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PAYING A PREMIUM

What's Driving Health Insurance Costs in Utah?

UTAH HEALTH COST SERIES: PART 2

APRIL 2018

PAYING A PREMIUM

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The mission of Utah Foundation is to promote a thriving economy, a well-prepared workforce, and a high quality of life for Utahns by performing thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues and providing practical, well-reasoned recommendations for policy change.

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INTRODUCTION

In Part 1 of the Utah Health Cost Series, Utah Foundation examined the factors driving the costs of medical care. The majority of Utahns pay for that care with health insurance policies. So as medical costs rise, Utahns are likely to feel the effects through increases in insurance premiums.

To be sure, health insurance costs are rising. During the past decade, employer-sponsored insurance plans in Utah saw a cumulative cost increase of at least 30%. Meanwhile, as a way of addressing rising insurance prices, employers have shifted a greater share of the cost to employees. In Utah, an unusually high percentage of residents get health insurance through employers.

Additionally, there have been dramatic increases in the individual market. While some individuals and families may be shielded from premium increases because of the financial assistance provided on the federal Health Insurance Marketplace (the Marketplace), others who either do not qualify for assistance or purchase off the exchange are subject to the increases.

In this report, Utah Foundation examines the employer-sponsored insurance market and the market for individuals purchasing insurance.¹ Utah Foundation also analyzes national trends regarding health care affordability for Medicare recipients. Finally, the report examines the factors driving health insurance costs.

BACKGROUND

Health insurance is a central feature of the U.S. health care system. It is meant to protect people from catastrophic and surprise medical expenses, and help people pay for routine, preventative and early intervention services. Health insurance provides



KEY FINDINGS OF THIS REPORT

- About 61% of Utahns purchase health insurance through employers. This is the highest in the nation and significantly higher than the U.S. average of 49%.
- Enrollment in high-deductible plans in Utah has increased from 3% to 30% during the past decade.
- The average total premium for an employer-sponsored individual plan in Utah increased by an inflation-adjusted 34% from 2006 to 2016, and 30% for a family plan.
- Despite significant increases in premiums since 2006 in the employer-sponsored market, the increases are modest compared to the increases in the late 1990s and early 2000s.
- The average deductible for individual and family employer-sponsored plans in Utah both nearly doubled from 2006-2016.
- On average, premiums for both individuals and families with employer-sponsored health insurance in Utah remain below a broadly accepted affordability benchmark of 10% of median income.
- The benchmark silver plan on the federal Marketplace in Salt Lake County increased 62% from 2017 to 2018, in part to compensate for the loss of federal cost-sharing reduction subsidies in the Marketplace.
- Half of Utah Medicare beneficiaries are low- to moderate-income, but do not qualify for Medicaid, potentially leaving them with high medical cost-burdens.
- In recent years, the key factors increasing insurance premiums nationally include: the rising cost of health care, increased risk in the health insurance pool, the loss of federal subsidies, uncertainty in national health care policy and consolidation in the insurance industry.

long-term financial and medical protection, which contributes to a family’s physical, emotional and financial well-being.

Health insurance also contributes to the well-being of society at large. Individuals and families pay into a system to collectively share the cost of health care. The healthier the overall group of people insured, the lower the average cost of health insurance. Additionally, health insurance tends to improve public health by encouraging beneficiaries to seek care when they have medical problems.

The rise in health care costs has a direct impact on the cost of health insurance. In Utah, premiums have increased over the past decade for individuals and families across all sources of health insurance. These increases may be straining Utahns’ budgets and placing a financial burden on employers, individuals and families.

METHODOLOGY, SCOPE & LIMITATIONS

To prepare this report, Utah Foundation interviewed experts in the medical field, the insurance industry, government and other stakeholders. The report draws on research reports, scholarly literature and data from the Henry J. Kaiser Family Foundation, the Commonwealth Fund and the State Health Access Data Assistance Center.

In examining the factors that drive health insurance costs, this report draws in large part from data on national trends. State variations in health insurance premiums depend on the health care policies, state regulations, health care costs and the risk pool within that state.

Data for the employer-sponsored market are from the Medical Panel Expenditure Survey conducted by the U.S. Agency for Health Care Research and Quality. The Medical Expenditure Panel Survey is a set of large-scale surveys of families, individuals, medical providers and employers across the U.S. This survey is the most complete source of data on the cost of employer-sponsored health insurance.

Data for individual plans both on and off the Marketplace are from the Utah Insurance Department for 2018 premium rates. Data for family plans on the Marketplace are from Centers for Medicare & Medicaid Services’ Health Insurance Oversight System for 2017 premium rates. Data for family plans off the Marketplace are from the Robert Wood Johnson Foundation’s HIXCompare database for 2016 premium rates. Both sources for off-exchange data are for plans that comply with the Patient Protection and Affordable Care Act (popularly known as “Obamacare”). There are plans that are still “grandfathered” and have not yet transitioned. These plans are probably not as expensive because they are not required to offer the same minimum benefits as plans that comply with the law. Other Marketplace data are from the Multi-Dimensional Insurance Data Analytics System, operated by Centers

KEY HEALTH INSURANCE DEFINITIONS

A premium is the monthly amount individuals and, if applicable, employers pay to a health insurance company. The deductible is the amount a beneficiary pays for health services before the insurance plan coverage kicks in. After the beneficiary pays out up to the deductible amount, the beneficiary continues to make copayments or pay coinsurance, depending on the insurance plan. A copayment is a fixed amount of money for a specific service. Coinsurance is a fixed percentage of the total cost of a specific service.



for Medicare & Medicaid Services. These are the most recent data available for each source of health insurance. Data for Medicare affordability are mostly inferred from national trends. Income data are from the U.S. Census Bureau.

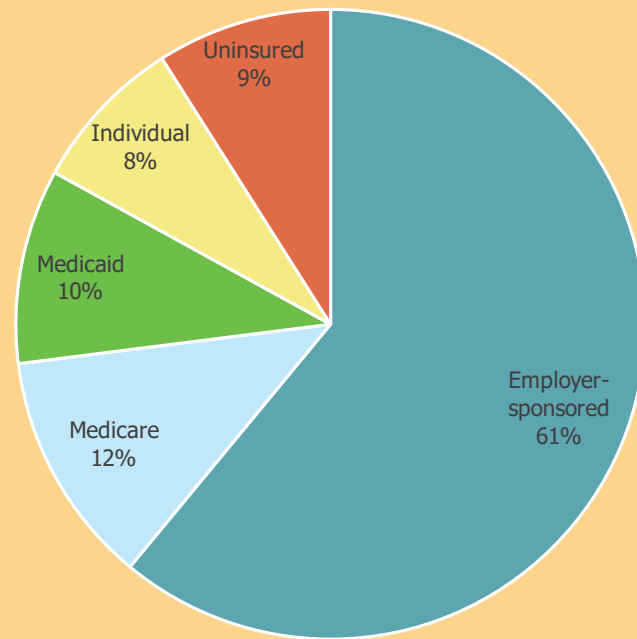
In providing examples of cost impacts on individuals and families, this report generally uses Salt Lake County as the location. This is because the county is by far the most populous in the state, containing roughly one-third of the state's population.

This report focuses on the affordability of health care for individuals and families purchasing health insurance through an employer-sponsored plan, the individual market and Medicare.

There is no single definition of affordability when it comes to health insurance. The Affordable Care Act uses a limited definition of affordability specifically as an eligibility criterion for premium subsidy qualification. The most common definition of affordability places the cost of health insurance at less than 10% of household income. This report uses that definition.

About 61% of Utahns purchase health insurance through their employers.

Figure 1: Health Insurance Coverage in Utah, 2016



Source: Utah Insurance Department, 2017 Health Insurance Market Report.

HEALTH INSURANCE COVERAGE IN UTAH

Many insured Americans purchase health insurance through their employers. Others purchase it directly on the individual market or are insured through Medicare and Medicaid.² This is also the case in Utah. (See Figure 1.)

About 61% of Utahns purchase health insurance through employers. This is significantly higher than the U.S. average of 49%³ and higher than the average among the other mountain states (47%).⁴ This is due in part to Utah's small elderly population, low poverty rate and robust middle class. Utah also has the largest percentage of residents aged 18 and under who have employer-sponsored health insurance, and the second largest percentage of residents aged 19 to 25 years old.⁵ Wyoming has the next highest percentage, with employer-sponsored health insurance at approximately 55%. In stark contrast, only 36% of New Mexico's population has employer-sponsored health insurance.⁶

The remaining 39% of Utah's population has health insurance through the individual market, Medicare or Medicaid, or is uninsured.



MEDICARE OR MEDICAID?

Perhaps the most common misnomer in the health care policy arena is to call Medicare "Medicaid" and vice-versa. Medicare covers the elderly and disabled while Medicaid covers low-income populations. Here's one way to remember the difference: Medicare ensures the public will CARE for older and disabled populations, but Medicaid comes to the AID of those who need financial assistance.

THE NATIONAL HEALTH INSURANCE LANDSCAPE

In Utah, 333 insurance companies offer health insurance plans, but only 38 of those offer comprehensive health insurance.⁷ Insurance companies collectively offer thousands of distinct health insurance plans, each with its own premiums, lists of covered services, drug lists and cost-sharing elements.⁸

In addition to private health insurance plans, there are several public health insurance plans that are sponsored by governments (both state and federal) and are designed to cover beneficiaries including the elderly, the disabled, those suffering from specific diseases, the poor and medically needy, children, veterans and the self-employed.



THE EVOLUTION OF HEALTH INSURANCE

One of the earliest forms of health insurance was created in 1929 through an arrangement involving Baylor University and the University Hospital in Dallas. In exchange for a \$6 annual premium, teachers received hospital coverage for room and board and specified services 21 days out of the year. Prepayment plans for physicians in the mining and logging industries were also popular. This led to the formation of the Blue Cross Blue Shield plans. Between 1940 and 1950, the percentage of the U.S. population with some form of health insurance increased from 9.1% to 50.6%.

