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Which plan is best for me?

Consumer transparency issues in an evolving individual health insurance market

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While there has been rigorous debate surrounding the future of the Patient Protection and Affordable Care Act (ACA), one thing can be certain: consumers in the individual and small group health insurance markets will want to understand the future of their health insurance. Finding the balance between giving issuers options for plan designs and features and giving consumers the tools they need to compare and understand their insurance is important. Here we discuss the steps the ACA took to promote consumer knowledge in the individual market surrounding health insurance and the pros and cons of removing such initiatives. We also discuss the impact that can be expected on consumer transparency by the proposed changes from the Department of Health and Human Services' (HHS) in the market stabilization rule and the March 6, 2017, version of the American Health Care Act (AHCA).

Transparency initiatives under the ACA

Consumers often struggle with choosing the health insurance plan that best fits their particular needs.[1] The seemingly endless amounts of plan design options available to consumers can cause significant confusion when shopping for health insurance. Plans can vary based on their services covered, cost-sharing terms (deductibles, copays, etc.), in-network versus out-of-network providers, and plan type—health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), exclusive provider network (EPO), etc.—among others.

The ACA requires ACA-compliant health plans in the individual market to cover essential health benefits (EHBs). The benefits included in EHBs under the ACA are:[2]

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive, wellness, and disease management services
- Pediatric services (pediatric dental can be purchased as a separate policy)

This list may grow from state to state, as states have the option to increase the number of required covered services. When purchasing health insurance through the exchanges created by the ACA, consumers can be confident that the plan will cover at least these 10 benefit categories. Without the EHB requirement, consumers would need to more thoroughly research what specific benefits are covered under a given plan in order to ensure that their anticipated expenses are covered. For example, prior to the ACA policies were available in the individual market that excluded such benefits as maternity, prescription drugs, or preventive care.

The ACA also required each plan to fit into one of four metallic tiers, based on its actuarial value (AV). A plan's AV is defined as the expected paid claims by the insurer divided by the expected allowed charges for all EHBs. This can also be thought of as the expected percentage of claims for EHBs that are paid for by the issuer. For regulatory purposes, a plan's AV is calculated based on a standardized population and set of assumptions as formalized in the Actuarial Value Calculator (AVC) released by HHS. The AV requirement of each metallic tier under the final 2018 Notice of Benefit and Payment Parameters is shown in Figure 1.

FIGURE 1: 2018 AV REQUIREMENTS BY METALLIC TIER

METAL	AV LOW RANGE	AV HIGH RANGE
PLATINUM	88%	92%
GOLD	78%	82%
SILVER	68%	72%
BRONZE*	58%	65 %

* The 2018 benefit and payment parameters allow bronze plans to have AVs up to 65% (the original limit was 62%) if the plan meets certain criteria discussed in detail below.

1 Frakt, A. (November 1, 2015). Why consumers often err in choosing health plans. New York Times. Retrieved March 17, 2017, from https://www.nytimes.com/2015/11/02/upshot/why-consumers-often-err-in-choosing-health-plans.html?_r=0.

2 Patient Protection and Affordable Care Act (PPACA) §1302(b)(1).

Catastrophic plans are also available to certain consumers based on their age or their ability to qualify for a hardship exemption. Such plans are not required to be valued by the AVC, but there are restrictions on the deductible and maximum out-of-pocket levels.

A qualifying silver plan must have an AV between 68% and 72%. For a plan with a 70% AV, that plan is expected to cover, on average, 70% of the costs for an insured's claims that fall into one of the EHB categories. Plans that fall outside of the ranges in Figure 1 are not currently allowed under the ACA in the individual and small group markets. However, many consumers enrolled through the exchanges under the ACA are enrolled in reduced cost-sharing silver plans, with AVs at either 73%, 87%, or 94%, depending on their income levels. Under these plans, issuers are reimbursed by the government for the difference in member cost sharing between the reduced cost-sharing plan and the standard silver plan.

Even though issues with the HHS AV Calculator have been noted,[3] consumers are still able to compare and shop for plans more easily when plans are split into these metallic tiers. By bucketing plans into one of these four metallic tiers, the ACA gave consumers information in terms of knowing which plans have comparable cost-sharing parameters. Without these metallic tiers, consumers would be on their own to determine which plans are comparable.

Finally, the ACA defined the maximum deductible and out-of-pocket limit available in the marketplace for in-network services in a given year. For plans in 2018, the limit is $7,350.[4] While this limits the amount of options available to consumers, they can be confident that their out-of-pocket expenses will never exceed this amount.

Transparency options in future policy changes

Whether it is repealing and replacing the ACA or simply making modifications to the existing legislation, the new administration and Congress will want to carefully consider consumer understanding of their health insurance.

Option #1: Leave metallic tiers and EHBs alone. One option available to policy makers would be to maintain the metallic tier and EHB requirements used by the ACA and focus the changes on other aspects of the law.[5] The goal of this approach is to bucket plans into categories that are actuarially similar in order to simplify consumer shopping and plan comparisons.

