The Impact of Pre-Deductible Features in Select Marketplaces

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EXECUTIVE SUMMARY

The US Department of Health and Human Services (HHS) has proposed new "standardized" plan benefit options for the individual federally-facilitated marketplace (FFM) in 2017[1]. The standardized plans have prescription drugs and office visits covered before the deductible is applied. While the standard options will not be mandatory in 2017, HHS encourages carriers participating in the marketplaces to offer standard levels of cost sharing on a set of defined services, many of which will not be subject to deductibles.

This report, commissioned by Families USA, illustrates the potential impact on premiums and member out of pocket costs if some of the existing popular plans in the FFM shifted to the standardized benefits. We analyzed three plans offered in the 2016 marketplace with relatively few pre-deductible services in states with substantial enrollment[2]. We focused on Silver plans because they concentrate most of the current enrollment[3]. In particular, we studied two of the four standard options: the Silver plan, which determines the premium subsidy levels, and the Silver 87% cost sharing reduction (CSR) level plan, one of the three options with reduced cost sharing for eligible people. The plans selected for the analysis are the lowest or second lowest premium Silver plans in the respective states.

The marketplace plans selected for this analysis provide coverage for some or all of office visits and drugs only after a deductible is met. To determine the potential impact on these plans of offering standardized benefits where these benefits are covered before deductible, we simulated costs for the current benefits and also for the standardized benefit. The simulation allows us to illustrate the effects on cost sharing and plan costs. It is not a prediction of rate changes for these plans as carriers will consider many factors when determining 2017 rates.

Figure 1 shows a summary of changes in the components of healthcare cost from moving to the standard benefits for the average member under the marketplace plan designs in our study. Lower cost sharing implies higher plan costs and therefore higher premiums. So while the average member's out of pocket spending increases for some plans and decreases for others, the total cost change (premium plus cost sharing) to a member is close to zero. Premium changes were +/- 5% for the plans analyzed.

Figure 1. Change in Components of Cost from Moving to Standard Plan (2017) for Selected Plans in Three States

Based on 2016 Marketplace Benefits (projected to 2017) and Standard Silver and Silver 87% CSR Benefits

	Change in Components of Cost					
	Silver Plan without Cost Sharing Subsidy*			Silver 87% Cost Sharing Reduction Plan		
Cost Component	Pennsylvania	Virginia	North Carolina	Pennsylvania	Virginia	North Carolina
Total Medical + Drug Spending[1]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average Member Cost Share	11.8%	-11.1%	-3.0%	4.3%	-3.6%	-8.0%
Member Premium (before Subsidies)	-4.1%	4.9%	1.1%	**	**	**
Total: Member Premium plus Cost Sharing[2,3]	-0.5%	0.5%	0.1%	**	**	**

[1]Equals plan covered expenses plus member cost share ("Allowed costs")
[2]Premium is before subsidy

[3]Note: Percent changes in the components of total member cost (premium and cost sharing) are not additive because they are calculated on different dollar amounts
(*) Silver plan is not eligible for premium subsidy.
(**) Member premium is determined by member income and second lowest Silver plan premium.

These results suggest that, for current Silver plans with limited pre-deductible benefits, moving to a standardized design might be a modest driver of premium changes. In addition, the total cost to the average member (including out of pocket cost sharing) is unlikely to change materially. While this report displays results for particular plans in three states, sensitivity analysis around geographic cost variations indicate that the range of changes will be similar for FFM sold plans in other states. Plans that already cover office visits or prescription drug benefits before the deductible will likely have even more modest changes if they converted to a standardized plan.

It's worth noting that out of pocket cost sharing can affect member behavior. The simulation used for this study holds utilization constant to examine direct changes in costs. Actual carrier premiums will reflect many factors including any anticipated changes in utilization due to changes in cost sharing levels. While these results reflect the cost impact of benefit design changes to the average member, cost changes for specific members will differ for a number of reasons.

This report was commissioned by Families USA and reflects the authors' findings and opinions. It should not be interpreted as an endorsement of any particular regulation by Milliman. Because extracts of this report taken in isolation can be misleading, we ask that this report be distributed only in its entirety. Two of the authors, Gabriela Dieguez and Bruce Pyenson, are members of the American Academy of Actuaries and meet its qualification standards to issue the opinions in this report.

BACKGROUND

In March 2016, the US Department of Health and Human Services (HHS) proposed optional "standardized" benefits that plans could sell in the individual marketplaces for the 2017. One feature of the standardized benefit designs is that a set of frequently used services will not be subject to a deductible. This benefit feature makes certain types of medical care lower cost for members who have not met their annual deductible in a given year. However, pre-deductible benefit features may lead to higher costs for health plans, which ultimately are passed to members in the form of higher premiums, unless they are balanced by reduced benefits after the deductible to meet actuarial value requirements.

