Health exchanges: Impact of health plan benefit changes on cost and utilization

Mary van der Heijde
FSA, MAAA

Doug Norris
ASA, MAAA, PhD

The Patient Protection and Affordable Care Act (PPACA) mandates changes to health insurance products if they are to be sold through an exchange starting in 2014. For products to be included inside the exchange, they must meet or exceed the minimum requirements for one of the bronze, silver, gold, or platinum plans based upon their "actuarial equivalence." As well, products must cover a series of mandated "essential" benefits. Some changes, such as providing preventive care with no cost sharing, apply to all plans, not just those sold through the exchange, and have already gone into effect. These benefit design changes will not only affect insurer cost because of changes in member cost sharing, but in fact may result in several other consequences—most notably changes in utilization by members as they respond to new plan designs.

EFFECTS

Health insurance benefit designs affect patient behavior. While some medical care is absolutely necessary, many other services are elective. This dynamic is further complicated by the level of member cost sharing required; depending on how much they have to pay out of their own pockets, patients may choose different providers, which affects the overall cost of care. Providing richer benefits can change member behavior because it reduces the out-of-pocket cost and thereby increases utilization of services. Certain medical services are highly susceptible to increased demand induced by changes in cost sharing. In addition, if a member must pay $1,000 for Hospital A, but the in-network alternative Hospital B is only $100, it is likely members will prefer Hospital B.

Significantly increasing the benefit richness of a plan can also create a potential for adverse selection. Typically, less healthy members opt to purchase products with lower cost sharing, because the member expects to require more care. Less healthy members will likely be attracted to the gold and the platinum products in the exchanges, and healthier members will be attracted to the bronze and silver products, causing adverse selection within those populations. A primary concern among insurers is how the mix of benefit options currently available in the market will change because of adverse selection. There are significant mechanisms within the PPACA to attempt to adjust for differences in health status, in order to equalize the impact of health status on health plans.

Other items such as changes in marketing practices can also bring about changes in product mix. Additionally, the gold and platinum products are sold at higher premium levels, and therefore if profits are on a percentage-of-premium basis, then these are more appealing to insurers and, hence, may be more heavily marketed by some insurers. Both of these factors, along with increased transparency in covered benefits, may increase the visibility of higher-end plans to consumers.

If consumers have perfect knowledge of the product offerings, changes in the mix of products purchased will largely depend on the health status of the new entrants into the exchange. If a large portion of these new entrants are unhealthy, there may be a shift toward richer products. With the supply remaining the same in the short term and induced demand from richer products, the average claim cost and therefore price of coverage may rise.

On the other hand, the relative health of new entrants will have a significant impact upon cost and utilization. The newly insured population will likely be a mix of healthy and unhealthy members, who will make plan choices that are optimal for their situations. The healthy members are likely to go for leaner products while the unhealthy are likely to go for the richer products, thus exacerbating the adverse selection process. As it stands now, it is difficult to predict changes in the mix of products selected.

BENEFIT CHANGES

All plans offered through the exchange must fall into one of four categories based on "actuarial equivalence" (bronze, silver, gold, or platinum) or offer catastrophic coverage for young adults. The actuarial values of the plans should be 60% for bronze plans, 70% for silver plans, 80% for gold plans, and 90% for platinum plans. Insurers participating in the exchanges must offer at least one silver and one gold plan. Starting in 2014, the annual cost sharing for exchange plans

cannot exceed $5,000 for single coverage and $10,000 for family coverage (the limit will be indexed annually thereafter). The deductible for 2014 cannot exceed $2,000 for single coverage and $4,000 for other coverage for employer-sponsored plans in the small group market. Thereafter, the deductible limit is indexed.

Health plans must also cover the Essential Benefits Package as defined in the law. The Essential Benefits Package generally includes coverage for ambulatory services, emergency services, hospitalizations, maternity, mental health and substance abuse treatments, prescription drugs, rehabilitation services, preventive and disease management services, and pediatric care. More specific details about coverage are yet to be laid out by the Department of Health and Human Services.

