Individual Health Insurance Primer

Health Insurance Affordability Task Force

Wyoming Department of Health

June 17th, 2026

Agenda

- **Purpose of health insurance**
  - Spread risk
  - Control costs
  - Improve health (?)
- **The Affordable Care Act (ACA) in Wyoming**
  - Significant changes
  - Trends in enrollment
  - Trends in cost
- **Next steps**
  - Recommendation: define the problem

Purpose of health insurance

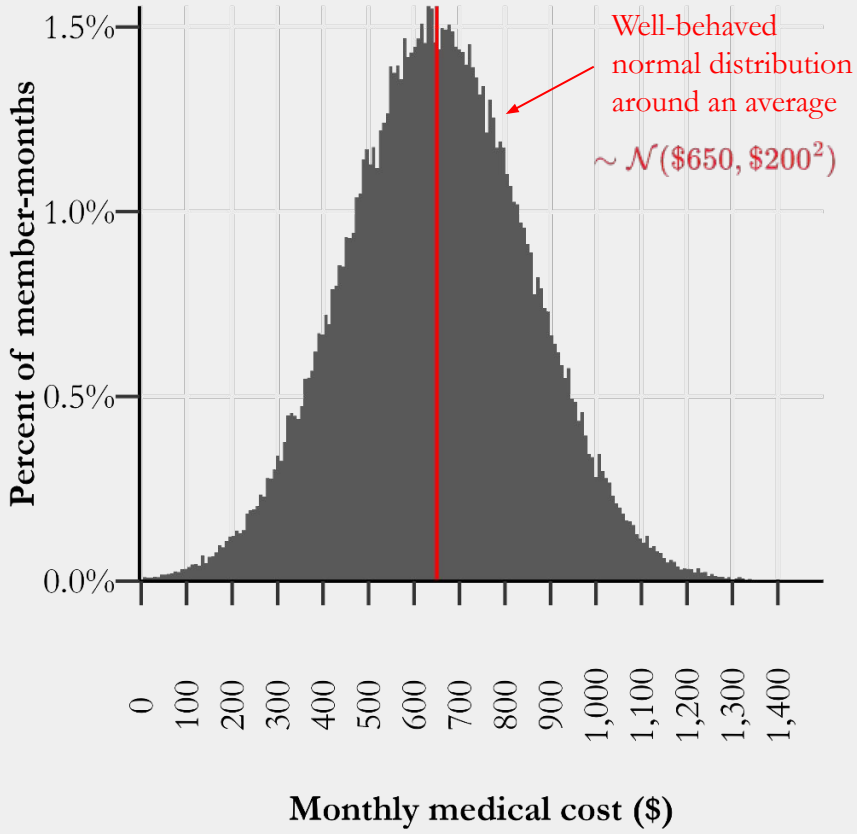
Purpose 1: Spread Risk

- → Health care costs are **highly variable**. For majority of people:
  - Often zero.
  - Low, but non-zero probability of **catastrophic** costs.

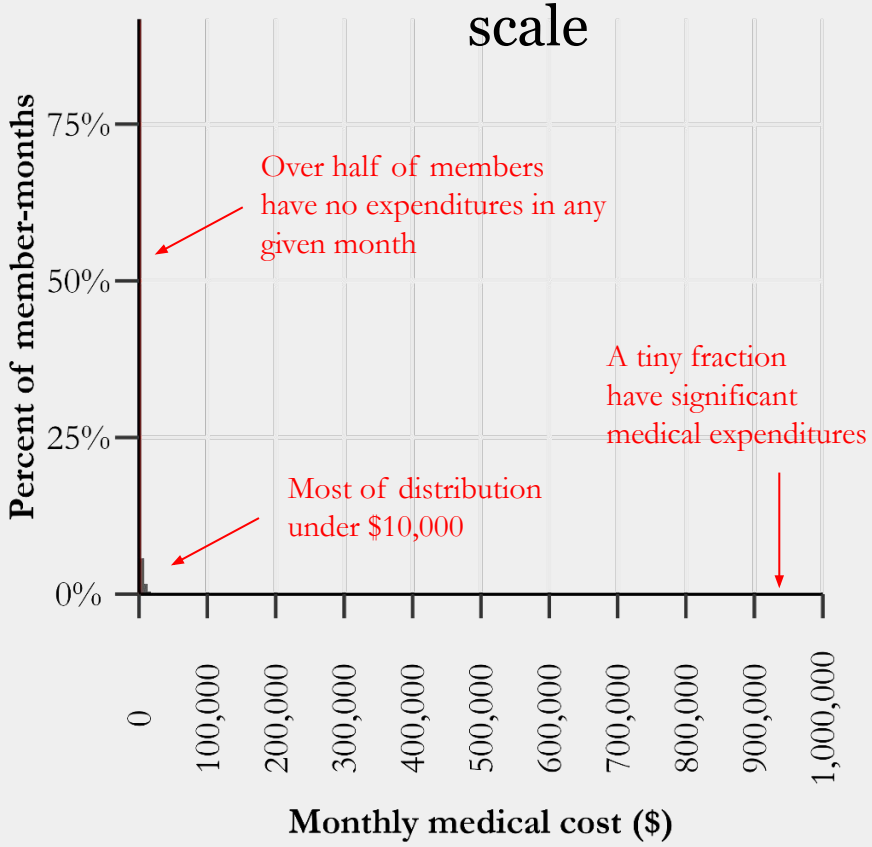
    (For small number of people, e.g., hemophiliacs, predictably high costs)
- → Insurance transforms these into **stable monthly premiums**.

Purpose 1: Spread Risk

Wishful thinking

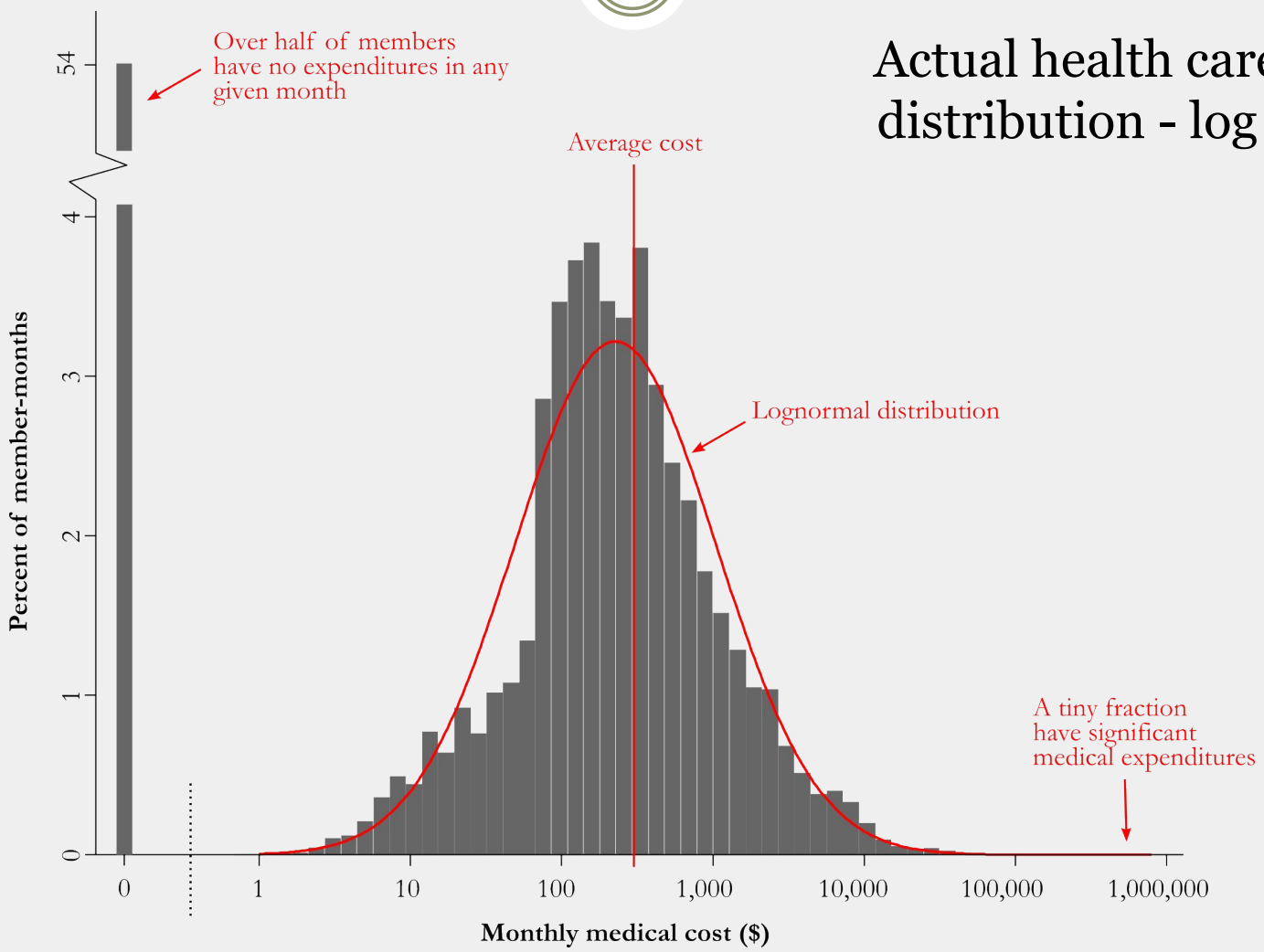


Actual health care cost distribution - linear scale



Purpose 1: Spread Risk

Actual health care cost distribution - log scale



Complication: Adverse Selection

- **Identity and character of policyholders drive underlying costs.**
  - Huge variation in health status (and thus expected medical costs) across people;
  - People know more about their own expected costs than insurers do.
  - Sicker people with higher expected costs are drawn to more generous insurance plans.
- **Increasing concentration** of sicker people in the pool drives up premiums, driving out healthier people and further concentrating the pool.
- **"Death spiral"**: when adverse selection gets out of control.

Complication: Adverse Selection

Person Type	Percent of population	Expected monthly health care costs	Contribution to average (Percent × Cost)
A	50%	$10	$5
B	35%	$100	$35
C	10%	$1,000	$100
D	5%	$10,000	$500
		Average pool cost	**$640**

- ➔ How would you price this pool if everyone is covered?
- ➔ If everyone is free to buy or not buy at that price, who will buy insurance?
- ➔ How will the insurance company adjust its premiums? What happens then?

