Insurance 101

- Fawn Barrie, Moda Health
- Richard Blackwell, PacificSource Health Plans
- Mary Anne Cooper, Regence BlueCross BlueShield of Oregon

What is our role?

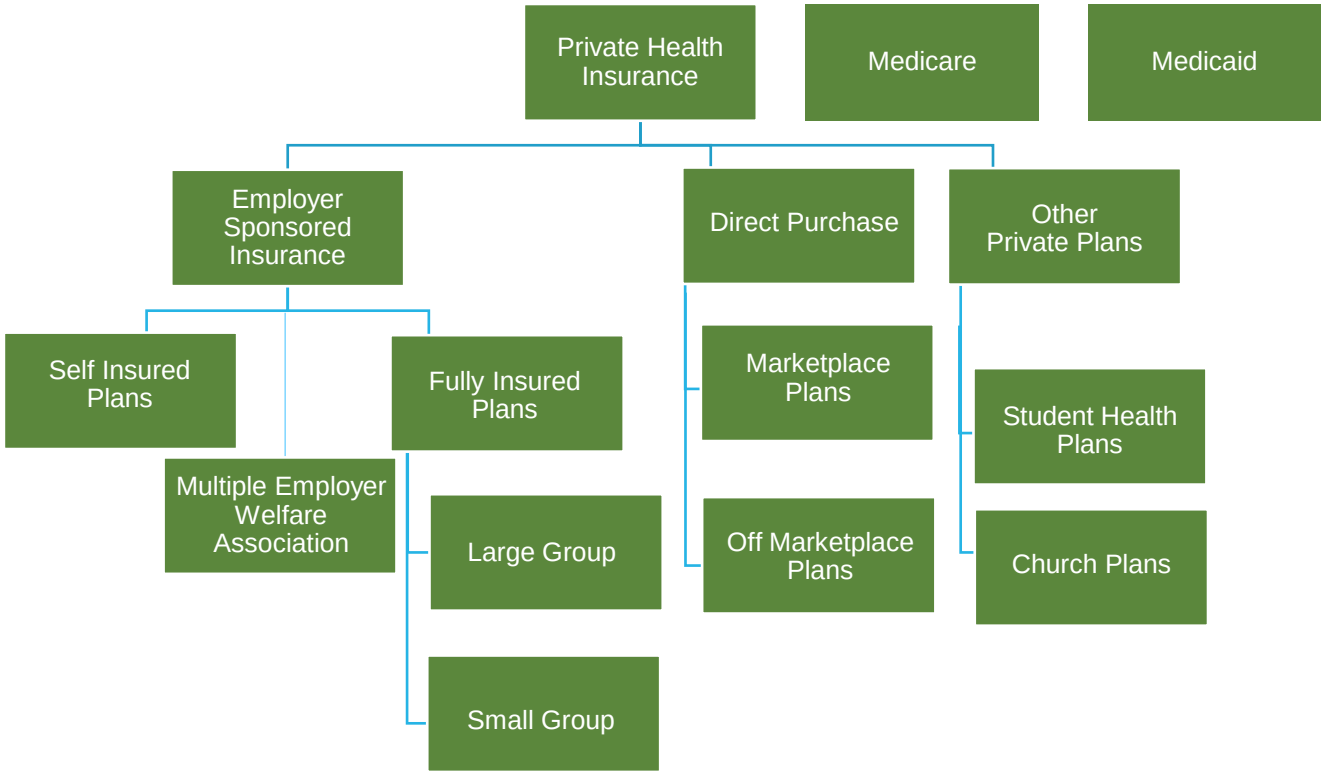
Ensure member access - to the right care, at the right time, at the right cost, in the right place with trusted providers.

Steward member dollars responsibly – as our costs go up, so do our members'. As a result, we contract competitively so each premium dollar can go as far as possible.

Innovate and reinvent – our work evolves as with our members and their needs. We are committed to transformation, for the good of our members and our state.

Simplify the health care system – we are invested in the experience of our members. We all want simple, more affordable health care.

