

# *Looking Beyond Technical Glitches:*

## *A Preliminary Analysis of Premiums and Cost Sharing in the New Health Insurance Marketplaces*

Monitoring the ACA's Health Insurance Marketplaces | November 2013

### **Background**

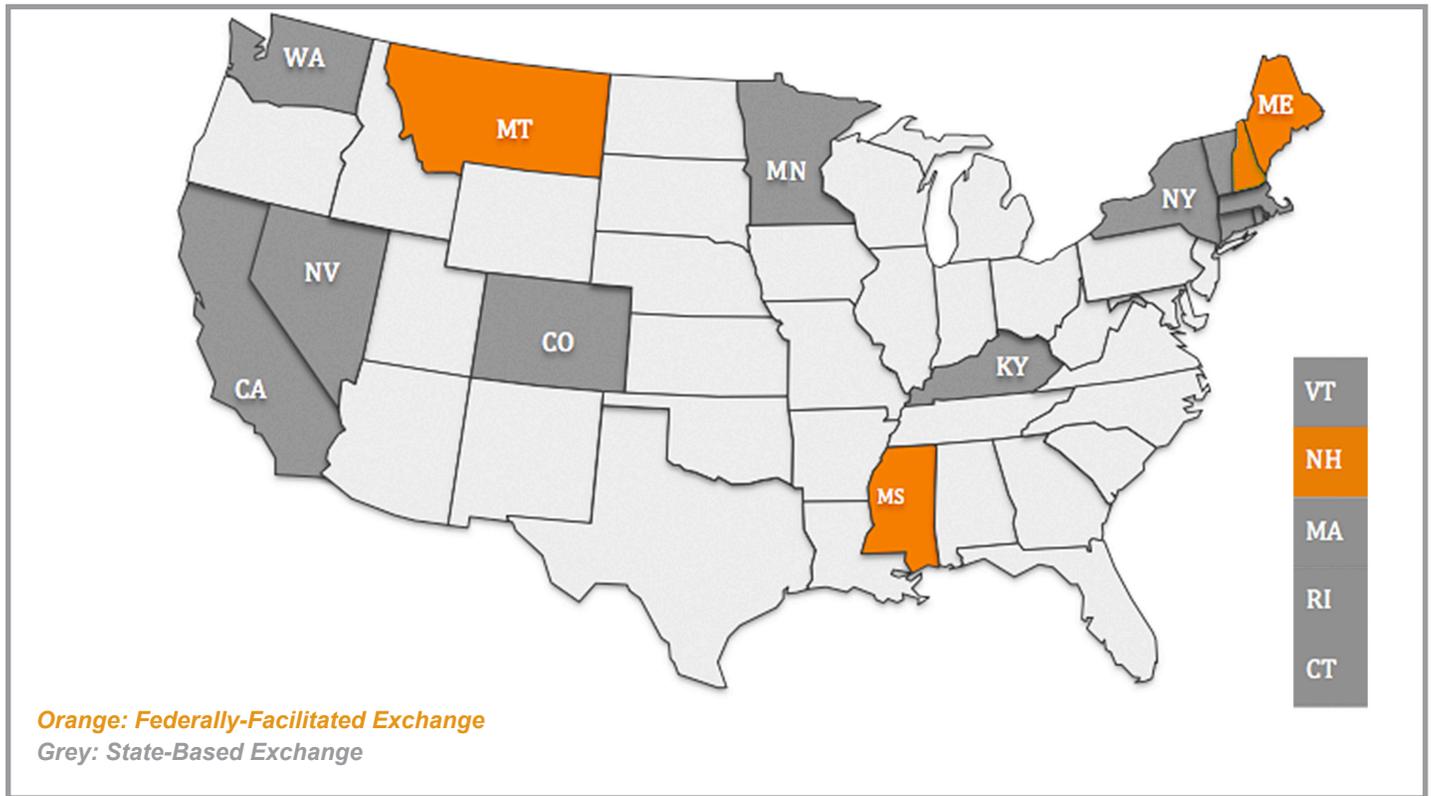
Open enrollment for the Affordable Care Act's (ACA) state health insurance exchanges, or marketplaces began on October 1, 2013. Prior to open enrollment, a great deal of attention had been focused on the premiums for the plans being sold in the new marketplaces. During the last several weeks, however, the systemic problems with healthcare.gov, the website for federally facilitated exchanges (FfEs) and, to a lesser extent, glitches with the websites for state-based exchanges (SBEs) have largely overshadowed any discussion of premiums or other benefit design features associated with these new plans.