The growth of health insurance was primarily influenced by federal policy and union activism. In 1942, the war-era Stabilization Act froze wages, except for fringe benefits, like health insurance. Due to labor shortages, industries offered health insurance benefits as an incentive to attract workers in the face of a war-depleted work force. In response, the federal government enacted three laws to protect employees receiving this benefit.

In 1945, the War Labor Board ruled insurance plans could not be canceled when the war was over. In 1949, the National Labor Board ruled unions could negotiate for insurance plans as a part of their benefits package. And finally, in 1954, the Internal Revenue Service issued the tax-exclusion policy, which excluded employer-sponsored health insurance from payroll taxes.

By the 1960s, insurance among the elderly became a key issue. Only half of those aged 65 to 74 had insurance and only about one-third aged 75 and older had any protection. This group had greater medical costs, but less financial protection than that of the younger demographic still in the work force. Medical advances during the postwar era, growth in personal income, the expansion of private insurance and constrained growth in the supply of physicians placed great inflationary pressure on medical prices. In fact, between 1950 and 1965, medical care prices rose twice as fast as consumer prices overall.

Addressing this problem figured into President Lyndon B. Johnson's War on Poverty, and in 1965, Medicare was signed into law as an amendment to the Social Security program. Congress also adopted Medicaid at this time, which provides publicly funded health insurance to those with low incomes.

Source: Scofea, p. 5. Field, et. al., p. 70. Social Security Administration, History of SSA During the Johnson Administration 1963-1968.

Within each of these systems, there is a great degree of choice. Employers can choose whether health insurance will be a part of the compensation, what health plans they will offer and how much they will contribute to the plans. Beneficiaries may also have a choice between health plans, providers and in some cases sponsors. Governments, both state and federal, have a role in deciding who is eligible for enrollment in government-sponsored programs, what services will be covered, how much providers will be paid and how costs can be contained. Each form of insurance, whether it is privately or publicly sponsored, also has its own payment system.

In addition, each source of insurance is regulated by a different set of laws and governing bodies. Government-sponsored health benefit plans like Medicare and Medicaid are regulated by federal agencies like the Centers for Medicare & Medicaid Services. Employer-sponsored self-funded plans are regulated under the federal ERISA statute through the U.S. Department of Labor, the Centers for Medicare & Medicaid Services, and the Internal Revenue Service. All other plans (individual, small and large group) are known together as the commercial health insurance market. These plans are governed by both state and federal laws and are regulated by state insurance departments.

The Patient Protection and Affordable Care Act

Before the Affordable Care Act went into effect, health insurance companies priced plans based on experience-rating – the costs an insurer could expect based upon an insured person's medical profile, including factors such as sex and medical history. Insurance companies could deny coverage based on a pre-existing



CONSEQUENCES OF REPEALING THE INDIVIDUAL MANDATE

Beginning in 2019, those without health insurance will not be financially penalized. The individual mandate is likely the most unpopular part of Obamacare. However, repealing the financial penalty will likely result in healthy enrollees departing from the Marketplace. As a result, Marketplace premiums will probably increase for the enrollees who remain insured. While some will be shielded from the increases due to their premium subsidy, those who do not qualify for financial assistance will feel the burden. The repeal may save the federal government money otherwise spent on health insurance subsidies for those who leave the market, or it may end up costing the more government. If healthy enrollees leave the Marketplace, premiums (and governmental subsidies) will increase to pay for a more costly, high-risk pool. The consequences of repealing the mandate are uncertain because the effects largely depend on the decisions of individuals, which are difficult to predict.

condition (or offer a plan that did not cover the services needed for the condition), charge a higher premium when a beneficiary became ill and put lifetime caps on the amount of insurance payments a beneficiary could draw.⁹ These practices were meant to protect the company from unsustainable financial losses.

The Affordable Care Act made these practices illegal, but to assist the insurance companies, it imposed the individual mandate to encourage healthy people to sign up for insurance and better balance the pool of insurance beneficiaries. Those who fail to obtain insurance are subject to a tax penalty; however, that penalty will be repealed beginning in 2019 under a law signed in December 2017.

With experience rating illegal under the Affordable Care Act, insurance companies must now follow a practice known as community-rating. This requires the company to offer the same health insurance policy within a given area at the same price to all persons regardless of their medical status. Within certain limits, however, insurers can adjust the price of individual premiums based on age, location, tobacco use, individual versus family enrollment (the number of people on a plan) and plan category.¹⁰ The law also requires insurance companies to offer a set of the same benefits to everyone, known as essential health benefits. (See the sidebar for more detail.)

Because of the extent of the benefits covered, the success of the Affordable Care Act depends somewhat on the participation of young and healthy applicants. This is to help subsidize the older, sicker population. Health care officials estimate that the Marketplace needs about 40% of enrollees to be between 18-34 years old for premiums to remain at relatively low rates.¹¹

ESSENTIAL HEALTH BENEFITS EXPLAINED

Essential health benefits are mandatory benefits that must be included in all individual plans that are offered both on and off the Marketplace (discussed later in this report) and small group plans. Self-insured plans, large group plans and grandfathered plans are not required to offer these benefits.

The benefits include ambulatory patient services (outpatient care without being admitted to a hospital); emergency services; hospitalization (surgery and overnight stays); pregnancy, maternity and newborn care; mental health and substance abuse services, including behavioral health treatment (psychotherapy and counseling); prescription drugs; rehabilitative and habilitative services and devices that help people with injuries, disabilities or chronic conditions to help gain or recover mental and physical skills; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Although not considered essential health benefits, plans must also include birth control coverage and breastfeeding equipment and counseling coverage.

Source: Healthcare.gov.





ARE HEALTH INSURANCE USERS “CONSUMERS?”

There are two prominent opposing philosophies that drive the debate on the U.S. health care structure. The difference revolves around one question: Is health care a right, or is it a commodity to be purchased?

Considering health care to be a right drives the argument for a national health insurance model, where everyone has access to sufficient and quality health care regardless of their ability to pay. Considering health care to be a commodity drives the argument for consumer-based, privatized model where market forces shape the destiny of care.

The U.S. is currently dominated by a consumer-driven model, where the cost burden is placed directly on employers and patients. Critics say this approach fails to recognize that health care does not function like a normal market, where users have access to price information and can shop around for lower prices and better quality. They also argue that access to health care is an essential feature of modern civilization, which should not be dependent on the ability to pay.

An alternative approach, embodied in programs such as Medicare and Medicaid, is to provide public funding for health care. Under this scenario, all taxpayers pay indirectly for those who are covered. Critics, who sometimes refer to this approach as “socialized medicine,” argue that covering health care through public funds would deprive the health care sector of incentives for high performance and competitive dynamism, ultimately resulting in worse and more expensive care.

Utah Foundation takes no position in this debate.

In Utah in 2017, only about 31% of Marketplace enrollees were in this age range.¹² Nationally, that number was worse: about 27%.¹³ Younger people are not signing up precisely because it can be too expensive. Even with subsidy assistance, premiums can often be a high-ticket item for a generation with entry-level salaries and high student loan debt. Part of the reason why premiums are expensive for the younger population is because of the way the modified community rating works.

Previously, insurance companies could price a plan for a 64-year-old five times more (in some cases seven times more) than a plan for a 21-year-old. This was because average spending among 64-year-olds is about 4.8 times as high as a 21-year-old.¹⁴ The Affordable Care Act reduced the age band to a three-to-one ratio. In other words, a premium for a 64-year-old cannot be more than three times the cost of a premium for a 21-year-old. The new age band effectively compresses the allowable premium ranges between age groups, leading to premium increases for younger people to make up the difference and subsidize the older ones.

Ironically, the reduced age band encourages older individuals to enroll while discouraging those younger individuals on whom the health of the Marketplace relies.

HOW HEALTH INSURANCE PLANS ARE DESIGNED

Actuaries – people who calculate insurance risks and premiums – develop premiums based on medical claims and administrative costs, which reflect pools of individuals or groups with insurance. Premiums are created by assessing the composition of the risk pool and the projected medical costs of the pool. In general, the larger the risk pool, the more predictable and stable premiums will be.

Although the Affordable Care Act prohibits insurers from charging different premiums to specific individuals based on their medical history, premiums reflect the health status of the entire risk pool.¹⁵ The higher the risk of the pool, the higher the health insurance premium. The risk of the pool reflects projected medical needs and costs. Most premium dollars are used to pay for medical services and supplies, which reflects the prices of services in a given area, utilization rate of services, the mix and intensity of services and the health insurance plan design. The make-up of the risk pool population, however, is not the only factor that influences premium costs.

Premiums are also used to pay for insurance companies’ administrative expenses. They include insurance product development, sales and enrollment, claims processing, customer service and regulatory compliance. Premiums also pay for taxes, assessments and fees, as well as risk charges and profit. State laws and regulations

may also influence the cost. For instance, prescription drugs are one of the essential health benefits that must be covered, but states get to decide what the covered drug list looks like.

As part of implementing the essential health benefits required under the ACA, states choose a benchmark plan as a reference point for insurance companies. While essential health benefits are a national requirement, each state selects a benchmark plan that sets the level of each benefit. Utah's benchmark plan, like those in 11 other states, covers the minimum number of pharmaceuticals (565 to 820), compared to 11 states with the largest number of pharmaceuticals covered (1,007 to 1,023).¹⁶

Health Insurance Plan Networks

Insurance companies design plans based on provider networks, which affect plan premiums. There are five main types of health insurance plans: fee for service, preferred provider organizations, health maintenance organizations, point of service and exclusive provider organizations.

A fee for service plan is a traditional insurance plan where the health plan pays the provider directly on the beneficiary's behalf or reimburses the user after a claim is filed. These plans have the highest-priced premiums but allow beneficiaries to go to any provider they choose. There are 20 insurance companies that offer fee for service health insurance plans in Utah.

Preferred provider organization plans contract with medical providers to create a network of participating providers. Beneficiaries can typically visit any provider in the network without a referral from a primary care physician. They can also visit providers outside of the network but must pay extra. There are 21 insurance companies that offer this type of plan in Utah.

