guaranteed renewability
- Coverage of preexisting health conditions (regardless of age)
- Rating restrictions (limited to age, individual versus family enrollment, geographic area and tobacco use)

High risk pools

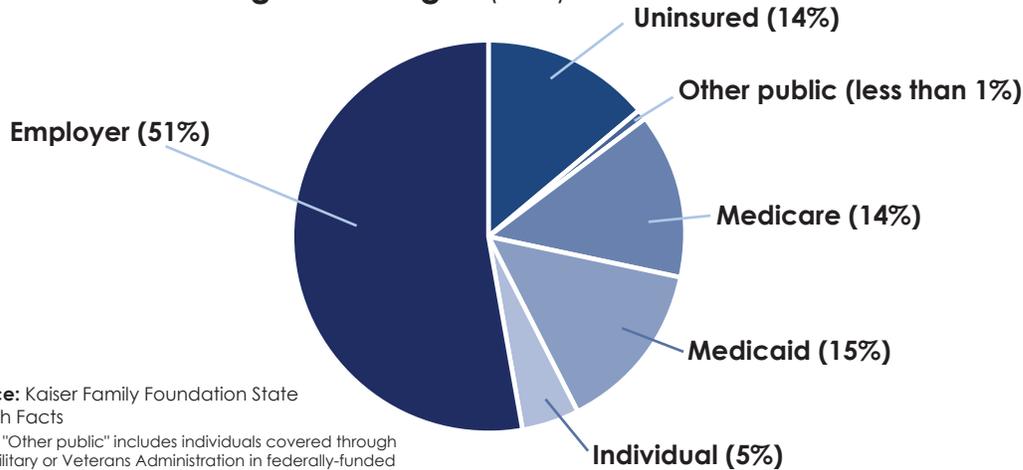
The ACA provides funding through 2013 for temporary high-risk pools for people who have been denied health insurance because of pre-existing conditions and who have been uninsured for at least six months. For more information, see page 9 or visit:

www.ohiohighriskpool.com

How are Ohioans covered?

The majority of the state's population — 5.8 million Ohioans — are covered by some form of employer sponsored or individually purchased private health care coverage. About 3.5 million Ohioans receive some form of public health insurance coverage including Medicaid, Medicare and other government programs. An additional 1.5 million, or 14 percent, of non-elderly Ohioans are uninsured.⁸

Where do Ohioans get coverage? (2011)

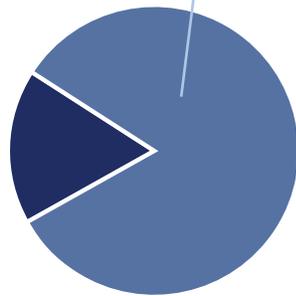


Source: Kaiser Family Foundation State Health Facts

NOTE: "Other public" includes individuals covered through the military or Veterans Administration in federally-funded programs such as TRICARE (formerly CHAMPUS) as well as some non-elderly Medicare enrollees

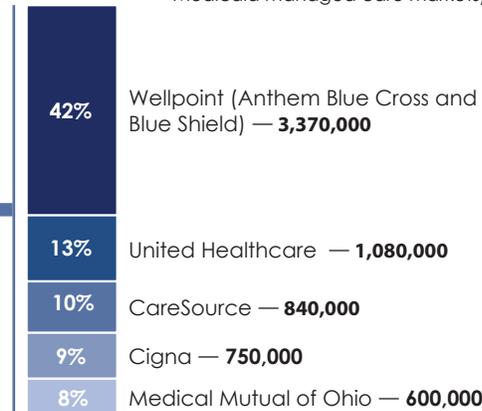
Who covers most Ohioans?

83% of insured Ohioans obtain their coverage from five health insurance carriers



Five largest insurance carriers in Ohio

by market share and total enrollment (includes individual, small and large group, self-insured and Medicaid managed care markets)