In partnership with the Robert Wood Johnson Foundation (RWJF), Breakaway Policy Strategies (Breakaway) is undertaking a review of the plans being offered in all 50 state marketplaces (plus the District of Columbia) that goes well beyond an examination of premiums. Breakaway's researchers are compiling a range of data on the health insurance benefit design features of products offered through the exchanges. This includes, but is not limited to, cost sharing data that encompasses deductibles, out-of-pocket limits and copayment and coinsurance amounts for specific services such as physician visits and prescription drugs. RWJF and Breakaway will release periodic reports summarizing findings from its ongoing analyses, focusing on research results relevant to consumers and health care stakeholders.<sup>1</sup>

In this first report, we provide a snapshot of premiums, deductibles, copayments and coinsurance amounts for primary care physician (PCP) and specialist visits for silver-level plans in 96 rating areas<sup>2</sup> across 15 state marketplaces.<sup>3</sup>

The premiums and cost sharing figures reported here do not reflect premium tax credits and/or cost sharing subsidies for which many applicants will be eligible. According to one analysis<sup>4</sup>, almost half of those predicted to buy insurance on the exchange will be eligible for tax credits that would reduce their premiums. Since premium tax credits are available to individuals and families having incomes up to 400 percent of the federal poverty level (FPL) while cost sharing subsidies are available to those with incomes up to 250 percent of the FPL, the cost sharing amounts reported here apply to more than half of the population now buying insurance in the individual market. Because premium<sup>5</sup> and cost sharing subsidies play an important role in plan selection for those eligible to receive them, an example of how premium tax credits and subsidies reduce an individual's out-of-pocket spending is provided at the conclusion of the report.

Figure 1: State Insurance Marketplaces Surveyed



### State Health Insurance Marketplaces Surveyed

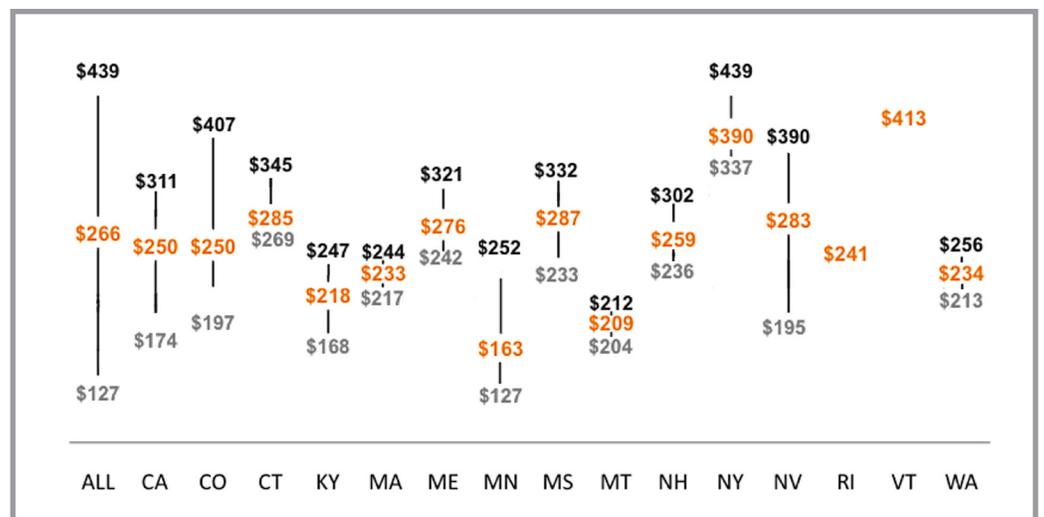
From October 1 through October 11, Breakaway collected and analyzed premium and cost sharing data for 196 silver-level plans<sup>6</sup> in 11 SBEs and 4 FFEs (See Figure 1).<sup>7</sup> We obtained premium information for a 27 year-old individual from the data published by the Centers for Medicare and Medicaid Services (CMS) for plans offered in FFE states and from the state exchange website for plans offered in SBE states.<sup>8</sup> Cost sharing information for plans offered in FFE states was obtained directly from the carriers' websites and data for the SBE states from either the carriers' websites or the state insurance departments.

### Exchange Plan Premiums

The ACA provides federal subsidies in the form of tax credits<sup>9</sup> to offset premium costs for individuals with incomes up to 400 percent of the federal poverty level (FPL). The second-lowest cost silver plan (SLCSP) in an individual's rating area is used as the benchmark for

determining the amount of his or her premium tax credit. For this reason, Breakaway examined premiums and deductibles associated with SLCSPs, which account for 98 of the 196 silver plans surveyed.<sup>10</sup> Although premiums varied from state to state and among rating areas within each state, the average premium for a 27 year-old individual across the 15 marketplaces surveyed was \$266 per month. As shown in Figure 2, premiums ranged from a low of \$127

Figure 2: Low, High, and Average Premiums for Second-Lowest Cost Silver Plans



in Minnesota to a high of \$439 in New York.

