Plan design strategies in the ACA marketplace

A review of Unified Rate Review Template data

Jordan Paulus, FSA, MAAA
Abigail Caldwell, ASA, MAAA

Milliman

INTRODUCTION

Although premium rates have always been a major consideration for consumers purchasing healthcare, the Patient Protection and Affordable Care Act (ACA) brought significant changes to the way many consumers shop for and purchase healthcare when marketplaces opened in 2014. New regulations grouped plans into metallic levels based on benefit richness, with the intent of allowing consumers to more easily compare plans. The federal marketplace at Healthcare.gov allows consumers to input their expected utilization levels (low, medium, or high) and sort plans by total plan cost (including both premium and cost sharing); however, because the default display sorts by premium level only, the first screen a potential marketplace consumer will see shows the lowest-premium plans first (not plans with the lowest total expected cost). This creates a climate where many insurers looking to achieve greater membership might attempt to do so by offering lower prices and gaining the advantage of being a consumer's first impression of the marketplace.

Not all low-price strategies are winning strategies. The ability to offer quality, low-cost, profitable coverage is limited by interactions with other stakeholders (such as reimbursements to providers), as well as regulatory constraints. One commonly used strategy to reduce premiums is to offer less rich plans, but insurers are constrained by ACA metallic level requirements. Metallic levels are assigned based on the "actuarial value" (AV) associated with the plan, which represents the portion of total average costs for a given set of benefits that are covered by the plan after applying cost sharing. Plans can be categorized as platinum, gold, silver, and bronze, and must have an actuarial value within two percentage points of 90%, 80%, 70%, and 60%, respectively. (For example, a gold plan must be between 78% and 82% AV.) One way for insurers to provide a lower premium is to provide a plan with an actuarial value toward the bottom of the metallic level range.

Although we have seen this practice anecdotally, our research aimed to determine if this represented a widespread practice, as well as to see what other patterns in plan design offerings have been seen in the marketplace during the first three years after the implementation of the ACA. By looking at trends in plan offerings, even at a macro level, insurers may be able to gain insight from the emerging patterns in the market to help frame marketplace strategies in future years.

DATA AND RESOURCES

In order to get a glimpse into what types of plans carriers are offering, and how those plan offerings have changed year after year, we reviewed aggregated Unified Rate Review Template (URRT) data for the three ACA plan years from 2014 to 2016.[1] The results and conclusions below are based on each carrier's assumed enrollment and other data points as entered into the URRT forms. To the extent that there were inaccuracies or inconsistencies in the URRT forms among the contributing carriers, the summaries will reflect these discrepancies. Note that we have not audited or verified these data and other information, but have reviewed them for reasonability. While this data doesn't show actual enrollment by plan, the data does represent insurers' filed estimates, and we can surmise that the plan options and population projections provide insight into how insurers have reacted to consumer preferences.

To the best of our ability, we removed all data from intermediate and unapproved filings, leaving only final approved rates. As mentioned above, methods for completing the URRT likely varied among carriers, especially for the 2014 plan year, which was the first year they were required. Note that the data includes all plans filed and approved, and has not been revised for any carriers that have exited the market since filing. Our objective was to present and summarize carriers' best estimates and projections at the time of filing, and no retrospective modifications were made to the data to account for subsequent changes to market participation.

METALLIC LEVEL AND PLAN TYPE TRENDS

Based on both metallic level and plan type projections, plan offerings in the individual market tended toward lower-cost plan options, while higher-cost options such as gold and preferred provider organization (PPO) plans were preferred in the small group market.

As shown in the table in Figure 1, projected membership in silver plans grew significantly in 2015 and 2016. This may have been due to a higher-than-expected portion of low-income members who selected cost-sharing reduction (CSR) plans. Unsurprisingly, projected membership for gold and platinum plans is a significantly smaller portion of the total projected membership in the individual market by 2016. Meanwhile,

[1] The Center for Consumer Information & Insurance Oversight (January 26, 2016). Rate Review Data. CMS.gov. Retrieved January 26, 2016 from https://www.cms.gov/CCIIO/Resources/Data-Resources/ratereview.html.

small group enrollment splits by metallic level remained stable year-to-year, with the highest projected membership in gold plans. Because of the ambiguity of the anticipated market composition when carriers were pricing for 2014, compared with later years, it is likely that the projections in 2015 and 2016 are more accurate reflections of the distribution of membership by metallic level.

Figure 1: Projected Membership by Year, Metallic Level

Market	Metal Level	2014	2015	2016
Individual	Platinum	7%	6%	6%
Individual	Gold	15%	15%	12%
Individual	Silver	45%	54%	57%
Individual	Bronze	30%	24%	23%
Individual	Catastrophic	4%	1%	2%
Small Group	Platinum	15%	14%	18%
Small Group	Gold	41%	43%	41%
Small Group	Silver	34%	33%	33%
Small Group	Bronze	11%	10%	8%

The table in Figure 2 shows a significant decrease from 2015 to 2016 in projected membership in PPO plans in the individual market, shifting to other narrow network and HMO plans. The trend is present, but less pronounced in the small group market.

Figure 2: Projected Membership by Year, Plan Type

Market	Plan Type	2014	2015	2016
Individual	EPO	10%	11%	13%
Individual	HMO	47%	39%	47%
Individual	POS	3%	7%	7%
Individual	PPO	40%	43%	32%
Small Group	EPO	7%	9%	11%
Small Group	HMO	22%	27%	27%
Small Group	POS	20%	17%	16%
Small Group	PPO	52%	48%	46%

Plan design offerings in the small group market reflected a greater preference for choice. There were over three times as many plans offered on the small group market in 2016 as offered on the individual market, both overall and on a per carrier basis.

ACTUARIAL VALUE DISTRIBUTION

The charts in this section show the distribution of AVs[2] within metallic levels, split into percentage point increments within the metallic ranges. Because each metallic range is +/-2%, a perfectly even split would put 25% of members in each bucket.

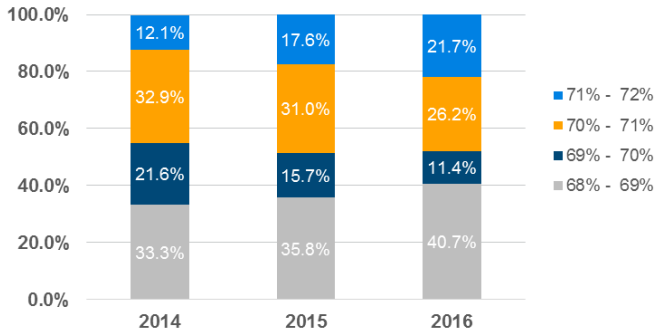
[2] For all identification of actuarial values, the "AV Metal Value" row of the URRT was used to assign metallic level ranges.

For individual silver plans, as shown in Figure 3, issuers' 2014 projections assumed that one-third of members would be in plans in the 68% to 69% range, and another third in the 70% to 71% range. As insurers reacted to 2014 experience, 2016 projections were revised such that the proportion of projected members in the 68% to 69% range increased to over 40%, while the 70% to 71% range decreased to 26.2% and the 71% to 72% range increased to 21.7%.

We suspect that the increase in projected membership in the 68% to 69% bucket over time reflects that a portion of members are in fact shopping on price and choosing the cheaper, lower-cost options. At the same time, the growth of the 71% to 72% bucket may be partially attributed to plans that are renewed without plan design changes, because the actuarial value of these plans increases over time as underlying costs increase but deductibles and copayments remain unchanged.

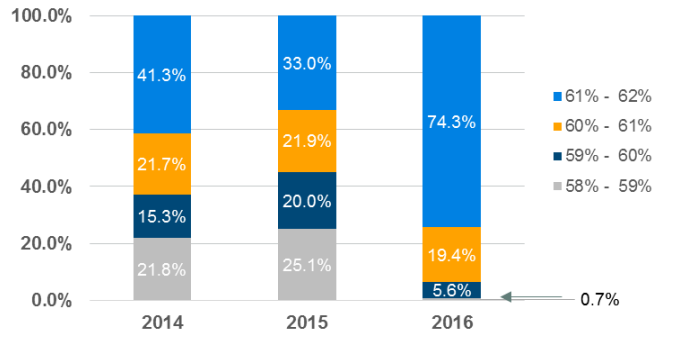
It is also important to note that a significant portion of silver members are enrolled in cost sharing reduction (CSR) versions of silver plans. By enrolling in a silver plan with a low unsubsidized (standard) AV of 68% to 69%, members not only pay lower premiums, but they actually receive a relatively richer benefit after factoring in the CSR subsidies.

