Report on Cost-Sharing Trends in Health Insurance

Prescribed by the 2019 Joint Chairmen's Report
Budget Code: D80Z01

Submitted to the
Maryland General Assembly
by the
Maryland Insurance Administration

Al Redmer, Jr.
Commissioner

October 01, 2019

For further information concerning this document contact:

Brad Boban, Sr. Actuary
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
410-468-2065

This document is available in alternative format upon request
from a qualified individual with a disability.
TTY 1-800-735-2258

The Administration's website address is: www.insurance.maryland.gov

Committee Narrative

Report on Trends in Health Insurance: The committees request a report on the trends and changes of health insurance benefit design and actuarial value, including cost-sharing and deductibles, of plans offered in the individual and small group market, on and off exchange, for all years between 2013 and 2018, and the impact of these changes on the utilization trends, by service category, reported by carriers.

Information Request: Report on health insurance trends
Author: Maryland Insurance Administration
Budget Code: D80Z01
2019 Joint Chairmen's Report Page: 40
Due Date: October 1, 2019

Executive Summary:

The average Actuarial Value (AV)[1] in the Individual and Small Group marketplaces increased slightly between 2013 and 2015, declined in 2016, and have been increasing between 2016 and 2018. The average medical deductible decreased slightly between 2013 and 2015 and has been increasing at steadily between 2016 and 2018. The average drug deductible saw a large jump between 2013 and 2014 followed by two years of small increases but has gradually been declining since 2016. The average Out-of-Pocket Maximum (OOP Max) has increased for all years from 2013 through 2018 and is converging with the maximum allowable under federal regulation. The impact of these cost-sharing changes on claims utilization trend has been a slight upward pressure on claims trends for all years, except for 2016 which saw a moderate downward impact on claims trends.

Background:

The 2019 Joint Chairmen's Report requested that the Maryland Insurance Administration (MIA) produce an informational report on Trends in Health Insurance. The request stated "The committees request a report on the trends and changes of health insurance benefit design and actuarial value, including cost-sharing and deductibles, of plans offered in the individual and small group market, on and off exchange, for all years between 2013 and 2018, and the impact of these changes on the utilization trends, by service category, reported by carriers."

Methodology and Definitions:

Under the Patient Protection and Affordable Care Act ("ACA"), carriers are required to submit informational Unified Rate Review Templates (URRTs) with each rate filing. Worksheet 2 of the URRT contains plan specific information by Health Insurance and Oversight System (HIOS) ID. For each year from 2014 through 2018, the URRTs for all carriers in the Individual ACA marketplace were combined and all the HIOS IDs in the Individual marketplace were ranked by the combined on and off exchange membership. For each year, a number of plans necessary to represent 95% of total enrollment were chosen as a comprehensive representative sample. Using the membership totals and Actuarial Values (AVs) from the URRT, a membership-weighted AV was computed for each year. For 2013, the most popular pre-ACA plan designs were run through the 2014 AV calculator, with additional adjustments being made to account for essential health benefits that were not yet being covered and to account for deductibles higher than the 2014 AV calculator limit.

To compare deductibles and cost-sharing, the AV calculator screenshots from the approved rate filings for each representative plan were referenced. These screenshots show all the details of plan cost-sharing that were entered into the federal AV calculator to derive the AV. With respect to the deductible, plan designs can either have separate medical and drug deductibles or integrated medical and drug deductibles. Separate deductibles were the norm in

[1] Actuarial Value is defined as the percentage of total average allowed costs for covered benefits that a plan is expected to cover after member cost-sharing is applied. For example, if a plan has an actuarial value of 70%, on average members will be responsible for 30% of the costs of all covered benefits.

the pre-ACA market, with the exception of High Deductible Health Plans (HDHPs) which could be paired with Health Savings Accounts (HSAs). In the ACA marketplace, integrated deductibles have become commonplace even for non-HDHPs that cannot be paired with an HSA. For the purpose of this report, an integrated deductible of a given value such as $6,000 is treated as both a $6,000 deductible in the medical calculation and $6,000 deductible in the drug calculation. This is so that the average deductibles will illustrate the full amount of deductible potentially facing a member who only incurs medical claims or who only incurs drug claims. However, because the integrated nature of the deductible means a member will never pay more than $6,000 in total medical/drug deductible, this methodology means that the average medical deductible cannot be added to the average drug deductible to calculate the average overall deductible. The average overall deductible has been calculated separately at the plan level taking into account the interaction between medical and drug.

