

INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS



Background

Private market health insurance—insurance offered through employers and on the individual market—is the predominant form of health coverage for most people. According to the most recent [U.S. census](#), about 217 million Americans are enrolled in some kind of private insurance coverage. Plans sold on the private market are sold by commercial insurance providers and are considered any kind of health insurance plan not offered by the government, such as Medicare or Medicaid. A provision in the Affordable Care Act (ACA) that required every American to purchase some form of health insurance took effect in 2014. Afterward, the number of uninsured Americans decreased substantially. However, in 2017, for the first time since the law was enacted, the number of nonelderly individuals (those from birth to age 64) who went without health insurance coverage increased by 700,000 people. This means approximately 10.2 percent, or 27.4 million, of this demographic did not purchase insurance coverage.¹

Commercial insurance providers are private companies that contract with businesses or individuals to cover certain health care services outlined in a health plan. Employers often offer health insurance as a benefit to their employees. Individuals and groups can also purchase plans directly from commercial insurers or by purchasing through the state's health insurance [exchange](#), or individ-

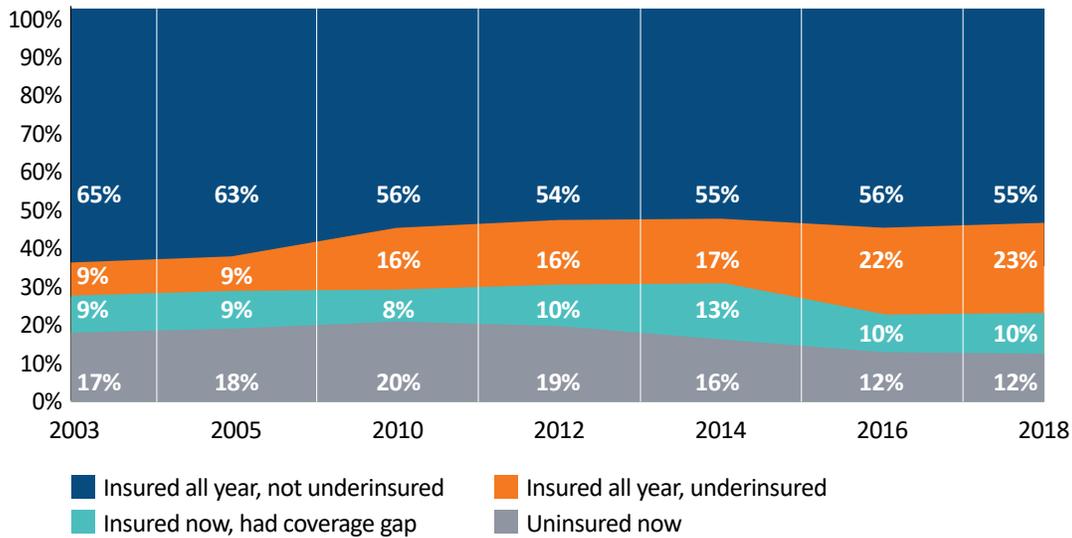
ual marketplace, as set forth in the ACA. The exchanges are administered through either a state or federal platform where both individuals and businesses can purchase private insurance plans.

Most private insurance policies are [designed](#) either as a health maintenance organization (HMO) or preferred provider organization (PPO). An HMO requires a patient to be evaluated by a primary care provider (PCP) to determine the appropriate plan of care. This could include making a referral to a specialist or ordering additional tests to confirm the correct course of treatment is followed. In contrast, a PPO plan allows patients to see any health care provider within the plan's network of providers without first being seen by a PCP. There are also fewer restrictions on seeing out-of-network providers. Because of the flexibility they offer, PPO plans are usually more expensive than HMO plans.