Insurance Landscape: Health Care Lines of Business (LOBs)



Plan Types Within LOBs:

- Preferred Provider Organization (PPO): Broad networks, including specialist services. Has higher premiums but lower out-of-pocket costs.
- Health Maintenance Organization (HMO): Narrower networks, no coverage for non-emergency out-of-network services. Lower premiums and deductible; lower OOP costs compared to PPO.
- Point of Service (POS): Hybrid PPO or HMO that member can choose at each encounter.
- Qualified High Deductible Health Plan (HDHP) with Health Savings Account (HSA): Plans can be an HMO, PPO, or Point of Service but must meet certain federal guidelines. Includes HSA eligibility; typically have lower premiums and a higher deductible. Plans with higher deductibles may cover at 100% once the deductible is met.

Source: Kaiser Family Foundation Health Policy 101. Available at: https://www.kff.org/health-policy-101/. Accessed July 2, 2024

Different Types of Health Insurance Lines of Business

Type of Insurance	Description	Plan sponsor's role	Benefits
Fully Insured	Individual/employer purchases health insurance plan and insurer assumes financial risk.	Pays a fixed premium; insurer manages claims, provider networks, and customer service.	Predictable costs for sponsor, less administrative burden, and uses insurer's expertise.
PLANS POTENTIALLY SUBJECT TO FEDERAL OVERSIGHT/LIMITED STATE OVERSIGHT			
Self-Insured (Self-Funded)*	Sponsor assumes the financial risk for employee health care costs.	Responsible for plan's design and employee cost share. May contract with a TPA or PBM to handle administrative tasks and claim processing.	Potential cost savings if claims experience is favorable, more flexibility in plan design, and the ability to retain unused premiums.
Level-Funded (Self-Funded)*	Hybrid approach; sponsor pays a fixed monthly fee, covering administrative costs and a portion of estimated claims. If claims exceed the estimate, insurer covers difference. If claims are lower, employer may receive a refund.	Pays a monthly fee and assumes some risk.	More cost control than fully insured plans, but less risk than self-insured plans.
Administrative Services Only (ASO)*	Sponsor self-insures its health plan but contracts with an insurance company or TPA to provide administrative services (e,g., claim processing, provider network, customer service).	Pays for claims and administrative costs.	Allows sponsor to retain the financial advantages of self-insurance while outsourcing administrative tasks.

* While exact numbers fluctuate, estimates suggest that a significant portion of Oregonians, potentially exceeding 50%, are covered under some form of self-funded plan. Administrative Services Only (ASO) arrangements are commonly used by self-funded plans in Oregon.