Comparing post-deductible cost-sharing is challenging for a number of reasons. First, some carriers are using copays and some are using coinsurances. Second, the copays/coinsurances tend to vary significantly both between broad service categories, and within each service category (different service types and/or sites of service in a given category). Third, the cost-shares interact with deductibles: for a given AV, a higher deductible necessitates lower cost-shares and vice versa. Therefore, in order to quantify the cost-sharing, the OOP Max was used. This represents the maximum cost-sharing (including the deductible) that an Individual would pay for covered services, at which point the carrier would pay 100% of all incurred claims. ACA plans must all have a single OOP max that applies to both medical and drug claims.

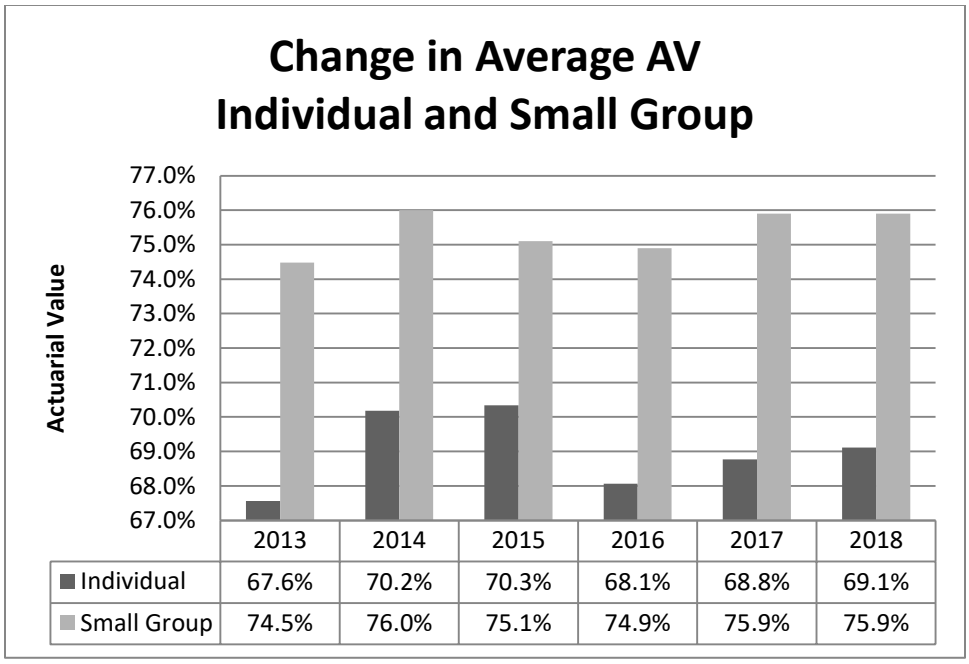
All deductibles and OOP Maxes represent the average values for self-only coverage. Family policies will have higher deductibles and OOP Maxes, as a rule of thumb the family level is twice the self-only level.

To estimate the impact of these AV and cost-sharing changes on utilization trends, the average amount of induced demand has been estimated using the federal induced demand curve from the AV calculator. This curve assumes that a bronze plan does not induce any demand. An average silver plan induces 3% higher utilization than bronze, an average gold plan induces 8% more utilization than bronze, and an average platinum plan induces 15% more utilization than bronze. These estimates are for total medical/drug claims combined. In general, there would be less induced utilization in service categories with little discretion in utilization like inpatient and higher induced utilization in service categories with more discretion, such as professional office visits. However, there is a lack of data to quantify the induced demand on the service category level.