### Exchange Plan Deductibles<sup>11</sup>

Of the 98 SLCSPs surveyed<sup>12</sup>, approximately half offer integrated deductibles, under which medical expenses and expenses for prescription drugs all accumulate toward a single deductible.

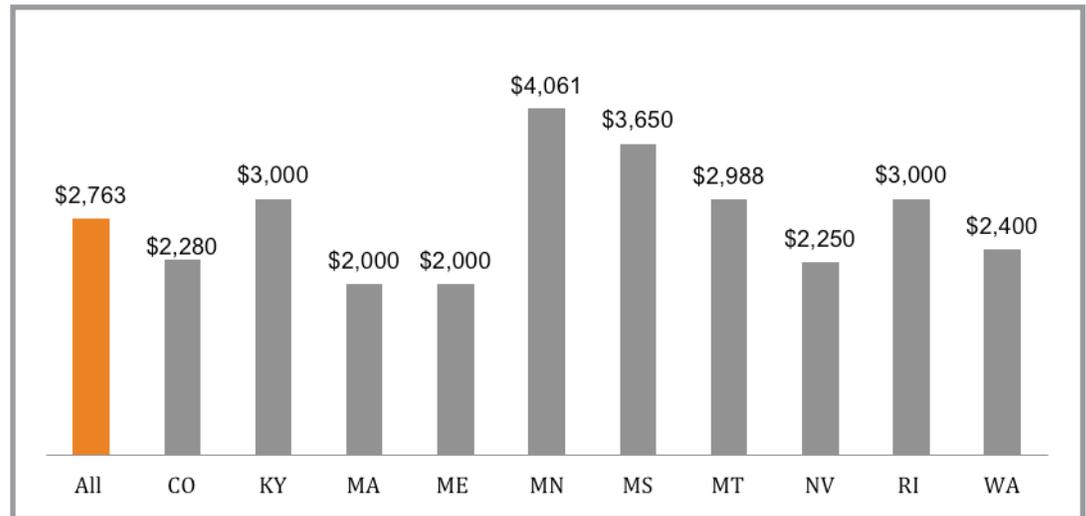
As shown in Figure 3, average integrated deductibles among the plans surveyed range from a low of \$2,000 in Massachusetts and Maine to a high of \$4,061 in Minnesota. The average integrated deductible among the 15 marketplaces is \$2,763.

The other approximately half of plans include two separate deductibles: a medical deductible towards which expenses for medical services accumulate and a drug deductible toward which expenses for prescription drugs accumulate. Among the plans summarized in these findings that include separate medical and prescription drug deductibles, the average medical deductible is \$2,770 (See Figure 4), and the average prescription drug deductible is \$933.

### Exchange Plan Physician Cost Sharing

In addition to premiums and deductibles, Breakaway examined the cost sharing for PCP and specialist visits under the plans analyzed. For this analysis, Breakaway limited its review to cost shar-

Figure 3: Average Integrated Deductibles



ing amounts for in-network services. Where plans reported cost sharing information for more than one in-network tier, amounts for the first tier were utilized. Of the 196 silver plans surveyed, approximately 75 percent (147 plans) charge a copayment for a PCP visit, while 25 percent (49 plans) utilize coinsurance to determine an individual's cost sharing.

Copayments for a PCP visit range from \$0 to \$45 with an average of \$30 (See Figure 5). Coinsurance ranges from 0 to 40 percent with an average of 15 percent (See Figure 6).

For specialist visits, 70 percent (137 plans) charge a copayment; 30 percent (59 plans) utilize coinsurance. Copayments for specialist visits range from \$0 to \$80 with an average of \$47 (See Figure

Figure 4: Low, High, and Average Medical Deductibles for Second-Lowest Cost Silver Plans

