LOUISIANA DEPARTMENT OF INSURANCE

HCR 203 of the 2014 Regular Session

HEALTH BENEFIT DEDUCTIBLES

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HCR 203

Health Benefit Deductibles
Louisiana Department of Insurance
January 15, 2015

Introduction

HCR 203 by Representatives Greene and Thibaut urged and requested the Louisiana Department of Insurance (LDI) to study the following issues:

Issue 1. The extent of coverage of Louisiana residents enrolled in individual or employer-sponsored health benefit plans.
Issue 2. The proliferation of health benefit plans containing high enrollee cost-sharing provisions.
Issue 3. The effects of health benefit plans with high cost-sharing provisions on the enrollee's ability to pay and meet: (a) the cost-sharing obligations and (b) the amounts that are left unpaid.
Issue 4. The effects of health benefit plans with high cost-sharing provisions on the ability of health care providers to be paid completely and timely.

Response of LDI Based on Available Information

To fulfill the request of HCR 203, the LDI offers the following available information.

Issue 1. The extent of coverage of Louisiana residents enrolled in individual or employer-sponsored health benefit plans.

Self-funded or self-insured employer-sponsored plans generally are governed by the Employee Retirement Income Security Act of 1974 (ERISA) as employee welfare benefit plans (Section (3)(1)) or employee pension benefit plans (Section (3)(2)).[i] The regulation of such employer-sponsored, self-insured, group plans is, in large part, not left to the LDI. Populations of insured persons such as those enrolled in health benefit plans offered by the Office of Group Benefits (OGB) and other large employer groups who offer health benefits plans as part of employee welfare benefit plans or employee pension benefit plans and/or who are self-funded are not subject to the LDI's jurisdiction. Thus, the ability of the LDI to obtain information on employer-sponsored plans is limited to those employer-sponsored plans that are fully-funded large group or small group plans. Similarly, the LDI does not regulate the Medicaid and Medicare programs that provide health benefits to a portion of Louisiana's population.

Thus, the information that is reported below is limited to fully-funded health benefit plans in the individual and group markets that are subject to the LDI's jurisdiction and the report data pursuant to Revised Directive 205.[1] Revised Directive 205 was issued by the LDI on November 27, 2013, and requires annual reporting of the information described in items (A) to (C) set forth below by March 1 of each year

[1] Revised Directive 205 is available at the following link: https://ldi.la.gov/docs/default-source/documents/legaldocs/directives/Dir205-Cur-InstructionsForDiscov

from all health insurance issuers and health maintenance organizations. The information submitted in the Revised Directive 205 annual reports must be current as of December 31 of the preceding year.

A. All health insurance products currently in force in the individual, small group, and large group markets categorized by the grandfathered, non-grandfathered, or transitional status of the products (identified by SERFF tracking numbers or LDI state tracking numbers). These figures include reported student health plans that are included in the individual market reporting.
B. The number of covered lives for each product and market type identified in (A.) above.
C. The number of policies for each product and market type identified in (A.) above.

Pursuant to Revised Directive 205, the most recent submission of data was made in July 2014 and is current as of April 30, 2014. Health insurance issuers are not required to furnish information for the remainder of 2014 until March 1, 2015. Thus, the data for the 2014 year will not be available until after the deadline for HCR 203 passes.

Based on the July 2014 data submissions, the following information on the numbers of covered lives enrolled in the grandfathered markets (individual, small group, and large group) and non-grandfathered markets (individual, small group, and large group) is available for the period ending April 30, 2014. Also available are the percentages of covered lives enrolled in grandfathered versus non-grandfathered products and plans and the decreases and increases in the percentages of covered lives enrolled in grandfathered and non-grandfathered products between July 1, 2013, and April 30, 2014.