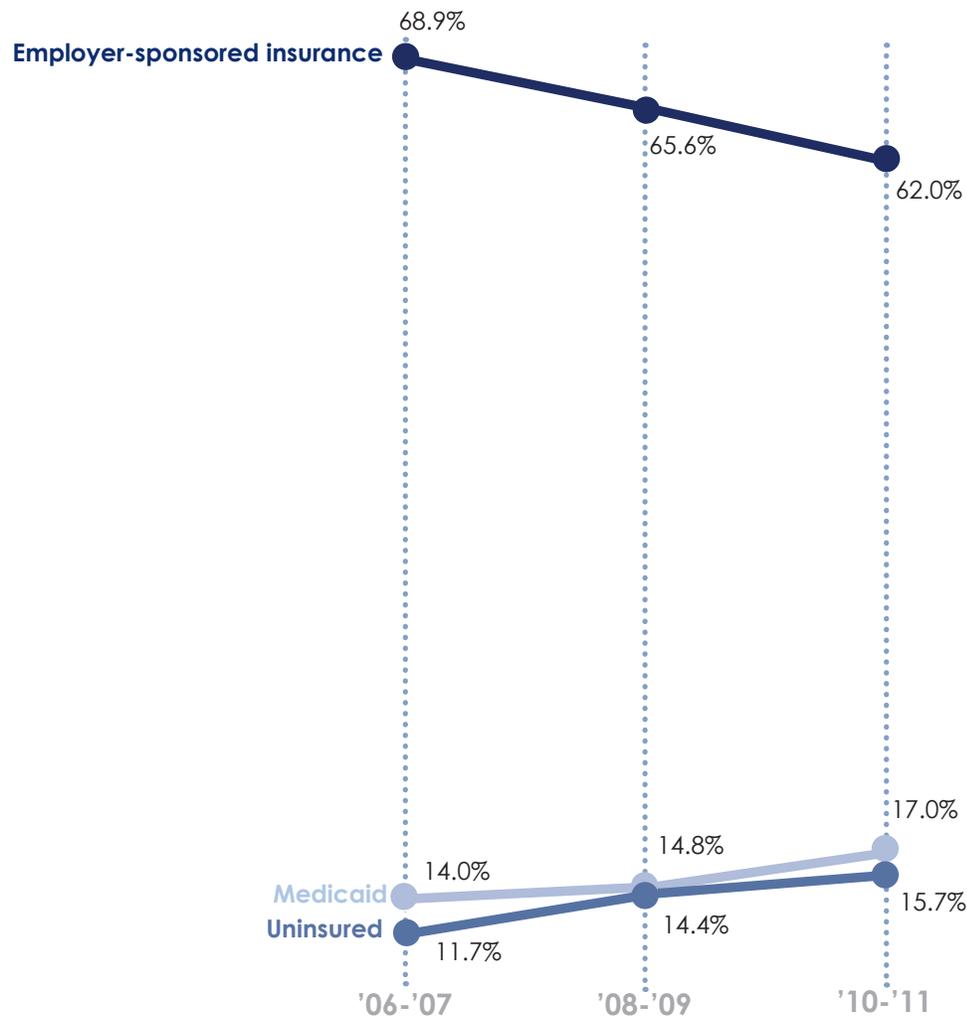
Source: Governor's Office of Health Transformation analysis of data from Milliman Inc. and Ohio Medicaid

Health premiums for employer-sponsored insurance in Ohio in 2011



Source: Kaiser Family Foundation Statehealthfacts.org

Health insurance coverage trend in Ohio, ages 18-64⁹



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. Additional calculations by HPIO

Health insurance regulation

Historically, states have been the primary regulators of health insurance companies and products.¹⁰ Over time, however, the federal government has become more active in the regulation of health insurance as evidenced by a number of significant federal laws enacted including the Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA) and, most recently, the Patient Protection and Affordable Care Act (ACA). Fully insured coverage is regulated by state law and rules. Self-insured coverage is regulated generally by federal laws and rules.

Federal regulation

ERISA

The majority of private-sector, employment-based health plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA is federal law that establishes a set of minimum standards and consumer protections that apply to most employee pension and group health plans within the private health insurance sector, including self-insured plans.¹¹ ERISA requires that health plans comply with a number of federal standards including providing plan enrollees with access to plan information; providing fiduciary responsibilities for those managing and controlling plan assets; establishing a grievance and appeals process for enrollees to

receive plan benefits; and providing plan enrollees with the ability to sue for plan benefits and breaches of fiduciary duty.

ERISA law preempts state regulation.¹² Notably, ERISA does not regulate individual or small-group health insurance coverage or health plans administered by churches, federal, state or local governments or health plans established solely to comply with workers compensation, unemployment or disability laws.¹³

COBRA

Passed by Congress in 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA), gives workers and their families who lose employer health coverage the right to temporarily continue group health coverage. Employers with 20 or more employees who provide group health coverage are subject to COBRA. Coverage through COBRA is provided for a limited period of time and only under certain circumstances. Specifically, COBRA benefits are available upon voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, or upon another qualifying life event.¹⁴ In many cases, the individual is responsible for the entire plan premium, making COBRA coverage comparatively more expensive than most ESI coverage.¹⁵

For employers with fewer than 20 employees, Ohio's state continuation of coverage, or "mini COBRA" law, provides similar coverage options.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. Title I increases access to health insurance by making individual and small group coverage "portable" in the event that a worker changes or loses their job, and by restricting or eliminating the denial of coverage based on pre-existing conditions. Title II focuses on improving the efficiency and effectiveness of the health care system through administrative simplification. It requires the establishment of national standards for electronic health transactions, mandates the adoption of privacy and security standards to ensure the confidentiality of patient records, and calls for the creation of national identifiers for patients, providers, health insurance plans, and employers when used in electronic data exchange.