Market-based strategies to avoid adverse selection

- **Risk premium**. Most people are risk averse, willing to pay a little more than their expected health costs for stability.
- **Insure only incidental groups (e.g., employers).** Pool the healthy and sick together in randomly-mixed groups.
- **Product tiering**. Price different levels of coverage for different types or groups of people (e.g., age rating)
- **Underwriting**. Price insurance to specific people based on their pre-existing conditions.
- **Stinting**. Making plans unattractive to sick people.
- **Enrollment windows**. “You can’t buy fire insurance when your house is on fire.”

Social policies to avoid adverse selection

- **Mandates** on individuals and employers
- **Premium subsidies** to attract healthier people
- **High-risk pools**. Move sicker people into separate, subsidized pool to make general pools more attractive to healthier people
  - **Medicare** and **Medicaid** take oldest and sickest members of society into public insurance pools.
- **Risk-balancing**. Transfer income across insurers based on risk profiles

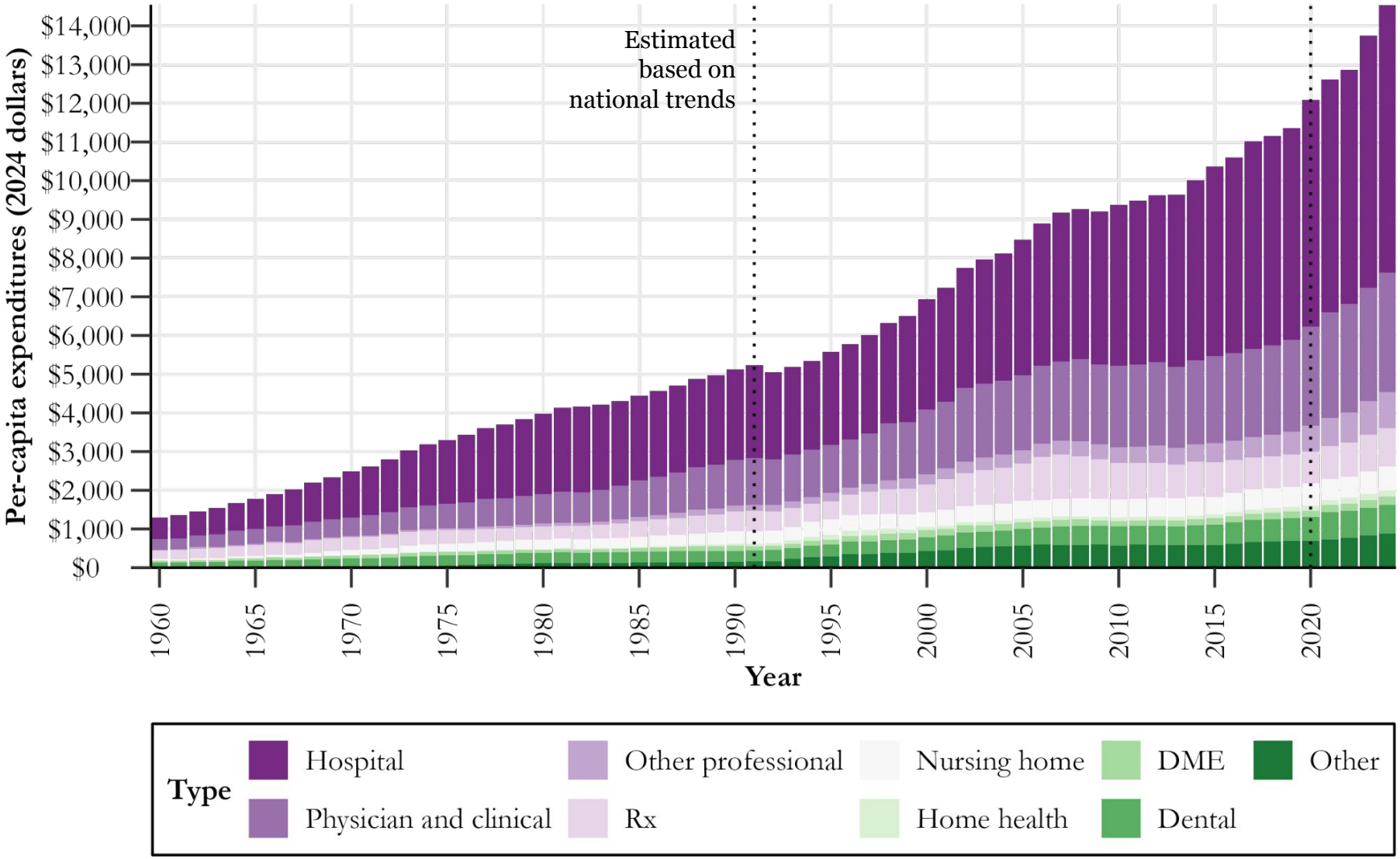
Purpose 2: Control Costs

- → **Costs drive premiums.**
- → Assuming competition, insurers need to **price premiums attractively** to get customers.
  - Premium price is just one aspect of insurance coverage decision
  - Customers also consider:
    - Plan generosity - how much of average medical costs are paid for by the plan vs. the customer.
    - Network size, coverage of favorite providers and prescriptions

Purpose 2: Control Costs

- ➔ **Insurers can pool volume to negotiate better prices than individuals could.**
  - Sometimes.
    - In many cases, providers prefer cash-pay over the hassle of billing and will offer significant discounts.
  - Depends on provider - insurer concentration and market share.
    - Insurers have more provider options for a network in denser areas, thus more leverage.
    - Providers have upper hand in more rural areas.

Real annual per-capita health care costs



Why are health care costs so high?

- ➔ **In 2024, US spent 17.2% of GDP on healthcare**, compared with 9.3% for OECD average. (Germany is next at 12.3%).
- ➔ General consensus on why: **prices**
  - For every unit of service, providers (physicians, pharmaceutical manufacturers, hospitals) are paid **higher rates** than in virtually every other developed country.
  - Not really driven by utilization: Americans consume at or below the OECD median on most services (e.g. physician visits, hospitalizations)
- ➔ **Administrative overhead** also significantly higher, for both providers and payers.
  - Est. 15-30% of all health care spending (2x OECD)
  - Multi-payer system - significant complexity in billing/claims

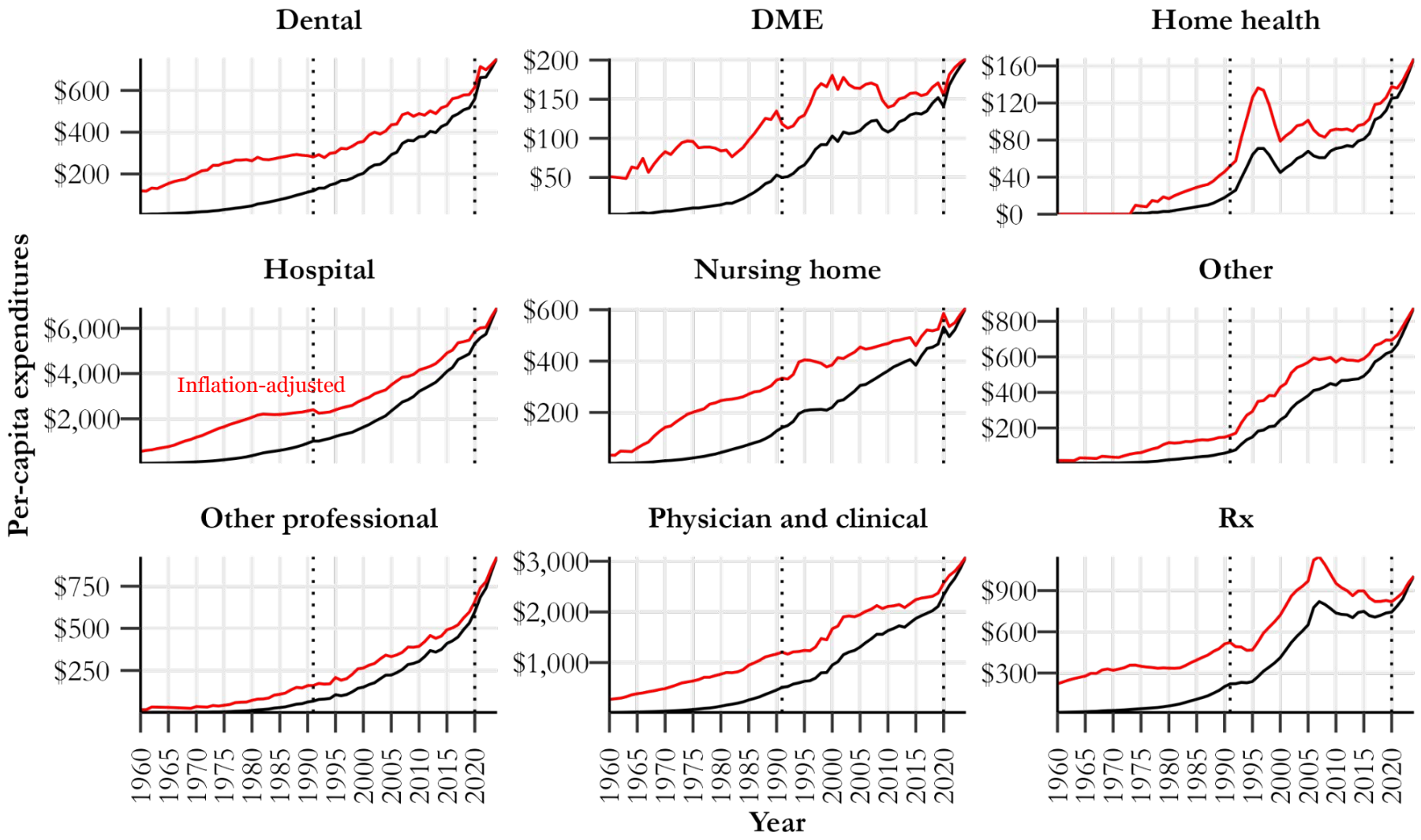
Example: Wyoming hospital cost structure