A group health plan or group or individual health insurance coverage is a grandfathered health plan with respect to persons enrolled on March 23, 2010.[ii] A health benefit plan with a grandfathered status does not have to meet all of the requirements of the Affordable Care Act or the ACA (the common name for the Patient Protection and Affordable Care Act and the Health Care and Reconciliation Act of 2010). For example, a grandfathered plan is not required to provide all ten categories of essential health benefits. Additional family members may enroll in grandfathered coverage, and new employees may enroll in grandfathered group coverage. Conversely, any of the following actions can cause a grandfathered health plan to lose its grandfathered status and force persons to obtain coverage in a plan that has non-grandfathered status:

- Elimination of benefits to diagnose or treat a particular condition;
- Any increase in percentage of cost-sharing requirements;
- An increase in fixed-amount cost-sharing other than a copayment (such as a deductible) of more than medical inflation plus 15%;
- An increase in a copayment of more than medical inflation plus 15% or $5 increased by medical inflation, whichever is greater;
- A decrease in the proportion of premiums paid by the employer of more than 5%;
- Addition of an annual limit on benefits if the plan had neither an annual nor lifetime limit in place on March 23, 2010;
- Addition of an annual limit that is lower than the lifetime limit the plan had in place on March 23, 2010; or
- Decrease to an annual limit that was in place on March 23, 2010.

The data available from the July 2014 submissions to Revised Directive 205 are as follows:

Grandfathered Market- July 2014 Data Submission (Current through April 30, 2014)				
	Individual	**Small Group**	**Large Group**	**Total**
Number of Covered Lives	66,789	95,399	112,513	274,701
% Change in Enrollment from July 1, 2013 Reports	- 60.9%	- 50.8%	- 46.5%	- 54.2%

Non-Grandfathered Market- July 2014 Data Submission (Current through April 30, 2014)				
	Individual	**Small Group**	**Large Group**	**Total**
Number of Covered Lives	157,498	122,440	178,211	452,149
% Change in Enrollment from July 1, 2013 Reports	+ 49.3%	+ 25.0%	+ 27.3%	+ 34.0%

The data shows a marked decrease in enrollment in grandfathered plans and shows a close distribution of enrollees in the non-grandfathered individual, small group, and large group markets, with more enrollees in the small group and large group markets than the individual market. This data suggests that in Louisiana there is greater enrollment in employer-sponsored, fully-insured small group and large group plans than in the individual plans. However, there is not data available to differentiate which exact portion of the reported small groups and large groups are employee-sponsored groups.

Issue 2. The proliferation of health benefit plans containing high enrollee cost-sharing provisions.

Issue 3. The effects of health benefit plans with high cost-sharing provisions on the enrollee's ability to pay and meet: (a) the cost-sharing obligations and (b) the amounts that are left unpaid.

Issue 4. The effects of health benefit plans with high cost-sharing provisions on the ability of health care providers to be paid completely and timely.

To address the issue of cost-sharing, the following information is provided because the LDI does not have data that directly addresses the information sought in Issues 2 to 4.

Cost-sharing is defined in the ACA at Section 1302(c) and 45 C.F.R. 155.20 as "any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services." (Emphasis supplied.) Thus, for the purposes of the ACA, the term cost-sharing is linked to the provision of essential health benefits. However, in general usage, the term cost-sharing has a similar meaning with respect to health benefits offered under any type of plan, even those that do not have to provide all categories of essential health

benefits (grandfathered and transitional plans). The term cost-sharing commonly includes deductibles, coinsurance, copayments, and other similar charges, but does not include premiums, non-network charges, or charges for non-covered services.

In the 2015 benefit year, for all plans except grandfathered individual market plans, the ACA has established annual limits on cost-sharing of $6,600 for self-only coverage and $13,200 for other than self-only coverage.[iii] Amounts paid in cost-sharing for benefits from in-network or contracted providers apply towards the cost-sharing limitation while amounts paid as cost-sharing for benefits from out-of-network or non-contracted providers do not count towards the cost-sharing limitations.[iv] This limit on cost-sharing is reviewed annually and adjusted by United States Department of Health and Human Services (HHS) in the Notice of Benefit and Payment Parameters and rounded to the next lowest multiple of $50. The final version of the Notice of Benefit and Payment Parameters that will set the cost-sharing annual limit for the 2016 benefit year has not yet been promulgated.

