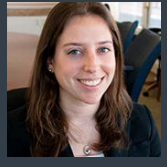
Advisory Board | Health Plan Advisory Council

Understanding the Health Insurance Business:
An Overview of Health Plans

Thursday, September 6, 2018
3:00 PM ET - 3:30 PM ET



Rachel Sokol
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1 Health Plan Fundamentals

2 Key Trends in Health Plan Strategy and Operations

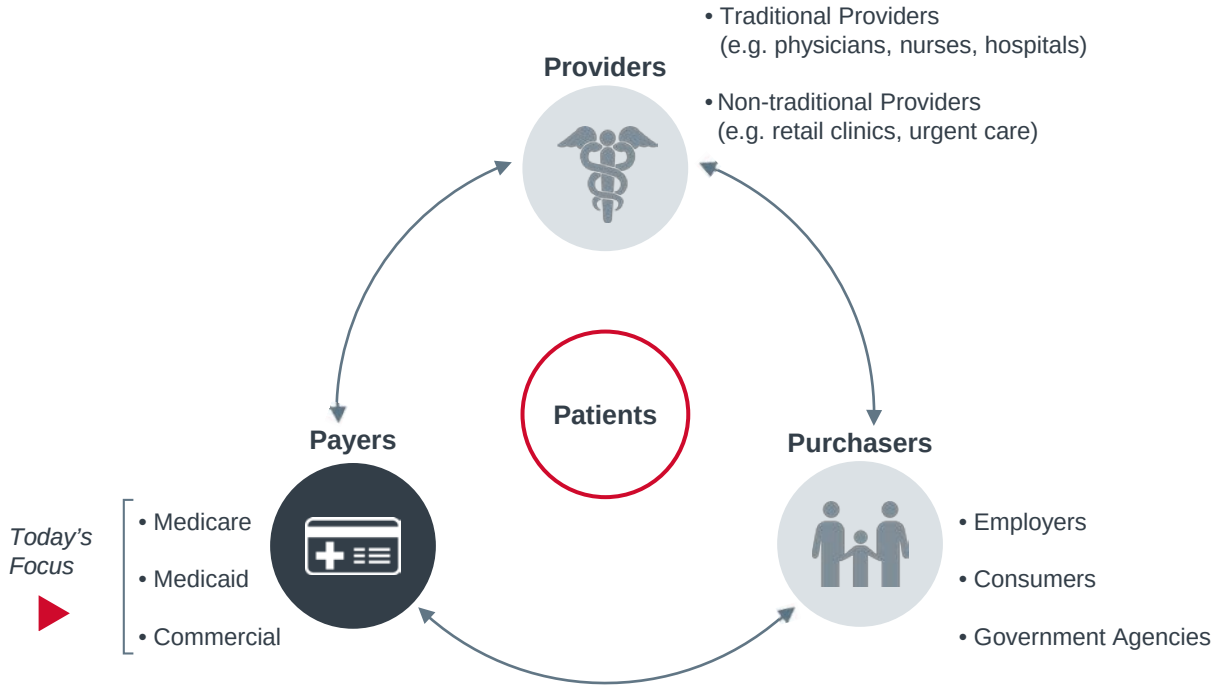
3 Recent Health Plan Policy Updates

4 Questions

5 Appendix: Health Plans 101 Resources

Health Care's Major Players

Key Stakeholders in the U.S. Health Care Delivery System



Source: Advisory Board interviews and analysis.

Who Purchases Health Coverage?

Major Health Plan Business Lines

Government Purchasers

Private Purchasers

Medicare Advantage

Medicaid Managed Care

Employer-Sponsored Insurance

Individual and Family Purchasers

Fully-Funded Small Employer Group[1]
(Up to 50 employees)

Fully-Funded Large Employer Group[1]
(51+ employees)

Self-Funded Employers

1) The small group definition was originally legislated to change to up to 100 employees for coverage in 2016, but the Protecting Affordable Coverage for Employees (PACE) Act of 2015 amended this change and leaves definition determination to the discretion of state regulators. For 2016, only California, Colorado, New York, and Vermont have expanded the definition of small group to up to 100 employees.

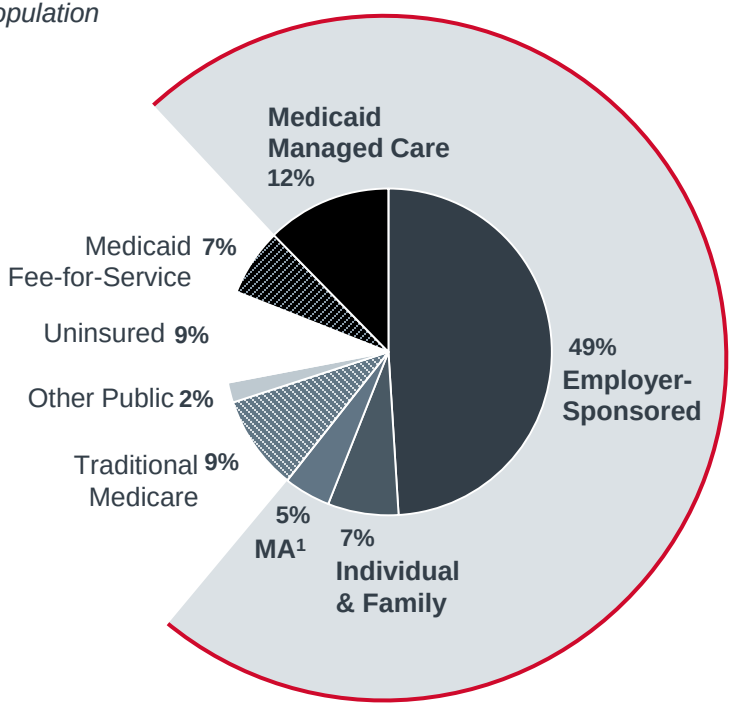
Source: Health Plan Advisory Council interviews and analysis.