Cost center	Report FY (% of total cost)														2024
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	($M)
Administration	18.3%	18.7%	18.4%	18.3%	18.1%	18.1%	18.0%	18.1%	18.7%	18.9%	18.4%	18.8%	20.0%	19.4%	$440
Ancillary	8.7%	8.4%	8.2%	7.7%	7.5%	7.9%	7.7%	7.8%	7.5%	7.0%	6.7%	7.3%	7.5%	7.7%	$174
Benefits	9.2%	8.1%	8.1%	8.3%	7.7%	7.4%	7.9%	6.7%	7.0%	6.8%	6.5%	5.9%	5.6%	7.1%	$160
Capital	5.4%	5.9%	6.0%	6.3%	6.2%	6.2%	6.1%	6.0%	5.5%	5.1%	5.2%	5.0%	4.7%	5.0%	$113
Drugs, DME	8.0%	8.1%	7.6%	7.8%	8.8%	9.1%	9.1%	10.0%	10.1%	11.0%	10.5%	10.7%	10.9%	11.1%	$253
Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	$1
Facility/plant	3.3%	3.2%	3.3%	3.2%	3.2%	3.2%	3.1%	3.3%	3.2%	3.0%	3.1%	3.3%	3.1%	3.2%	$72
Imaging/dx	9.4%	9.0%	8.7%	8.5%	8.4%	8.4%	8.3%	8.2%	8.2%	8.2%	8.5%	8.7%	8.8%	8.6%	$196
Inpatient	10.1%	10.2%	9.6%	9.6%	9.4%	9.1%	9.0%	8.8%	8.8%	8.6%	10.4%	10.6%	10.2%	9.6%	$218
Long-term care	3.8%	3.6%	3.5%	3.1%	3.1%	3.2%	3.1%	3.0%	2.7%	2.8%	2.7%	2.7%	2.5%	2.4%	$56
Non-reimbursable	4.3%	4.7%	6.8%	7.2%	7.3%	7.4%	6.8%	6.9%	7.4%	7.0%	7.0%	6.3%	5.4%	5.2%	$119
Operations	2.0%	1.8%	1.7%	1.6%	1.5%	1.4%	1.5%	1.5%	1.4%	1.4%	1.3%	1.1%	1.1%	1.1%	$26
Other	0.5%	0.5%	0.6%	0.7%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.7%	0.8%	0.8%	0.8%	$17
Outpatient	9.5%	10.3%	10.3%	10.4%	11.0%	10.7%	11.5%	11.9%	11.8%	12.4%	11.9%	11.8%	12.3%	11.8%	$268
"Hotel" services	3.8%	3.7%	3.6%	3.5%	3.3%	3.3%	3.2%	3.2%	3.1%	3.0%	2.9%	3.0%	3.1%	3.0%	$68
Therapy	3.7%	3.7%	3.7%	3.6%	3.7%	3.7%	3.9%	3.9%	3.9%	4.1%	4.1%	4.1%	3.9%	4.0%	$91
Total cost ($M)	**$1,169**	**$1,223**	**$1,303**	**$1,423**	**$1,533**	**$1,565**	**$1,588**	**$1,713**	**$1,812**	**$1,788**	**$2,059**	**$2,143**	**$2,249**	**$2,271**	

Data: Hospital Cost Report Information System (HCRIS)

Worksheet A, Column 3 - See pivot table here

Real annual per-capita health care cost



Complication: Moral(e) Hazard

- → The **more risk** an insurer takes from its insureds, the **more cost** and waste it will induce.
- → "Moral" refers to psychology (i.e., "morale"), **not** morality, and means that costs are driven by an insured's state of mind rather than chance.

> "The likely malfeasance of an individual making purchases that are partly or fully paid for by others"
>
> - Cutler and Zeckhauser

Complication: Information Asymmetries

→ Significant differences in information across the parties:

- **Patients**
  - Health habits
  - Symptoms
- **Physicians**
  - Diagnoses
  - Treatment
- **Insurers**
  - Cost of care
  - Future premiums

"The result is that patients and physicians want essentially all care that improves health, respectively ignoring and welcoming resource expenditures."

- Cutler and Zeckhauser

Complication: Moral Hazard

1. Imagine you have plaque psoriasis
2. Based on your (very generous) plan, you have these options:

Cost to your insurer	$30	$2,000
Cost to you	$10	$10
Effectiveness	Likely effective	Likely more effective, and faster

3. What would you pick? What would your physician prescribe?

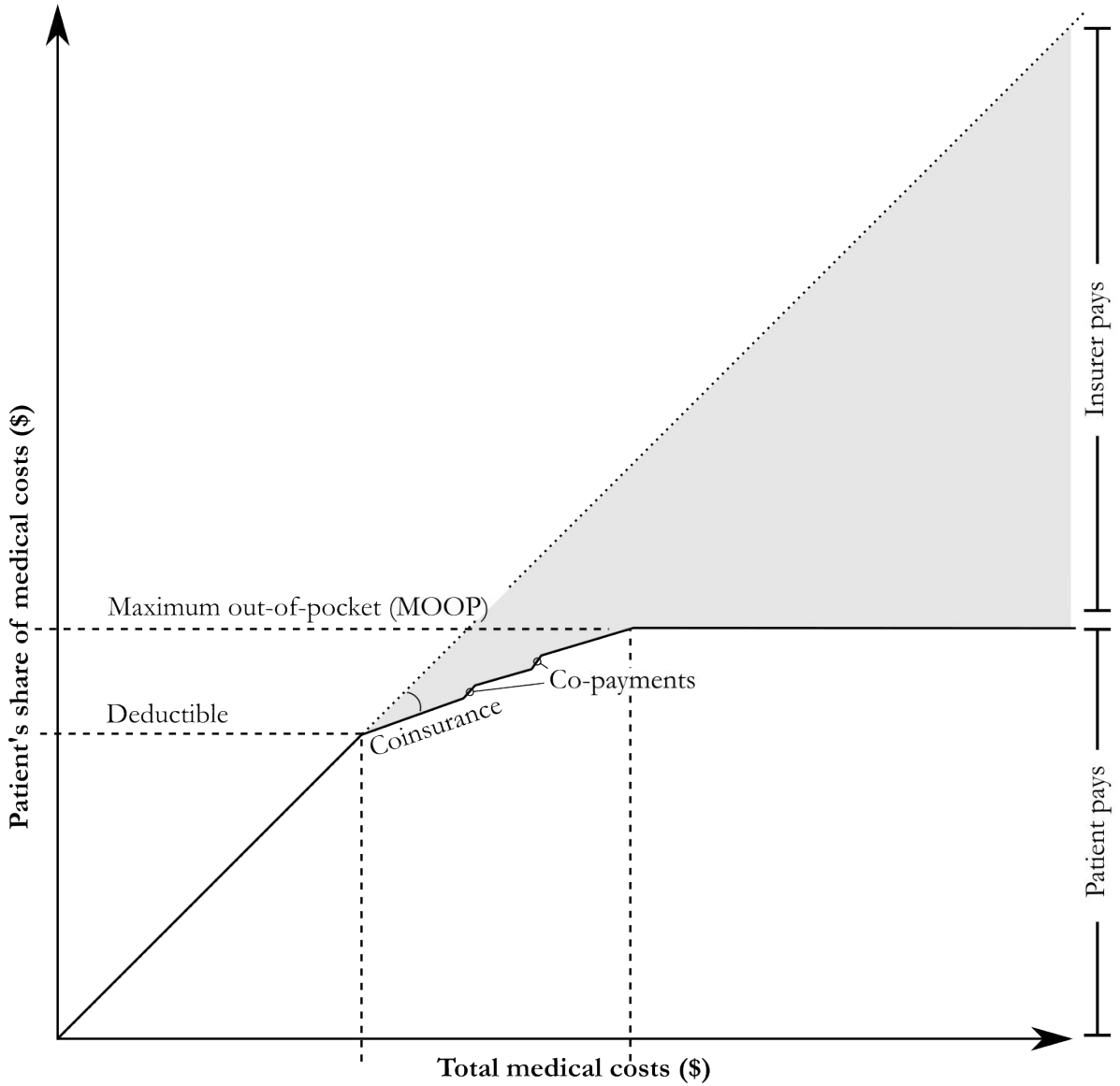
Strategies to mitigate moral hazard: provider-facing

- **Utilization management**
  - **Primary care referrals**. "Filter" before seeing specialists
  - **Step therapy**. Try lower cost drugs first.
  - **Prior authorization**. Require third-party review of expensive elective procedures before authorizing payment.
- **Payment methodologies**
  - **Salaried** (e.g. Kaiser health system)
  - **Capitated** (flat rate per patient per month)
  - **Bundled payments** (e.g., one rate for an episode in a hospital)

Strategies to mitigate moral hazard: patient-facing

- **Cost sharing - "skin in the game"**
  - **Deductible** - "first dollar" exposure to health care costs
  - **Copayments and coinsurance** - paid after deductible, before maximum out-of-pocket ("MOOP")
- **Network design**
  - **Limited networks** - channel patients to insurer-preferred providers
  - **Reference pricing** - inform patients that insurer will pay $X for a procedure; they pay any difference above $X.

Cost sharing - “skin in the game”



Actuarial value: The *average share of medical costs* that are paid by the insurer across a standard population.

Cost sharing - “skin in the game”

- **Actuarial value** is standardized by the Affordable Care Act into “metal levels”:
  - Platinum: 90%
  - Gold: 80%
  - Silver: 70%
  - Bronze: 60%
  - Catastrophic: <60%
- **Exceptions**: “Silver”-level Cost Sharing Reduction (CSR) plans
  - Actuarial values of 94%, 87% and 73%, depending on income (e.g. 94% plans available for 100-150% FPL)

Purpose 3: Improve Health?

- → Healthcare only contributes a small amount (10-20%) to overall health
- → Genetics, environment, social determinants of health matter.
- → Individual behavior matters
  - Diet
  - Exercise
  - Life choices