Option #2: Expand the allowable ranges for each metallic tier. The final 2018 Notice of Benefit and Payment Parameters[6] allows for increased plan design flexibility for bronze plans sold in 2018. Bronze plans can have actuarial values up to 65% (rather than 62%, which was used in plan years 2014 through 2017) if the plan meets one of the following criteria:

- Is a high-deductible health plan (HDHP)
- Has at least one major service not subject to the deductible

Bronze plans that do not meet either of these requirements are still subject to a maximum AV of 62%. This change reduces the minimum possible AV differential between a bronze and silver plan from 6% (62% versus 68%) to 3% (65% versus 68%). It is interesting to note that with the expanded ranges there can be a larger difference between a low AV silver plan (68%) and a high AV silver plan (72%) than there is between a high AV bronze plan (65%) and a low AV silver plan (68%). In other words, it is possible for two different silver plans within the proposed range to have a greater cost-sharing difference than a bronze and silver plan.

HHS has proposed a market stabilization rule[7] that would, among other actions, allow insurers to offer plan designs that fall within -4%/+2% of the average AV for a given metallic tier. Under this scenario, a silver plan would be defined as any plan with an AV between 66% and 72%. Bronze plans would be defined as any plan with an AV between 56% and 65% (only plans that meet the criteria mentioned above can be allowed to have AVs between 62% and 65%). However, based on the current limitations on deductibles and maximum out-of-pocket amounts, the leanest possible bronze plan has an AV of 58.5%, resulting in a practical range of 58.5% to 65%.

While the expanded range proposal gives more benefit plan options to insurers and consumers (and potentially lower premiums), it may not give consumers the information they desire. Under the current structure, the minimum AV difference between a bronze and silver plan is 3% (68% versus 65%). The expanded range decreases this difference to only 1% (66% versus 65%).

3 Alcocer, P. (October 29, 2015). Actuarial Value, Benefit Richness, and the Implications for Consumers. Milliman Healthcare Reform Briefing Paper. Retrieved March 17, 2017, from **http://us.milliman.com/insight/2015/Actuarial-value--benefit-richness--and-the-implications-for-consumers/**.

4 CMS (December 22, 2016). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program. Federal Register. Retrieved March 28, 2017, from **https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018**.

5 Busch, F. et al. (January 18, 2017). Repeal, Replace, or Reform: Key Policy Discussions Affecting the Individual Health Insurance Market. Milliman White Paper. Retrieved March 17, 2017, from **http://us.milliman.com/insight/2017/Repeal--replace--or-reform-Key-policy-discussions-affecting-the-individual-health-insurance-market/**.

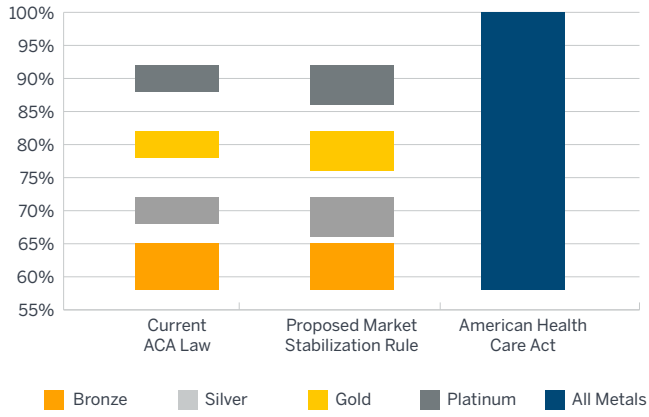
6 HHS Notice, ibid.

7 HHS (February 17, 2017). Patient Protection and Affordable Care Act; Market Stabilization. Federal Register preview. Retrieved March 17, 2017, from **https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-03027.pdf**.

Reducing the difference between metallic tiers is likely to reduce consumer transparency because most consumers will view plans in a given metallic tier as having relatively similar cost-sharing structures. If the bucketing approach is maintained under future policy changes, then consumer transparency will be maximized when there are significant differences between the various buckets so that each is distinct from all other buckets.

Option #3: Remove metallic tiers and/or EHB requirements to maximize design flexibility. A third option available to policy makers would be to remove the metallic tier approach used by the ACA, which is included in the proposed March 6, 2017, version of the AHCA.[8] Although the AHCA does maintain the EHB requirements from the ACA, more flexibility could be given to issuers by reducing the number of required covered benefits. This would open the door for issuers to offer a wide range of benefit options, both in terms of covered services and required member cost sharing. Theoretically, this would allow issuers to offer plans with actuarial values anywhere from 0% to 100%. However, under the proposed AHCA, the actuarial value of such plans would be limited to around 58.5%[9] by maintaining the maximum amount an issuer can charge for a deductible or maximum out-of-pocket. Figure 2 shows the actuarial value options available to issuers under the ACA, the proposed market stabilization rule, and the AHCA.

FIGURE 2: ACTUARIAL VALUES OPTIONS



Consumer transparency considerations

In order to maintain consumer transparency under scenarios without predefined metallic tier buckets, such as the American Health Care Act, issuers could be required to submit each plan's actuarial value with the filing, which would then be made available to consumers when shopping for plans.