We measured the premium impact of offering the standardized plans compared to a sample of plans with no pre-deductible services (except for the obligatory preventive care) in states with high marketplace enrollment. For this comparison, we examined plans that:

1. Were offered in states with marketplace enrollment higher than 400,000 individuals (Pennsylvania, North Carolina, and Virginia),
2. Were the lowest or second lowest premium Silver plans in the region, where most of the enrollment is concentrated, and
3. Covered limited or no pre-deductible services (except for preventive care)

The Silver plans that meet these criteria in 2016, and their Silver 87% CSR variations, tend to offer relatively similar deductible and cost sharing levels (within the same metal tier). Most of the popular Silver and 87% CSR Silver plans that we analyzed do not impose a deductible for frequently used services such as primary care or specialist visits, generics, and preferred brand drugs; less frequently used services such as inpatient stays, emergency room, and non-preferred brand and specialty drugs are more likely to be subject to the deductible

To analyze the potential impact of moving to standardized plan designs from these type of existing plans, we selected marketplace benefit designs with little or no pre-deductible coverage for office visits and drugs. These plans were located in three states with high enrollment: Pennsylvania, Virginia, and North Carolina. Figures 2a and 2b provide a summary of the sample plan designs from the 2016 Individual FFM. The deductible and out of pocket maximum values have been trended forward from their original 2016 values (as found on www.healthcare.gov) so that the selected plan can be compared on an even basis to the 2017 HHS standardized plan designs.

Figure 2a. Summary of Benefits - Silver Plans without Cost Sharing Subsidy for Selected Plans in Three States

	2017 HHS Standardized Silver Plan		2017 Sample Pennsylvania Silver		2017 Sample Virginia Silver		2017 Sample North Carolina Silver	
	All		Pennsylvania		Virginia		North Carolina	
Service Category	Cost Sharing	Deductible Applies?	Cost Sharing	Deductible Applies?	Cost Sharing	Deductible Applies? [1]	Cost Sharing	Deductible Applies?
Deductible	$3,500		$2,100		$4,200		$5,000	
Out of Pocket Maximum	$7,150		$6,800		$7,150		$5,000	
Primary Care Visit	$30	N	$25	Y	$25	N	$25	N
Specialist Visit	$65	N	$50	Y	$50	N	0%	Y
Emergency Room	$400	Y	$500	Y	30%	Y	0%	Y
Outpatient Surgery	20%	Y	0%	Y	20%	Y	0%	Y
Inpatient Hospital Stay	20%	Y	$750	Y	20%	Y	0%	Y
Generic Drugs	$15	N	$10	Y	$15	Y	$10	N
Preferred Brand Drugs	$50	N	$50	Y	$40/50%[2]	Y	0%	Y
Non-preferred Brand Drugs	$100	N	20%	Y	$60/50%[3]	Y	0%	Y
Specialty Drugs	40%	N	30%	Y	50%	Y	0%	Y

[1] A separate deductible of $260 (trended to 2017)applies to prescription drugs
[2]Greater of $40 copay or 50% coinsurance
[3]Greater of $60 copay or 50% coinsurance

Figure 2b. Summary of Benefits - Silver 87% Cost Sharing Reduction Plan for Selected Plans in Three States

	2017 HHS Standardized Silver 87% CSR Plan		2017 Sample Pennsylvania Silver 87% CSR		2017 Sample Virginia 87% CSR		2017 Sample North Carolina 87% CSR	
	All		Pennsylvania		Virginia		North Carolina	
Service Category	Cost Sharing	Deductible Applies?	Cost Sharing	Deductible Applies?	Cost Sharing	Deductible Applies? [1]	Cost Sharing	Deductible Applies?
Deductible	$700		$600		$550		$1,400	
Out of Pocket Maximum	$2,000		$2,350		$1,400		$1,400	

Primary Care Visit	$10	N	$10	Y	$25	N	$25	N
Specialist Visit	$25	N	$30	Y	$50	N	0%	Y
Emergency Room	$150	Y	$250	Y	20%	Y	0%	Y
Outpatient Surgery	20%	Y	0%	Y	10%	Y	0%	Y
Inpatient Hospital Stay	20%	Y	$750	Y	10%	Y	0%	Y
Generic Drugs	$5	N	$5	Y	$15	Y	$10	N
Preferred Brand Drugs	$25	N	$40	Y	$40/50%[2]	Y	0%	Y
Non-preferred Brand Drugs	$50	N	20%	Y	50%[3]	Y	0%	Y
Specialty Drugs	30%	N	30%	Y	50%	Y	0%	Y

[1] A separate deductible of $260 (trended to 2017)applies to prescription drugs
[2]Greater of $40 copay or 50% coinsurance
[3]Greater of $60 copay or 50% coinsurance

FINDINGS

We found the estimated pre-subsidy premium impact of moving to the standardized benefit designs varies by plan and region, from about a 4% decrease to about a 5% increase. Premium changes were offset by a change in member cost sharing, such that the total member cost for the average member, which includes premiums (before subsidy) and member out of pocket costs, was similar to what it would be without the change..