Health maintenance organizations are similar to preferred provider organizations. They also have a network of providers, but usually have a smaller pool of options. The beneficiaries usually need to get referrals from primary care doctors to see specialists, and services from out-of-network doctors are not covered unless it is an emergency. This type of plan often provides integrated care, whereby the organization is both the provider and the insurer. There are six insurance companies in Utah that offer this type of network.

A point of service plan is a combination of a preferred provider organization and a health maintenance organization plan. Like a health maintenance plan, participants must choose an in-network primary care physician, but like a preferred provider plan, they can also see out-of-network providers at an additional cost. There are only two insurance companies in Utah that offer plans with these features.

Exclusive provider organization plans require participants to use providers only within the network. These plans are similar to preferred provider plans, except that beneficiaries are not allowed to go to a provider outside of network unless it is an emergency. Only two insurance companies offer this type of plan in Utah.¹⁷

About 96% of Utahns with comprehensive individual, small or large group health plans have some form of managed care, with the remaining 4% on fee for service plans.¹⁸ The average premium per member per month collected by insurance companies was highest for the fee for service plan, at \$425, and lowest for a health maintenance organization plan, at \$281.

High-Deductible Health Plans

A plan could also have a high deductible. A high deductible plan for 2018 is defined by the IRS as any plan with a deductible of at least \$1,350 for an individual or \$2,700 for a family. These plans qualify for health savings accounts, which are a type of savings account specifically meant for medical services, whereby the funds are not subject to taxation.

The Utah Insurance Department in 2016 found that membership in high-deductible plans that qualify for health savings accounts has grown rapidly in Utah.¹⁹ Across the individual, small-group and large-group markets, enrollment in qualified high deductible health savings plans increased from nearly 3% in 2006 to about 30% in 2016, most of which – approximately 23% – is from the small and large group employer plans.²⁰

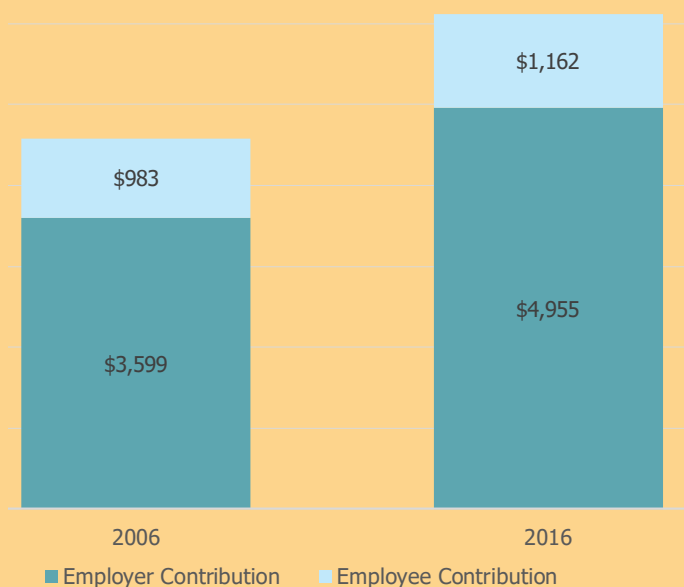
EMPLOYER-SPONSORED HEALTH INSURANCE

Types of Plans

There are three different categories of employer-sponsored health insurance: small group plans, large group plans and self-funded plans. Small group plans are for employers with fewer than 50 employees. Large group plans are for employers with 50 employees or more. Self-funded plans do not require a specific employee count, but they are most popular with large companies. In this type of plan, the employer itself collects premiums from enrollees and takes on the responsibility of paying medical claims. These plans are popular among companies that have reliable revenue and tend to cross state borders.²¹ In Utah, about 6% of the population has a small group plan, 12% has a large group plan and about 43% are part of a self-funded plan.

The average total premium for an individual increased 34%.

Figure 2: Employer & Employee Contribution Increase for an Individual, Utah 2006-2016



Source: Medical Panel Expenditure Survey, adjusted for inflation, 2016 dollars.

Premium Cost Trends

Premiums in Utah have increased significantly in recent years, imposing financial burdens on both employers and employees. From 2006 to 2016, the annual premium for an individual increased 34%; the employer contribution increased 38%, and the employee contribution increased 18%. (See Figure 2.) These increases are adjusted for inflation.

Compared to the U.S. national average, Utah's average premium in 2016 was \$16 more expensive for an individual plan. The premium increase was also greater than the U.S. average, which saw a 24% increase in the total premium for an individual plan.²² However, the U.S. employee contribution towards an individual plan was higher than in Utah – \$1,325 compared to \$1,162. The increase in the employee contribution was also substantially greater nationally than in Utah, 41% compared to 18%.

Families also experienced an increase in the average annual premium. From 2006 to 2016, family plan total premiums increased 30%; the employer contribution increased 31%, and the employee contribution increased 27%. (See Figure 3.) Again, the increases are adjusted for inflation.

The average total premium for a family in the U.S. in 2016 was \$17,710 compared to \$17,025 in Utah. The increase in the total premium was also in line with trends in Utah; the total premium increased 31% compared to 30% in Utah. The employee contribution for a family plan is much higher for the U.S. than Utah, \$4,956 compared to \$3,966. The increase in the employee contribution over this decade was also much higher, 44% compared to 27%.

The lower premiums are due in part to Utah having the lowest per capita health care costs in the U.S. – a key finding in Part 1 of Utah Foundation’s Health Cost Series. Low health care costs help keep insurance premiums down.

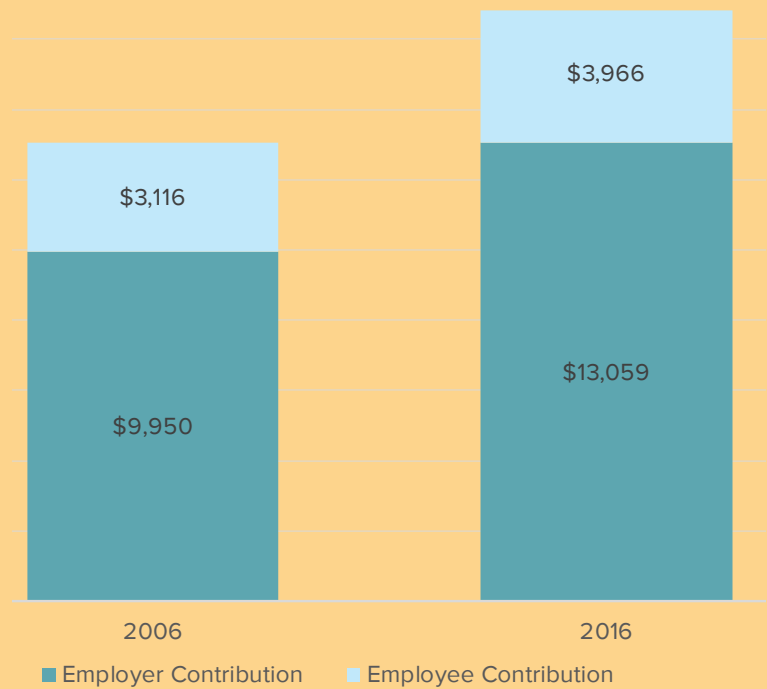
Despite popular perceptions, the increases in premiums in the employer-sponsored market are relatively stable. In earlier decades, premium increases sometimes amounted to double digits. (See Figure 4.)

This was in large part a result of rapid growth in health care costs since Medicare and Medicaid were enacted. Between 1966 and 1982, the average annual growth rate in national health expenditures was 13%, mostly due to an increase in the prices charged and increased consumer demand.²³ In response to the growth, employers sought out managed care plans, like health maintenance organizations and preferred provider organizations through the 1990s. By the late 1990s, beneficiaries demanded less restrictive health care plans. Consumer demand from pent up health care needs contributed to the increases in premiums.²⁴ Since 2006, the average annual increase in premiums has begun to stabilize, exhibiting annual increases that are modest by comparison.

However, it should be noted that despite relatively slower growth in premiums, the U.S. was in a period of slow wage growth during the past decade, making the hikes in insurance premiums that much harder for workers to absorb.²⁵ And while employers have shouldered the majority of the new cost burden, in

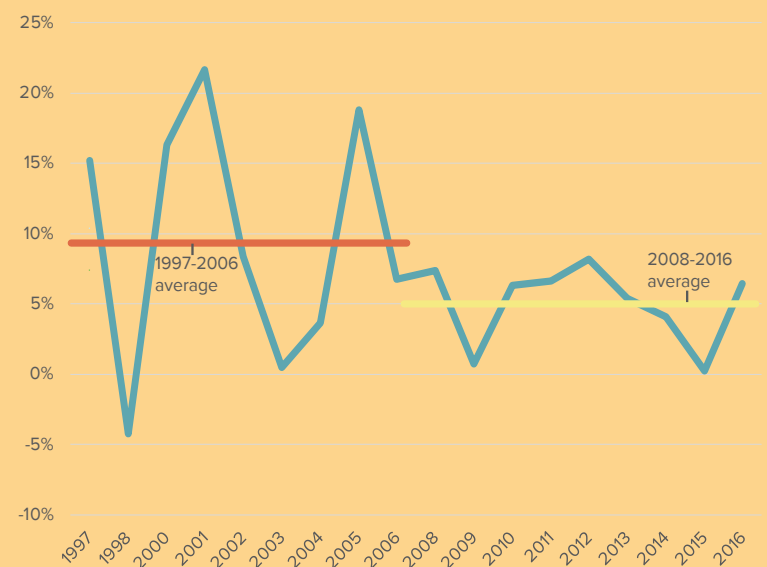
The average total premium for a family plan increased 30%.

Figure 3: Employer & Employee Contribution Increase for a Family Plan, Utah 2006-2016



Family premiums increased by double digits in the late 1990s and mid-2000s.