The Patient Protection and Affordable Care Act (ACA)

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. The ACA enacts a number of reforms within the public and private insurance markets. Many of the reforms aim to increase access to health insurance coverage, increase the value of coverage provided to consumers and decrease the cost burden of health insurance coverage on consumers.

A summary of the regulatory changes to private insurance in the ACA are listed in the Appendix. In addition to those changes, the ACA includes other provisions that also impact the insurance market, such as:

- Individual requirement to have health insurance ("individual mandate")
- Expanded Medicaid coverage (now optional for states)
- Establishment of affordable insurance exchanges
- Employer penalties for not providing coverage

ERISA plans

ERISA-regulated health plans are required to provide the following benefits:

- "Continuation" health coverage
- Group plan guaranteed issue and renewability
- Pre-existing condition exclusion requirements
- Nondiscrimination in premiums and eligibility
- Maternity hospital length of stay standards
- Post mastectomy surgery
- Limited mental health parity

Ohio regulation

The Ohio Department of Insurance (ODI) is charged with regulating the health insurance industry in Ohio. Specifically, the mission of the department is “to provide consumer protection through education and fair but vigilant regulation while promoting a stable and competitive environment for insurers.”¹⁶

Generally, ODI has the authority to ensure that plan enrollees receive the benefits dictated by their health plan or policy.¹⁷ ODI does not regulate the benefit or cost structure of group health plans or set health insurance plan premiums or rates. However, for certain individual policies, ODI does review rates to make sure that they are within legal requirements.¹⁸ ODI has only limited authority over self-insured plans, as these plans are generally regulated under the federal Employee Retirement Income Security Act (ERISA).

Mandated benefits

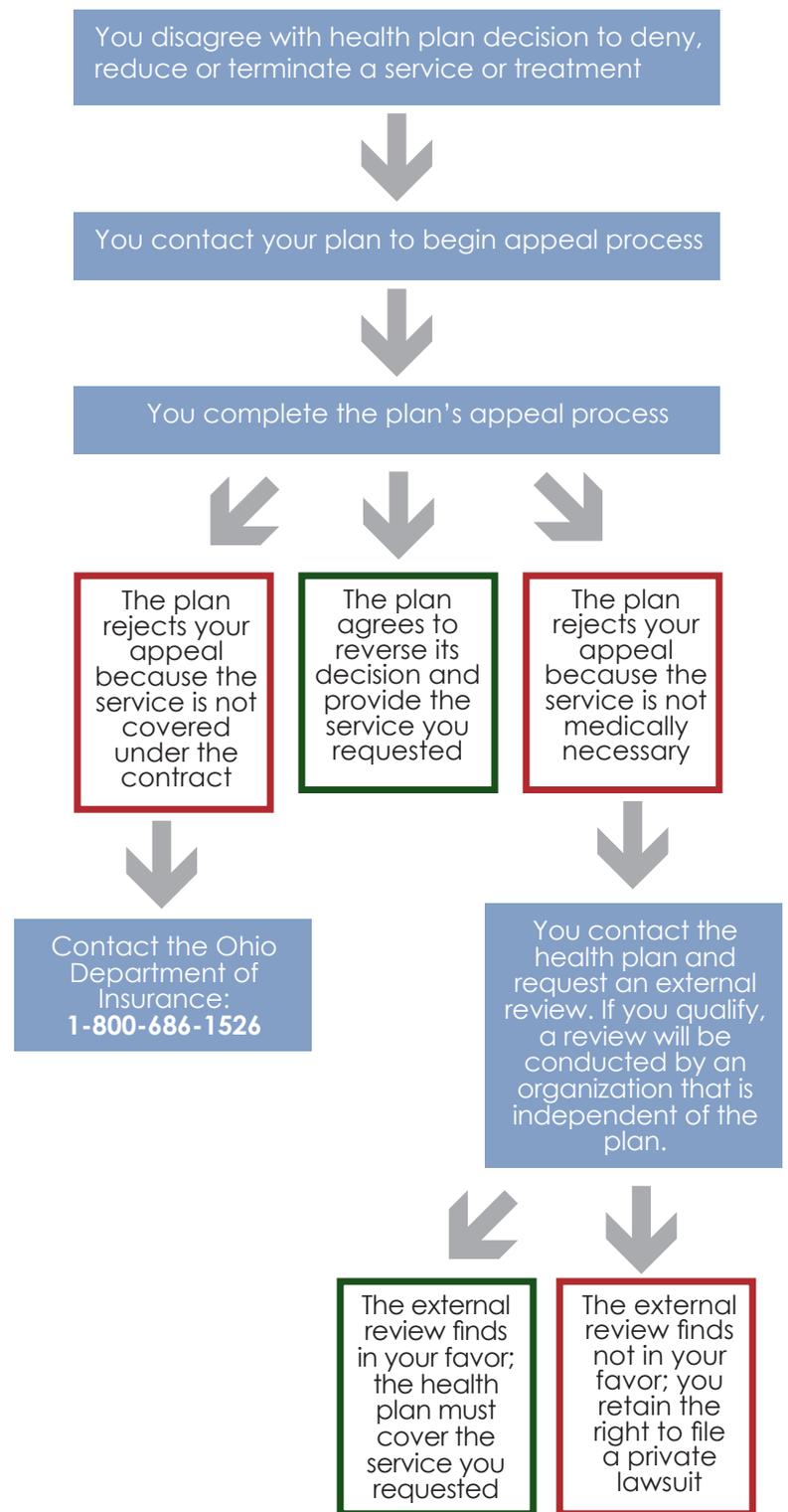
Ohio law guarantees that health plans provide certain benefits to their enrollees. However, many health plans in Ohio also cover additional benefits leading to variation in covered services among plans.