Figure 3: AV Distribution, Individual Silver



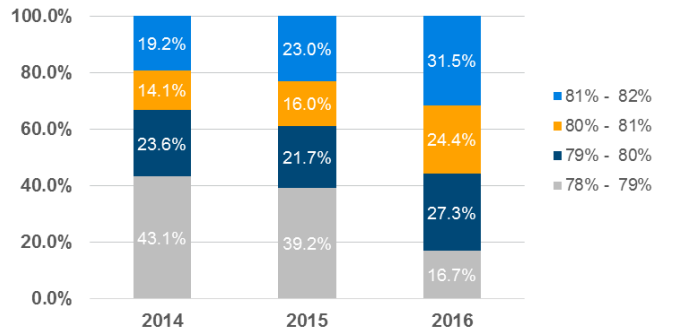
Projected membership for bronze plans, shown in Figure 4, indicates a very different trend. Projected enrollment in plans in the lower half of the AV range slightly grew from 2014 to 2015, but there was very little projected enrollment in these plans in 2016. The U.S. Department of Health and Human Services (HHS) did not release a new AV calculator for the 2015 plan cycle, but did release a new AV calculator for 2016. Many issuers found it difficult to develop plans that were palatable to consumers and in the bottom portion of the metallic level range, or even more than one or two unique designs in total, likely resulting in most plans falling into the 61% to 62% AV range.

Figure 4: AV Distribution, Individual Bronze



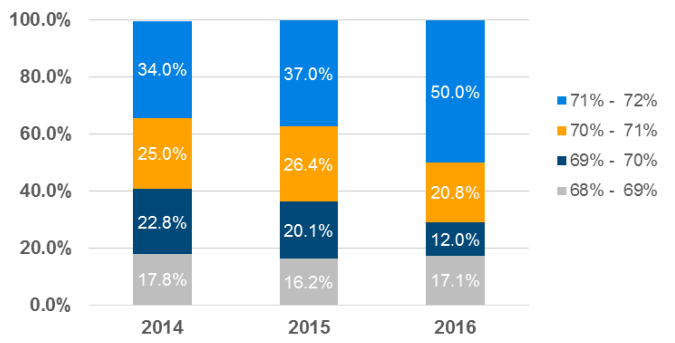
In the small group market, gold plan trends, shown in Figure 5, suggested shifting in membership projections from lower AV ranges in 2014 to higher AV ranges in 2016. Even after the introduction of the marketplace, most small group enrollment is obtained off-marketplace, through the broker community, where more emphasis is put on cost-sharing features during the purchasing process.

Figure 5: AV Distribution, Small Group Gold



Membership projections for silver small group plans, shown in Figure 6, again show an increase in projected enrollment in the higher range (71% to 72%), suggesting an increased emphasis among purchasers on cost-sharing features as compared with the individual market.

Figure 6: AV Distribution, Small Group Silver



CONCLUSION

Individual market membership projections exhibited a preference for lower-cost plans, with health maintenance organization (HMO) plans and plans at the lower-end of the allowable actuarial value range being the most popular. Although we did see a higher portion of members in the 68% to 70% AV range in silver individual plans, this wasn't true across the board—particularly among bronze plans in 2016, where the actuarial value calculator limited the number of bronze plan designs that could be priced.

In contrast, small group membership projections actually shifted toward higher AV ranges within metallic levels, which illustrates different preferences in the small group market, including a larger emphasis on maintaining low cost-sharing features. The greater number of plan design offerings in the small group market—over three times as many as in the individual market—reflect consumer demand for choice in the small group market.

Health plans should develop separate plan design strategies for the individual and small group markets to best serve consumer preferences in each market. In the individual market, cost is king, while the small group market prefers richer plan designs and greater choice (though cost is certainly important). These unique market forces exist to a greater extent than issuers predicted in 2014, as evidenced by the shifting of issuer projections by 2016. Of course, strategies differ by state and even city. This is especially true in small group markets with influential broker communities.

As well, it is important to note that the AV calculator is not a pricing tool, and that while in many cases the calculator's results will correlate well with actual plan richness, this is not always the case. There are a number of aspects of a plan that are important for premium development that are not considered in the AV Calculator, such as refined utilization assumptions, provider discounts, degree of healthcare management, risk scores, and population morbidity. Benefit design is just one of many factors ultimately affecting the final premium rates, and the actuarial value calculated by the AV calculator is a crude simplification of the cost of a plan. Nevertheless, it is interesting to see how the ACA's introduction of the AV Calculator has affected plan design offerings.

Jordan Paulus is a consulting actuary with the Denver office of Milliman. Contact Jordan at jordan.paulus@milliman.com or at 303.672.9064.

Abigail Caldwell is an actuary with the Denver office of Milliman. Contact Abigail at abigail.caldwell@milliman.com or at 303.672.9036.