Moreover, Section 2713 of the Public Health Service Act requires that plans provide coverage without cost-sharing for the following preventive health services:

- Services recommended by the US Preventive Services Task Force.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control.
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration.
- Preventive care and screenings for women supported by the Health Resources and Services Administration.[v]

Also, emergency services provided by non-participating (non-contracted) providers must be provided with cost-sharing that is no greater than that which would apply for a participating (contracted) provider and without regard to any restriction other than:

- An exclusion or coordination of benefits,
- An affiliation or waiting period, and
- Cost-sharing.[vi]

Because all plans, except grandfathered individual market plans, are subject to the cost-sharing limitations described herein and required by 45 C.F.R. 156.130, the information from Directive 205 can indicate that as of April 30, 2014, there were approximately 660,061 insureds in Louisiana that would be subject to the cost-sharing limits of $6,600 for self-only coverage and $13,200 for other than self-only for essential health benefits provided by participating (contracted) providers for the 2015 benefit year. With respect to Issues (3) and (4), the LDI does not have additional information available to respond to these requests. Any calculations or figures would not be supported by adequate data and, thus, none are provided.

HCR 203 Additional resources

http://kff.org/

While there is no information currently on the Kaiser Family Foundation website regarding the impact of high deductibles on patients and their health care providers, the KFF is a trusted source of current data on national health issues. The website provides helpful information to public policy members and to the public at large and includes state-by-state comparisons on health coverage and the uninsured, health costs and budgets, and other relevant topics at http://kff.org/statedata/.

http://www.usatoday.com/story/money/personalfinance/2013/09/24/high-deductible-health-care-plans/2848181/

To the extent high deductible plans are coupled with health savings accounts or flexible spending accounts, the financial impact of unexpected medical events is reduced and health care providers are paid timely. This article explores the plusses and minuses of such use-it-or-lose-it accounts.

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[i] 29 U.S.C. §1002.
[ii] ACA Section 1251 and 45 C.F.R. 147.140.
[iii] 45 C.F.R. 156.130.
[iv] 45 C.F.4. 156.130.
[v] 45 C.F.R. 147.130
[vi] 45 C.F.R. 147.130

ENROLLED

Regular Session, 2014

HOUSE CONCURRENT RESOLUTION NO. 203

BY REPRESENTATIVES GREENE AND THIBAUT

A CONCURRENT RESOLUTION

To urge and request the Louisiana Department of Insurance to study the issue of the extent of coverage of Louisiana residents enrolled in individual or employer-sponsored health benefit plans, the proliferation of benefit plans containing high enrollee cost-sharing provisions, and the effects of those plans on enrollees and providers relative to the ability of enrollees to meet those obligations and the amounts that are left as unpaid, as well as the process and timing involved with patients and providers obtaining health benefit deductible accumulation and the timing of claims payment and deductible accumulation within health benefit plans.

WHEREAS, many of the health benefit plans on the market today contain high-deductible provisions relative to enrollee responsibility; and

WHEREAS, because of these provisions and potential lack of understanding these complex policy provisions, enrollees are faced with rising costs and healthcare providers are faced with rising amounts of uncollectible patient responsibility and growing administrative costs as a result of trying to collect these amounts; and

WHEREAS, it is in the public interest for the Legislature of Louisiana to have a greater understanding of the health insurance market today, its effects on consumers and providers, and areas where administrative simplification opportunities may exist.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby urge and request the Department of Insurance to conduct a study of the extent of coverage of Louisiana residents enrolled in individual or employer-sponsored health benefit plans, the proliferation of health benefit plans containing high enrollee cost-sharing provisions, and the effects of those plans on enrollees and providers relative to the ability of enrollees to meet those obligations and the amounts that are left unpaid.

BE IT FURTHER RESOLVED that the Legislature of Louisiana does hereby urge and request the Department of Insurance to include in such study the process and timing involved with patients and providers obtaining health benefit deductible accumulation and the timing of claims payment and deductible accumulation within health benefit plans.

BE IT FURTHER RESOLVED that the Department of Insurance shall submit its findings from the study in the form of a report to the House Committee on Insurance and the Senate Committee on Insurance on or before January 15, 2015.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the commissioner of insurance, the Louisiana Association of Health Plans, the Louisiana Hospital Association, and the Louisiana State Medical Society.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE