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The Voluntary Health Insurance Market—Old Market, New Growth

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Over the last several years, both participants and consumers in the health insurance industry have faced many challenges. As a result, the health insurance market has changed in many significant ways.

A Change to the System

Insurers

Provisions in the Patient Protection and Affordable Care Act (ACA) created a great deal of uncertainty for insurance companies. One such provision is the Medical Loss Ratio (MLR) requirements of 80 percent in the individual and small group markets and 85 percent in the large group market for major medical policies.

Many small to mid-sized health insurers are concerned about meeting these requirements due to high levels of administrative costs, marketing expenses and fees. High levels of retention can make it difficult for insurers to price at profit levels that are supportable to the long-term health of the insurer.

The ACA regulatory environment in tandem with profit pressures has resulted in an influx of insurers entering other lines of business that are not materially impacted by the regulatory restrictions of the ACA.

Consumers

For decades, the vast majority of consumers in the United States have been receiving health insurance coverage from their employers, with few choices when it came to selecting coverage. Many consumers just took what they were given without a lot of thought, and the system worked well enough for many individuals and companies. Meanwhile, consumers who preferred to buy their own coverage were few and far between, and millions of Americans simply went without coverage due to affordability concerns.

Then, as health care expenditures and insurance premiums increase, employers typically shift more costs to workers in the form of copays and increased deductibles. These actions help reduce the financial impact of medical inflation on their health care budgets. This often results in employer health plans with burdensome cost-sharing for consumers.

The ACA took steps to reduce those concerns and, as a side effect, seems to have made consumers more conscious about their health care costs and their type of health coverage. This has led many health insurance companies and employers offering coverage to rethink the ways they create and provide coverage to consumers.

This increased consciousness has prompted critical thinking about the kind of coverage people buy, and what they're actually paying for. This is especially true among those who chose to forgo coverage when having to decide between purchasing coverage or paying the fee for the ACA's individual mandate. Therefore, many consumers have to think about health insurance costs for what could be the first time in their adult lives.

Employers

The ACA created a large amount of uncertainty with regard to providing benefits to consumers. Since 2010, employers have been attempting to determine which parts of the law apply to them and how to manage benefits accordingly. While dealing with all of these complexities, employers have several key issues that they must address:

- **The employer mandate**

  Employers are contemplating whether it will be more cost-effective to pay the penalties for not offering health coverage. Some consumers may be able to find affordable and adequate coverage on the public exchanges; however, not all consumers (e.g., those who don't qualify for subsidies) will be able to find the right kind of coverage at an affordable price.

- **The Cadillac tax**

  In order to avoid this excise tax, employers are taking steps to adjust their high-premium health plans.

- **Overall employee satisfaction**

  A reduction or elimination of benefits could be seen as a reduction in compensation and could hurt morale and recruitment.

Stabilizing the Future

With the cost of health care weighing so heavily on consumers, a major disruptive trend in 2015 and beyond could be their increasing purchasing power and access to information that can be used to drive health care decisions. The act of balancing low premiums and out-of-pocket costs while providing coverage that is both adequate to meet personal needs and governmental requirements has been the focus of many insurers and employers.

For Consumers

After several years of shifting responsibility for copays, premiums and deductibles, it's no longer just the employer paying for coverage—it's the consumers' money, and they want a voice in deciding where and how to spend it, and what courses of treatment to follow. Providing a reasonable balance between high-quality health care—which gives consumers not only buying power but flexibility when it comes to choosing from a wide variety of doctors for their specific medical needs—and a low price point is key for insurers for many reasons. What consumers tend to want out of these plans are, again, relatively simple: low prices, but with lots of choices.

Supplemental health insurance plans give consumers more diversity in their benefits packages. Consumers with family histories of illness, for example, could opt to buy a critical illness plan to help offset expenses should they contract that illness. Beyond choice, though, supplemental plans have the ability to reduce overall costs and liability for consumers, which becomes critical as the ACA takes full effect.

Since the ACA has led to premium increases in some locations, consumers may be able to save on their health insurance expenditures by coupling a high-deductible traditional health insurance plan with a less costly supplemental policy.

As out-of-pocket medical costs grow for many Americans, the insurance industry is offering an alternative, while expanding its business by selling supplemental policies that fill the gaps for consumers. The supplemental plans getting the most attention currently include hospital indemnity, critical illness, disability and accident plans.