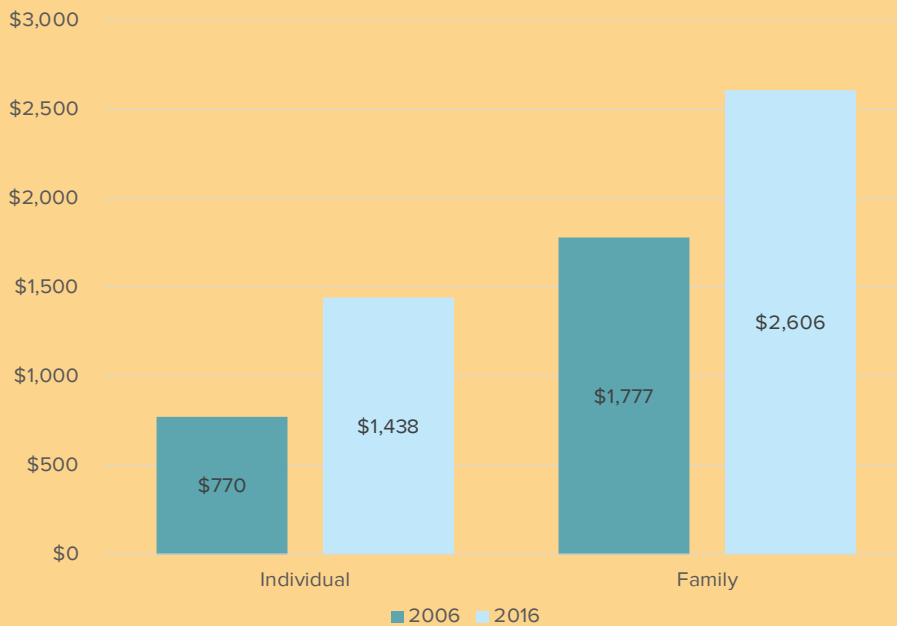
Figure 4: Annual Percent Change in Total Family Premiums in the Employer-Sponsored Health Insurance Market in Utah, 1997-2016



Source: Medical Panel Expenditure Survey, 1997-2016. Data was not collected for years 1999 and 2007.

The average deductible for an individual plan increased 87%, while the family plan deductible increased 47%.

Figure 5: Increases in Average Deductibles for Individuals and Families, 2006-2016, Utah



Source: Medical Panel Expenditure Survey, 2006-2016.

some cases employees may have absorbed at least a portion of the employer costs indirectly in the form of lower salaries and other benefits.

The leveling out of premium increases over the past decade is in part due to cost management strategies from employers – primarily increasing the cost-sharing with their employees. Employers are more aggressive in shifting more of the cost of health care to their employees by increasing the deductible and offering health savings accounts. Employers have also taken several other approaches, including: encouraging workers to purchase plans with cheaper networks, promoting health and wellness in the company, increasing the share employees contribute toward the premium or prescription drugs, and placing limits on spousal coverage.

For example, from 2006-2016 the percentage of private sector employees in Utah enrolled in health insurance plans with a deductible increased from 75% to

87%. Looking back a bit further to 2002, only 51% had a deductible. This trend has placed a higher financial risk on employees.

The average deductible also increased for both an individual and a family plan during the past decade. After adjusting for inflation, the average deductible for an individual plan in Utah increased from \$770 to \$1,438, and from \$1,777 to \$2,606 for a family plan. (See Figure 5.)

How Affordable is Health Insurance in Utah?

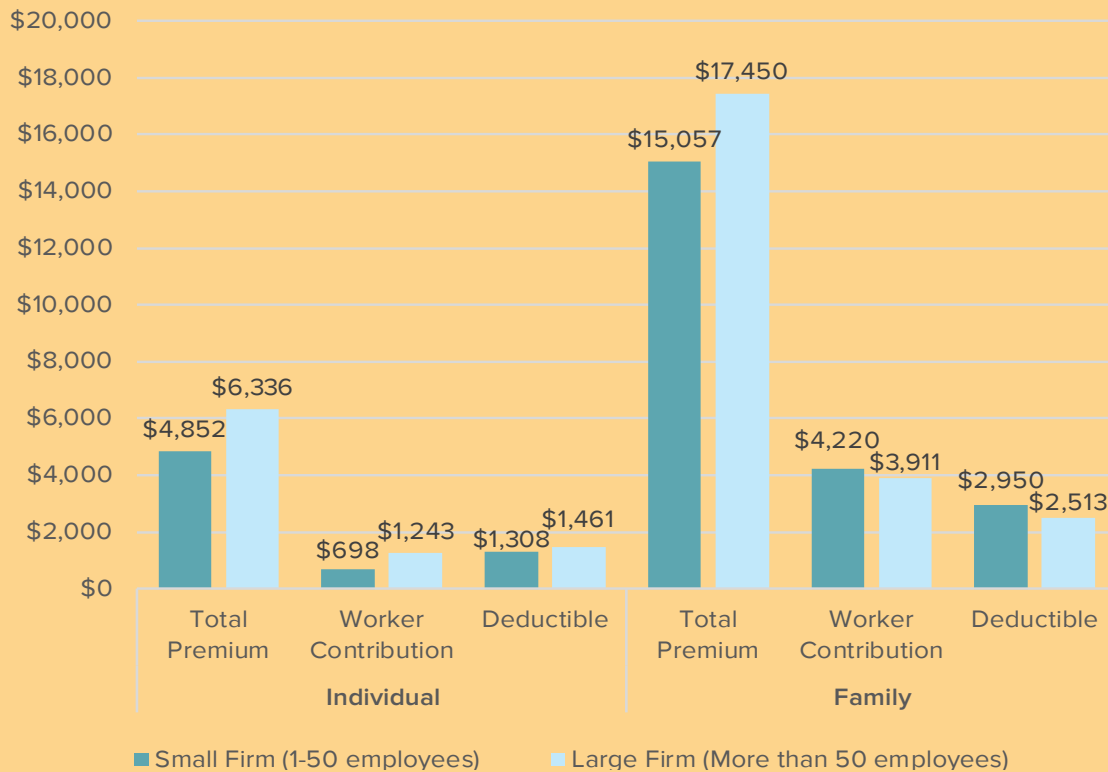
In 2016, the median income for a one-person household in Utah was \$30,707.²⁶ On average, in 2016, an individually insured Utahn contributed \$1,162 annually toward the premium of a health insurance plan. This amounts to approximately 3.7% of their income, an affordable plan under the definition in this report.

In 2016, the median income for a four-person household in Utah was \$81,144.²⁷ The average annual premium takes up nearly 5% of a family's income.

Based on the metrics set forth for this report, on average, employer-sponsored health insurance appears affordable. However, there are additional factors to consider that may make the health insurance plan unaffordable, like the additional costs of deductibles, copayments and coinsurance. (See sidebar on page 12 for a hypothetical case.)

The worker contribution for individuals is less at small firms than large. The opposite is true for family coverage.

Figure 6: Average Annual Premiums and Worker Contributions, Individual and Family Coverage, by Firm Size, Utah 2016



Source: Medical Panel Expenditure Survey, State-Specific Premiums and Contributions of Plans of Employees Enrolled at Private-Sector Establishments by Firm Size, 2016.

Small and Large Group Variations

Not everyone pays the same amount within the employer-sponsored market. There are significant cost differences between small and large group health insurance plans. (See Figure 6.)

For single coverage, the total premium and worker contribution is less expensive in small firms than in large firms. For family coverage, workers in small firms have lower average annual premiums than in large firms (\$15,057 compared to \$17,450), but those workers in small firms contribute more toward their plans and have higher deductibles. This is likely because it is more difficult for small firms to absorb the costs of family health insurance plans, causing them to shift the burden to workers.

While small firms generally offer lower premium rates, this is likely because the plans come with limited health benefits and higher deductibles. Employees of smaller firms also tend to earn less than those at large firms, perhaps placing a greater cost burden on those employed at smaller firms.²⁸



HYPOTHETICAL FRACTURED WRIST CASE

Let's say an individual with the average cost profile has a skiing accident and fractures a wrist. The median charge for a fractured hand/wrist without surgery at the three largest Utah hospitals (based on the number of beds) ranges from \$15,000 to nearly \$19,000. If the individual has insurance through a large company, it is possible those charges are negotiated down by approximately 21%. Let's further assume the individual has a 20% coinsurance payment after reaching the deductible. At this point, the individual has paid \$3,838 in addition to the monthly premium payments.

From just the deductible and the coinsurance alone, the cost takes up 12.5% of an individual's income. (As noted, the median income for a one-person household in Utah is \$30,707.) The combination of the negotiated rate from the insurance company, the deductible and the cost-sharing amount will all vary by the benefits offered by the employer and the insurance company. While the premium is affordable, as soon as the individual uses the plan, the expenditures on health care can move out of the "affordable" range.

Cost Process	Cost Breakdown
Hospital median charge	\$15,193
Negotiated rate from insurance company	12,002
Individual deductible	1,438
Individual coinsurance after insurance	2,400
Total Individual Contribution	\$3,838

Source: Utah PricePoint, *Fracture or Dislocation Except Thigh, Pelvis, Back*, 2014. A study by Health Affairs found that large insurance companies with market shares of 15% or more negotiated prices for office visits that were 21% lower than prices negotiated by insurers with shares of less than 5%. Roberts, Eric T., Michael E. Chernew, and J. Michael McWilliams, "Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices," *Health Affairs*, Vol. 36, No. 1.

The Affordable Care Act implemented provisions that addressed the scope and cost of insurance for different firm sizes, such as offering tax credits to businesses with 25 or fewer full-time employees who purchase their insurance through the Small Business Health Options Program (SHOP). In Utah, only 0.5% of the population uses Avenue H SHOP. In fact, beginning this year, Utah's Avenue H is not accepting new groups because it is being eliminated. In 2016, Utah's Health Reform Task Force found the exchange's enrollment numbers would not reach the level originally hoped.²⁹ The task force cited several challenges for Avenue H SHOP: a reduction in the number of carriers offering plans, the lack of out-of-state options and increasing premium rates.³⁰

THE INDIVIDUAL MARKET

There are two separate individual markets. One is the federal Health Insurance Marketplace at Healthcare.gov, which was implemented under the Affordable Care Act. It is an online service that helps people shop for and enroll in health insurance plans. It is operated by the federal government in most states, including Utah. By purchasing through the Marketplace, enrollees may qualify for income-based subsidies.