Utilization trends at the service category level have been reported for the Individual Marketplace by combining data for the two remaining carriers, CareFirst and Kaiser. These companies combined comprised 90 to 95% of enrollment, including all of the most popular plans, in early years of ACA and the combined utilization trends are representative of the overall market. The utilization trends at the service category are influenced by a variety of factors including morbidity and demographic changes, change in provider network mix, and change in member cost-sharing. Disentangling the contribution of these different factors would require

significantly more detailed data that has historically been included in the rate filings. Utilization trends for small group have been estimated using the combined data from the same two carrier, to minimize network differences when comparing Individual to Small Group data.

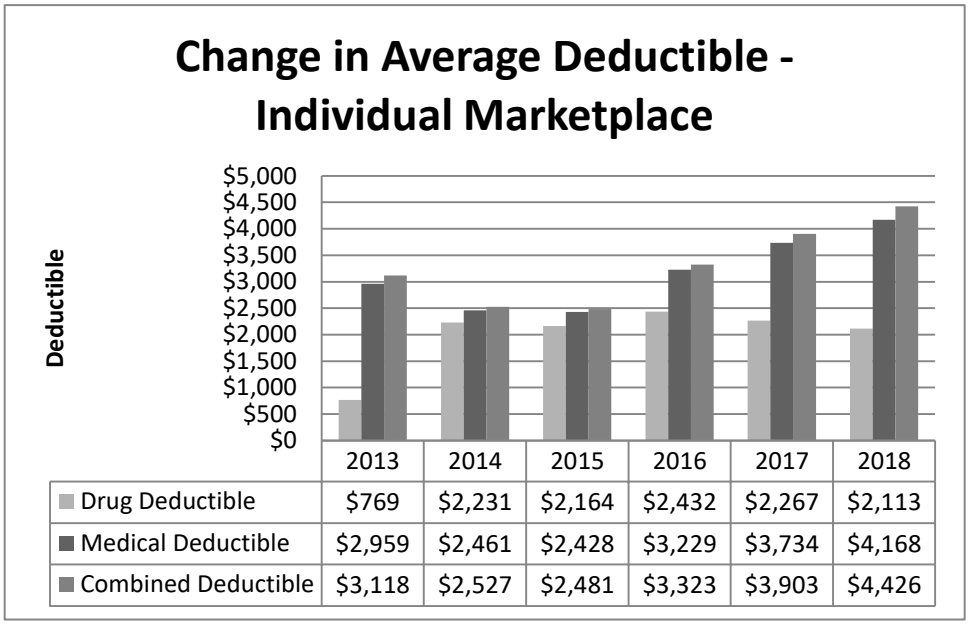
Results:



	2013	2014	2015	2016	2017	2018
Individual	67.6%	70.2%	70.3%	68.1%	68.8%	69.1%
Small Group	74.5%	76.0%	75.1%	74.9%	75.9%	75.9%

The average AV in the Individual market increased from 67.6% pre-ACA to just over 70% (the midpoint of Silver) in 2014 and 2015. This can primarily be attributable to new essential health benefits such as maternity, pediatric dental, and pediatric vision being mandated to be covered under ACA. In 2016, the first year where carriers had ACA experience when developing rates and that experience indicated double-digit rate increases were necessary, the average AV fell to just over 68% (the low-end of the Silver range) as carriers lowered the AVs of their plan designs to offset a portion of the premium increase. AVs since 2016 have been slowly increasing, which can primarily be attributable to deductible leveraging (the average deductible is increasing at a slower rate than the underlying claims).

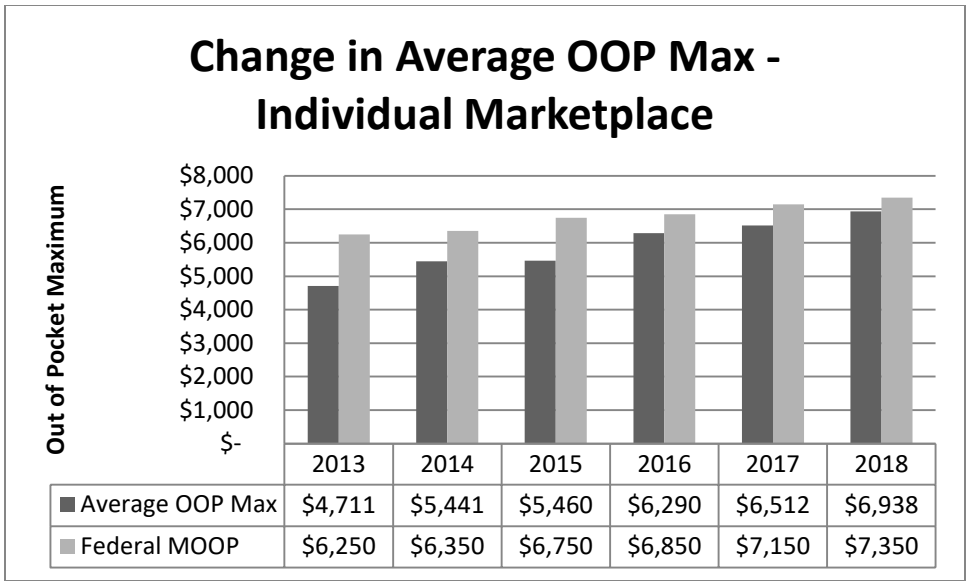
Small Group AVs have been higher than Individual AVs since pre-ACA. The gap between the two markets narrowed by about 1% in 2014 (maternity coverage was more widespread in Small Group than in Individual), but then widened by 1% in 2016 as the Individual market saw a much sharper decline in AV. This leaves about the same 7% gap between small group and Individual AVs in 2018 as was present in 2017.



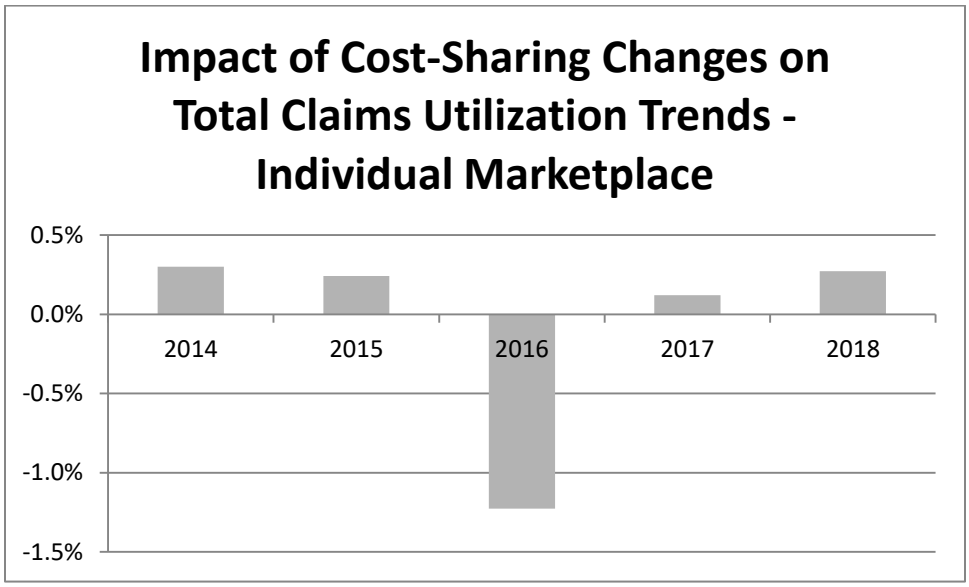
	2013	2014	2015	2016	2017	2018
Drug Deductible	$769	$2,231	$2,164	$2,432	$2,267	$2,113
Medical Deductible	$2,959	$2,461	$2,428	$3,229	$3,734	$4,168
Combined Deductible	$3,118	$2,527	$2,481	$3,323	$3,903	$4,426

The average medical deductible decreased from just under $3,000 pre-ACA to just under $2,500 in 2014 and 2015. This was driven by $10,000 deductible plans being relatively popular in 2013 while ACA did not permit any deductibles higher than $6,350 in 2014. In 2016, the average medical deductible saw a significant increase and that trend continued through 2018.

The average drug deductible increased very significantly between 2013 and 2014, almost tripling in magnitude. This was driven by the fact that pre-ACA, the only plans in the market with an integrated medical and drug deductible were HDHPs. All non-HDHPs incorporated separate drug deductibles of $100 to $500. In 2014, a large number of non-HDHPs were designed with integrated medical and drug deductibles. This was not a requirement of ACA, however integrating the medical and drug OOP Max was a requirement. Carriers chose to integrate the deductible both to achieve lower premiums and for administrative simplification. In 2016, the average drug deductible jumped in line with the medical deductible. But between 2016 and 2018, the trend has reversed, and the average drug deductible has come down.

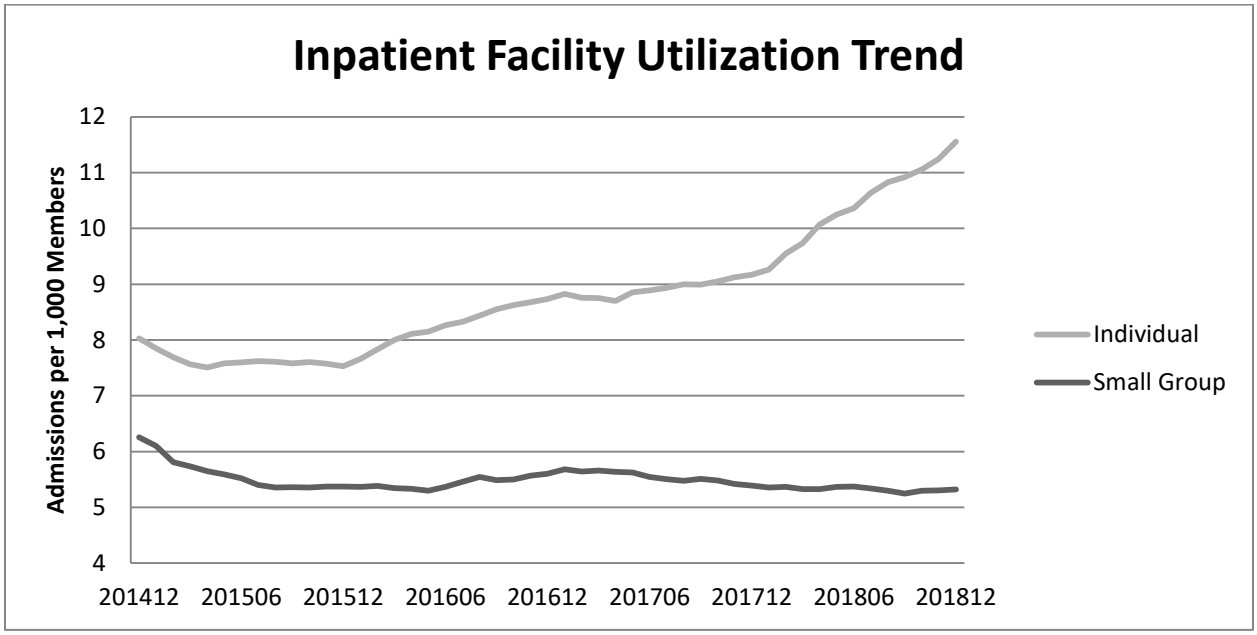


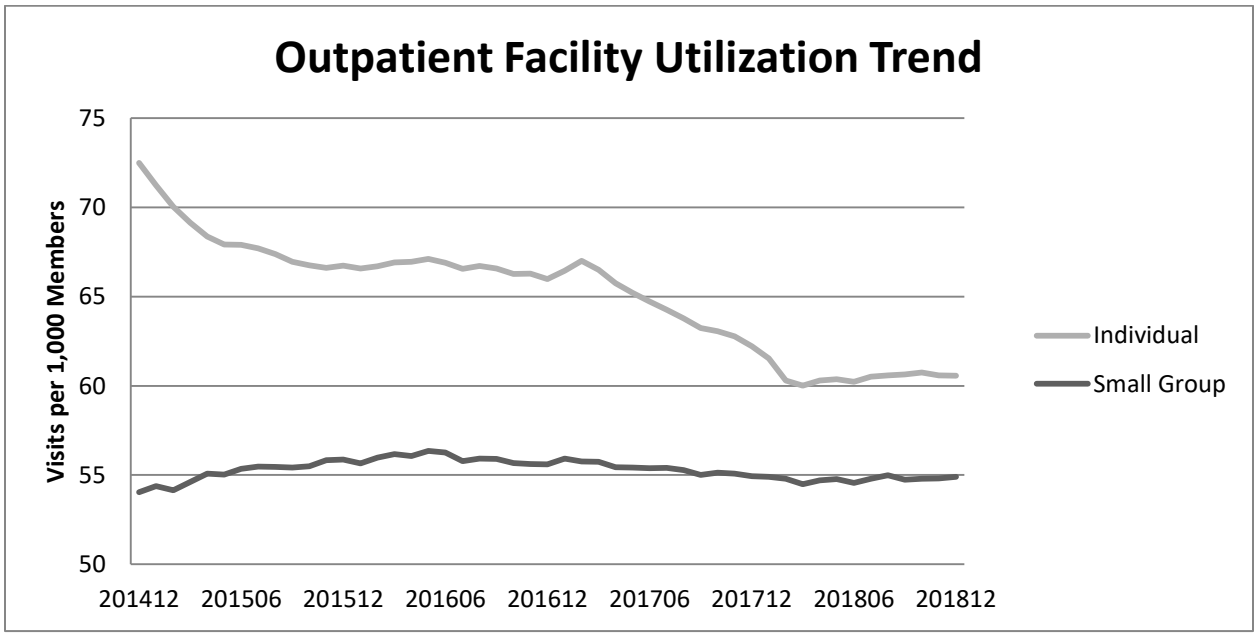
The average OOP max increased from just over $4,700 pre-ACA to just under $5,500 in 2014 and 2015. A significant increase was seen in 2016, in which the average OOP increased to just under $6,300, bringing the average much closer to the maximum OOP (MOOP) permitted under the ACA. Since 2016, the trend has been for the average OOP max to increase at about the same pace as the MOOP.