Although HMOs and PPOs are the most common plan types, other designs are available. An exclusive provider organization (EPO) is an arrangement where coverage only applies if the person receives treatment at facilities and from providers that are in their network. They are like PPOs in that members are not required to see a PCP first, but they are also like HMOs because enrollees must use a specific network of providers. Point of service, or POS, plans are a hybrid of HMOs and PPOs. In these plans, members are required to choose an in-network PCP but can see an out-of-network physician for a higher fee.

Health Insurance Coverage for American Adults

Ages 19-64



Notes: “Underinsured” refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% of income. “Insured now, had a coverage gap” refers to adults who were insured at the time of the survey at any point in the 12 months prior to the survey field date. “Uninsured now” refers to adults who reported being uninsured at the time of the survey.

Source: The Commonwealth Fund

Plans range in price and in the scope of services covered. Coverage depends on several factors, including an individual’s personal medical history and the amount of money the patient, or the sponsoring employer, is willing to spend on monthly premiums, copayments, co-insurance and deductibles. The deductible is the cost that must be covered by the enrollee before the plan begins to cover costs. Copayments are typically paid at the time of service in the form of a flat fee by the enrollee to cover a portion of the care that is otherwise covered by the plan. Co-insurance is similarly a portion of the cost covered by the enrollee but is based on a percentage of the cost of care.

Private Insurance Overview

Plans purchased either on the exchanges or directly from an insurer are called “fully insured” plans. There are two types of fully insured plans: individual and group. Employers and other group sponsors typically purchase group insurance plans and then allow their employees to elect in or out of coverage. Employers with fewer than 50 full-time employees are known as **small groups**, although a few states have increased that threshold to 100 employees. These private market insurance plans are different not only from public insurance options, but also from “self-insured” plans, in which employers front the costs of their employee’s medical care instead of paying premiums to an insurer.

Companies with 51 or more employees (or 101 for select states) are known as **large groups** and are not subject to the same ACA requirements as the individual and small group markets. Despite this, as of

2016, employers in the large group market have been required under the ACA to offer affordable insurance plans that meet the minimum essential coverage (MEC) provision to 95 percent of their full-time employees.² Full-time employees are those who work 30 or more hours a week.³ A plan is considered affordable if an employee’s contributions for employee-only coverage (not including dependents) does not exceed a certain percentage of his or her household income. The MEC requirement is defined as “bronze level” on the ACA marketplace, meaning the health insurer will pay at least 60 percent of the cost of each health service or treatment. Employers can elect to offer higher levels of coverage, including “silver,” where the insurer covers 70 percent of a service or treatment cost, “gold,” which covers 80 percent of the cost, and “platinum,” which covers 90 percent.⁴

States have the option of allowing health insurance issuers that offer coverage in the large group market to offer such coverage through the marketplace. Those plans, however, must include the **10 essential health benefits** (EHBs), such as maternity care, prescription drugs and hospitalization. Larger employers often forego the private market and opt instead to cover employees’ medical costs directly. These self-insured plans offer employers some flexibility in plan design and face different regulations at the state and federal levels than fully insured plans. In 2018, 56 percent of small firms and 98 percent of large firms offered health insurance to at least some of their workers, with an overall rate of 57 percent.⁵

Although this report describes health insurance obtained through the private market, it should be noted that consumers can purchase

Percentage of Firms Offering Health Benefits, by Firm Size, Region and Industry, 2018

	Percentage of Firms Offering Health Benefits
Firm size	
3-9 workers	47*
10-24 workers	64*
25-49 workers	71
50-199 workers	91
200-999 workers	96
1,000-4,999 workers	99
5,000 or more workers	100
All small firms (3-199 workers)	56
All larger firms (200 or more workers)	98
Region	
Northeast	64
Midwest	57
South	49
West	61
Industry	
Agriculture/Mining/Construction	61
Manufacturing	68
Transportation/Communications/Utilities	64
Wholesale	69
Retail	42*
Finance	64
Service	53
State/local government	90*
Health care	59
All Firms	57

Note: Estimates 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.

* Estimates statistically different from estimate for all firms not in the indicated size, region or industry category.

Source: KFF Employer Health Benefits Survey, 2018

alternative forms of [coverage](#) such as an association health plan (AHP) or [short-term limited duration plan](#) (STLD). These plans often provide a less costly option, but they do not have to comply with the guidelines outlined in the ACA. To learn more about these types of plans, please read the complementary brief in this toolkit, “Alternative Coverage Options.”



Costs of Coverage

Unsurprisingly, much of the legislative focus on insurance has involved the cost of coverage. The increasing price of insurance premiums, as well as the related charges of sometimes expensive medical treatments, are complicated issues that state legislatures grapple with perennially. In the private market, enrollees pay a monthly premium to take part in an insurance plan. If the enrollee is insured through his or her employer, the employer may cover part or all the enrollee’s premium. Most insurance plans also contain deductibles, copayments and sometimes, co-insurance.

The ACA attempts to increase coverage by creating incentives such as tax credits and other subsidies for individuals and employers. As an example, the ACA allows employers in the small group market to deduct up to half the cost of premiums they pay for their employees. People living under 400 percent of the federal poverty level may be eligible for advance premium tax credits (APTCs) and cost-sharing reductions (CSRs) under the ACA. As of mid-2018, approximately 87 percent of the people who purchased a plan on the marketplace received one of these subsidies.⁶

Private Insurance Policy Levers and Options

States are the primary regulators of fully insured plans but have a limited role in regulating self-insured plans. Self-funded, large employer sponsored plans are federally regulated under the Employee Retirement Income Security Act (ERISA) of 1974. While the ACA sets rules and minimum standards to guide insurers in the private market, states are free to regulate as they see fit as long as their regulations do not circumvent federal law. All states have an insurance commissioner or department that acts as an intermediary between insurance companies and consumers within the state. There are several ways in which states can regulate insurance with various policy objectives in mind.



First, states might consider legislation to define or refine how their [state insurance department](#) works. State insurance departments and commissioners are responsible for protecting consumers' rights. Their duties include making information, such as complaints against insurers, available to consumers, and answering customers' questions about claims. Legislators can consider how comprehensive this information is and how easy it is to access. Furthermore, states can task their insurance commissioners with enhancing the rights of consumers. Examples include laws strengthening patients' rights to certain treatments that might not be covered by most insurers or allowing patients who need urgent care access to treatments that normally require a lengthy prior authorization process.

States that use the federal platform for their health insurance exchanges could also consider shifting to a state-based exchange. While Oregon has only considered such a move, [Nevada and New Mexico](#) hope to have their new state-run platforms for the 2020-2021 plan years.

Legislators in many states have been engaged in overseeing and reviewing the results of marketplace enrollment and some have considered changes to open enrollment periods. Most states have open enrollment periods between Nov. 1 and Dec. 15. However, [seven states](#)—California, Colorado, Connecticut, Massachusetts, Minnesota, New York and Rhode Island—plus the District of Columbia extended the time for both the 2018 and 2019 enrollment periods.

States, usually through the insurance department, will annually [review rates](#) submitted by insurers selling products on the exchange to determine whether their rate increases are reasonable. The federal default threshold rate increase beginning in 2019 is 15 percent.⁷ States also have the option to apply for a state-specific threshold. If rates are determined to be unreasonable, state responses will vary according to state law.

Every state has a statutory list of required coverage for specific treatments and access to specialty care, almost all of which were enacted 10 years ago or more. For example, treatment for diabetes is mandated in 46 states.⁸ Prior to the passage of the ACA, many insurers did not provide coverage for preexisting con-

ditions the patient had before joining the health plan. Since the ACA now mandates EHBs, this “federal floor” can be expanded upon by states, which can mandate that insurers provide coverage for additional conditions and treatments.

According to the [Commonwealth Fund](#), there are three provisions built into the ACA designed to protect people living with preexisting conditions:

- The “guaranteed issue” requirement prevents insurance companies from denying a policy to someone with a preexisting condition.
- The “preexisting condition exclusion” does not allow carriers to refuse coverage of services that people need to treat a preexisting condition.
- The “community rating” provision prevents an insurer from charging a higher premium based on a person’s health status.

With uncertainty at the federal level, protections for individuals with preexisting conditions have generated significant interest among state lawmakers on both sides of the aisle. As of August 2018, four states—Colorado, Massachusetts, New York and Virginia—have adopted all three ACA equivalent protections. An additional 14 states have incorporated partial provisions into state law, and 29 states have not enacted any protections.

Another provision in the ACA prohibits dollar limits, or caps, on yearly or lifetime spending by an insurance company on an individual patient. Some states, reacting to the unpredictable nature of federal health care reform, have considered legislation to maintain the prohibition of these bans at the state level.

Not only can states affect change through state regulation and legislation, they can explore applying for a federal [1332 waiver](#). Also known as State Relief and Empowerment Waivers, a 1332 waiver allows states to tailor their individual and small group markets to address specific populations in their state. The federal government established broad guidelines to encourage states to initiate reform. These include allowing states to experiment with alternative versions of insurance exchanges, letting states change the set of mandated health benefits covered, increasing the number of people covered, and implementing creative payment structures for financing their health care programs. These waivers and the process of applying for them are discussed in more detail in a subsequent brief in this toolkit on reinsurance, “Reinsurance Programs and High-Risk Pools.” Currently, eight states have received CMS approval.

Conclusion

State legislatures have several options to consider in regulating health insurance and coverage. As the national conversation on health care continues to evolve, and as gridlock in Congress deters federal action, states have taken up the mantle of health care reforms. Goals and policy tactics vary from state to state but generally aim to contain costs, improve coverage and expand access. As lawmakers continue to grapple with which approaches will be best for residents in their districts, the accompanying briefs in this toolkit focus on strategies they can use.

Notes

1. Kaiser Family Foundation (KFF), “Key Facts About the Uninsured Population (San Francisco, Calif.: KFF, Dec. 7, 2018), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.
2. National Conference of State Legislatures (NCSL), Small and Large Business Health Insurance: State and Federal Roles (Denver, Colo.: NCSL, Sept. 12, 2018), <http://www.ncsl.org/research/health/small-business-health-insurance.aspx>.
3. Internal Revenue Service (IRS), “Identifying Full-Time Employees” (Washington, D.C.: IRS, July 2018), <https://www.irs.gov/affordable-care-act/employers/identifying-full-time-employees>.
4. National Conference of State Legislatures, Small and Large Business Health Insurance.
5. Kaiser Family Foundation, “2017 Employers Health Benefits Survey” (San Francisco, Calif.: KFF, Sept. 19, 2017), <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/view/print/#figure24>.
6. Louise Norris, “The ACA’s Cost-Sharing Subsidies,” [healthinsurance.org](https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/) (blog), Dec. 27, 2018, <https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/>.
7. Bernadette Hernandez, Vanessa C. Forsberg, and Ryan J. Rosso, Federal Requirements on Private Health Insurance Plans (Washington, D.C.: Congressional Research Service, Aug. 28, 2018), <https://fas.org/sgp/crs/misc/R45146.pdf>.
8. National Conference of State Legislatures, Diabetes Health Coverage: State Laws and Programs (Denver, Colo.: NCSL, Jan. 1, 2016), <http://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx>.

Supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers or staff.

NCSL Contact:

Colleen Becker

Policy Specialist, NCSL Health Program

303-856-1653

Colleen.Becker@ncsl.org

Dick Cauchi contributed to this report.

William T. Pound, Executive Director

7700 East First Place, Denver, Colorado 80230, 303-364-7700 | 444 North Capitol Street, N.W., Suite 515, Washington, D.C. 20001, 202-624-5400

www.ncsl.org

© 2019 by the National Conference of State Legislatures. All rights reserved. ISBN 978-1-58024-962-2