Ohio mandated benefits

- Dependent coverage up to age 28 (for those who meet eligibility requirements)
- Alcoholism/Substance Abuse treatment
- Breast Reconstruction
- Cervical Cancer/HPV Screening
- Cancer Clinical Trial
- Emergency Service
- Mammography
- Maternity Minimum Stay
- Mental Health (General)
- Mental Health Parity
- Newborn Hearing Screening
- Off Label Drug Use*
- Well Child Care
- Outpatient Kidney Dialysis

* Subsection 3923.60 of the Ohio Revised Code states that off-label drugs must be covered “provided that the drug has been recognized as safe and effective for treatment of that indication in one or more standard medical reference compendia...or in medical literature....” The extent to which off-label drug usage is included in the essential benefit package is not yet clear.

Ohio Department of Insurance appeals process



Source: Ohio Department of Insurance
(<http://www.insurance.ohio.gov/consumer/publications/iroflowchart.pdf>)

Additional ODI regulatory functions

ODI also performs additional health insurance regulatory functions including:

- Licensing of health insuring corporations in Ohio and review of rates, contracts and certificates of authority
- Regulating market conduct and monitoring insurers' compliance with Ohio insurance laws and regulations including insurers underwriting, marketing and claims handling practices.
- Issuing licenses to insurance agents and TPAs and monitoring continuing education requirements
- Monitoring the financial solvency of health insuring corporations licensed in Ohio to ensure that they have enough money to pay out health claims filed by consumers.
- Investigating and preventing health insurance fraud¹⁹

Plan design: Benefits and cost structure

What are the different types of health insurance plan designs?

Health insurance can be offered under a traditional or a managed care plan. Under traditional health insurance, which is also known as indemnity or fee-for-service health insurance, a consumer generally is able to receive health care services through any healthcare provider.²⁰ These plans have less tools in place to restrict services and manage the cost of insurance, but offer the greatest consumer flexibility.

Alternatively, in a managed care plan, consumers are limited to receiving services from a select group of participating providers who have contracted with the health plan.²¹ Managed care plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point of service plans (POS). In Ohio, HMOs are referred to as health insuring corporations (HICs). These are typically less expensive than traditional plans because they restrict consumer flexibility.

- **Health maintenance organization (HMO):** Referred to as HICs in Ohio,²² HMOs contract with health care providers to assume the financial risk of providing their members with comprehensive medical services in exchange for a fixed, prepaid fee. Typically, HMOs limit coverage to care from health care providers who work with or contract with the HMO. Out-of-network services are generally not covered with the exception of emergency services.
- **Preferred provider organization (PPO):** In a PPO, health care providers agree to provide services to consumers at a negotiated rate.²³ Enrollees generally have cost-sharing obligations, such as deductibles or co-pays. PPOs may also offer more flexibility by allowing visits to out-of-network providers,²⁴ but at greater expense to the enrollee. There is often a deductible for out-of-network expenses and a higher co-payment.
- **Point-of-service plan (POS):** Also known as open-ended HMO, POS is a blend of HMO and PPO coverage. POS plans are similar to HMOs for services provided within network.²⁵ However, enrollees have the option of utilizing providers outside of the network at a higher cost. POS plans generally require that enrollees obtain referrals from their primary care physician prior to seeing a specialist.

How do insurers and consumers share costs?

"Cost sharing" refers to the way that health care costs are shared between insurers and consumers. The following list defines some common cost sharing mechanisms:

- **Co-payment:** A fixed dollar amount paid by a consumer at the time of receiving a health care service included within a consumer's health care coverage. The required fee varies by the service provided and by the health plan.
- **Deductible:** A set amount of health care expenses a consumer must pay during the benefit period before an insurer starts to make payments for covered services.
- **Co-insurance:** A method of cost sharing in which the consumer is required to pay a defined percentage of their medical costs after their deductible has been met.