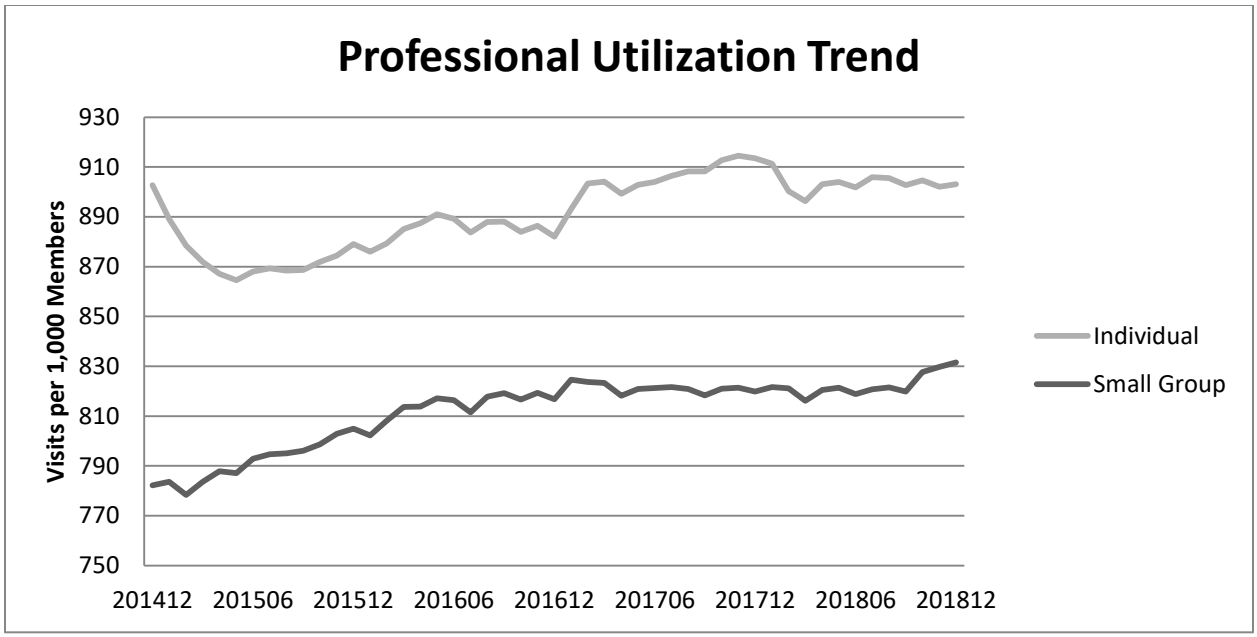


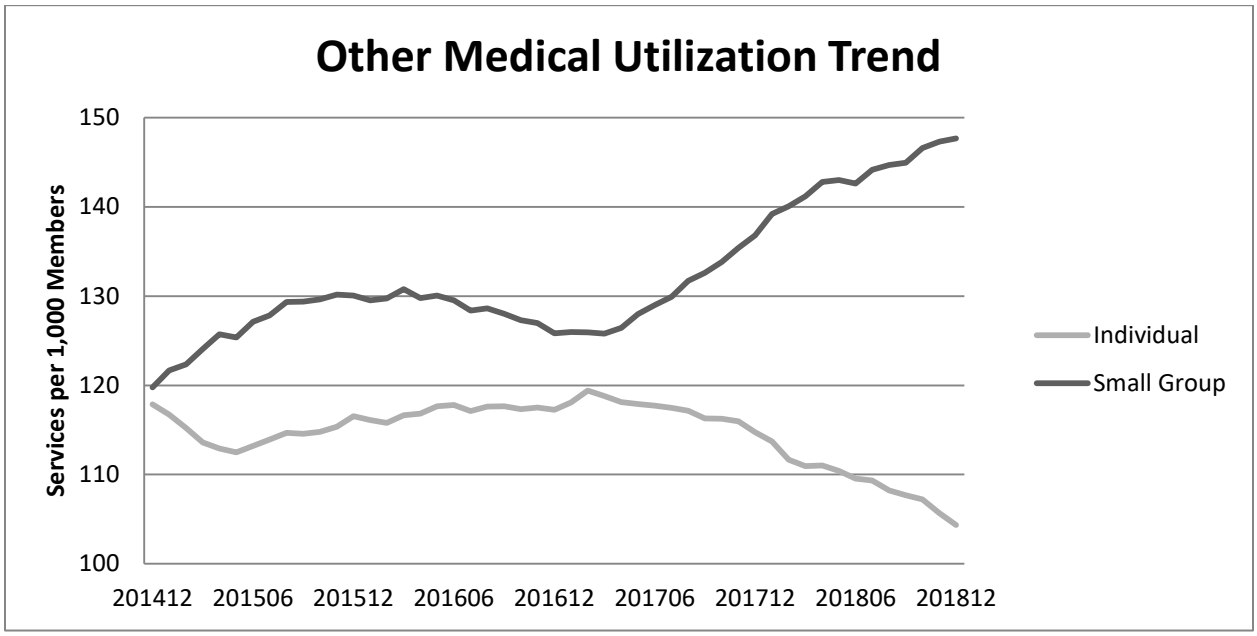
The combined impact of the changes in average cost sharing on the claims utilization trend is summarized in the chart above. In general, these impacts on trends are negatively correlated with the change in AV. When the AV increases and average member cost-share declines, there is upward pressure on the claims trend. And when AV decreases and average member cost-share increases, there is downward pressure on the claims trend.