Private Payers Offering Majority of Coverage

Breakdown of U.S. Insurance Coverage Types

Percent of Total Population

2016-2017 Estimates



73%

Americans have coverage administered by health plans

1) Medicare Advantage.

Source: Kaiser Family Foundation, "Medicare Advantage," 2017, https://www.kff.org/medicare/fact-sheet/medicare-advantage/; Kaiser Family Foundation, Total Monthly Medicaid and CHIP Enrollment," 2017, https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment; Kaiser Family Foundation, **Total Medicaid MCO Enrollment**," 2017, https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment; Kaiser Family Foundation, "**Health Insurance Coverage of the Total Population," 2016, https://www.kff.org/other/state-indicator/total-population/;** Health Plan Advisory Council research and analysis.

What Keeps Health Plans Up at Night?

Key Strategic Objectives for Health Plans

Objective	*Major Drivers*	*Business Impacts*	*Strategic Considerations*
 **Grow and retain membership**	Premiums, out-of-pocket costs, network composition, benefits, quality rating, member satisfaction	• Total revenue • Actuarial soundness	Purchasers prioritizing member convenience, usability in coverage and care
 **Drive appropriate utilization**	Consumer behavior, preventive care, care management, access, site of care differences	• Total cost of care • Product price • Quality-adjusted revenue	Greater expectation for members to use products effectively
 **Contract efficient, high-quality providers**	Provider contracting, market consolidation, quality incentives, regional supply and labor costs	• Total cost of care • Product price • Quality-adjusted revenue • Network appeal	Growing prevalence of value-based payment and provider focus on population health

Source: Health Plan Advisory Council interviews and analysis.

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Source: Health Plan Advisory Council interviews and analysis.

Purchaser Demands Evolving and Pressure Plans

Purchasers Seek Lower Costs Through Diverging Techniques

Emerging Plan Roles in Response to Prescriptive Purchasers

	Individuals	Employers	Medicare Advantage	Medicaid
Purchase Objective	Lower premiums	More cost-effective decisions	Fewer expensive care needs	Predictable trend
New Purchaser Demand for Plan	Piecemeal coverage	Consumer guidance	Supplemental services	Eligibility monitoring
New Plan Role	**Utility**	**Concierge**	**Social Support**	**Gatekeeper**

Source: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-health-spending-growth-outpaced-growth-u-s-economy_2017; Health Plan Advisory Council interviews and analysis.

Heavily Investing in Experience

Plans Executing on Their Promises to Improve Member Experience

Media Coverage of Plan Investments in Member Experience

mHealthIntelligence

August 16, 2018

Anthem Launches mHealth Program in Ohio for COPD Care Management

"Anthem is launching an mHealth program in Ohio that will use a remote patient monitoring platform to improve care management for members living with COPD"

Nasdaq

August 24, 2018

Humana Inks Deal to Offer Value-Based Care to MA Members

KANSAS CITY BUSINESS JOURNAL

November 8, 2017

Blue KC plan cuts co-pays for doctor visits

catalyst FOR PAYMENT REFORM

National Scorecard on Payment Reform

"97% of Plans Offer or Support a Cost Calculator"

Source: Reuter E, "Blue KC plan cuts co-pays for doctor visits", *Kansas City Business Journal*, November 8, 2017, https://www.bizjournals.com/kansascity/news/2017/11/08/blue-kc-plan-cuts-co-pays-for-doctor-visits.html; Wicklund E, "Anthem Launches mHealth Program in Ohio for COPD Care Management", *mHealth Intelligence*, August 16 2018, https://mhealthintelligence.com/news/anthem-launches-mhealth-program-in-ohio-for-copd-care-management; "2014 National Scorecard", Catalyst for Payment Reform, https://www.catalyze.org/product/2014-national-scorecard/; "Cigna Launches One Guide– Simplified, Personalized Service to Help Choose a Health Plan, Improve Health and Reduce Costs", BusinessWire, November 30, 2016, http://www.businesswire.com/news/home/20161130005175/en/Cigna-Launches-Guide-%E2%80%93-Simplified-Personalized-Service; Zacks Equity Research, "Humana Inks Deal to Offer Value-Based Care to MA Members", Nasdaq, August 24, 2018, https://www.nasdaq.com/article/humana-inks-deal-to-offer-value-based-care-to-ma-members-cm1012791; Health Plan Advisory Council research and analysis.