Many consumers may require additional resources in order to understand what an actuarial value represents, because presentation as a numerical value may be more confusing to some than grouping plans by metallic tiers. A calculator similar to the current HHS AV Calculator would need to be used by all issuers so that each reported AV is calculated on a consistent basis. The March 6, 2017, version of the AHCA maintains the federal EHB requirement. However, if the EHB requirement is removed, then a standard set of benefits would need to be defined in order to ensure that each plan's actuarial value uses the same denominator (the average allowed charges for the prescribed benefits). This means that, for two plans with identical cost-sharing structures, where one covers prescription drug benefits and the other does not, the one covering prescription drugs will have a higher AV than the one excluding this benefit because not covering prescription drugs can be thought of as covering prescription drugs with 100% member cost sharing.

If future legislation maintains the EHB requirement from the ACA, then consumers can still be confident that each plan covers the 10 benefits listed above. However, if the EHB requirement is removed, then a standardized format of covered benefits will make comparisons more efficient and less burdensome for consumers. This will allow consumers to quickly determine which plans exclude certain benefits, such as maternity or prescription drugs.

Another option to help the consumer understand the cost sharing of different plan options would be similar to the cost calculator used by the Medicare Advantage program. This could be combined with an approach where issuers submit their actuarial values in order to give more detail. Consumers would be able to enter in the drugs they are currently taking and calculate their expected cost under each plan. Consumers might also be able to compare cost sharing under various other scenarios, such as going to the emergency room or having a baby, to compare what their expected cost would be under each scenario by plan. However, this cost calculator approach would be more challenging to develop than that used by the Medicare Advantage plans. For Medicare Advantage, the cost calculator can be developed using the standardized Medicare fee schedules. In the individual market, each insurer negotiates its own fee schedules with providers. Therefore, the cost to the consumer is not only impacted by their expected services and the cost sharing of the plan chosen, but also by the fee schedules of the selected insurer. To further complicate the cost calculator approach, even different networks within the same insurer can have different fee schedules. The consumer will need to be carefully educated about any simplification of the underlying fee schedules and the limitations.

Providing a cost calculator to consumers may provide more value to them than having issuers submit the actuarial values of plans. This is because actuarial values are intended to be

8 American Health Care Act. Join the Fight. Retrieved March 17, 2107, from https://housegop.leadpages.co/healthcare/.

9 The 58.5% is based on the 2018 AV Calculator and the maximum out-of-pocket allowed in 2018. Future changes in these two items could cause this minimum AV to change.

the expected portion of claims covered by the issuer across all members in that plan, whereas the cost calculator can provide the consumer an estimate of their expected cost sharing under a given scenario. A consumer shopping for a silver plan with a 70% actuarial value who mainly expects to utilize preventive services will see that their expected cost sharing is low from the cost calculator (the AV close to 100% because preventive services require no member cost sharing). Another consumer shopping for a silver plan who has a chronic illness with significant medical costs (but still below the maximum out-of-pocket level) will see from the cost calculator that their expected cost sharing will be high, which is due to a large deductible and copays.

Figure 3 demonstrates the difference in percentage of claims paid by the issuer (or actuarial value) with one member who utilizes only preventive services and another member whose chronic illness results in a $3,000 inpatient facility stay. This scenario assumes both members are enrolled in the same silver plan, which has a $1,000 deductible, 25% member coinsurance, a $4,500 maximum out-of-pocket amount, and that preventive services require no member cost sharing.

FIGURE 3: COST-SHARING EXAMPLE

ITEM	MEMBER 1	MEMBER 2
SERVICES UTILIZED	PREVENTIVE SERVICES	INPATIENT FACILITY STAY
ALLOWED CLAIMS	$100	$3,000
MEMBER-PAID CLAIMS	$0	$1,500
INSURER-PAID CLAIMS	$100	$1,500
PERCENTAGE OF CLAIMS PAID BY ISSUER	100%	50%

Other issues

There are several other issues to consider when discussing the proposed legislative changes for the individual health insurance market. For example, the current risk adjustment program under the ACA includes a risk score adjustment for each member based on the metallic tier of that member. If metallic tiers are removed, then how will the risk adjustment methodology be altered? Also, if federal law no longer requires plans to fall into one of the metallic tiers, will states pass laws requiring plans to fall into prescribed AV ranges? Finally, will consumer demand increase with more plan design options?

It is important for future legislation to carefully consider the balance between giving consumers and issuers options and having transparency about what plans are being offered. Maintaining a version of the metallic tier approach used by the ACA allows for consumers to better make comparisons across plans but decreases plan options. Requiring the submission of plan actuarial values provides some transparency in the absence of metallic tiers but the AV concept is not easily understood outside of the insurance community and will take a significant education effort. Although using a cost calculator may provide the most transparency for an individual making a plan selection, the development of a universal industry calculator will be significantly more complicated than the version used by the Medicare Advantage program.

Caveats and limitations

Esther Blount is a consulting actuary with Milliman and Andrew Bourg is an associate actuary with Milliman. Both are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to issue this report and render the actuarial analysis contained herein. The report reflects the authors' findings and opinions, which are not necessarily representative of the views of Milliman and its other employees. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the prior written consent of Milliman.

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