- **Out-of-pocket maximums:** Once a consumer pays a certain amount, the insurer pays 100 percent of claims.
- **Out-of-network benefits:** An insurer may require the consumer to pay more if treated by a provider that is not in the insurer's network.

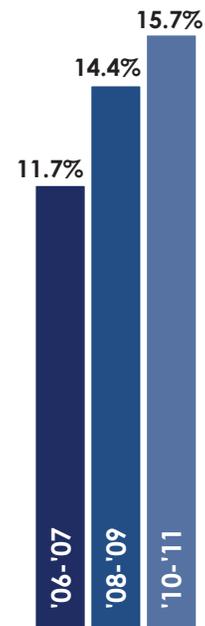
What happens today if you do not have insurance?

There were approximately 1,500,000 uninsured Ohioans in 2011, according to the Kaiser Family Foundation's State Health Facts. Uninsured individuals face substantial challenges in accessing timely, appropriate and affordable health care services. HPIO released Ohio Access Basics in October 2012 (<http://bit.ly/OaWS0z>) to explore challenges and opportunities related to health care access.

High-risk pool plans

Some states offer government subsidized high-risk pool plans for individuals who are considered high risk and are denied coverage or are unable to purchase health insurance through the private market.²⁶ However, high-risk pool plans generally have high premiums and can often still be unaffordable for consumers. The Affordable Care Act included funding for a temporary high risk pool in order to provide some people with pre-existing health conditions the opportunity to purchase partially subsidized coverage. Ohio's high-risk pool plan is operated by Medical Mutual of Ohio.²⁷ Federal funding for the program runs through the end of 2013. Because a person must be uninsured for six months and have the means to pay for a portion of the insurance coverage, the ACA-funded high-risk pools have provided coverage to just 2,819 Ohioans, as of June 30, 2012.

Uninsured rate in Ohio (0-64)



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. Additional calculations by HPIO

How are health insurance premium rates determined?

Health insurance premium rates are determined through a process in which the insurer evaluates the health risks of an individual or group applying for coverage. While health risk is based currently on data such as age, gender and location, lifestyle and medical/claims history may also be considered when setting rates. For example, people with health problems, those who engage in unhealthy activities, or those who work in dangerous fields can expect to pay significantly more for health insurance. Notably, starting in 2014 under the Affordable Care Act's community rating rules, insurers may only consider age, family size, tobacco use and geographic area when setting premium rates.

In setting rates, the insurer weighs the potential health risks in its pool of insured people against the potential costs of providing coverage. The insurer attempts to set rates such that the amount the company pays out in claims is less than what the enrollee pays. Typically, insurers will increase premium rates if there is a higher than expected number of claims and/or if the underlying costs of health care rise.

What is medical loss ratio?

Premium dollars are used to pay enrollees' medical claims and to pay for activities that improve the quality of care provided to enrollees. They are also used to cover administrative costs such as overhead expenses, marketing, profits, salaries and agent commissions. As of 2011, under the ACA, health insurers are required to spend 80 to 85 percent of enrollees' premiums on

direct care for patients and on efforts that improve care quality, rather than on administrative costs. Known as the medical loss ratio (MLR), insurers are required to spend 85 percent in the large group market and 80 percent in the small group and individual markets on direct patient care. Insurance companies not meeting MLR standards are required to provide rebates to their customers.

What are high deductible health plans (HDHPs)?

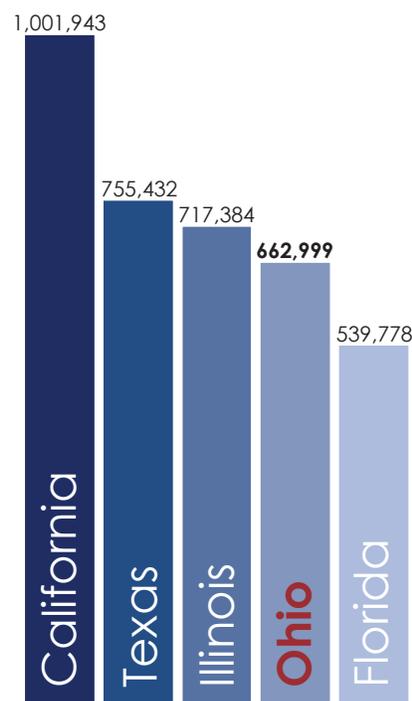
In order to mitigate the rising cost of health insurance, many employers have implemented high deductible health plans (HDHP), also known as consumer-directed health plans (CDHPs). HDHPs, accounting for almost 13 percent of ESI nationally,²⁸ are one approach to managing the cost of health insurance by encouraging consumers to be more engaged in health care spending decisions. These plans have a higher deductible than typical health plans and are often coupled with Health Spending Accounts (HSAs) that may be used to pay for the cost of medical services until the deductible is met.²⁹ Enrollees in HDHPs incur greater risk for the cost of health care expenses and therefore have a financial incentive to explore more cost-effective alternatives.