However, plan design changes may have implications for premium subsidies. Changes to benefit designs that alter premiums may potentially impact the second lowest Silver plan benchmark, which is used to determine the premium subsidy amount for Silver CSR plans. This impact was not addressed in our analysis and was considered beyond the scope of our work.

Figure 3 shows estimated components of the 2017 per member per month (PMPM) costs for the three plans used in this analysis. We provide a side by side comparison of the commercial plans to the standardized plans in a given region to isolate the impact of the benefit design on total member costs. These results are based on a simulation of claims that reflects the regional market corresponding to the plan selected: mid-Atlantic (for Pennsylvania) and south-Atlantic (for both North Carolina and Virginia).

Figure 3. Components of Cost per member per month (PMPM) for Selected Plans in Three States and the Standard Plan (2017)
Based on 2016 Marketplace Benefits (projected to 2017) and Standard Silver and Silver 87% Cost Sharing Reduction (CSR) Benefits

	Change in Components of Cost					
	Silver Plan without Cost Sharing Subsidy			Silver 87% Cost Sharing Reduction Plan		
	2017 Sample Marketplace Silver	2017 HHS Standardized Silver Plan	Change	2017 Sample Marketplace Silver 87% CSR	2017 HHS Standardized Silver 87% CSR Plan	Change
2017 Sample Pennsylvania Silver Based on claims simulation for Mid-Atlantic region						
Total Medical + Drug Spending	$454.79	$454.79	0.0%	$454.79	$454.79	0.0%
Average Member Cost Share	$117.32	$131.11	11.8%	$52.51	$54.76	4.3%

Member Premium (before Subsidies)	$397.03	$380.80	-4.1%	*	*	*
Total: Member Premium plus Cost Sharing[2,3]	$514.35	$511.91	-0.5%	*	*	*
2017 Sample Virginia Silver Based on claims simulation for South-Atlantic region						
Total Medical + Drug Spending[1]	$472.53	$472.53	0.0%	$472.53	$472.53	0.0%
Average Member Cost Share	$144.11	$128.08	-11.1%	$54.20	$52.23	-3.6%
Member Premium (before Subsidies)	$386.38	$405.23	4.9%	*	*	*
Total: Member Premium plus Cost Sharing[2,3]	$530.49	$533.32	0.5%	*	*	*
2017 Sample North Carolina Silver Based on claims simulation for South-Atlantic region						
Total Medical + Drug Spending[1]	$472.53	$472.53	0.0%	$472.53	$472.53	0.0%
Average Member Cost Share	$131.99	$128.08	-3.0%	$56.78	$52.23	-8.0%
Member Premium (before Subsidies)	$400.63	$405.23	1.1%	*	*	*
Total: Member Premium plus Cost Sharing[2,3]	$532.63	$533.32	0.1%	*	*	*

[1]Equals plan covered expenses plus member cost share ("Allowed costs")
[2]Premium is before subsidy
[3]Note: Percent changes in the components of total member cost (premium and cost sharing) are not additive because they are calculated on different dollar amounts
(*) Member premium is determined by member income and second lowest Silver plan premium.

To test the sensitivity of these results, we observed how the cost changes vary by geographic area. Figure 4 summarizes the changes in the components of cost from moving to the standard benefits in different regions, using regional claims data in our simulation for four areas: Nationwide, Mid Atlantic, South Atlantic, and South West. The values shown below represent the percent difference in costs between the selected marketplace plan and its standardized version in each region.

Figure 4. Change in Components of Cost from Moving to Standard Plan for Selected Plans in Three States, by Claim Simulation Region (2017)
Based on 2016 Marketplace Benefits (projected to 2017) and Standard Silver Benefits
Claims Simulation for Nationwide, Mid Atlantic, South Atlantic, and South West Regions