The second market is known as off-exchange. Plans purchased off the exchange are often bought through an insurance broker or an agent. These plans are not always subject to the requirements of the Affordable Care Act. If an individual health insurance policy was purchased on or before March 23, 2010, these plans are considered "grandfathered" and are not required to include the mandates under the Affordable Care Act. About 1.6% of Utahns with individual plans, 1.6% of Utahns with small group plans and 3.4% of Utahns with large group plans have grandfathered plans. Individuals who purchase off the exchange do not qualify for federal subsidies.

The Marketplace in Utah

The Marketplace offers financial assistance from the federal government to enrollees with incomes between 100% and 400% of the federal poverty level (see Appendix A for income ranges). The subsidies come in two forms. One is the advanced premium tax credit – also known as the premium subsidy – which assists enrollees with their monthly premiums. The cost-sharing reduction subsidy is the other form. The cost-sharing subsidy reduces the amount insurers can ask low-income enrollees (those earning up to 250% of the federal poverty level) to pay toward deductibles and other cost-sharing amounts. In years past, these subsidies have been reimbursed by the federal Department of Health and Human Services to the insurance companies using funds appropriated for a different purpose.

In fall 2017, the White House announced it would no longer fund the cost-sharing

subsidy in 2018, arguing that the reimbursements were illegal because Congress needed to make a specific appropriation. Congress has so far declined to do so. However, the Affordable Care Act requires insurance companies to offer reduced deductibles and cost-sharing amounts regardless of the reimbursements from the federal government. As a result, insurers are passing some of the costs on to market-rate customers. One analysis predicted that premiums would have to increase 15% in Utah to cover the cost of the cost-sharing subsidy.³¹

To compensate for losing the cost-sharing reduction payment, insurance companies primarily increased the premium for the 2018 benchmark silver plan. For instance, the cost of the benchmark silver plan in Salt Lake County increased nearly 62%.³² The bronze plan increased 19%, and the gold plan increased 20%. The benchmark silver plan determines how large an enrollee's premium subsidy will be, which is determined by the beneficiary's income level. Each income level has a cap on how much of their income is legally allowed to go toward a Marketplace plan. The premium caps increase with income. (See Appendix A.) The federal government picks up the difference. In other words, by increasing the benchmark silver plan, enrollees receiving a premium subsidy will not feel the increase, but market-rate customers and the federal government will.³³

Premium Cost Trends. The average monthly premium for individual Marketplace plans in Utah increased from \$159 in 2013 (the year before the federal exchange was created) to \$319 in 2017 – a 101% increase.³⁴ Compared to the 39 states using Healthcare.gov, the national average increase in monthly premiums in the individual market was from \$232 to \$476 – a 105% increase during the same time period. The median state increase was 108%.³⁵ However, it should be noted there was significant variation in premium increases in the individual market – the lowest premium increase was 12% in New Jersey, compared to the highest premium increase of 222% in Alabama.

In Utah, there were also substantial premium increases from 2017 to 2018. On average, health insurance premiums increased 39% in 2018 for Utah's two remaining insurers that offer plans on the Marketplace.³⁶

The cost trends vary substantially between the employer-sponsored market and the individual Marketplace. The individual market is a distinct market that is made up of a different risk pool that is governed by differing regulations and policies.

The premium increases reflect the financial status of Utah's health insurers. In 2016, Utah health insurers had a collective decrease in net income of 3.2%.³⁷ Nationally, the industry average for net income was an increase of 0.8%, indicating that Utah health insurers performed significantly lower than the industry average during 2016.³⁸ This is likely to be due to the substantial losses Utah insurer's experienced in the individual market. On average, for every \$1.00 insurers received in premiums,



MEASURING INSURERS' FINANCIAL HEALTH

One measure of an insurer's financial health is the ratio of incurred losses to premiums earned, known as the loss ratio. A ratio of less than 100 indicates that an insurance company received more premium income than it paid out in claims. A ratio of more than 100 indicates that an insurance company paid more in claims than it received in premium income. In 2016, the loss ratio in Utah for the large and small group markets came in at 85 and 84, respectively. The medical loss ratio in Utah's individual market was 115.

It should be noted that while insurance companies in the state and nationally experienced losses in the individual market, four out of the five largest U.S. health insurance companies reported profits remained steady or increased between 2013 and 2016. This is largely due to an increased dependence on Medicare and Medicaid beneficiaries that offset the losses.

they paid \$1.15 in claims.³⁹ The national average is much lower; for every \$1.00 received in premiums, insurers paid \$0.93.⁴⁰ This is known as the medical loss ratio.

The first full year of implementation of the Affordable Care Act was financially difficult for Utah's comprehensive health insurers. Insurers had limited claim history to work with and underpriced the claim costs of new enrollees. Additionally, the federal risk corridor program, a premium stabilization program (discussed later in the report), produced lower than expected payments for insurers. And finally, the transitional grandfathered plans created a separate risk pool of healthy individuals who could maintain non-ACA-compliant coverage at lower premiums.⁴¹ The second full year, insurance companies experienced even greater losses for the same reasons. In 2016, insurers continued to experience losses but less so than in 2015. The increases from 2016 to 2017 were in large part an estimated one-time market correction. The increases from 2017 to 2018 were in large part due to the loss of the cost-sharing reduction subsidy.

It should be noted that while insurance companies in the state and nationally experienced losses in the individual market, four out of the five largest U.S. health insurance companies reported that profits remained steady or increased between 2013 and 2016. This is largely due to an increased dependence on Medicare and Medicaid beneficiaries that offset the losses.⁴²

To some extent, increased profits can help the insured. The Affordable Care Act implemented a provision that requires insurance companies to spend a base amount on claims and quality of care improvements for individual, small and large group plans. For small and individual plans, insurance companies must spend at least \$0.80 for every \$1.00 on medical claims and improvements to care, and for large groups they must spend at least \$0.85 for every \$1.00. If insurers do not meet the requirement, beneficiaries enrolled in these plans are entitled to rebates. In 2016, nearly four million people received rebates in the U.S.⁴³

Marketplace Enrollment. There are five tiers of health insurance plans offered in Utah's Marketplace. They include catastrophic, bronze, silver, gold and platinum plans. The plans are ranked by their actuarial value, a method to measure the generosity of the plan. The greater the actuarial value, the more the plan is required to cover. The lower the percentage, the higher the cost-sharing for the enrollee. Bronze plans must cover a minimum of 60% of services, silver must cover 70%, gold must cover 80%, and platinum must cover 90%. Catastrophic plans are not required to have a minimum actuarial value, except that they must be less generous than the bronze plan. Enrollees who are under the age of 30 or qualify for a hardship exemption can purchase catastrophic plans. Because the plans are tiered based on their actuarial value, the cost-sharing profile can vary substantially from one plan to another.

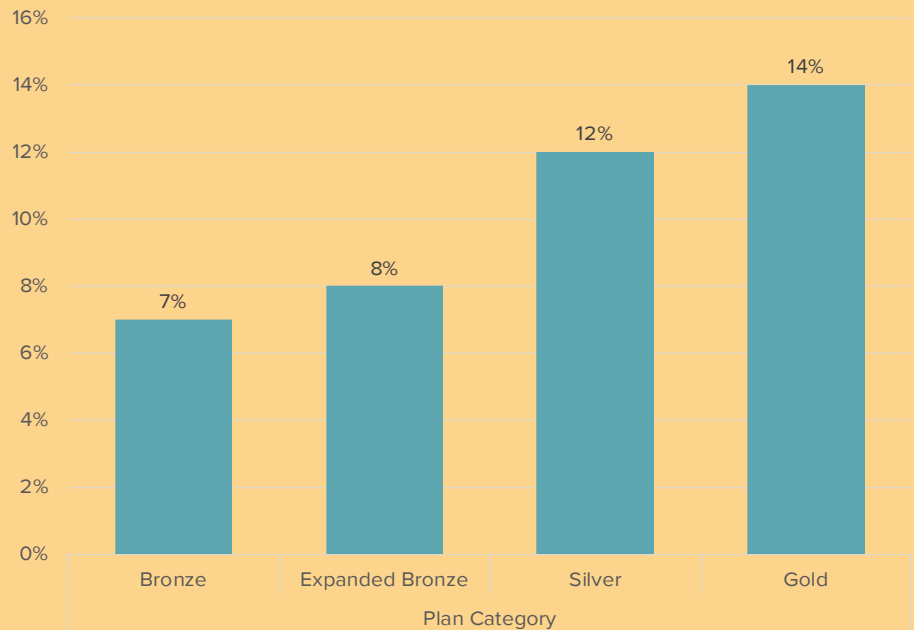
In Utah, approximately 73% of Marketplace enrollees have silver plans, 25% have bronze plans, 2% have gold plans, and less than 1% have catastrophic plans. Of the total enrollment in the Marketplace, 86% receive premium subsidies, which can

be applied towards any plan, and 60% receive cost-sharing reductions, which can be applied only toward silver plans.⁴⁴

Marketplace Costs. The premium cost of a Marketplace plan varies from person to person. The benchmark plan for an individual age 30 in Salt Lake County in 2018 is \$350. The subsidy is the benchmark plan minus the premium cap. For example, if an individual earns \$11,880, the cost will be no more than 2.04% of the household income for a health insurance premium, or no more than \$20 a month. The individual receives a \$330 subsidy (\$350 minus \$20), which can be applied to any plan. The health insurance premium for an individual making \$47,520 a year or more pays the full premium price because the premium cap is greater than the benchmark plan (\$384 and \$350 a month respectively). Depending on income level and plan choice, there are substantial differences in premium costs. (See Appendix B.)

The bronze and expanded bronze are under the 10% affordability threshold.

Figure 7: Premium Cost as Percent of Income for a Non-Smoking Individual, Age 30, from Salt Lake County, \$48,000 Annual Income, 2018



Source: Utah Insurance Department, calculations by Utah Foundation for the cheapest plan available.

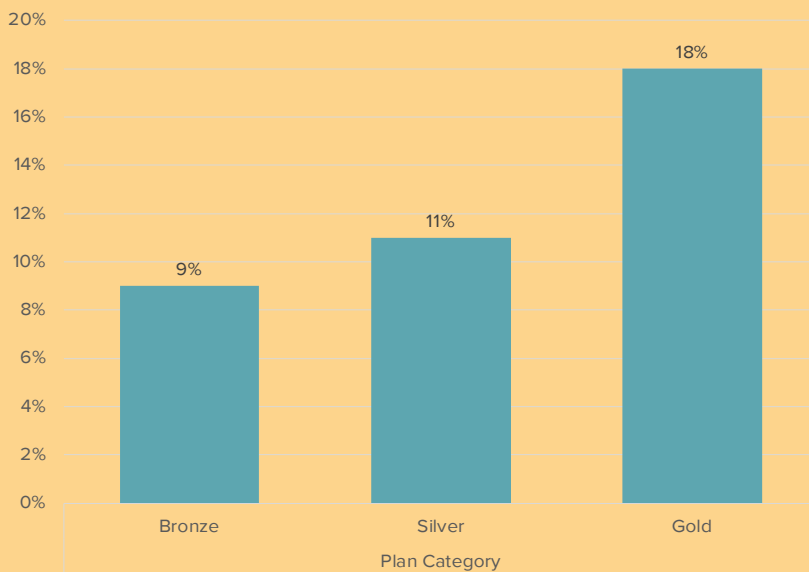
Statewide, the average premium in 2017 for those receiving the premium subsidy was \$89 a month.⁴⁵ The average premium subsidy varied county by county in Utah (see Appendix C), ranging from \$195 in Utah County to \$388 in Wayne County. This suggests that most people receiving a premium tax credit are benefiting. However, while 86% of enrollees receive premium assistance, only 60% of enrollees receive assistance with their deductibles and other cost-sharing amounts. For an individual, the deductible ranged from \$6,350 for the cheapest bronze plan to \$1,500 for the cheapest gold plan. For a family, the deductible ranged from \$11,400 for the cheapest bronze plan to \$2,500 for gold. Although a premium may be considered affordable, the deductibles could cause a financial burden for moderate-income enrollees who do not receive the cost-sharing reduction subsidy.

The 14% of Marketplace plan enrollees who do not receive any premium cost assistance feel the full cost burden.⁴⁶ Utah Foundation estimated premium costs as a percent of income for an individual and a family making just over 400% of the federal poverty level. Figure 7 shows the calculation for an individual making \$48,000.

The bronze and expanded bronze plans both cost less than 10% of income. The gold plan, however, is approximately 14% of an enrollee's income. The gold plan offers the best coverage, often with substantially lower deductibles and cost-sharing requirements. While the bronze plans all come under the afford-

The bronze plan is the only option for a family to stay under the 10% affordability threshold.

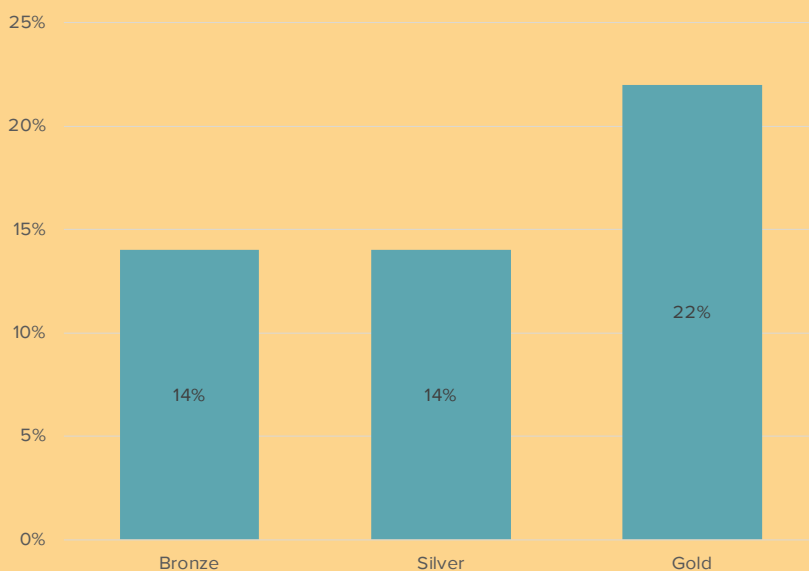
Figure 8: Premium Cost as Percent of Income for Non-Smoking Couple, Age 30, Two Children, Salt Lake County, \$98,000 Annual Income, 2017



Source: Centers for Medicare & Medicaid Services, Health Insurance Oversight System. Calculations by Utah Foundation for the cheapest plan available.

All off-exchange plan options are over the 10% affordability threshold for individuals.

Figure 9: Premium Cost as Percent of Income for Off-exchange Plan for an Individual, age 30, Salt Lake County, \$30,707 Annual Income, 2018



Source: Utah Insurance Department. Calculations by Utah Foundation for the cheapest plan available.

ability definition, these plans come with steep deductibles. For a family plan, just over 400% of the federal poverty level is \$98,000 a year. The estimates are shown in Figure 8.

If a family of four wanted to keep health insurance premium spending under 10% of their income, their only option would be a bronze plan. The deductible for the cheapest bronze plan is \$11,400. The deductibles for the cheapest silver and gold plan are more forgiving, \$3,000 and \$2,500. Based on average market increases from 2017 to 2018, a bronze plan could take up nearly 11% of income, silver may take up 17%, and gold may take up more than 22% of a family's income.

Off-Exchange Plans

Beneficiaries who purchase plans off the exchange are not eligible for subsidies, may not have essential health benefits and are more vulnerable to premium increases. Figure 9 shows premiums for an individual, age 30, from Salt Lake County.

For an individual with a median income of \$30,707, there are no plans that cost less than 10% of income.⁴⁷ For a family with a median income of \$81,144, there are also no health insurance plans off the exchange that are less than 10% of their income. (See Figure 10 on the next page.) Further, it is likely that the premiums for family plans off the exchange have also increased in price since 2016.

There are a few reasons why beneficiaries purchase an insurance plan off the exchange. There is the notion of convenience and familiarity with an insurance company or broker

they have always had. Some may assume they do not qualify for a subsidy. There may be some who avoid the exchange because of political opposition to the Affordable Care Act. Some beneficiaries want a larger network of providers to choose from, or do not want to risk losing their current provider. It is possible some people do not know financial assistance is available through the Marketplace.

The division between on- and off-exchange plans is noteworthy. The beneficiaries of both are a part of the same risk pool and are regulated by the same department. However, the two differ significantly in affordability and access, and do not exhibit the same extent of transparency and continuity in the delivery of information.

MEDICARE

Yet another option for insurance is Medicare. There are four parts to Medicare – Parts A, B, C and D. Individuals are eligible for Medicare if they are 65 years and older, or under the age of 65 with allowable permanent disabilities.⁴⁸ In 2017, 64% of Utahns enrolled in Medicare were enrolled in Original Medicare, and 36% were enrolled in a Medicare Advantage Plan (replacement plans sold by private insurance companies). Of those enrolled in Original Medicare, more than half (55%) had Part D – the stand-alone prescription drug plan.

Medicare is included in this report because, like the employer-sponsored market and the individual market, beneficiaries are required to pay a premium, and are subjected to deductibles and cost-sharing. This raises an affordability question.

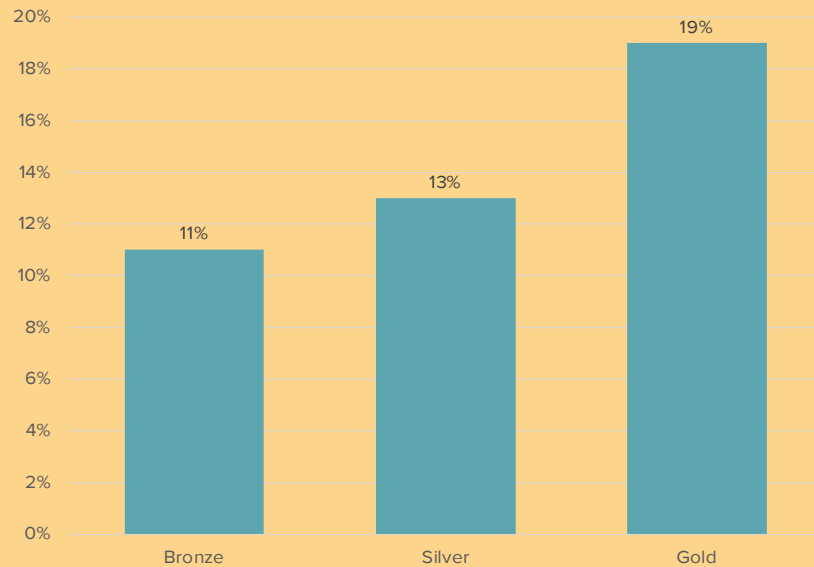
Original Medicare

Original Medicare is broken into Part A and Part B. Part A covers most medically necessary inpatient hospital visits, some care in skilled nursing facilities, hospice care and some home health aide services. Most people receive Part A without having to pay a premium.⁴⁹ If an individual seeking Medicare Part A worked and paid Social Security taxes for at least 40 calendar quarters (10 years), there is no premium. If the beneficiary paid Medicare taxes for 30-39 quarters, the standard Part A monthly premium is \$227. If the beneficiary paid Medicare taxes for less than 30 quarters, the standard premium is \$413 per month. Part A also has deductibles and copays, which are based on time spent in hospitals.

Part B of the Medicare program covers most medically necessary doctors' ser-

All off-exchange plan options are over the 10% affordability threshold for families.