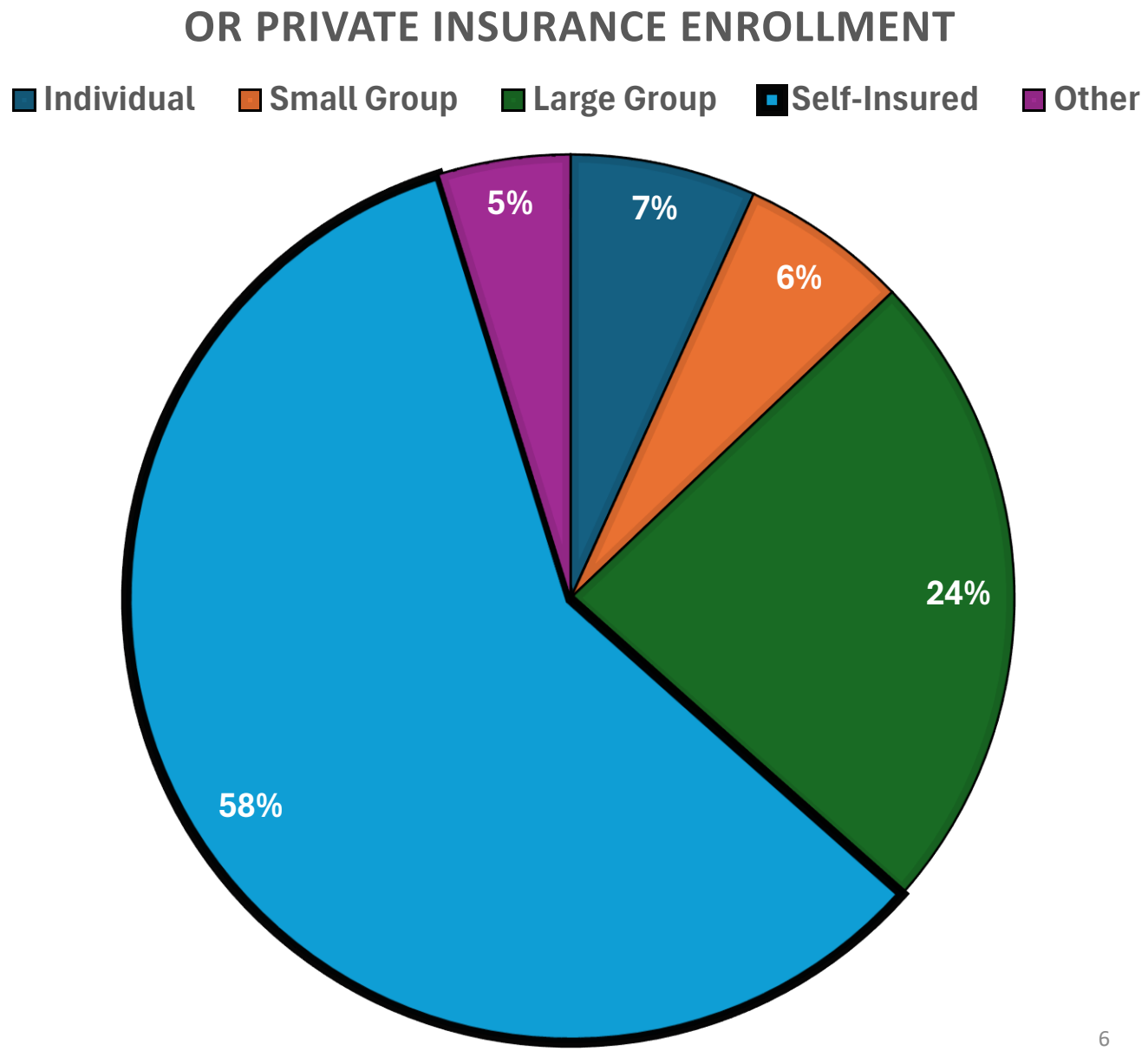
Oregon Insurance Market Overview

Type of Health Insurance	Estimated Percentage of Insured Population (Oregon, 2023)
Employer Provided (Fully and Self-Insured)	44%
Individual/Small Group (ACA-Compliant)	9%
Medicare (including MA)	17%
Medicaid	30%

Source: AHIP Health Coverage: State-to-State (2023). Accessed Jan. 16, 2025

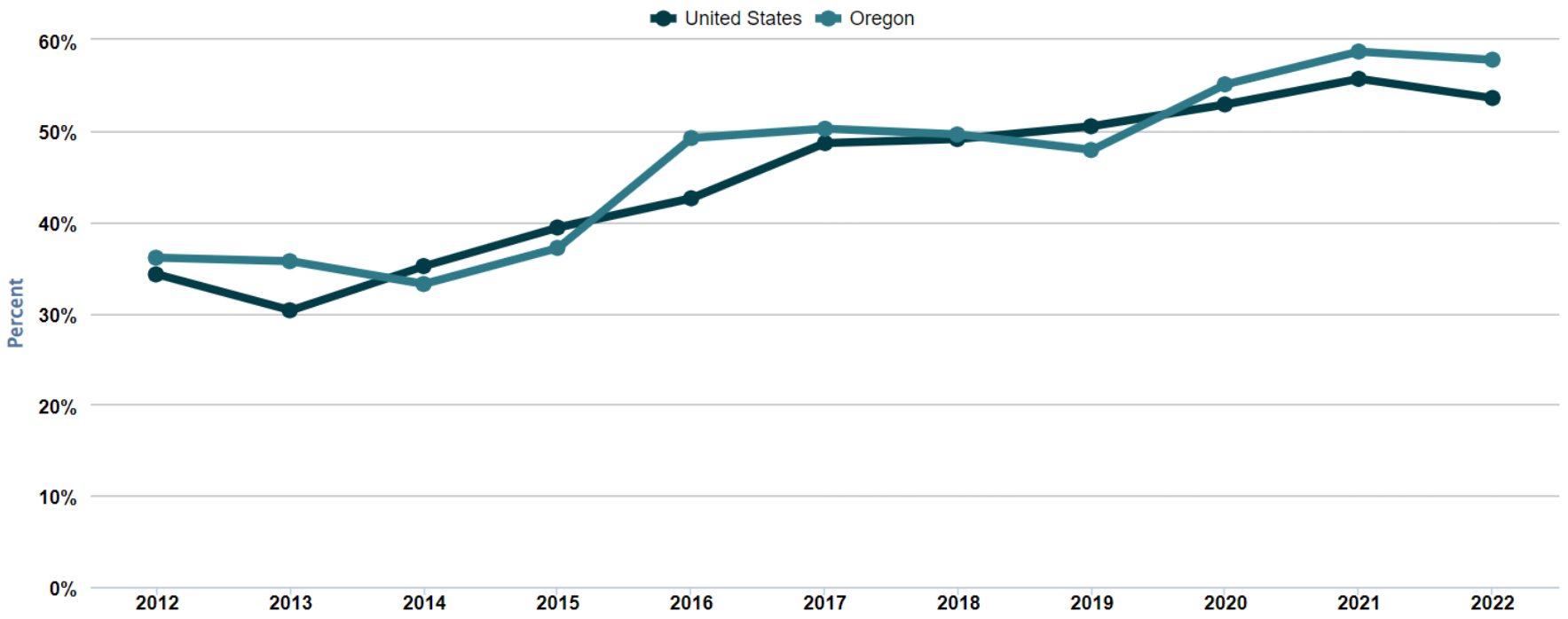
Insurance Landscape: OR Enrollment by Payer Type