A Growing Market for a Growing Problem

Navigation Vendors Supplementing Plan Services

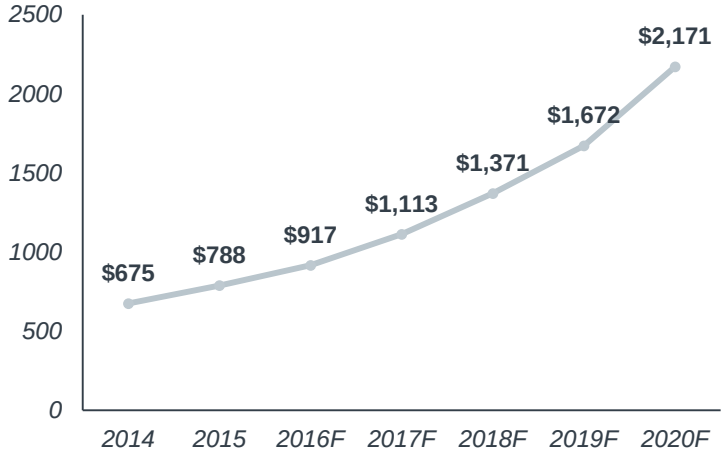
Members Lack Navigation from Plans

25%

Of members receive care coordination support from their health plan

Care Coordination Software Market for Payers

Revenue in millions of dollars, 2015



Source: "Care Coordination Software US Overview and Outlook", Frost & Sullivan, May 2015; "US Member Health Plan Study", J.D. Power, 2017, http://www.jdpower.com/resource/us-member-health-plan-study; Health Plan Advisory Council interviews and analysis.

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Source: Health Plan Advisory Council interviews and analysis.

How Are Health Insurance Products Structured?

Major Categories of Insurance Products

Health Maintenance Organization (HMO)

- Provides coverage for in-network providers with a referral
- Generally only covers out-of-network medical expenses in the case of emergency
- Focuses on integrated care, prevention, and wellness

More Restrictive
Lower Cost

Preferred Provider Organization (PPO)

- Offers in-network services at a reduced cost in comparison to out-of-network services
- Allows members to go out-of-network without a referral for an additional cost

Less Restrictive
Higher Cost

Consumer Directed Health Plan (CDHP)

- Combines a high deductible with a health savings account (HSA) to motivate consumer accountability for healthcare spending
- Generally offers care coordination and cost-sharing tools

Variable Restriction
Variable Costs

Source: "Health insurance plan & network types: HMOs, PPOs, and more," Healthcare.gov, https://www.healthcare.gov/choose-a-plan/plan-types/; Beaton T, "What are the Pros and Cons of Consumer Directed Health Plans?" HealthPayer Intelligence, https://healthpayerintelligence.com/news/what-are-the-pros-and-cons-of-consumer-directed-health-plans; Health Plan Advisory Council interviews and analysis.

It All Comes Down to Price

Distilling Complex Care Decisions into Dollars

Plan Methods for Signaling 'Correct' Choices to Members

CARE DECISION ATTRIBUTE	PLAN FOCUS	SAMPLE PLAN ACTIVITIES
	Out-of-Pocket Cost	*Transparency tools assist members in quantifying out-of-pocket costs among options*
	Discounted Premiums	*15% reductions in premiums for narrower-network products*
	Direct Rewards	*$50 Visa® gift card available for selecting a plan-preferred PCP*

Source: Health Plan Advisory Council interviews and analysis.

You're Hired!—As Your Own Care Navigator

Navigating Care a Full Time Job for Members

Plan Member Job Description

HIRING: Health Plan Member

The purpose is to navigate the health system for care that is both high quality and low cost

Responsibilities:

- **Identify appropriate treatment and provider**
  - Review quality information about providers
  - Inform treating providers about benefit considerations
  - Seek second opinions on treatment plan
- **Contact providers to schedule appointments**
  - Utilize provider finder tools and directories
  - Alter schedule to fit into provider's availability
  - Travel to and from appointment and be prompt
- **Calculate out-of-pocket costs from benefit design**
  - Understand health plan contract
  - Read mail from plan on any updates
  - Understand multiple EOBs[1] and billing statements

Apply Now

Navigation Skill Only Comes with the Practice No Member Should Need to Have

"People who are good at navigating health care are spending their whole days doing that"

Charu Juneja, Design Director

Design Institute for Health

Dell Medical School at the University of Texas

1) Explanation of benefits.

Source: AHIP Institute & Expo 2017; Health Plan Advisory Council interviews and analysis.

If At First You Don't Succeed, Keep Texting

Recurring Reminders Keep Care Options Top-of-Mind

Lily Health Plan's[1] Savings Reminder Messaging Strategy

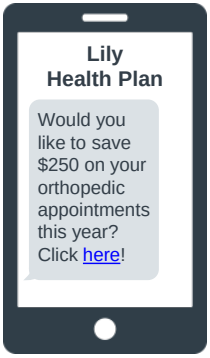
TYPICAL PLAN OUTREACH | ADDITIONAL OUTREACH POINTS

Provider Selection — *Appointment 1* — *Appointment 2* — *Appointment 3* — *Appointment 4*

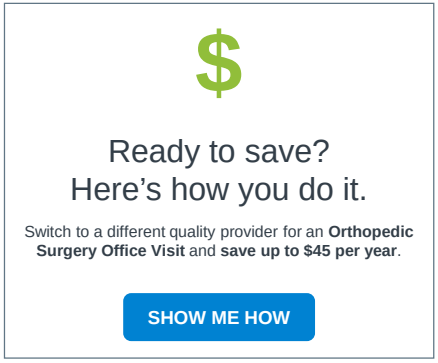
Ongoing Reasons to Change Provider

- Clinician relationship
- Location, hours
- Services and amenities
- Affordability
- Appointment delays
- Treatment outcomes

Text Alerts



Email Alerts



1) Pseudonym.