Figure 10: Premium Cost Percent of Income for an Off-exchange Plan for a Couple, age 30, with Two children with \$81,144 Annual Income, 2016



Source: Robert Wood Johnson Foundation, HIXCompare. Calculations by Utah Foundation for the cheapest plan available.

vices, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care and some home health and ambulance services. The standard premium for 2017 was \$134 per month. For those receiving Social Security benefits, the average monthly premium was \$109.⁵⁰ Part B also has deductibles and coinsurance. In 2017, the annual deductible was \$183 a year. Once the deductible is met, the beneficiary typically pays 20% of the Medicare-approved amount for most doctor and hospital visits (inpatient and outpatient).⁵¹

Neither Part A nor Part B have out-of-pocket maximums, meaning there is no cap to what the beneficiary will be required to pay.

Medicare Advantage

Medicare Advantage plans are required to provide the same base coverage as Part A and Part B but may also include (and often does) additional benefits such as prescription drug coverage, vision, dental and other health and wellness initiatives. Beneficiaries still pay the premium required through Part B, but additional cost-sharing is subject to the plan details. The Centers for Medicare & Medicaid Services also pay insurance companies a fixed amount of money per enrollee every month to offset the cost of the plan.

The average monthly premium for a 2017 Medicare Advantage plan in Utah was \$31.46, with an average deductible of \$180.96.⁵²

Part D (Prescription Drug Plan)

Medicare Part D is the outpatient prescription drug component, a voluntary program offered through private insurance companies. Part D plans are required to offer a set of benefits, known as “standard coverage.” Standard coverage for the 2017 plan had a \$400 deductible and a 25% coinsurance thereafter for costs between \$400 and \$3,700.⁵³ After this, beneficiaries had limited coverage until \$4,950, the annual out-of-pocket maximum.

In Utah, there are 28 Part D plans to choose from, offered by 15 different insurance companies.⁵⁴ They range from \$17.00 - \$159.30 in monthly premiums, with varying deductibles, benefits and drug lists.⁵⁵

Medicare Affordability

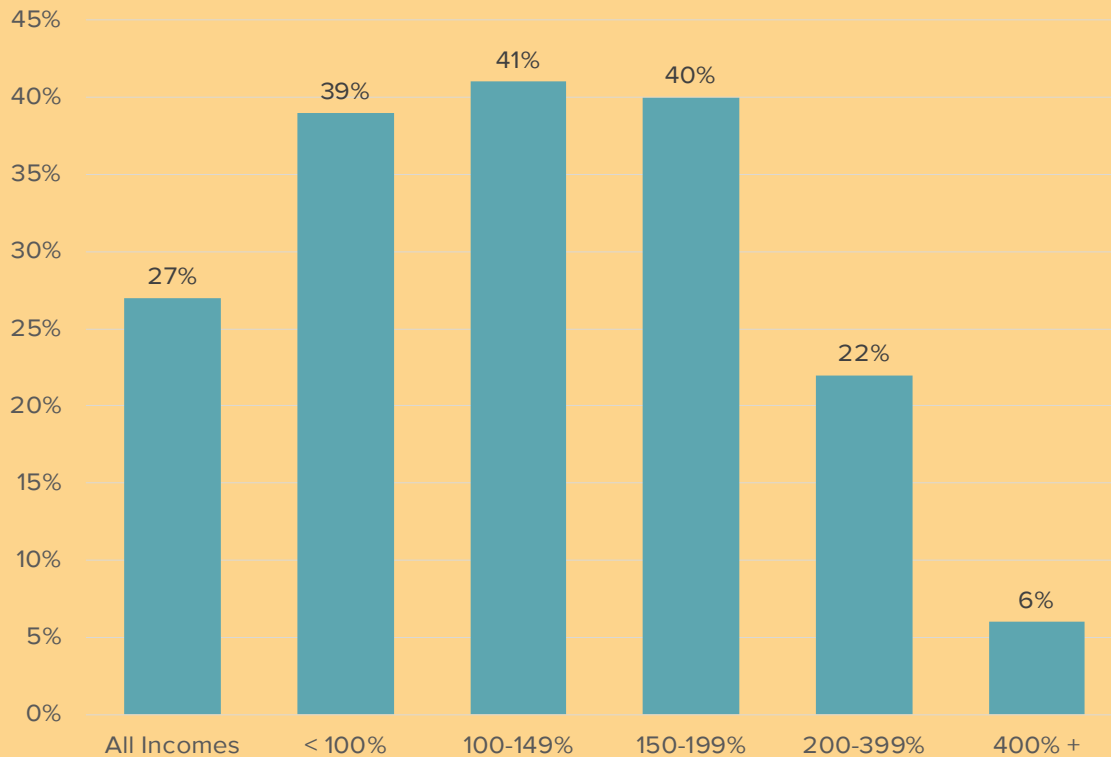
Health care affordability often extends beyond the cost of premiums. The Commonwealth Fund found that after considering both premium and non-premium expenses, Medicare beneficiaries, nationally, pay a substantial portion of their income towards health expenses, with the low-income beneficiaries paying the highest proportion of their income. (See Figure 11 on the next page.)

Utah Medicare beneficiaries are vulnerable to the high cost of medical care. Approximately 59% of Medicare beneficiaries in Utah are below 400% of the federal poverty level.⁵⁶ Only 10% of Medicare beneficiaries are also eligible for Medicaid.⁵⁷

Like the other forms of health insurance, Medicare beneficiaries may have seemingly affordable premiums, but additional costs from deductibles, cost-sharing and out-of-pocket expenses may be placing a cost burden on Utahns.

Low- and moderate-income Medicare beneficiaries contribute a substantial portion of income towards health care.

Figure 11: Medicare Beneficiary Spending by Poverty Level, Nationally 2016



Source: The Commonwealth Fund.

HEALTH INSURANCE PREMIUM COST DRIVERS

The cost of health insurance continues to rise in response to the national health care landscape. Health insurance prices fluctuate with the condition of the market, and the health care market is increasing in price and laden with uncertainty.

Cost of Care

Health insurance premiums are chiefly the manifestation of the cost of medical care. Premiums rise as a direct response to the cost of health care. In Part 1 of the Health Cost Series, Utah Foundation found the cost of health care has been increasing for decades. The cost of health care is primarily a reflection of the prices charged – ultimately negotiated with insurance companies – for goods and services provided. High and rising prices for medical technology and prescription drugs are both prominent contributors. Find *Bills of Health: What's Driving Medical Service Costs in Utah?* at www.utahfoundation.org/reports/bills-health-whats-driving-medical-service-costs-utah/.

The U.S. spends more on health care than all other nations with comparable incomes. Research shows this is due to substantially higher prices charged in the U.S. than abroad.

Specialty drugs are particularly costly. One report found the retail price for 101 specialty drugs widely used by Americans increased 9.6% from 2014 to 2015.⁵⁸ In fact, specialty drugs are among the costliest pharmaceuticals on the market. For instance, the average annual cost for a single specialty medication used on a chronic basis was more than \$52,000 in 2015. By comparison, this was only slightly less than the median U.S. household income in 2015 (\$55,775), but more than twice the median income for Medicare beneficiaries (\$25,150), a population for which specialty drugs are most common. And the cost is growing. From 2006 to 2015, the retail price for 29 chronic use specialty drugs cumulatively increased by an average of 177.3%.⁵⁹ These products are projected to be the fastest growing category of pharmaceuticals in the decade to come. But they are just one part of the picture.

The U.S. spends more on health care than all other nations with comparable incomes. Research shows this is due to substantially higher prices charged in the U.S. than abroad. For instance, the International Federation of Health Plans found that the same prescription of Xarelto, a drug to prevent or treat blood clots, was on average \$289 in the U.S., compared to \$126 in the United Kingdom, the country with the second-highest cost. Similarly, Humira, a drug to treat arthritis, was on average \$2,669 in the U.S., compared to \$1,362 in the United Kingdom.⁶⁰

The U.S. also has higher prices for common diagnostic screenings. For example, in 2015, the average price for an MRI screening was \$1,119 in the U.S., compared to \$811 in New Zealand, the country with the second-highest cost, and \$130 in Spain, the country with the lowest cost. For an appendectomy, a common procedure, the U.S. was nearly double the cost compared to the country with the second-highest cost, the United Kingdom – \$15,930 versus \$8,009.⁶¹

Apart from three instances of the 21 given by the International Federation of Health Plans for both drug and diagnostic costs, prices in the U.S. were significantly higher than in comparable nations.

The Risk of the Pool

Health care spending is highly concentrated among a small percentage of the population. In 2014, the top one percent of persons (ranked by their health care expenditures) accounted for 22.8% of total health care expenditures, with an annual per person average expenditure of \$107,208.⁶² In fact, the top 5% of the population accounted for 50.4% of total health care expenditures. The bottom 50% of the population accounted for only 2.8% of total spending, with an annual per person average of \$264. The healthier the risk pool, the more expensive the premiums for the entire insured population.

This problem was particularly significant for insurance plans sold on the Marketplace. One reason for this: Many of the newly enrolled beneficiaries on Marketplace plans were previously uninsured and had a pent-up need for health care services. This pent-up need increased the overall risk of the pool in Marketplace plans.

Loss of Federal Subsidies & Programs

One of the concerns with guaranteeing access to health insurance regardless of pre-existing conditions is that beneficiaries who are in the most need of health care may be more likely to purchase insurance, a phenomenon known as adverse selection. This can increase premiums and cause insurers to be more cautious in setting their premiums. In an effort to alleviate some of those concerns, the Affordable Care Act enacted three premium stabilization programs, known as the three R's: risk adjustment, reinsurance and risk corridors.

The risk adjustment program collects a fee from plans with lower-risk individuals and redistributes it to plans with higher-risk individuals. The goal of the program is to encourage insurers to compete based on value and efficiency rather than by attracting healthier enrollees. It applies to the individual and small group plans. This is a permanent program; the other two were not.