- Self-insured plans comprise most of the private insurance enrollment in Oregon. These plans are not subject to state-level insurance mandates.
- Within the fully-insured market that can be state-regulated, there are many plan types. This results in varied consumer sensitivity to pricing changes.
- Increased prices pass through to the consumer. As we assess solutions, it is vital to keep an eye to consumer affordability and equitable access.



Source: Division of Financial Regulation 2024 Quarterly Enrollment Data (Q3). https://dfr.oregon.gov/business/reg/reports-data/annual-health-insurance-report/Pages/health-ins-enrollment.aspx. Accessed: Jan. 16, 2025

Insurance Landscape: Oregon HDHP Enrollment



Growth of HDHP Enrollment Over Time Among Private Employee Members

- Source: State Health Access Data Assistance Center. Percent of private-sector employees on high deductible health plans. Available at: https://statehealthcompare.shadac.org/trend/172/percent-of-privatesector-employees-enrolled-in-highdeductible-health-insurance-plans-by-total#0/1,39/a/5,6,7,8,15,24,25,27,32,37,42/205. Accessed July 16, 2024.

High Deductible Health Plans (HDHP)

	Upside	Downside
Consumers	• Lower monthly premiums • Potential for tax savings with HSAs • More control over healthcare spending • Potential for member savings if members choose lower-cost options	• Higher out-of-pocket costs if significant medical care is needed • Risk of delaying or avoiding care due to high deductibles • Potential financial strain if unexpected medical expenses arise
Payers	• Lower claims costs (including Rxs) • Increased enrollment	• Can lead to higher-than-expected claims costs based on utilizing population • Potential for backlash if consumers feel the plan is inadequate if they require care • Lower prescription adherence

FSAs and HSAs

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) can both be used to pay for prescription drugs. They offer tax advantages to help consumers save money on healthcare expenses.

FSAs	HSAs
• Offered through employers only.	• Available to individuals enrolled in high-deductible health plans (HDHPs).
• Members can set aside pre-tax dollars to cover eligible medical expenses, including prescription drugs.	• Members can contribute pre-tax dollars to cover qualified medical expenses, including prescriptions.
• Funds can be used throughout the plan year.	• Are portable; members own the account and can take it with them if they change jobs.
• Typically have a "use-it-or-lose-it" rule.	• Funds roll over from year to year; no need use them up within a specific timeframe.
• Can use debit card at pharmacy POS or pay out of pocket and submit for reimbursement later.	• Can use debit card at pharmacy POS or pay out of pocket and submit for reimbursement later.

Federal Pre-Emption

ERISA and Medicare

ERISA

- The federal Employee Retirement Income Security Act of 1974 (ERISA) pre-empts some state health care laws for employer-sponsored health plans.
- It serves to standardize benefit plans offered in the self-funded employer market and protect private employee pension plans.