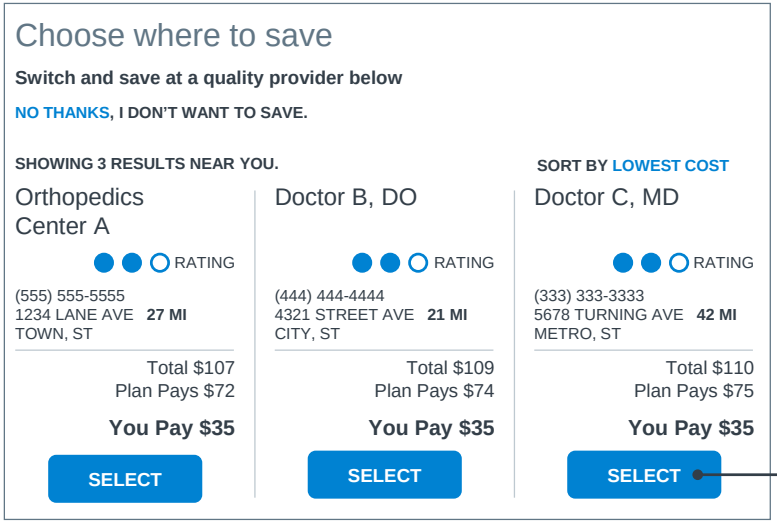
Source: Health Plan Advisory Council interviews and analysis.

Comparative Savings

Guided Steps Trigger Switching to More Affordable Providers

Features of Lily Health Plan's[1] Savings Messages

Clear Comparison of Options



Easy Next Steps

We're happy to help you choose a more affordable orthopedic provider! To switch, please contact:

(333) 333-3333
(Doctor C, MD)

You can tell them the following:

Hi, I am in the middle of therapy for my lower back and my insurer, Lily Health Plan, has provided me with cost estimates to let me know I may have savings with your office. Can I set up an appointment?

Alerts opened, February to April 2016

1) Pseudonym.

Source: Health Plan Advisory Council interviews and analysis.

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Source: Health Plan Advisory Council interviews and analysis.

Network Spend at the Core of Our Cost Conundrum

Health Plan Leaders Echo Same Cost Concerns

Network Management Leaders Bemoan Their Network Performance

> **Utilization is too high**. We're not getting integrated care at the level we want.

> Our hospital owners are still about trying to **fill beds**.

> If we aren't able to solve our network cost problem, we'll go **out of business**.

> We struggle with getting enough providers who are **high quality and low-cost**.

> "Unless you can bring Avocado Health System[1] in, you can't meet network adequacy standards where we want to expand. But their rate demands don't meet what we can finance. So we'll have to be **satisfied without growing** until Avocado is willing to manage under a budget."
>
> Senior Vice President, Medicare Advantage Plan

1) Pseudonym.

Source: Health Plan Advisory Council interviews and analysis.

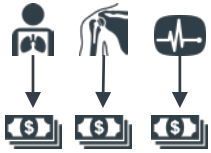
Health Care Payment Models in a State of Flux