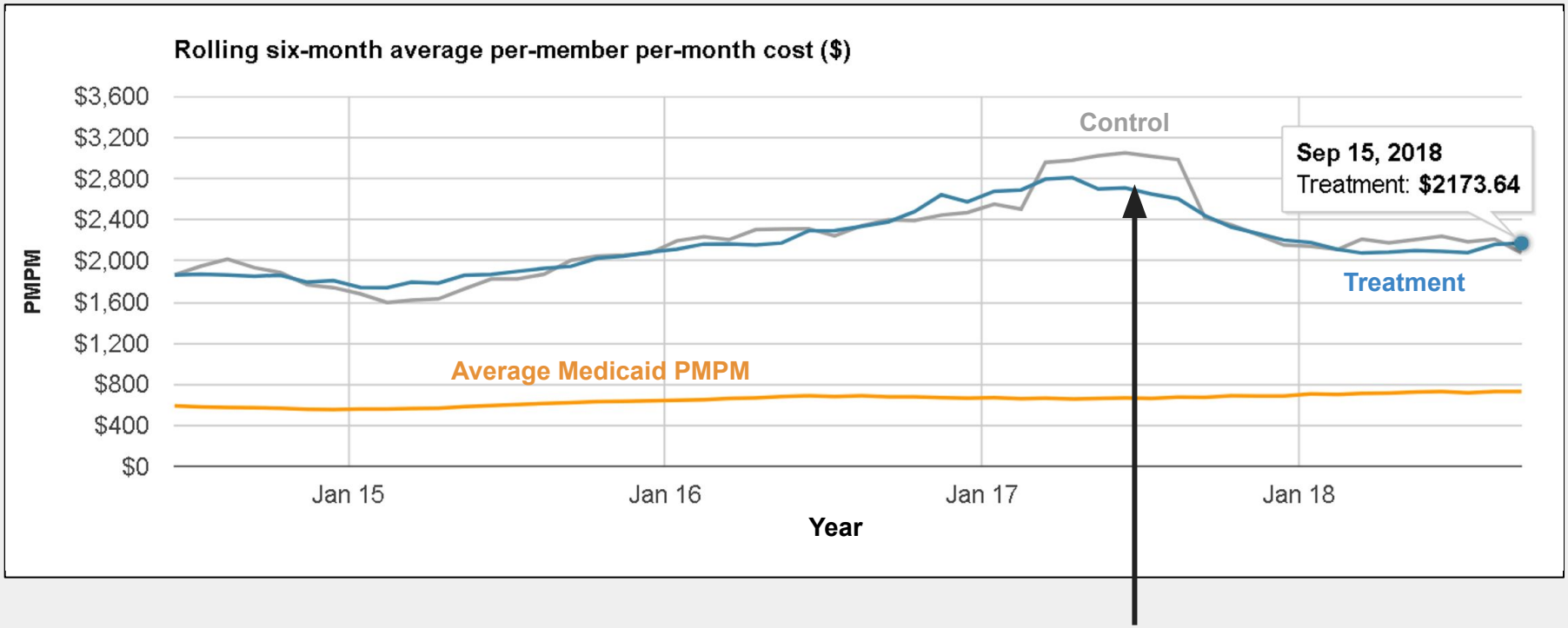
Purpose 3: Improve Health?

- How can insurers improve the health of their insureds?
  - **Wellness** programs: broad-based
  - **Disease management** programs: targeted at people with specific conditions (e.g. diabetes)
  - "**Hotspotting**": targeting highest utilizers for more comprehensive care management

Complications: Effectiveness

- → **Little evidence** that these programs **actually work** or are cost-effective.
- → Example: Wyoming Medicaid launched a "Super-utilizer" program in 2017.
    - RCT with control group found no impact on cost or ED utilization
    - MIT study on 'hotspotting' (2020) had similar results.

Wyoming Medicaid - Super-utilizer RCT

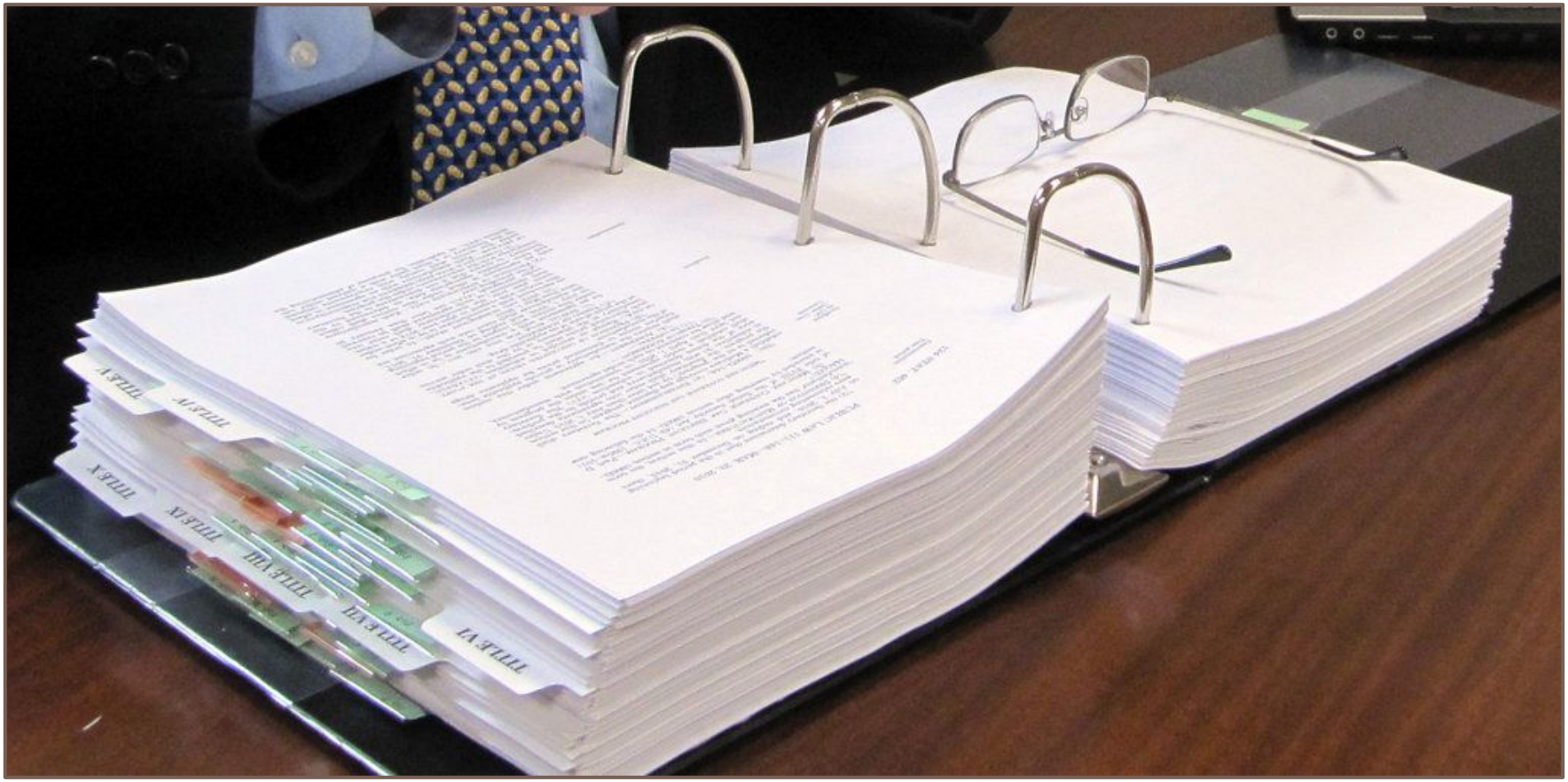


PMPM for both treatment and control peaked at selection, then both “regressed to the mean”

Complications: Incentives

- → Prevention, if it does work, is **long-term**.
- → "**Churn**" (people losing eligibility or switching coverage) is significant. Annual estimates:
  - 20% in Medicaid
  - 26% on the exchange
  - 12 - 22% for employer-sponsored groups
- → Ultimately, virtually all privately-insured end up on Medicare at 65.
- → So **who benefits** from prevention activities?

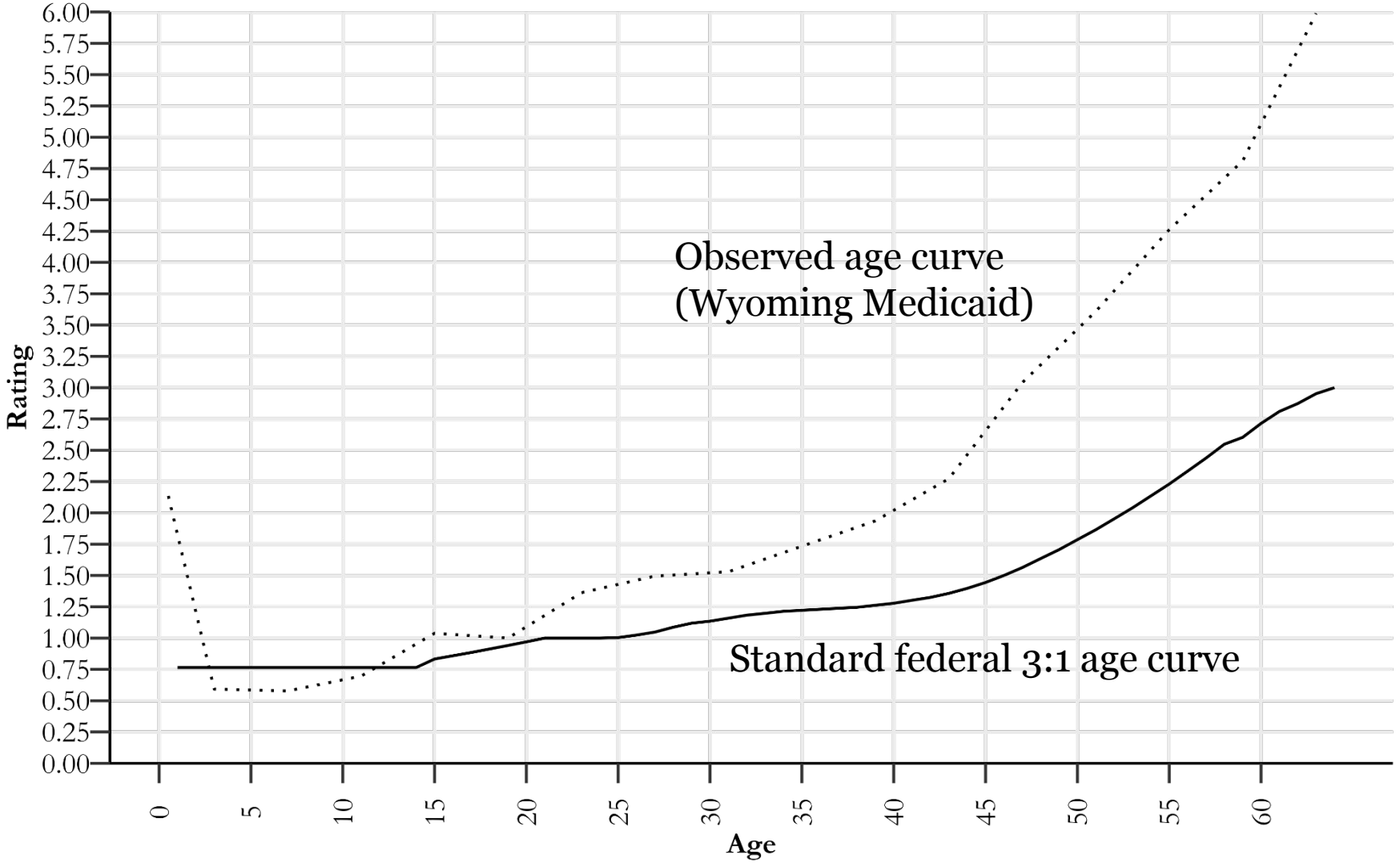
The Affordable Care Act and Wyoming



Significant Changes

- **Standardized Essential Health Benefits**
  - Outpatient
  - Emergency
  - Hospitalization
  - Maternity/newborn
  - Behavioral health
  - Prescription drugs
  - Rehabilitative
  - Laboratory
  - Preventive
  - Pediatric
- **Standardized pricing and purchasing**
  - Federally-facilitated Marketplace ("Exchange")
- **Cross subsidies**
  - Risk adjustments
  - Age rating