Medicare Advantage

- Federal Medicare Part C regulations contain an explicit preemption provision, where standards within the Medicare regulations supersede state laws and regulations respecting Medicare Advantage (except solvency).

Federal and State Regulatory Oversight of Insurers

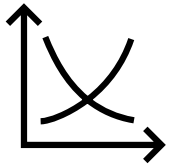
Standards and reporting

Medical Loss Ratio (MLR). Share of total health care premiums spent on medical claims and efforts to improve quality of care; minimum 85% for large employers and 80% for qualified health plans.

Rate Setting. Each year, the DFR reviews health insurance rates in the individual market, involving annual rate reporting and a public hearing.

Network Adequacy. Federal standards exist for qualified health plans on the Exchange, in addition to state-level requirements in the fully insured commercial market.

Reporting. Carriers in Oregon have various mandatory reports, for example the All Payers All Claims database, Prompt Pay reporting, ORSA, and others.



Market Share. Market concentration drives up costs; a diverse health insurance market requires carriers be competitive, negotiating low costs and rich benefits. Preserving Oregon's competitive environment has historically been a priority of the DFR.

Cost Growth Target. Oregon carriers are required to report on their annual cost growth, disaggregated by line of business. Cost growth is held to a 3.4% maximum year to year.

Additional Regulatory Considerations

Essential Health Benefits (EHB) – 10 categories of services that health insurance providers must cover under the Affordable Care Act. Specific services cover vary by state.

Metal Tiers – There are four metal levels (bronze, silver, gold, and platinum) of plans offered on the Marketplace; each tier indicates the amount of member cost share. Regardless of member cost share, all EHBs must still be covered. State-regulated standard plans we must offer also follow metal level tiers.

Reserves Requirements - All carriers are required to maintain healthy reserves to ensure that insurers can always cover unexpected events without having to ask for General Funds or disrupt member coverage and care. For not-for-profit insurers, this is the only resource they have to cover unexpected events (pandemics, natural disasters, etc.) due to their non-profit structure.

Cost Growth Trends

Key drivers and mitigation tools

PHARMACY

Pharmaceuticals are a primary driver of health care costs; from 2022-2023, drug costs increased 15.2% nationally[1].

Specialty drugs make up a large portion of that. Oregon's 2024 Drug Price Transparency Report shows spending averaged $7,296 per enrollee on specialty drugs compared to $42 per enrollee for generics for individuals with drug spend.[2]

UTILIZATION: RX & MEDICAL

Expanded indications for use of pharmaceuticals, largely in the specialty and high-prevalence condition space, contribute to increased utilization and costs.

Utilization review is a tool to ensure that treatments are evidence based and accessible to members at the right time, place, and cost.