Spectrum of Payment Methodologies to Shift Provider Business Strategy

Current State

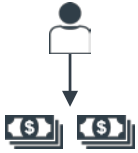
Fee-For-Service

Providers Receive Payment Per Service Provided



Population Health & Value-Based Care

Providers Receive Payment Per Patient

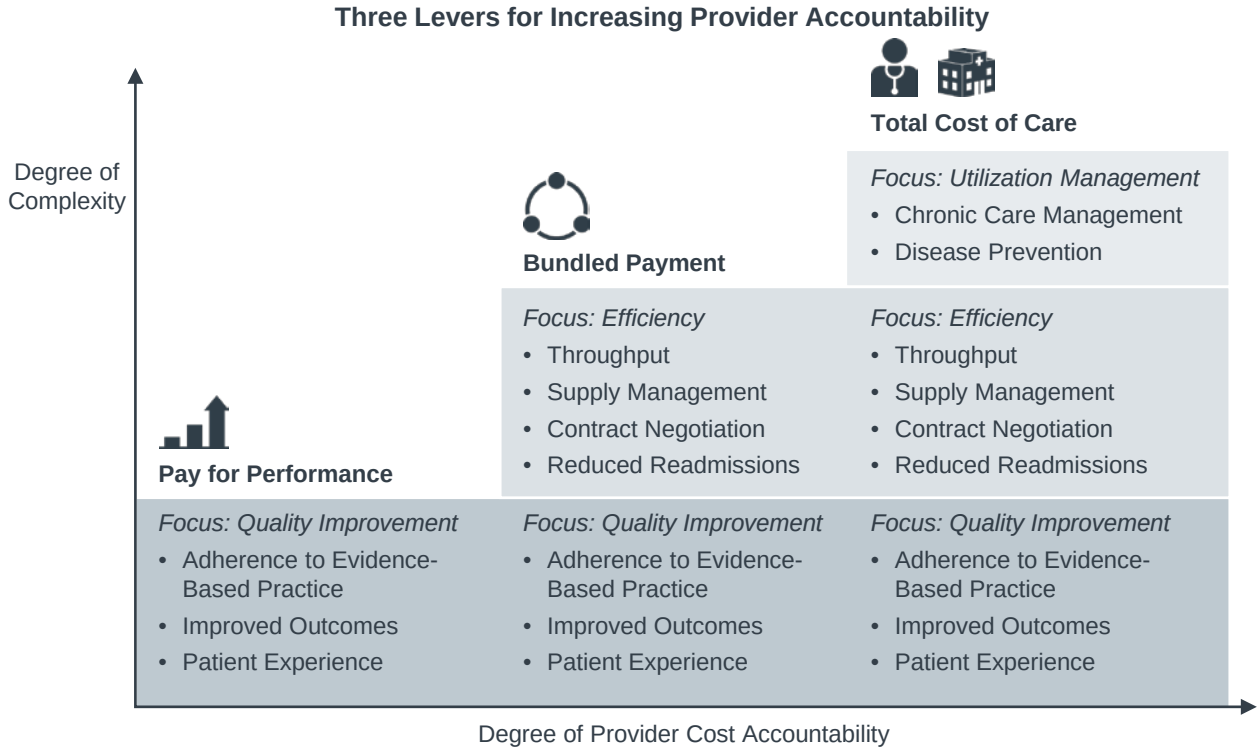


	Fee-For-Service	Population Health & Value-Based Care
Provider strategy	**Grow by being bigger:** Securing volumes and extracting price increases cornerstone of growth	**Grow by being better:** Effectively manage chronic conditions to become a high-quality caregiver of choice for patients and employers
Key provider success drivers	• Increase utilization • Strengthen service lines • Exert pricing leverage	• Expand access • Compete on outcomes • Minimize total cost
Provider performance metrics	• Discharges • Service line share • Fee-for-service revenue	• Share of lives • Geographic reach • Risk-based revenue

Source: Advisory Board interviews and analysis.

New Payment Models Strive to Change Incentives

An Overview of Accountable Payment Models

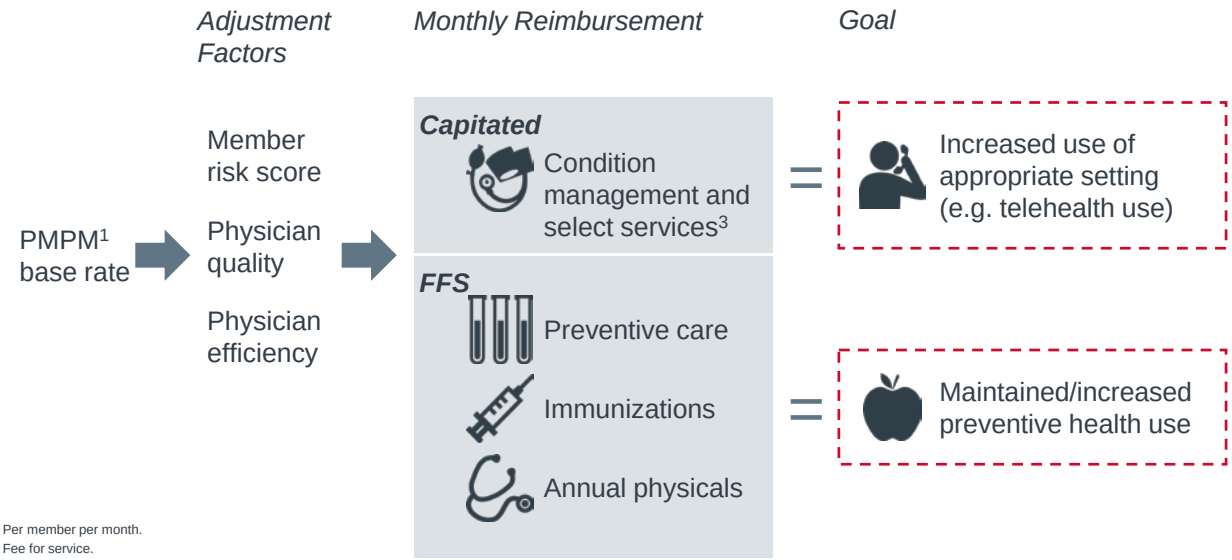


Source: Centers for Medicare and Medicaid Services; Advisory Board interviews and analysis.