For Employers

To help balance changes in medical benefits, many employers are offering benefits that can help protect employees' finances while also reducing costs. This type of financial protection must be health-care-reform-ready and must complement their current benefits program.

Offering voluntary group supplemental products is an option that many employers view as allowing them to balance their own costs while providing desired choices to their employees. Because these types of products are typically low-cost and payroll-deducted, they can provide employees with a smart and convenient way to manage out-of-pocket costs that may no longer be covered under traditional major medical plans.

Because supplemental plans are seen as cost-effective, employers of all sizes also are able to offer an expanded roster of voluntary benefits. Also, when an employer offers a possible solution to an employee's needs, a positive message is sent.

Benefit Offerings Now Being Advanced

Supplemental benefits sold to employees on a voluntary basis are a relatively simple concept:

- Offer benefits to employees through their employer where the employee typically pays 100 percent of the premium.
- The premiums are paid through payroll deduction.
- Employees typically pay less in monthly premium versus purchasing the policy on their own.
- Employees who do not qualify for a product on their own may be able to obtain coverage through their employer.

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Insurance companies generally need to recognize that the developments in their industry going forward are going to be more consumer-driven than they have been at any point in the past.

- Policies are often portable, meaning the employees can take the policy with them if they leave the company or retire.

Even if consumers do not have the opportunity to purchase coverage through an employer, consumers who purchase coverage directly from an insurer can still receive many benefits from these types of policies—e.g., relatively low premiums, portability and limited medical underwriting.

Insurers are increasingly marketing these supplemental policies that pay a fixed indemnity amount (i.e., cash) after a hospital stay, a specific disease diagnosis, a disability, or an accident. The policies are typically promoted as helping cover the out-of-pocket expenses that can dramatically impact consumers.

Hospital Indemnity

A typical hospital indemnity plan covers copays, deductibles, prescriptions and other out-of-pocket expenses a policyholder accrues during a hospital stay. Not long ago these plans were thought to be doomed or severely restricted by the ACA. Sales of supplemental hospital policies plunged in 2012 as the industry prepared for rules requiring minimum coverage and requiring payments on a per-period basis (e.g., on a daily or weekly basis). Instead of disappearing, however, the plans are rebounding due to guidance from the Department of Labor that it would allow benefits to be paid by medical service such as hospitalization or office visit. This reversed a previous rule that required payments on a per-period basis.

Critical Illness

A critical illness policy provides benefits related to an employee's expenses associated with cancer or other chronic diseases. This can help relieve the financial burden that is often associated with these diseases. It can be useful, especially when an employee must miss work due to the illness or treatments, at a time when consumers have bigger issues to worry about.

Critical illness policies can offer additional protection for consumers that have minimal coverage, or they can be used to supplement rich benefit packages. It combines elements of health and disability insurance in a simplistic design that is an attractive option for employers.

Accident

An accident plan can be designed to mirror the benefits of a hospital indemnity or major medical plan; however, no benefits are paid for any treatments generated by a sickness. This is often provided when employers want to offer some financial protection, but it is determined that comprehensive coverage is unaffordable.

Disability Insurance

Disability insurance continues to be a popular coverage for both employers and consumers. It is considered an excepted benefit, so it is not impacted by ACA regulations. The coverage can be designed to replace income for accidents only or it can cover both accidents and sicknesses. It can have short elimination periods of less than 30 days, or as long as six to 12 months for those employers looking for lower-cost options. Disability insurance is a flexible product that can fit the needs of a variety of employers.

What Issues Remain?

The problem for both insurers and employers is that the "ideal" health insurance plans are typically unrealistic financially. For that reason, it is important for consumers to receive proper education throughout the shopping process about what they can expect to pay for any given type of coverage, and exactly what that monthly premium pays for. This might help to shape their expectations for coverage and cost going forward, and serve to make them better at shopping for and identifying the kinds of coverage they need given their unique circumstances, in terms of both financial and health needs.

Essentially, insurers that want to put their best foot forward and succeed in the emerging industry ecosystem will have to focus not only on continually developing products that fit consumers' needs, but also determine what those needs are throughout the year. Positive and negative feedback can be used to shape policies that will prove to be more successful in meeting consumers' evolving needs in the future.

Insurance companies generally need to recognize that the developments in their industry going forward are going to be more consumer-driven than they have been at any point in the past. This impact will likely continue to increase for several years to come, as a growing number of people who are currently uninsured come into the market and are looking for cost-effective solutions.