

# Ohio health insurance basics

## executive summary

### 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. 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.

### 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.

#### 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. 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 35.7 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.

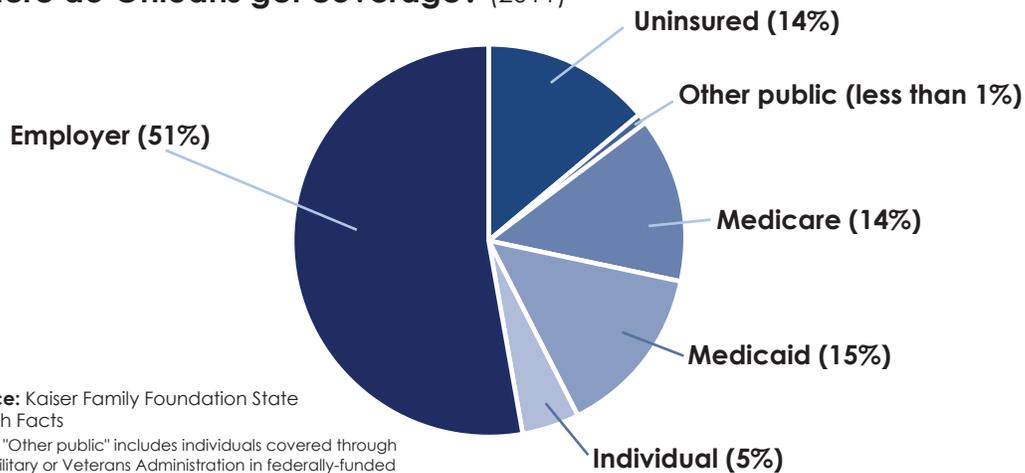
#### Individual health insurance coverage

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.

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. 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) requires a number of reforms to the individual health insurance market.

## 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

## Health insurance regulation

Historically, states have been the primary regulators of health insurance companies and products. 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 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.

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."

Generally, ODI has the authority to ensure that plan enrollees receive the benefits dictated by their health plan or policy. 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. ODI has only limited authority over self-insured plans, as these plans are generally regulated under the federal Employee Retirement Income Security Act (ERISA).

## Plan design: Benefits and cost structure

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. 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. 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.

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. "Cost sharing" in any type of insurance plan refers to the way that health care costs are shared between insurers and consumers.

## 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.