FFS is Fee-for-Value for the Care You Want

Hybrid FFS-Capitated Reimbursement Reinforces Appropriate Care

HealthNow Primary Care FFS[2]-Capitated Reimbursement Model



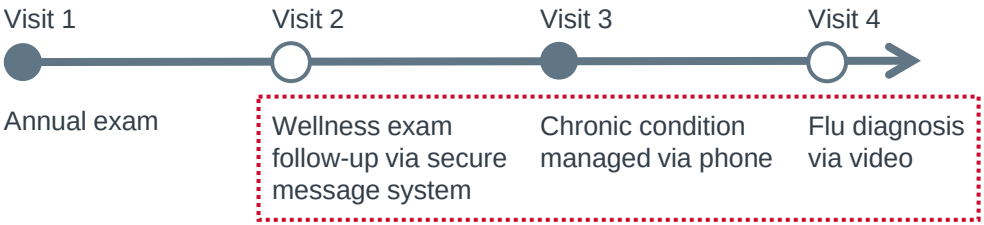
1) Per member per month.
2) Fee for service.
3) Capitated codes include the following code types: allergy testing/immunotherapy, evaluation and management, EKG, hearing and speech exams, lab, non-classified, ophthalmology, pulmonology and radiology-non MRI.

Source: HealthNow New York Inc., Buffalo, NY; Health Plan Advisory Council interviews and analysis.

Save Time and Money for Members and Physicians

Capitation Encourages Physicians to Manage Members In Right Setting

Member Visits Converted to Clinically Appropriate Setting



1400

Number of physicians participating in model

Sources: HealthNow New York, Inc., Buffalo, NY; Health Plan Advisory Council interviews and analysis.

More from the Health Plan Advisory Council

Key Strategic Objectives for Health Plans

Objective	*Key Health Plan Advisory Council Resources*
 **Grow and retain membership**	**Services Preference Portal** Understand what services consumers want most from their plan **Health Plan Precision Investment Timing** A strategic discussion guide for adapting to future market disruption
 **Drive appropriate utilization**	**How to Influence Where Members Seek Care** Five ways health plans can change the decision-making environment **The 10-minute HRA Makeover** A guide to better data from more members
 **Contract efficient, high-quality providers**	**Population Health Delegation for Value-Based Performance** How to transfer historically plan-held responsibilities to providers **Care Management Readiness Audit** Tool for measuring providers' care management capabilities

Contact us at hpac@advisory.com for access to these and more resources to address these health plan priorities

Source: Health Plan Advisory Council interviews and analysis.

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How Does the ACA Affect Health Plans?

Key Impacts of the Revised Affordable Care Act (ACA) on Health Plans

PROVISIONS

Individual Mandate Repeal[1]

Requirements for larger employers to offer coverage *(but individual requirements to obtain qualifying health insurance repealed)*

Health Insurance Marketplaces[2]

Government-supported venues where individuals and small businesses can buy insurance; subsidies available

Medicaid Expansion

Extension of Medicaid eligibility to include individuals and families with incomes up to 133% of FPL[3] in states opting to do so

IMPACTS ON PLANS

- Confusion over coverage regulations
- Enrollment Drop

- Competition for members
- Expensive, risky member pool

- Increased market size
- Less risky member pool

1) Takes effect beginning in 2019
2) Also referred to as "exchanges".
3) Federal poverty level.

Source: Taccihino A, "What the New Tax Law Means for Health Care, Individual Mandate," AccountingWeb, February 9, 2018, https://www.accountingweb.com/tax/business-tax/what-the-new-tax-law-means-for-health-care-individual-mandate; Health Plan Advisory Council interviews and analysis.

How Does the ACA Affect Health Plans? (Cont.)

Key Impacts of the Affordable Care Act (ACA) on Health Plans

PROVISIONS

Premium Stabilization Programs

Initiatives to enable market stability and promote appropriate competition (risk corridors and reinsurance ended; risk adjustment remains permanently)

Health Insurance Tax (HIT)

Tax on all health insurers based on net premiums written, graduating up over time; implementation delayed until 2020

Provider Payment Transformation

New population health- and risk-based payment structures imposed in Medicare, Medicaid, and CHIP, to reduce costs and increase quality

IMPACTS ON PLANS

- Alleviate initial excess costs
- Uncertain profitability
- Increased premium rates
- Adverse selection
- Providers under reform pressure
- Broad provider interest in risk

Source: Mangan D, "ACA health insurance tax would be delayed 2 years under bipartisan bill," CNBC, January 23, 2018, https://www.cnbc.com/2018/01/23/obamacare-taxes-were-suspended-in-deal-to-end-government-shutdown.html; Morse S, "CMS to Continue Risk Adjustment Payments to Insurers," Healthcare Finance, July 25, 2018, https://www.healthcarefinancenews.com/news/cms-continue-risk-adjustment-payments-insurers; Health Plan Advisory Council interviews and analysis.