The reinsurance program provided payments to plans that enroll higher-cost individuals. All individual, small group, large group and self-insured plans with major medical products contributed funds to the reinsurance program. The U.S. Department of Health and Human Services collected and distributed payments to plans with high-cost enrollees. This program protected against premium increases by offsetting the expenses of high-cost individuals. This program applied to the individual market only. This program was only temporary and ended in 2016.

The risk corridor program was intended to discourage insurers from setting initially high premiums in response to the uncertainty about who will enroll and what they will cost. Plans with lower than expected claims were charged and paid into a federal fund. The fund then paid plans with higher than expected claims. This program applied to individual and small group plans. Like the reinsurance program, this program was only temporary and ended in 2016.

Insurance companies increased premiums for 2017 Marketplace plans in part to compensate for the expected impact from the ending of federal premium programs.

Finally, as discussed earlier, the loss of the federal cost-sharing subsidy has led to significant premium increases for 2018 Marketplace plans.

Consolidation

There are a wide range of payers for health care in the U.S. – ranging in size from massive public payers like Medicare to individual buyers of health care. Generally, the larger the buyer the greater their share of the local health care market and the greater their leverage and negotiating power. In other words, large commercial insurers can capture local markets, crowd out other commercial insurers and establish agreements with providers that give them preferential status over other insurers.⁶³ A study by the Commonwealth Fund found the

One of the concerns with guaranteeing access to health insurance regardless of preexisting conditions is that beneficiaries who are in the most need of health care may be more likely to purchase insurance. This can increase premiums and cause insurers to be more cautious in setting their premiums.

estimated national market shares of the four largest insurers increased from 74% to 83% from 2006 to 2014, the most recent year for which data are available.⁶⁴ It should be noted, however, the level of national concentration is not necessarily relevant to most consumers, as the degree of local market control can be far more significant.

Insurance company consolidation has been steadily increasing in Utah. Between 2011 and 2016, the market share of the largest insurer in the individual market increased from 43% to 61%.⁶⁵ This was also true for the small group market, where the largest insurer's share increased from 43% to 60%.⁶⁶ The opposite was true for the large group market, where the largest insurer's market share declined from 49% to 43%.⁶⁷ This is likely due primarily to an increase in employers self-insuring, which increased in Utah from 36% to 43% during the same time period.⁶⁸

In 2015, the latest year for which there is comprehensive data, three insurers dominated the individual market, making up 81% of the market share. Three insurers dominated 80% of the small group market in 2014. A similar picture was also true for the large group market in 2014, with 86% controlled by three insurers.

While decreased competition generally tends to drive up prices, this might not be the case in Utah. The largest insurer operates with an integrated health care system, functioning as both a provider and an insurer, helping to keep costs low by reducing administrative complexity.

Still, the effects of consolidation deserve careful attention. Several studies have shown lower insurance premiums in areas with more insurers.⁶⁹ The studies span the Marketplace, the large-group market and Medicare Advantage plans. One study found that between 2014 and 2015, cost increases in the second cheapest silver premium was 8.4% lower in counties that experienced a net gain in insurers.⁷⁰ Specifically, a 2.8% reduction in cost increases was associated with every new insurer gained.

The best available information on the impact of consolidation on premiums comes from major insurance consolidation events. One study found that following the merger of Aetna and Prudential, premiums significantly increased in areas where there was market overlap from both the merging insurers and neighboring rival insurers.⁷¹ Another study examined the impact on small-group premiums in two Nevada markets after the Sierra Health and UnitedHealth merger. When comparing to two control cities, the researchers found premiums increased by 13.7% following the merger.⁷²

It should be noted that in some cases consolidation of health insurance providers may reduce the prices paid to providers due to increased bargaining power. However, there is uncertainty as to whether savings are passed on to consumers in the form of lower premiums.⁷³

The effects of consolidation deserve careful attention. Several studies have shown lower insurance premiums in areas with more insurers.

CONCLUSION

Health care costs are on the rise, as is the cost of health insurance plans. For the majority of Utahns, who purchase their health insurance through employers, costs have been increasing significantly in the past decade – although at a more modest pace than in prior years. In addition, more of the cost has been transferred from employers to employees in the form of higher deductibles and increased cost-sharing.

There are several variations in cost. For instance, individuals at small firms tend to pay smaller premiums than at large firms, while families at small firms tend to pay higher premiums. Meanwhile, premiums for individuals and families buying through the Marketplace may vary substantially depending on income and plan choice.

There are several reasons that health insurance premiums have been increasing, both in Utah and nationwide. The primary driver is the cost of care. The cost of health care has a direct impact on how premiums are determined and priced. This is in large part due to the prices charged for pharmaceutical drugs and common diagnostic practices, which are in some cases nearly double the prices charged in comparable nations.

The risk of the pool of beneficiaries also contributes to increased premiums. In addition, reduced competition among health insurance companies may decrease pressure on insurers to keep prices low. The loss of the federal premium stabilization program and the cost-sharing reduction subsidy contributed to increased Marketplace premiums.

At the end of the day, perhaps the most important consideration is whether health insurance makes health care affordable. Individuals and families with employer-sponsored health insurance appear to have affordable premiums. This is also the case for Marketplace enrollees who receive premium financial assistance.

However, for Marketplace enrollees who do not receive assistance, there are few options for affordably priced plans. For those purchasing outside of the Marketplace, health insurance plans are largely unaffordable. Based on national trends, Utah Medicare beneficiaries may also be struggling with the affordability of health care costs.

Finally, regardless of which market health insurance is purchased from, out-of-pocket expenses for medical care through increased deductibles and cost-sharing may place a financial burden on individuals and families. While many may be able to afford the monthly payment, the costs that accompany using the plan benefits may push health care costs into the unaffordable range.

APPENDIX A:

PREMIUM SUBSIDY RANGES AND CAPS FOR MARKETPLACE ENROLLEES BY INCOME FOR THE 2018 BENEFIT YEAR

Poverty Level	Income for Single Individual	Income for Family of Four	Premium Cap
Under 100%	Less than \$11,880	Less than \$24,300	No cap
100% - 133%	\$11,880 - \$15,800	\$24,300 - \$32,319	2.04%
133% - 150%	\$15,800 - \$17,820	\$32,319 - \$36,450	3.06% - 4.08%
150% - 200%	\$17,820 - \$23,760	\$36,450 - \$48,600	4.08% - 6.43%
200% - 250%	\$23,760 - \$29,700	\$48,600 - \$60,750	6.43% - 8.21%
250% - 300%	\$29,700 - \$36,640	\$60,750 - \$72,900	8.21% - 9.69%
300% - 400%	\$36,640 - \$47,520	\$72,900 - \$97,200	9.69%
Over 400%	-	-	No cap

Source: The Henry J. Kaiser Family Foundation.

APPENDIX B:

POST-SUBSIDY PREMIUM COST BY METAL CATEGORY AND INCOME LEVEL FOR A NON-SMOKING, INDIVIDUAL, AGE 30, SALT LAKE COUNTY, 2018

Household Income Eligibility for Subsidy	Premium Cap	Premium Subsidy	Premium Monthly Cost			
			Bronze (\$265)	Expanded Bronze (\$339)	Silver (\$469)	Gold (\$543)
\$11,880	2.04%	\$330	\$0	\$9	\$139	\$213
\$15,800	3.06%	310	0	29	159	233
\$17,820	4.08%	289	0	50	180	254
\$23,760	6.43%	223	42	116	246	320
\$29,700	8.21%	147	118	192	322	396
\$36,640	9.69%	55	210	284	414	488
\$47,520	9.69%	0	265	339	469	543

Source: Estimates done by Utah Foundation for the cheapest plan available. Plan data available from Utah Insurance Department.

POST-SUBSIDY PREMIUM COST BY METAL CATEGORY AND INCOME LEVEL FOR A NON-SMOKING, COUPLE, AGE 30, WITH TWO CHILDREN, SALT LAKE COUNTY, 2017

Household Income Eligibility for Subsidy	Premium Cap	Premium Subsidy	Premium Monthly Cost		
			Bronze (\$727)	Silver (\$911)	Gold (\$1,434)
\$24,300	2.04%	\$884	\$0	\$27	\$550
\$32,319	3.06%	843	0	68	591
\$36,450	4.08%	801	0	110	633
\$48,600	6.43%	665	62	246	769
\$60,750	8.21%	509	218	402	925
\$72,900	9.69%	336	391	575	1,098
\$97,200	9.69%	140	587	771	1,294

Source: Estimates done by Utah Foundation for the cheapest plan available. Data is not available for expanded bronze plans. Plan data available from Centers for Medicare & Medicaid Services, *Health Insurance Oversight System*.

APPENDIX C:

AVERAGE MONTHLY ADVANCED PREMIUM TAX CREDIT BY COUNTY IN UTAH, 2017

Wayne County has the highest average monthly advanced premium tax credit; Utah County has the lowest.

County	Average Premium Subsidy
Beaver	\$320
Box Elder	\$225
Cache	\$267
Carbon	\$372
Daggett	*
Davis	\$202
Duchesne	\$333
Emery	*
Garfield	\$370
Grand	\$371
Iron	\$310
Juab	\$262
Kane	\$359
Millard	\$321
Morgan	\$230
Piute	*
Rich	*
Salt Lake	\$226
San Juan	\$350
Sanpete	\$331
Sevier	\$329
Summit	\$224
Tooele	\$214
Uintah	\$321
Utah	\$195
Wasatch	\$244
Wayne	\$388
Weber	\$229

*Data are not available.

Source: Centers for Medicare & Medicaid Services, Multi-Dimensional Insurance Data Analytics System (MIDAS), 2017.

ENDNOTES

1 This includes both individuals with plans on the individual exchange who do not receive premium assistance and individuals with plans purchased off the exchange. Utah Foundation estimated the cost of a premium for an individual and family that do receive premium subsidies. Individuals who purchase plans on the Marketplace and qualify for a subsidy have a cap on how much of their income goes towards their health insurance premium.

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