ACA age rating



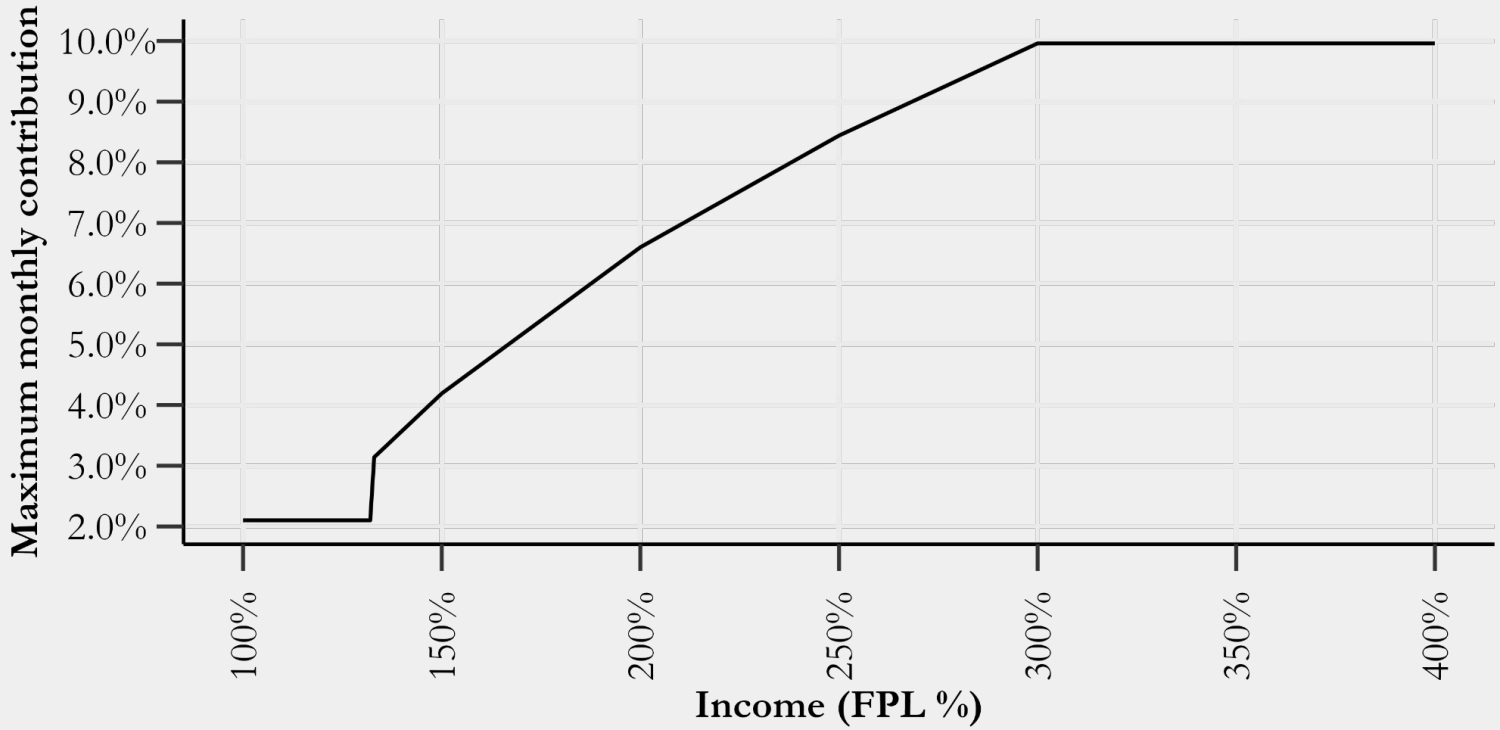
Data: Wyoming Medicaid claims/enrollment data (10 yrs)

Significant Changes

- **Insurer restrictions**
  - No rating/denial on pre-existing conditions
  - Coverage of dependents until age 26
  - No annual or lifetime limits
  - Preventive services without cost-sharing
  - 80% minimum Medical Loss Ratio
- **Employer mandate**
- **Subsidies**
  - Cost-Sharing Reduction (CSR) subsidies
  - Advance Premium Tax Credits
  - Medicaid Expansion (90% match)

Advance Premium Tax Credits

Advance Premium Tax Credit (APTC) = **Second lowest Silver premium** - **Maximum monthly contribution**



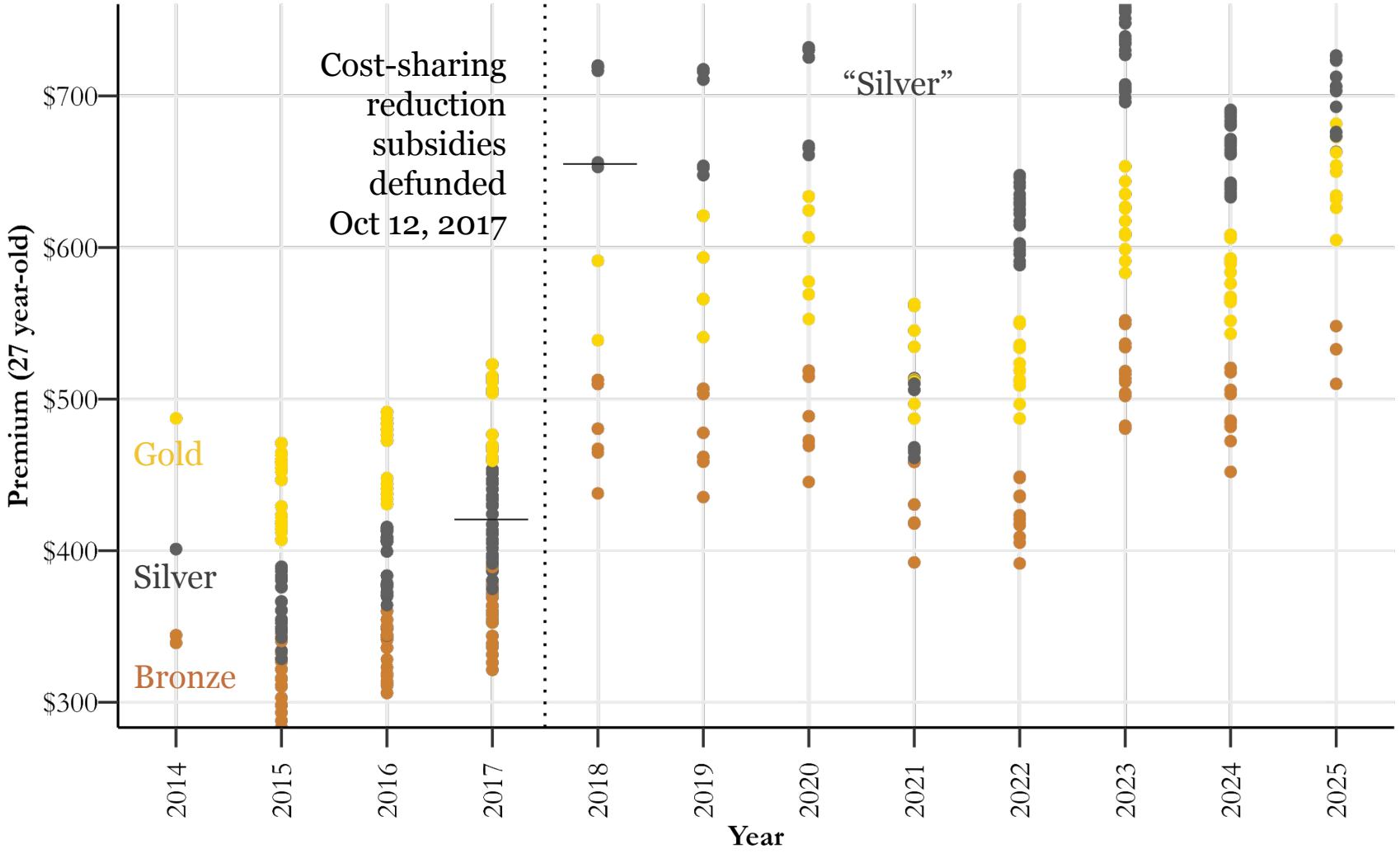
Advance Premium Tax Credits

Example: I am a 27-year old non-smoker making 300% FPL ($47,880 per year). My maximum monthly contribution is 9.96% of income ($397.40 per month)

➔ APTC if 2nd-lowest Silver is $420 (2017): **$22.59**

Plan	**Bronze**	**Silver**	**Gold**
Premium	$371.71	$444.40	$506.23
Premium after APTC	**$349.12**	**$417.81**	**$483.64**
Deductible (in-network)	$6,500	$2,000	$750
MOOP (in-network)	$6,500	$6,000	$6,600

“Silverloading”



Advance Premium Tax Credits (Silverloading)

Example: I am a 27-year old non-smoker making 300% FPL ($47,880 per year). My maximum monthly contribution is 9.96% of income ($397.40 per month)

➔ APTC if 2nd-lowest Silver is $650 (2018): **$252.60**

Plan	**Bronze**	**Silver**	**Gold**
Premium	$480.45	$716.61	$591.25
Premium after APTC	**$227.85**	**$464.01**	**$338.65**
Deductible (in-network)	$4,500	$1,500	$500
MOOP (in-network)	$6,650	$7,350	$7,350

Subsidized health insurance by age and income (non-disabled)

<table>
<tr><th>FPL</th><th>Children</th><th>Adults (21 - 64)</th><th>Older adults (65+)</th></tr>
<tr><td>0 - 100% ($15,960 for individual)</td><td rowspan="3">Medicaid / CHIP
- No premiums
- ~ 97% AV</td><td>Medicaid Expansion population
None</td><td>Qualified Medicare Beneficiary (QMB)
- No premiums
- 100% AV</td></tr>
<tr><td>101 - 138%</td><td>ACA
- 2.1% income premium cap
- 94% AV</td><td>Other Medicare Savings Programs
- No premiums</td></tr>
<tr><td>139 - 150%</td><td>ACA
- 3.14% to 4.19% of income
- 94% AV</td><td rowspan="6">Medicare
- $202.90 standard Part B premium (up to <$109,000 income)

- ~ 84% AV for traditional Medicare [Note: this has no max out-of-pocket]