How to Buy Less for Less

Consumers Likely to Reduce Coverage to Save in the Present

Regulatory Actions Give Flexibility to Individuals

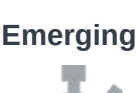
- **Individual Mandate:** Tax Cuts and Jobs Act of 2017 repealed the Affordable Care Act's (ACA) individual mandate penalty, effective for 2019
- **Short-Term Health Plans (STHPs):** HHS final rule in 2018 extended maximum duration to 3 years for STHP policies, which are not required to meet ACA coverage and eligibility requirements
- **Association Health Plans (AHPs):** HHS final rule in 2018 broadened access and eased restrictions on coverage and premium rating

15%
Compound annual growth in individual marketplace benchmark premium rates, 2014-2018

Changing Enrollment Outlooks with Emerging Coverage Options

3-6M
Expected **reduction in enrollment** by 2021 due to repeal of individual mandate

3-10%
Healthy consumers that could **defect from ACA to AHPs**



1.6M
Projected **STHP enrollment**, 2021

Expert Predictions for AHPs, STHPs

ADVOCATES Enable more **consumer choice and lower costs**

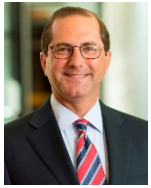
CRITICS Cause **adverse risk pools** and **consumer surprises**

Source: Healthcare Finance, "Up to 10% of healthy consumers could defect from ACA to association health plans, study shows"; Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028"; The Washington Post, Trump administration widens availability of skimpy, short-term health plans; Collins SR, "First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse," To the Point Blog, May 1st, 2018; Congressional Budget Office, Washington, D.C.; King R, "The Obamacare individual mandate is repealed. Here's what's next," The Washington Examiner, January 14, 2018.; Andrews M, Read The Fine Print Before Picking An Association Plan For Your Small Business, *NPR*, June 27, 2018; Health Plan Advisory Council interviews and analysis; https://www.healthleadersmedia.com/finance/short-term-health-plans-allowed-3-years; https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D .

A New Era for Medicare and Medicaid

Current Administration Setting a Higher Performance Bar

Alex Azar and Seema Verma Lay Out Four-Pronged Regulatory Agenda



- Reduce burdensome regulations
- Promote patient control of health data (0101 1100 1111)
- Encourage greater transparency
- Advance value-based models

Key Observations

Coverage expansion and coverage reform no longer a top federal priority, increasingly delegated to state governments

The administration is taking an unsentimental, performance-focused approach to **delivery system reform via payment reform**

Source: Azar A, "Remarks on Value-Based Transformation to the Federation of American Hospitals," *HHS,* March 5, 2018; Health Care Advisory Board interviews and analysis.

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Join Us for More in this Webconference Series

Understanding the Health Insurance Business: Commercial Insurance
Thursday, September 13, 2018
3:00 PM ET - 3:30 PM ET
In this session, the presenter will explore the commercial side of health insurance and review current policy and market trends that shape health plan strategic decisions.

Understanding the Health Insurance Business: Medicare Advantage
Wednesday, September 19, 2018
3:00 PM ET - 3:30 PM ET
In the final session of the series, the presenter will provide an in-depth review of Medicare's privately-administered Medicare Advantage (MA) program, highlighting some of the current policy shifts within the MA industry.

Understanding the Health Insurance Business: Medicaid Managed Care
Tuesday, September 25, 2018
3:00 PM ET - 3:30 PM ET
In this session of the series, the presenter will discuss key features of Medicaid managed care and address current opportunities and challenges for health plans operating Medicaid managed care business lines.

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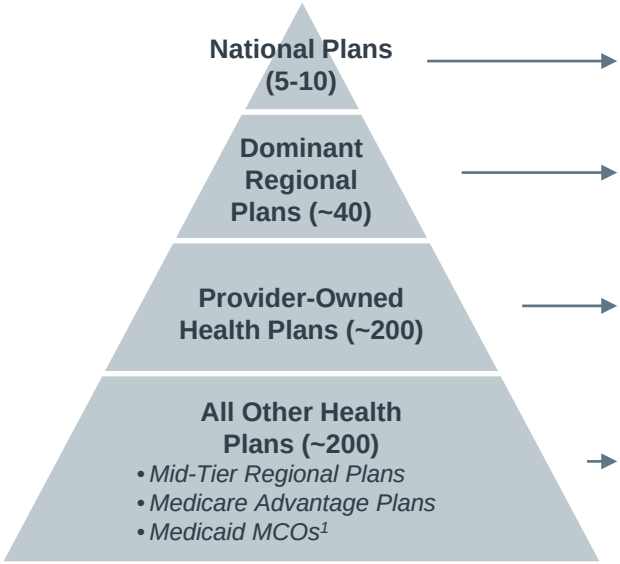
What Kinds of Health Plans Are There?

Breakdown of the U.S. Health Plan Sector



Examples: United, Humana, Aetna, Cigna, Anthem, Centene
Typical size: 5+ million covered lives

Example: Blue Cross Blue Shield
Typical size: 1-2 million covered lives

Examples: Sharp Health Plan, Geisinger Health Plan
Typical size: 50-400K covered lives

Examples: CO-OP Plans, HealthPlus (regional plan in Flint, MI)
Typical size: <100K covered lives

1) Managed care organizations.

Source: "AIS's Directory of Health Plans: 2015," AIS Health; "About Blue Cross Blue Shield Association," BCBSA, http://www.bcbs.com/about-the-association/; Health Plan Advisory Council interviews and analysis.

What Do Health Plans Do?