	Change in Components of Cost Silver Plan without Cost Sharing Subsidy			
	Nationwide	Mid Atlantic	South Atlantic	South West
2017 Sample Pennsylvania Silver				
Total Medical + Drug Spending[1]	0.0%	0.0%	0.0%	0.0%
Average Member Cost Share	7.7%	11.8%	9.0%	7.8%
Member Premium (before Subsidies)	-2.6%	-4.1%	-3.0%	-2.5%
Total: Member Premium plus Cost Sharing[2,3]	-0.3%	-0.5%	-0.3%	-0.3%
2017 Sample Virginia Silver				
Total Medical + Drug Spending[1]	0.0%	0.0%	0.0%	0.0%
Average Member Cost Share	-7.6%	-9.2%	-11.1%	-11.9%
Member Premium (before Subsidies)	3.2%	4.3%	4.9%	5.0%
Total: Member Premium plus Cost Sharing[2,3]	0.4%	0.5%	0.5%	0.6%
2017 Sample North Carolina Silver				
Total Medical + Drug Spending[1]	0.0%	0.0%	0.0%	0.0%
Average Member Cost Share	-0.3%	-1.0%	-3.0%	-2.8%

Member Premium (before Subsidies)	0.1%	0.4%	1.1%	1.0%
Total: Member Premium plus Cost Sharing[2,3]	0.0%	0.0%	0.1%	0.1%

[1]Equals plan covered expenses plus member cost share ("Allowed costs")

[2]Premium is before subsidy

[3]Note: Percent changes in the components of total member cost (premium and cost sharing) are not additive because they are calculated on different dollar amounts

METHODOLOGY AND SOURCES

We researched benefit designs currently offered on the individual FFMs. There were 38 states that used the federal HealthCare.gov enrollment and eligibility platform in 2016 (including four states with Federally-supported Marketplaces), with the remainder having state-operated Exchanges. We focused on states with high marketplace enrollment in 2016, as reported by the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE)[4].

Marketplace subsidies are based on the cost of the second lowest Silver plan in each region. To estimate plan designs with the greatest amount of enrollment per region in this analysis, we chose plan designs that were either the lowest or second lowest cost Silver and Silver 87% cost sharing reduction (CSR) variant plans on the individual marketplace. We analyzed the top six states by enrollment, each with over 400,000 individuals enrolled in individual marketplaces in 2016: Florida, Georgia, North Carolina, Pennsylvania, Texas, and Virginia.

We obtained the 2016 benefits for 26 Silver and Silver 87% CSR plans in these states from the Centers for Medicare & Medicaid Services (CMS)[5].Many of these plans already have a pre-deductible feature for commonly used benefits. Therefore, we focused on plans that cover these benefits only after the deductible is met. We chose one plan in each state for Pennsylvania, North Carolina and Virginia because of their state's high marketplace enrollment and their plan's limited pre-deductible coverage. Finally, to estimate the changes in the components of cost from moving to the standardized plans in 2017, we trended both the deductible and out of pocket maximum forward at 4%, which is consistent with the recent annual trend of the national out of pocket maximum limit.

We modeled the member cost sharing and plan cost using a model that simulates the payment of claims by the member and health plan under the specified plan's cost sharing features. This model operates on a large sample of medical and pharmacy claims-level data from the Milliman's 2014 *Health Cost Guidelines* database. Claim costs were trended to 2017 using projections from the CMS[6].

To isolate the impact of regional differences, we used a sample of claims for the simulation that reflected the regional market corresponding to the plan selected: mid-Atlantic (for Pennsylvania) and south-Atlantic (for both North Carolina and Virginia). South West and national claims simulation data were used for sensitivity analysis. The simulation of regional claims used a representative sample of 200,000 commercial lives in each region.

The member and plan cost sharing was calculated for each claim, and all claims were then aggregated to derive the average per member per month cost for the sample population. To estimate the premium, we assumed a 15% retention was added to the plan cost to reflect administrative expenses, taxes and fees, and a provision for profit. This retention is illustrative

and does not include the impact of some additional pricing adjustments, such as risk adjustment transfer payments from HHS.

In the marketplaces, carriers have different costs and strategic goals, and many marketplaces exhibit a wide range of premiums for any metallic level. We note that carriers can differ in their enrolled population, reimbursement and networks, and these differences can produce widely different premium rates. While our models produce premium estimates in the range of actual observed premiums, the actual premium impact of benefit changes for specific plans certainly will vary and will depend on the above variables and other considerations.

LIMITATIONS

The figures presented in this report are estimates based on historical data and average members in the geographic areas analyzed. Actual results for specific plans and for specific members will differ for a number of reasons. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in our projections. Random or non-random fluctuations could cause actual results to be different from those presented here.

Because our analysis is based on claim simulations based on historical databases, our estimates do not reflect the potential impact of changes in utilization. It is likely that pre-deductible benefits will result in higher use of services, which may in turn affect premiums to a greater degree than illustrated. We did not attempt to quantify this effect for this study.

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Two of the authors, Gabriela Dieguez and Bruce Pyenson, are members of the American Academy of Actuaries and meet its qualification standards to issue the opinions in this report.

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