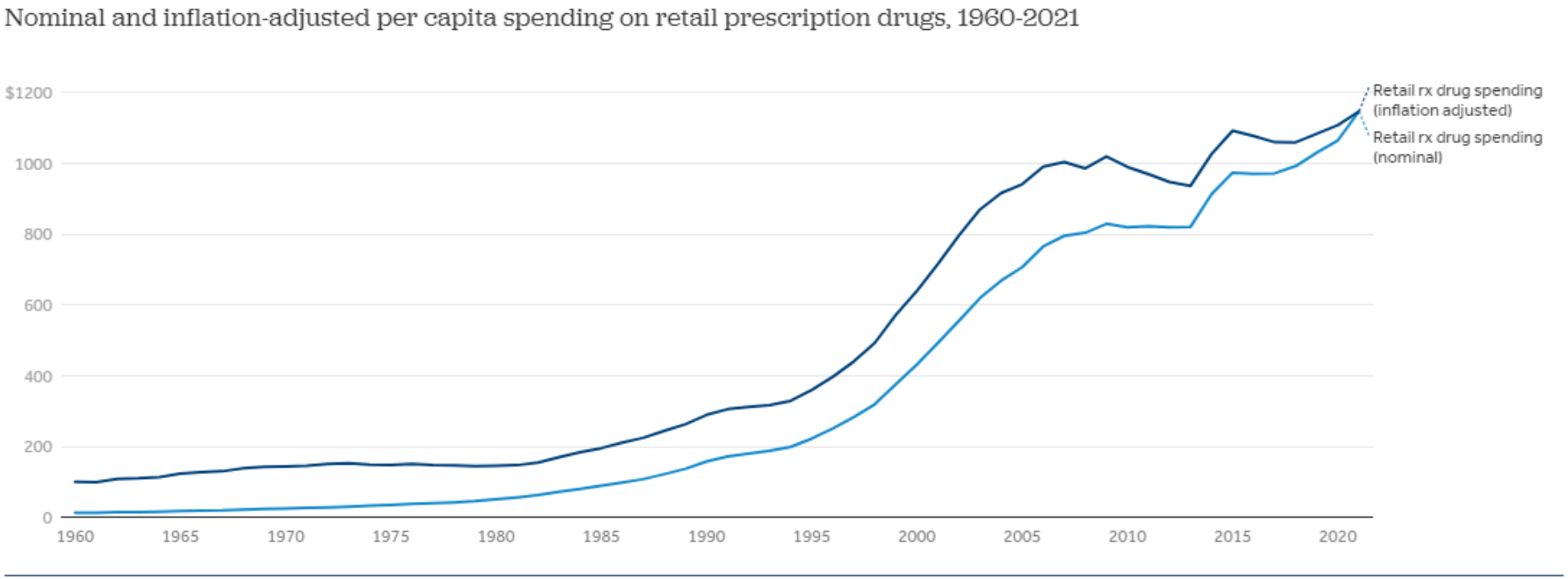
HOSPITAL COST GROWTH

Hospital costs made up 31% of national health expenditures in 2023, or $1.5 trillion.[3]

Oregon Cost Growth Target data shows that Hospital Outpatient spending growth outpaced all other categories from 2021-2022 at 6.5%. Combined, Hospital Inpatient and Outpatient spend accounted for 42.6% of total claims and non-claims spending in 2022.[4]

1. . Source: Office of the Assistant Secretary for Planning and Evaluation. *Changes in the List Prices of Prescription Drugs.* Accessed: Jan. 17, 2025
2. Source: Oregon Division of Financial Regulation. *Prescription Drug Price Transparency Program results and recommendations – 2024.* Accessed: Jan. 16, 2025
3. Source: Centers for Medicaid and Medicare Services. *National Health Expenditures 2023 Highlights.* Accessed: Jan. 17, 2025
4. Source: Oregon health Authority. *2024 Oregon Cost Growth Target Annual Report.* Accessed: Jan. 17, 2025

Prescription Drug Spend Over Time



Per capita spending on retail Rx has skyrocketed over the past 20 years. From 2022 to 2023 total Rx expenditures grew by 13.6%, equal to $722.5 billion.[1]

Oregon's 2024 Drug Price Transparency Program Report shows that Oregon insurers spent $1.194 billion on prescription drugs across large, small, and individual markets.

Any change to the Rx pricing structure will impact what consumers pay and where they choose to buy.