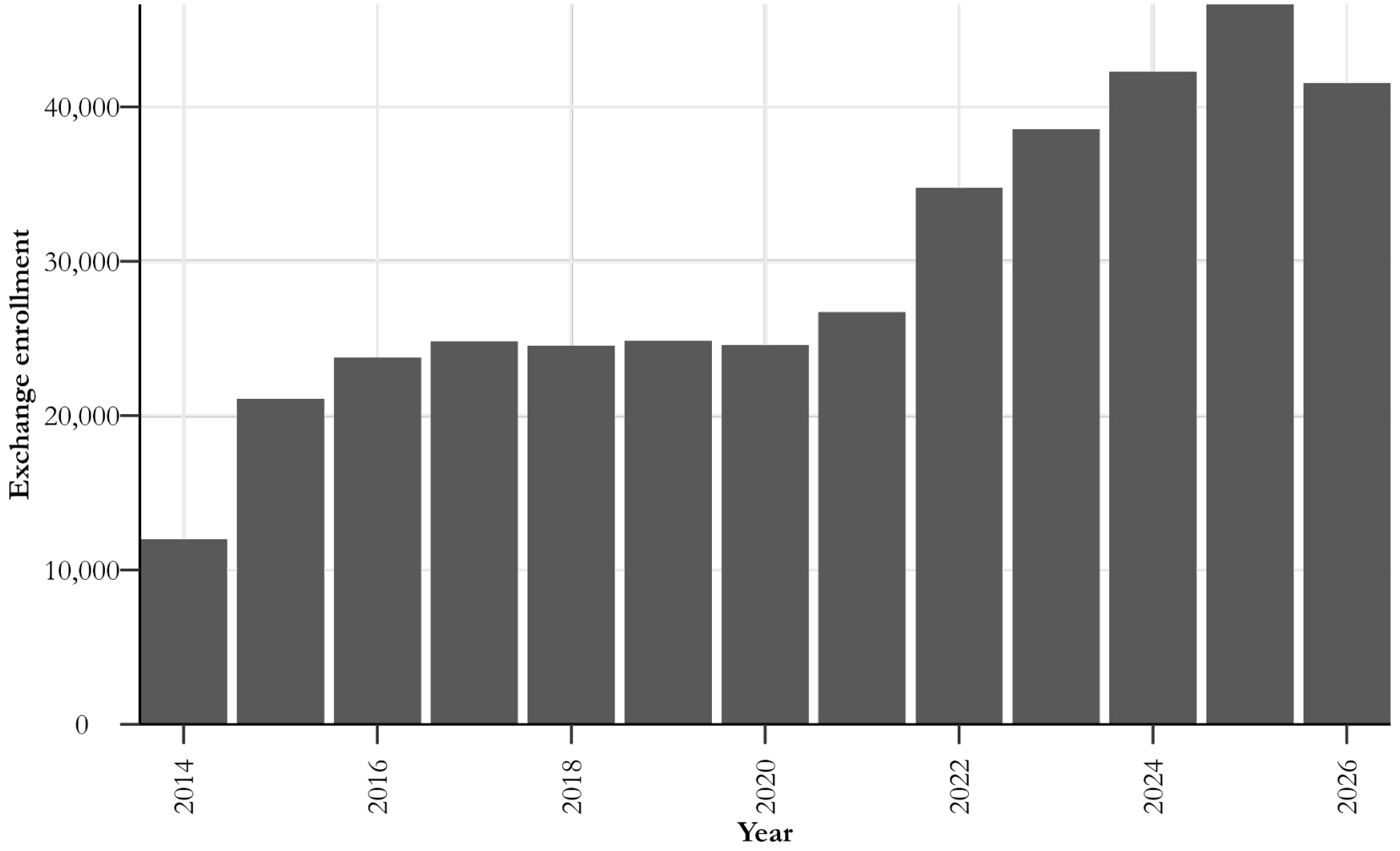
- ~ 90 - 99% AV depending on MediGap supplemental or Medicare Advantage plan</td></tr>
<tr><td>151 - 200%</td><td>ACA
- 4.19% to 6.6% of income
- 87% AV</td></tr>
<tr><td>201 - 250%</td><td colspan="2">ACA
- 6.6% to 8.44% of income
- 73% AV</td></tr>
<tr><td>251 - 300%</td><td colspan="2">ACA
-8.44 to 9.96% of income</td></tr>
<tr><td>301 - 400%</td><td colspan="2">ACA
- 9.96% of income</td></tr>
<tr><td>400% +</td><td colspan="2">None</td></tr>
</table>

Est. population by age and income (non-disabled)*

FPL	Children	Adults (21 - 64)	Older adults (65+)
0 - 100% ($15,960 for individual)	34K [31 - 36K]	Medicaid Expansion population 16K [14 - 18K]	11.3K [9 - 14K]
101 - 138%		10.5K [8 - 12K]	6.7K [4 - 8K]
139 - 150%		2K [1 - 3K]	96.5K [94 - 98K]
151 - 200%		9.5K [8 - 11K]	
201 - 250%	7.5K [5 - 9K]	8.3K [6 - 10K]	
251 - 300%	4.8K [3 - 6K]	7.7K [6 - 9K]	
301 - 400%	6.6K [4 - 8K]	10K [8 - 11K]	
400% +	8.8K [7 - 10K]	20K [17 - 22K]	

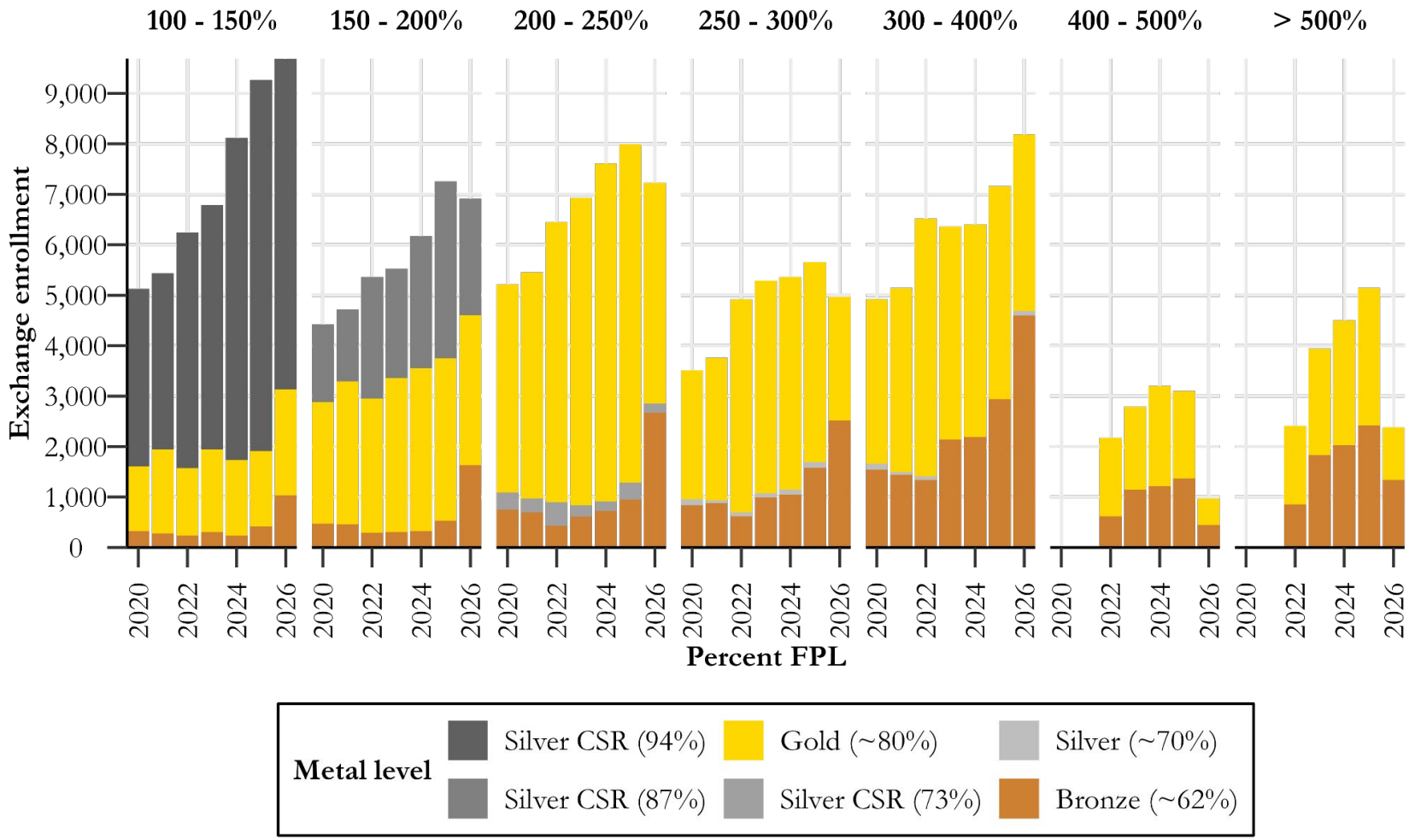
** Excludes employer-sponsored insurance and TRICARE/VA for all, and Medicaid/Medicare for adults*