What are health spending accounts?

Health spending accounts can be set up either by an employer or a qualified individual to help pay for an employee or qualified individual's cost sharing or other qualified medical expenses through tax-exempt dollars. The various forms of health spending accounts are:

- Health flexible spending accounts (FSA)** — A health FSA is an arrangement set up through an employer to assist in paying for out-of-pocket qualified medical expenses incurred by the employee with tax-free dollars. Out-of-pocket qualified medical expenses can include insurance copayments and deductibles, as well as qualified prescription drugs, insulin and medical devices. The FSA is funded with pre-tax dollars via payroll deductions subject to Internal Revenue Service (IRS) and employer annual limits. Starting in 2013, employee contributions to FSAs made through salary reductions are limited to \$2,500. After 2013, the limit is also subject to a cost-of-living adjustment. FSA funds cannot be carried over unless an employer's FSA plan has a grace period (up to two and half months after the end of the FSA plan year).³⁰
- Health reimbursement accounts (HRA)** — HRAs are employer-funded group health plans that reimburse employees tax-free for qualified medical expenses up to a set dollar amount per benefit year. Unused amounts within an HRA can generally be carried over from year to year – however, this may be dependent upon an employer's plan. The HRA is funded solely through employer contributions and is subject to limits set by the employer.³¹
- Health savings accounts (HSA)** — HSAs are medical savings accounts that are available to certain eligible individuals enrolled in high deductible health plans (HDHPs). Funds placed in HSAs are tax-exempt and can be used to pay for an individual's qualified medical expenses. Contributions to an individual's HSA can be made by the individual, the employer, or both. Funds placed in an HSA are subject to IRS annual limits. Unused amounts within an HSA can be carried over from year to year, and may earn interest.³²

States with the highest enrollment in HSAs/HDHPs 2011



Source: America's Health Insurance Plans. January 2012 Census Shows 13.5 Million People Covered by Health Savings Accounts/High Deductible Health Plans (HSAs/HDHPs). May 2012.

Appendix

Regulatory changes to private insurance in the ACA³³

	Health insurance market reform	Description	Health plan applicability	
			Non-grandfathered	grandfathered
2010	Insurance plan appeals process for consumers	New health plans must implement an effective process for consumers to appeal health plan decisions. New health plans must also establish an external review process.	<ul style="list-style-type: none"> Large group market: fully-insured and self-insured plans Small group market: fully-insured and self-insured plans Individual market plans 	Not applicable
2010	Extension of dependent coverage	Individual and group policies that offer dependent coverage must extend dependent coverage to adult children up to the age of 26.	<ul style="list-style-type: none"> Large group market: fully-insured and self-insured plans Small group market: fully-insured and self-insured plans Individual market plans 	<ul style="list-style-type: none"> Group market fully-insured and self-insured plans Individual market plans <p>Note: Grandfathered group health plans are not required to make dependent coverage available to adult children who can enroll in an eligible employer-sponsored health plan prior to 2014.</p>
2010 (fully phased in by 2014)	Prohibition of lifetime limits and restriction of annual limits	Insurers may not set lifetime dollar limits on coverage for essential health benefits. Annual dollar limits must not be set below \$1.25 million until September 23, 2012 and not below \$2 million from September 23, 2012 to January 1, 2014 for essential health benefit coverage. Beginning January 1, 2014, plans cannot impose any annual dollar limits on essential health benefit coverage.	<ul style="list-style-type: none"> Large group market: fully-insured and self-insured plans Small group market: fully-insured and self-insured plans Individual market plans 	<ul style="list-style-type: none"> Group market fully-insured and self-insured plans Applies to individual market plans only for lifetime limits.
2010	Prohibition of rescissions	Rescissions are prohibited except in circumstances where an enrollee has committed fraud. "Rescission" refers to the retroactive cancelation of health coverage after an enrollee has become medically ill or injured.	<ul style="list-style-type: none"> Large group market: fully-insured and self-insured plans Small group market: fully-insured and self-insured plans Individual market plans 	<ul style="list-style-type: none"> Group market fully-insured and self-insured plans Individual market plans