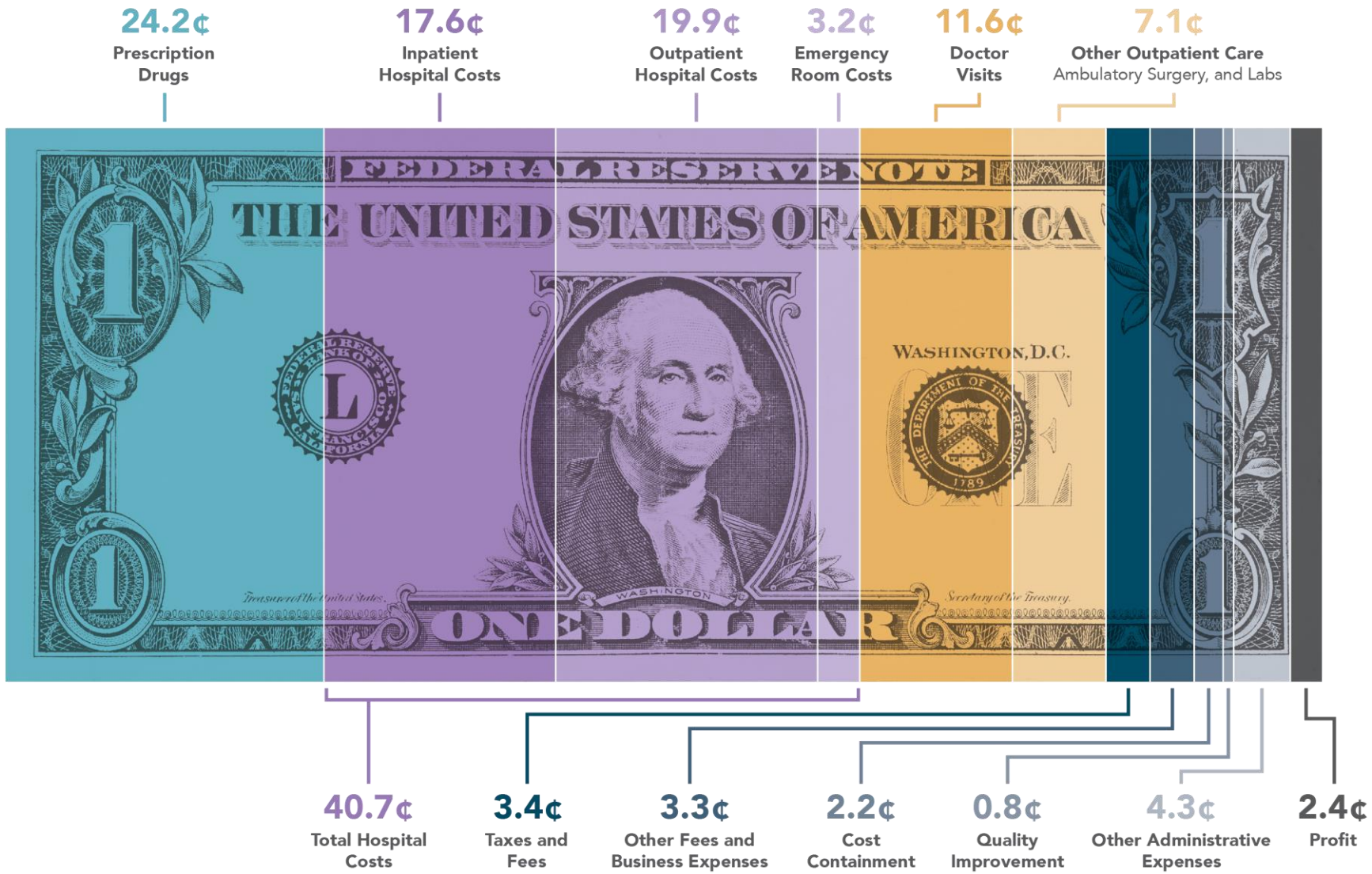
Graph Source: Kaiser Family Foundation Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#Nominal%20and%20inflation-adjusted%20per%20capita%20spending%20on%20retail%20prescription%20drugs,%201960-2021. Accessed: July 18, 2024

1. Source: American Journal of Health-System Pharmacy. National trends in prescription drug expenditures and projections for 2024. Accessed: Jan. 17,2025
2. Source: Oregon Division of Financial Regulation. Prescription Drug Price Transparency Program results and recommendations – 2024. Accessed: Jan. 16, 2025

Where Does Your Health Care Dollar Go?

AHIP
Guiding Greater Health

Your premium is how much you pay for your health insurance coverage each month. It helps cover the costs of the medications and care you receive and improves health care affordability, access and quality for everyone. **Here is where your health care dollar really goes.**



This data represents how your commercial health plan premiums pay for medical care, as well as related services and essential operations. This data includes employer-provided coverage as well as coverage you purchase on your own in the individual market. Data reflects averages for the 2020-22 benefit years. Totals may not add up to 100% due to rounding.

Insurer and Provider Assessment

Early passage is critical to Medicaid

- Oregon's insurance companies support renewal of the provider and premium assessment (HB 2010) early in the legislative session.
- This funding is critical for funding Medicaid and reducing costs for enrollees on the individual market through our reinsurance program.
- Failure to have the bill signed by the Governor by April 1st could create a $90M Medicaid budget hole and ultimate jeopardize the reinsurance program.
- It is critical that we pass this package as it’s drafted and early in the legislative session to avoid exacerbating Medicaid funding issues.

Questions?