ACA enrollment



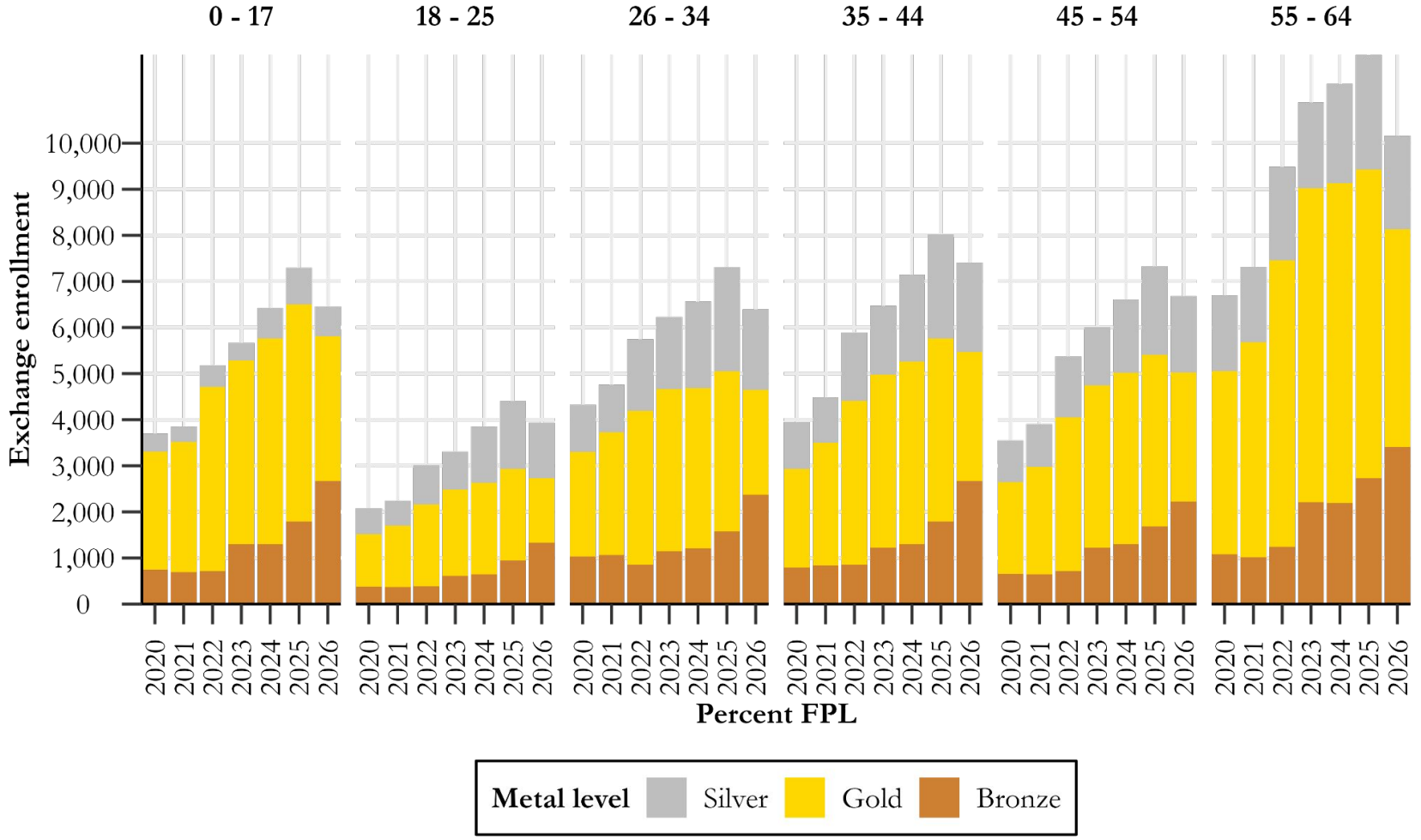
Data: Open enrollment PUFs

ACA enrollment by income (FPL)