Health plans are also required to provide preventive care, as defined primarily by the United States Preventive Services Task Force, at zero cost sharing.

Plans may also offer through the exchange catastrophic coverage for young adults (those under 30 years of age), and for persons who are exempt from the individual coverage mandate. The deductibles on these plans should not exceed the amounts specified as the out-of-pocket limits for health-savings-account-qualified high-deductible health plans, and deductibles cannot apply to at least three primary care visits. The stated intent of allowing these products to be sold and count as creditable coverage for these younger members is to address the issue that young, healthy members are likely most prone to not purchase insurance and merely pay the penalty. However, inclusion of these members into the rest of the insurance pool is an important element of maintaining a lower average member cost. At the same time, a likely result of the existence of catastrophic coverage is that many of these young, healthy members will opt out of buying a bronze through platinum product in lieu of these less expensive catastrophic options. Removal of these younger and healthier members from the overall pool may increase the average claim cost of the members who do purchase coverage within the bronze through platinum plans. Because these lower-cost members are not purchasing the bronze through platinum plans, the overall average cost of the members with bronze through platinum plans would be relatively higher, resulting in an increase in average premiums.

COMPARISON TO CURRENT MARKET

Using the Milliman Health Cost Guidelines™ (HCGs), we estimate the expected impact on cost and utilization of various benefit designs offered within the exchange. If the shift is from higher-deductible plans to lower-deductible plans, then, in addition to the reduced cost sharing, plans must also account for changes in member behavior that often constitute significant portions of a plan's cost increases.

We have generated illustrative examples of benefit designs that correspond to the mandated actuarial values of the bronze through platinum plans, based on a nationwide average experience. These examples are shown in Figure 1.

FIGURE 1: EXAMPLES OF BENEFIT DESIGNS FOR VARIOUS ACTUARIAL VALUES

Plan	Actuarial Value	Deductible	Out-of-Pocket Maximum	Coinsurance
Platinum	90%	$250	$2,000	15%
Gold	80%	$500	$4,000	35%
Silver	70%	$1,500	$5,000	45%
Bronze	60%	$2,000	$7,500	50%

* These are illustrative designs only, and are not required by the PPACA.

Using the HCGs as our guide, we find that the illustrative platinum plan in Figure 1 costs 15.6% more than the gold plan. Of this 15.6% difference in cost, 3.2% is the result of 3% higher utilization in the platinum plan, while the other 12.4% comes from lower member cost sharing. The higher utilization is the expected member behavioral response to lower cost sharing. This difference in cost does not include the impact of adverse selection, which must be accounted for separately. Similarly, the illustrative gold plan is expected to cost 18.6% more. Six percentage points of this higher cost is the result of a 4% higher utilization than the silver plan, and the rest is due to lower member cost sharing. The illustrative silver plan is expected to cost 13% more. Three and a half percentage points are the result of 2% higher utilization than the bronze plan.

WHAT DOES THIS MEAN?

Insurers need to be aware of the potential for increased utilization and adverse selection from the new, richer portfolio of products that may appear on the market. It is important to properly prepare for and manage the potential for increased utilization and adverse selection when designing plans for entry into the exchange. Although the risk adjustment process may compensate for some of the increased cost from higher morbidity, understanding the changes in utilization patterns caused by adverse selection will be critical for controlling cost.

Mary van der Heijde, FSA, MAAA, is a principal and consulting actuary with the Denver office of Milliman. Contact her at mary.vanderheijde@milliman.com.

Doug Norris, ASA, MAAA, PhD, is an associate actuary with the Denver office of Milliman. Contact him at doug.norris@milliman.com.

FOR MORE ON MILLIMAN'S HEALTHCARE REFORM PERSPECTIVE

Visit our reform library at www.milliman.com/hcr
Visit our blog at www.healthcaretownhall.com
Or follow us on Twitter at www.twitter.com/millimanhealth