2010	Coverage of preventive health services with no cost-sharing	Plans are required to provide preventive health services without cost sharing for plan enrollees. Preventive health services include certain immunizations and health screenings.	<ul style="list-style-type: none"> • Large group market: fully-insured and self-insured plans • Small group market: fully-insured and self-insured plans • Individual market plans 	Not applicable
2010	Coverage of preexisting health conditions for children	Plans cannot deny children (under the age of 19) coverage on the basis of pre-existing health conditions.	<ul style="list-style-type: none"> • Large group market: fully-insured and self-insured plans • Small group market: fully-insured and self-insured plans • Individual market plans 	Group market fully-insured and self-insured plans
2011	Review of health plan premium rate increases	Insurer premium rate increases of 10 percent or more or rate increases that are more than a state-specific threshold must be publicly disclosed and justified for non-grandfathered plans within the individual and small group markets. ³⁴ Ohio is one of 44 states that conduct its own rate reviews.	<ul style="list-style-type: none"> • Small group market: fully-insured • Individual market plans 	Not applicable
2011	Medical loss ratio (MLR) standards and enrollee rebates	Plans in the individual and small group markets must meet a minimum MLR of 80 percent and 85 percent in the large group market. Health plans that do not meet specified limits must provide rebates to policyholders on a pro rata basis.	<ul style="list-style-type: none"> • Large group market: fully-insured plans • Small group market: fully-insured plans • Individual market plans 	<ul style="list-style-type: none"> • Group market fully-insured plans • Individual market plans
2012	Uniform coverage summaries for consumers	Private individual and group health plans must provide a uniform summary of benefits and coverage to all applicants and enrollees.	<ul style="list-style-type: none"> • Large group market: fully-insured and self-insured plans • Small group market: fully-insured and self-insured plans • Individual market plans 	<ul style="list-style-type: none"> • Group market fully-insured and self-insured plans • Individual market plans
2014	Essential health benefit coverage	Requires most small group and individual health insurance plans to offer a comprehensive package of covered items and services, as defined by states, within federal guidelines.	<ul style="list-style-type: none"> • Small group market: fully-insured plans • Individual market plans 	Not applicable
2014	Guaranteed issue and renewability	Plans must accept every applicant for health coverage as long as the applicant agrees to the terms and conditions of the insurance policy or plan. Plans must renew individual coverage at the option of the policyholder or plan sponsor.	<ul style="list-style-type: none"> • Large group market: fully-insured plans • Small group market: fully-insured plans • Individual market plans 	Not applicable

2014	Non-discrimination based on health status	Plans cannot base eligibility or coverage on health-status-related factors including but not limited to an individual's medical condition, claims experience, disability, medical history or evidence of insurability.	<ul style="list-style-type: none"> • Large group market: fully-insured and self-insured plans • Small group market: fully-insured and self-insured plans • Individual market plans 	Not applicable
2014	Coverage of pre-existing health conditions for all	Plans cannot deny coverage on the basis of pre-existing health conditions regardless of the individual's age.	<ul style="list-style-type: none"> • Large group market: fully-insured and self-insured plans • Small group market: fully-insured and self-insured plans • Individual market plans 	Group market fully-insured and self-insured plans
2014	Community rating rules	Requires insurers use an adjusted community rating (ACR) which restricts premium variation to the following factors: age, family size, tobacco use and tobacco use.	<ul style="list-style-type: none"> • Small group market: fully-insured plans • Individual market plans 	Not applicable

Glossary

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

Affordable Insurance Exchanges — Established in the ACA, the American Health Benefit Exchange facilitates the purchase and sale of qualified health plans in the individual market in states. Likewise, The Small Business Health Options Program (SHOP) Exchange enables small businesses with up to 100 employees to purchase qualified health coverage. The aim of the exchanges is to reduce the number of uninsured, increase transparency in the insurer marketplace, provide consumer education and assist individuals with access to public health insurance programs, premium assistance and cost-sharing reductions.

Annual limit — A yearly cap placed by a health plan on benefits that can be paid to an enrollee to cover health care services provided.

Community Rating — A method for setting premium rates under which all policy holders are charged the same premium for the same coverage. “Modified community rating” generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders. Under health reform, beginning in 2014, health plans will be required to adopt modified community rating. Variations in premiums will only be allowed for differences in geography, family structure, age (limited to a 3 to 1 ratio) and tobacco use (limited to a 1.5 to 1 ratio).

Cost sharing — Cost sharing refers to the way that health care costs are shared between insurers and consumers through health plans or policies. Cost sharing can include premiums, deductibles, co-insurance and co-payments.

Enrollee — Individual enrolled in a health plan or policy.

Essential health benefits (EHB) — As specified in the ACA, plans in the health insurance exchange are required to offer coverage for “essential benefits” that must include: emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services (including pediatric oral and vision care). States define EHB within federal guidelines.

Federal Poverty Level (FPL) — Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various public programs. In 2012, 100 percent FPL for a family of four is \$23,050, 138 percent is \$31,809 and 400 percent is \$92,200.

Fully-insured plan — A plan to provide health coverage that is purchased from a state-licensed insurance carrier who then assumes the full risk of paying the medical claims of the plan's enrollees.

Guaranteed Issue — Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason. Beginning in 2014, the health reform law will require guarantee issue and renewability.

Grandfathered plan — A group health plan that was created or an individual health insurance policy that was purchased on or before enactment of the ACA, March 23, 2010. Grandfathered plans are exempt from many of the changes implemented by the ACA.