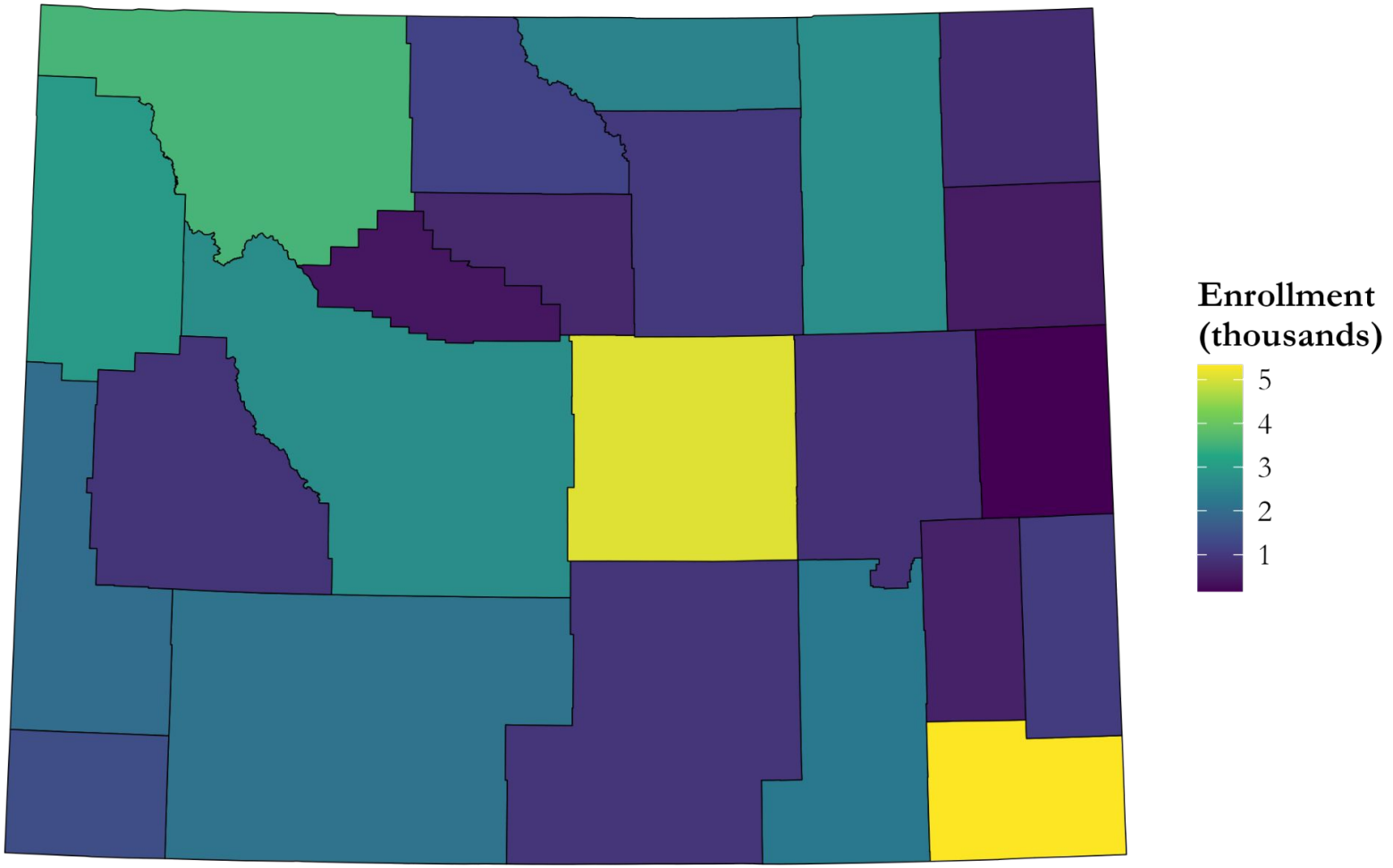
Data: Open enrollment PUFs

ACA enrollment by age group



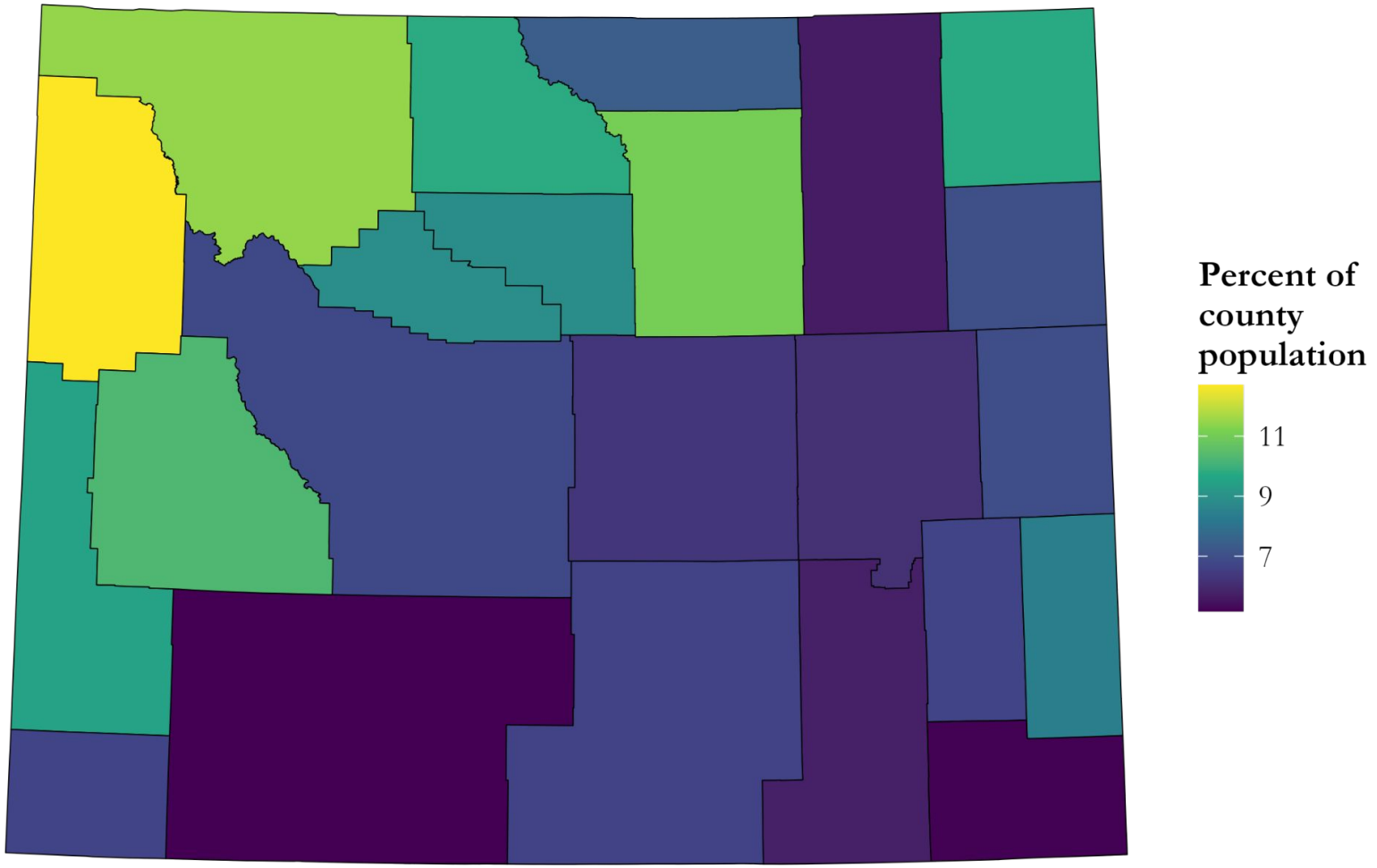
Data: Open enrollment PUFs

2025 ACA enrollment by county



Data: Open enrollment PUFs

2025 ACA enrollment as percentage of county population



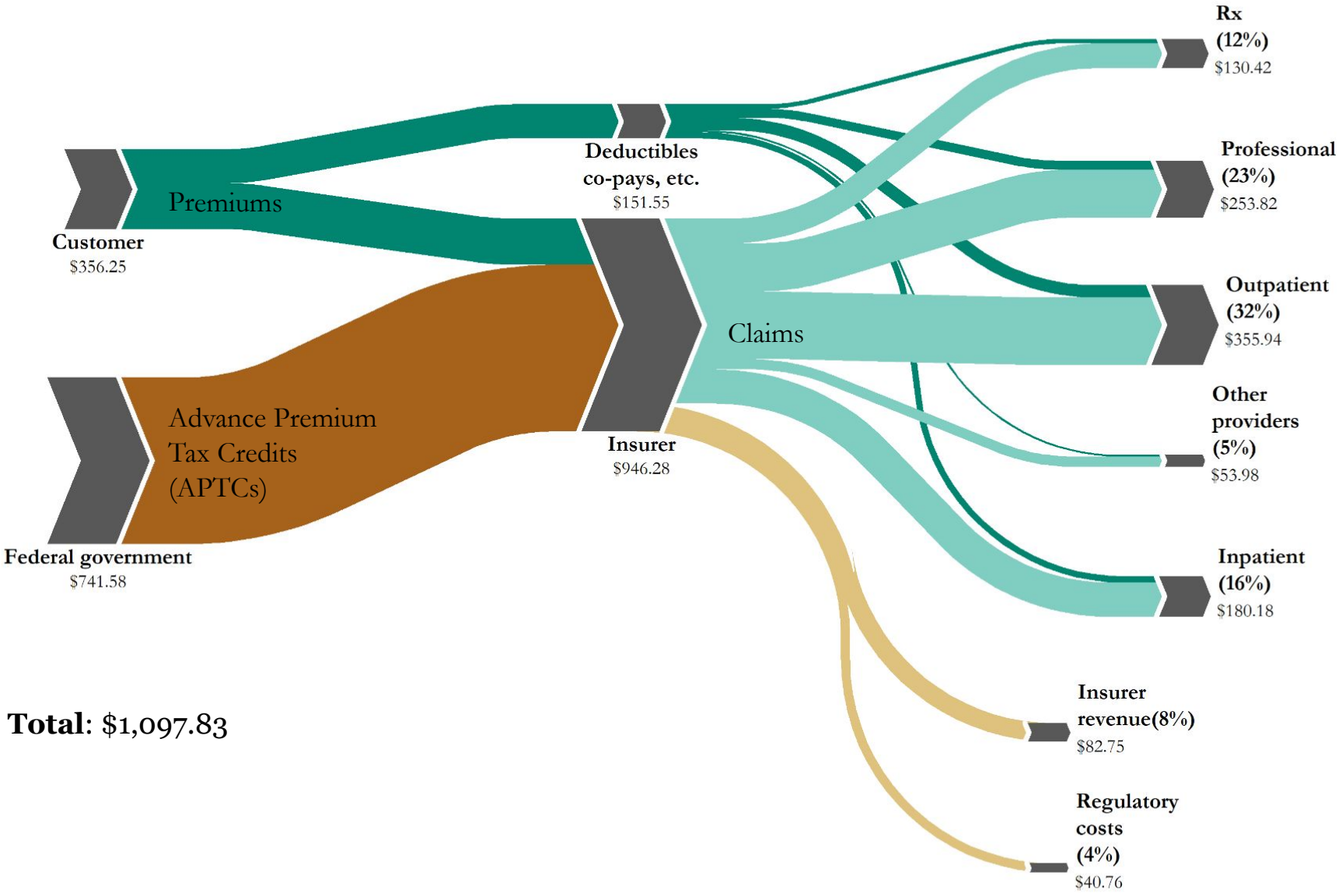
Data: Open enrollment PUFs

Estimated Wyoming ACA market trends

Year	Enrolled	Claims	Premium	Subsidies	Subsidy %	Raw MLR
		(millions of dollars)				
2014	11,970	$65	$77	$35	45%	84%
2015	21,092	$134	$153	$98	64%	88%
2016	23,770	$174	$180	$123	68%	97%
2017	24,826	$188	$191	$119	62%	98%
2018	24,529	$191	$270	$203	75%	71%
2019	24,852	$194	$274	$208	76%	71%
2020	24,574	$196	$276	$215	78%	71%
2021	26,728	$250	$273	$217	79%	91%
2022	34,762	$311	$350	$283	81%	89%
2023	38,565	$384	$453	$343	76%	85%
2024	42,293	$468	$475	$392	82%	99%
2025	46,643	$545	$563	$448	80%	97%
2026	37,643	$507	$550	$300	55%	92%

Data: CCIIO MLR reporting, enrollment PUFs

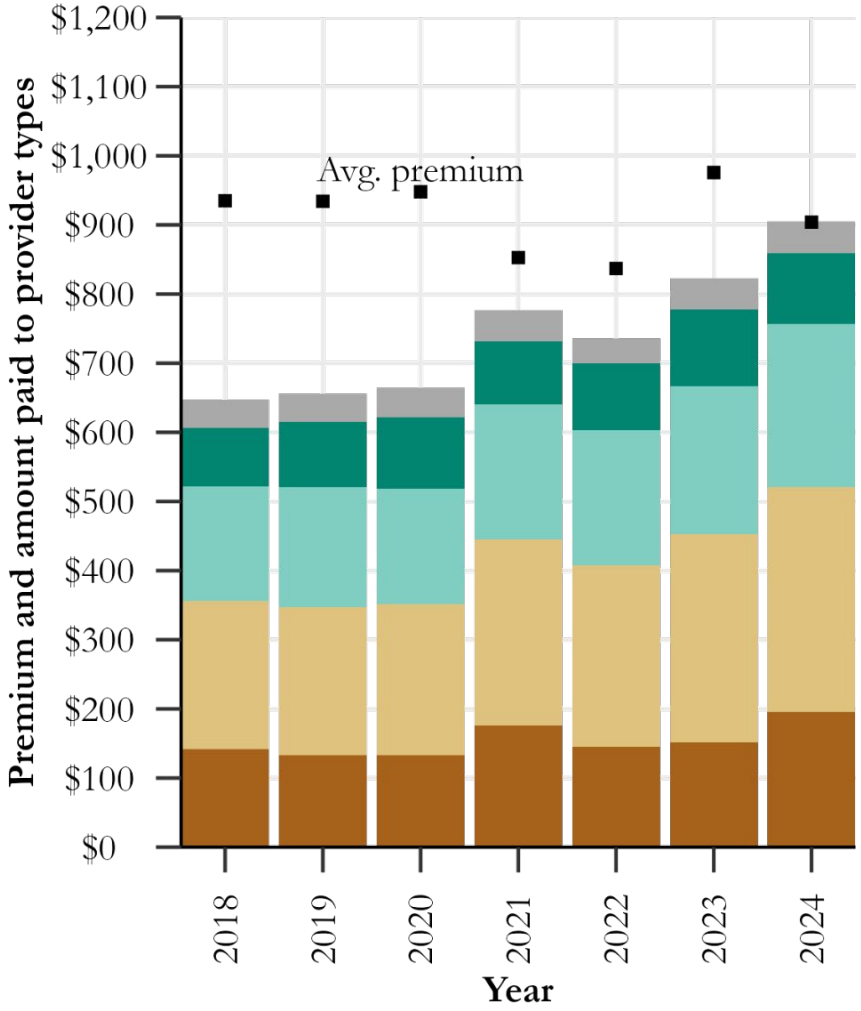
Individual marketplace payment flows - 2023

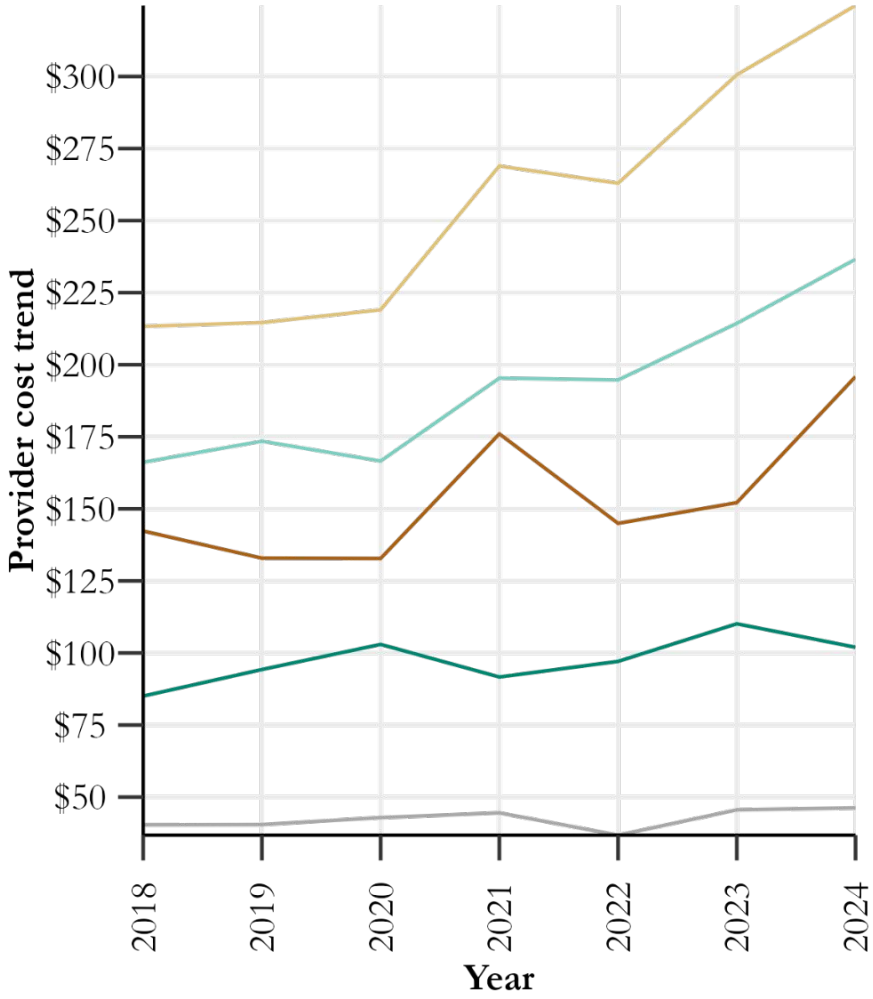


Total: $1,097.83

Data: CCIIO rate reviews, 2023 experience

ACA premium and provider cost trends





Data: CCIIO rate reviews, 2023 experience

What now?

- **Define the problem**
  - What does "affordability" mean? Affordable for whom?
    - People who can't buy subsidized insurance?
    - People with high health care costs?
    - Employers?
    - The federal government?
  - What is the role of State government (if any)?
- **Explore policy options to address the defined problem**
  - Apply concepts (e.g. adverse selection, moral hazard) to assess pros and cons, risks, feasibility

Why is health policy so hard?

"Every dollar of health spending is someone else's health-care income … including fraud, waste and abuse."

- Uwe Reinhardt

[citing Alfred E. Neuman's Cosmic Law of Health Policy]