Major Health Plan Operational Activities

Reimbursement Administration

- Estimate expected care costs of the membership to set premium and reimbursement rates
- Enable members to use their insurance product and pay bills efficiently
- Process claims to reimburse providers for services

Network Management

- Establish a contracted network of providers
- Ensure that providers meet cost and quality performance goals

Medical and Care Management

- Manage the care utilization of the membership by:
  - Preventing avoidable conditions or services
  - Ensuring that cost-effective services are delivered

Business Development

- Design health insurance products that are financially viable and meet purchaser needs
- Attract desired customers and clients, and maintain business relationships

Source: Health Plan Advisory Council interviews and analysis.

What's the "MLR"?

A Mandatory Metric for Plan Performance

Example MLR[1] Calculation Summary

$$\text{MLR} = \frac{\text{Health Expenses}}{\text{Premium Revenue}}$$

Health Expenses

- Incurred claims
- Quality improvement activities[2]
- Certain program integrity activities[3]
- Less deductions[4]

Premium Revenue

- Total premium revenue[5]
- Special life-event payments
- Fines, penalties
- Less deductions[6]
- Credibility adjustment applied[7]

Mandatory Minimum MLRs

85%

- Medicaid managed care
- Medicare Advantage
- Individual
- Small employer group

80%

- Large employer group

1) Medical loss ratio.
2) Includes meaningful use and external quality review.
3) Expenditures related to fraud prevention activities as adopted for the private market at 45 CFR part 158.
4) Deductions include overpayment recoveries received from network providers and prescription drug rebates received.
5) Includes state capitation payments, unpaid cost-sharing amounts, and net payments or receipts to risk sharing mechanisms.
6) Deductions include Community Benefit Expenditures (up to the greater of 3% of premium revenue or the highest premium tax rate), licensing or regulatory fees, and certain taxes.
7) Adjustment is calculated so that a managed care entity would be expected to experience an MLR under the threshold only 25% of the time.
8) Managed care organization.

Source: CMS, Final Rule CMS-2390-F, *Federal Register*, 81 FR 27497; CMS, Proposed Rule CMS-2390-P, 80 FR 31097; "Medicaid MCO Average Medical Loss Ratios," Kaiser Family Foundation, http://kff.org/other/state-indicator/medicaid-mco-average-medical-loss-ratios/; Health Plan Advisory Council interviews and analysis.

The Many Meanings of Risk

Two Often-Mistaken Definitions

Risk = Likelihood of Utilization

"Is this member going to use care?"

Applies to:
Members, market populations, patient panels

Used for:
Actuarial analysis, rate setting (risk adjustment), care management, provider evaluation

Risk = Responsibility for Outcomes

"Who will be financially responsible if this member uses care?

Applies to:
Providers, health plans, purchasers, consumers

Used for:
Value-based payment models, joint ventures, cost sharing

Source: Health Plan Advisory Council interviews and analysis.

Commercial Payments Can Vary Wildly

Itemized Negotiations Foster a "Wild West" for Commercial Payment

One Insurance Company's Payment to Six New Jersey Hospitals

	Normal Delivery	CABG	Appendectomy	Hip Replacement
Hospital A	$2,178	$26,342	$2,708	$3,330
Hospital B	$2,787	$32,127	$2,852	$3,444
Hospital C	$2,906	$34,277	$3,320	$4,200
Hospital D	$3,187	$36,792	$3,412	$4,230
Hospital E	$3,276	$37,019	$3,524	$5,028
Hospital F	$3,629	$45,343	$4,230	$5,787
Range	**$1,451**	**$19,001**	**$1,522**	**$2,457**

Source: "Final Report," New Jersey Commission on Rationalizing Health Care. 2008, available at: http://www.nj.gov/health/rhc/finalreport/documents/entire_finalreport.pdf; Advisory Board interviews and analysis.

Reining in Costs with "Patient Skin in the Game"

High-Deductible Health Plans Encourage Patient Price Sensitivity

Elements of Patient Cost-Sharing

Premium

Monthly amount paid for insurance coverage

Copay

Fixed fee paid per visit to provider

Deductible

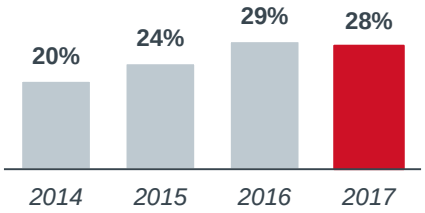
Annual amount owed for care before insurance begins to pay

Coinsurance

Percentage share of remaining costs

OUT-OF-POCKET COSTS

High-Deductible Health Plan Enrollment[1] Among Covered Workers, 2014-2017



Changing Consumer Behavior

23%

Consumers report they are **postponing** care after enrolling in a CDHP[2]

17%

Consumers report they are **sacrificing** care after enrolling in a CDHP[2]

1) Health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage offered with a Health Reimbursement Arrangement (HRA); or high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to an health savings account (HSA).
2) Consumer directed health plan.

Source: "Percentage of Covered Workers Enrolled In an HDHP/HRA or HSA-Qualified HDHP, 2006-2017 9060," Kaiser Family Foundation https://www.kff.org/report-section/ehbs-2017-section-8-high-deductible-health-plans-with-savings-option/attachment/figure%208_5-10/; Aon Hewitt et al, "The Consumer Health Mindset," 2013; Pickens G et al, "Thomson Reuters Healthcare Indexes: Consumer Confidence," Thomson Reuters 2009; Advisory Board interviews and analysis.