High-risk pool plans — High-risk pool plans are typically government subsidized plans for high risk individuals who are denied coverage or are unable to purchase health insurance through the private market. High-risk pool plans can have very high premiums and may still be unaffordable for consumers.

Individual health market — Health insurance coverage on an individual, not group, basis. The premium is usually higher for an individual health insurance plan than for a group policy.

Individual mandate — Enacted under the ACA, the individual mandate requires most Americans to have minimum coverage health care insurance or face monetary penalties beginning in 2014. The penalty, in the form of a tax, will be \$95 per individual or up to 1 percent taxable income in 2014, whichever is lower. It increases to \$325 or up to 2 percent taxable income in 2015 and \$695 or up to 3 percent taxable income in 2016.

Lifetime limit — A cap placed by a health plan on total lifetime benefits that an enrollee may receive from their health plan.

Patient Protection and Affordable Care Act — The federal health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” or “ACA” refers to the final, amended version of the law.

Prior authorization — Prior authorization refers to when an insurer requires that an enrollee obtain pre-approval of coverage for a specific medical service, procedure, or treatment. An insurer may require that an enrollee meet certain conditions before a medical service or treatment is approved for coverage under a health insurance plan.

Pre-Existing Condition — A medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company.

Self-insured plan — Self-insured plans are employer-sponsored group health plans that take on the full risk of providing health insurance coverage for their employees. These plans generally pay for health benefits directly and bear the risk of paying the medical claims for their plan enrollees.

Qualified health plan — A qualified health plan (QHP) is a health plan certified by an Exchange and that meets minimum standards of quality, value, and benefit design.

Underwriting — Underwriting is a process used by insurers in evaluating the health risk and cost of providing coverage to a potential plan enrollee. Historically, insurers looked at many factors such as health status, age and gender to evaluate the health risk of a potential enrollee. Under the new Affordable Care Act community rating rules, insurers are restricted in the factors they can use to evaluate an individual's health risk through the underwriting process.

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Timeline of health insurance in the United States

1930s

1929

First modern insurance plan

Under the "Baylor plan," a group of Dallas-based teachers formed a partnership with Baylor hospital to provide a set amount of sickness and hospitalization coverage in exchange for a fixed, prepaid fee. Teachers paid 50 cents per month in exchange for the guarantee that they could receive medical services for up to 21 days per year.



1940s

1938-1939

First physician coverage plan

Blue Shield emerged in 1939 as the first prepayment plan to cover physician fees. Coverage for the first group of patients under this plan began in February 1939.

1950s

1954

IRS exempts health benefits from taxes

Employer and employee contributions to health plans became tax exempt under the 1954 Internal Revenue Code.

1960s

1965

Medicare and Medicaid created

The Social Security Tax Amendment was passed by Congress to enact Medicare and Medicaid. These programs established health care insurance coverage for qualified persons aged 65 and older and certain low-income individuals.



1970s

1974

Congress passes ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted setting minimum standards for most voluntarily established pension and health plans within the private industry for the purpose of providing consumer protections for plan enrollees.

1986

COBRA signed into law

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted giving workers and their families who lose their employer health coverage the right to temporarily continue group health coverage for a limited period of time and under certain qualifying circumstances.

1980s

1996

Congress passes HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was enacted providing a number of protections for consumers covered under group health plans including: limiting exclusions for preexisting conditions, prohibiting discrimination against employees and dependents based on their health status and allowing individuals to enroll for health coverage in the event they lose other health coverage, get married or gain dependents.

1990s

Congress passes Mental Health Parity Act

The Mental Health Parity Act requires annual or lifetime dollar limits on mental health benefits be no less than limits in place for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. The Mental Health Parity and Addition Equity Act enacted in 2008, expanded upon the Mental Health Parity Act of 1996. The act applies to group health plans with more than 50 insured employees/dependents.

2000s

1997

Congress establishes SCHIP

The State Children's Health Insurance Program (SCHIP) was created in 1997 to expand publicly funded health insurance to children whose families make too much money to qualify for Medicaid, yet still cannot afford private insurance.

2003

Medicare Part D created

Congress signed into law the Medicare Prescription Drug, Improvement and Modernization Act which included Medicare Part D, making prescription drug coverage available for all Medicare beneficiaries.

2010s

2010

ACA enacted

The Affordable Care Act was passed by Congress and then signed into law on March 23, 2010. The ACA implements a number of insurance market changes including reforms focused on expanding access to care, improving health care outcomes and reducing health care costs.



2012

SCOTUS upholds key provisions of the ACA

On June 28, 2012 the Supreme Court of the United States (SCOTUS) rendered a final decision upholding the constitutionality of the ACA with the exception of the ACA's mandated state Medicaid expansion. Through the SCOTUS decision, states were provided with the option to choose whether or not to expand their state Medicaid programs without fear of penalty from the federal government.



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