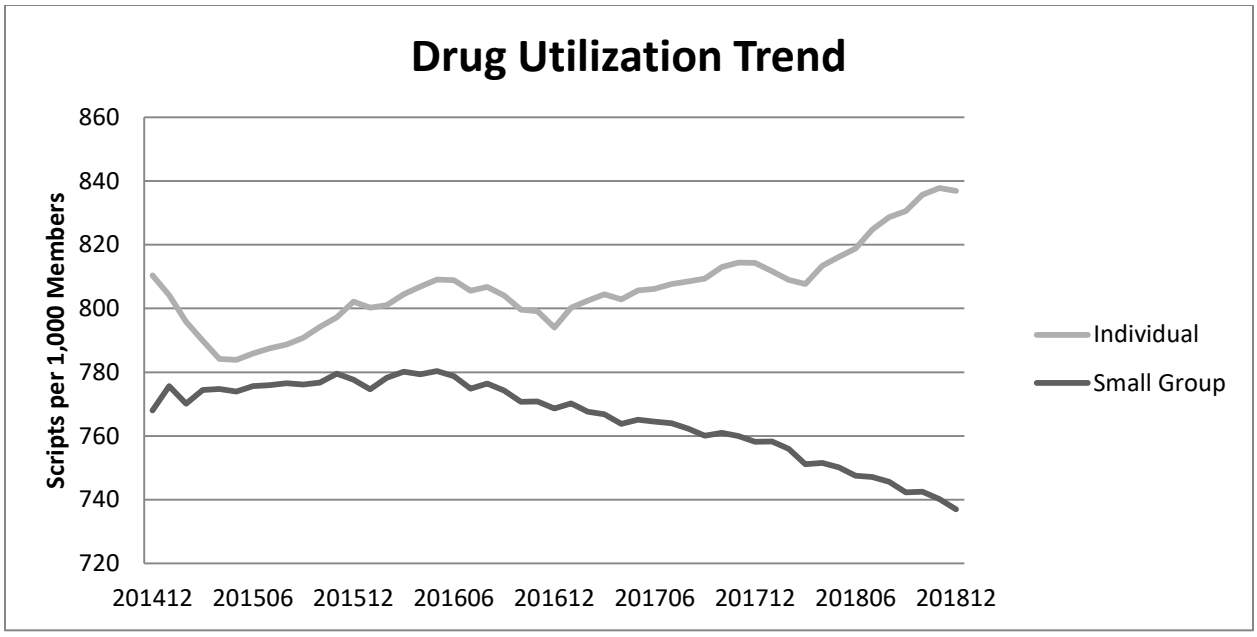
Utilization trends by service category are shown below. These represent raw observed utilization trends in the Individual marketplace between 2014 and 2018. The values reported are "rolling-12" averages in order to adjust for seasonality in the claims utilization pattern. "Other Medical" consists of medical services that do not fall in inpatient/outpatient/professional such as ambulances, home health care, durable medical equipment, pediatric dental, and pediatric vision.






Professional Utilization Trend
Visits per 1,000 Members
930
910
890
870
850
830
810
790
770
750
201412
201506
201512
201606
201612
201706
201712
201806
201812
Individual
Small Group


Other Medical Utilization Trend
Services per 1,000 Members
150
140
130
120
110
100
201412
201506
201512
201606
201612
201706
201712
201806
201812
Individual
Small Group


Drug Utilization Trend
Scripts per 1,000 Members
860
840
820
800
780
760
740
720
201412
201506
201512
201606
201612
201706
201712
201806
201812
Individual
Small Group