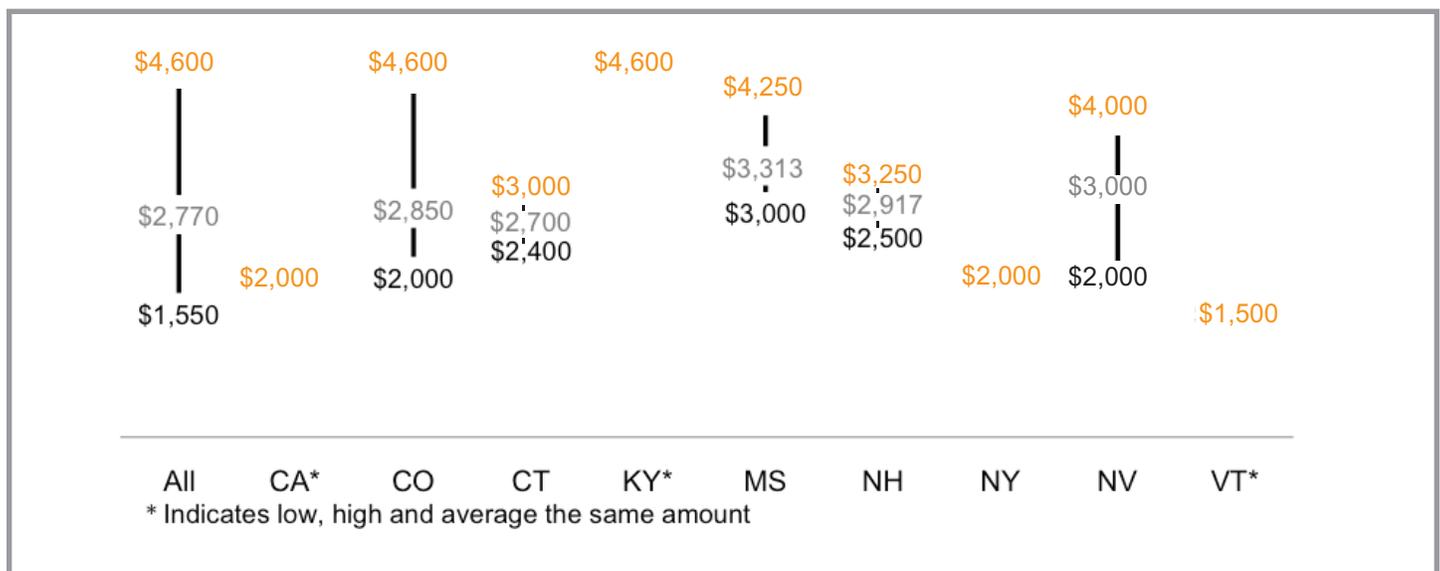
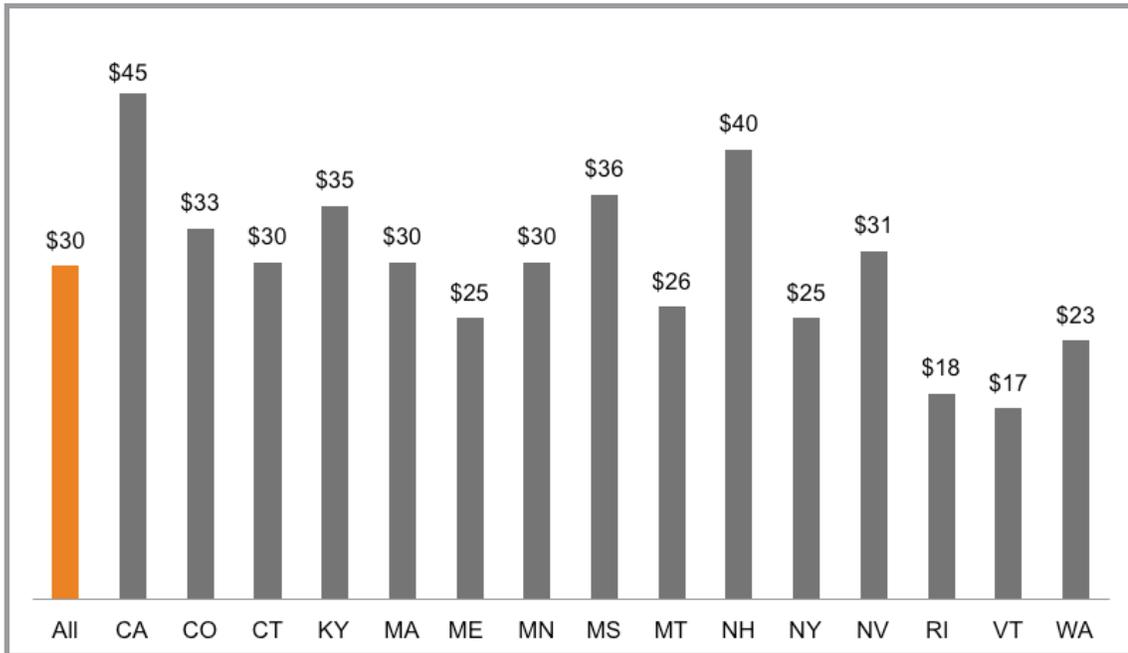


Figure 5: Average Copayments for PCP Visits

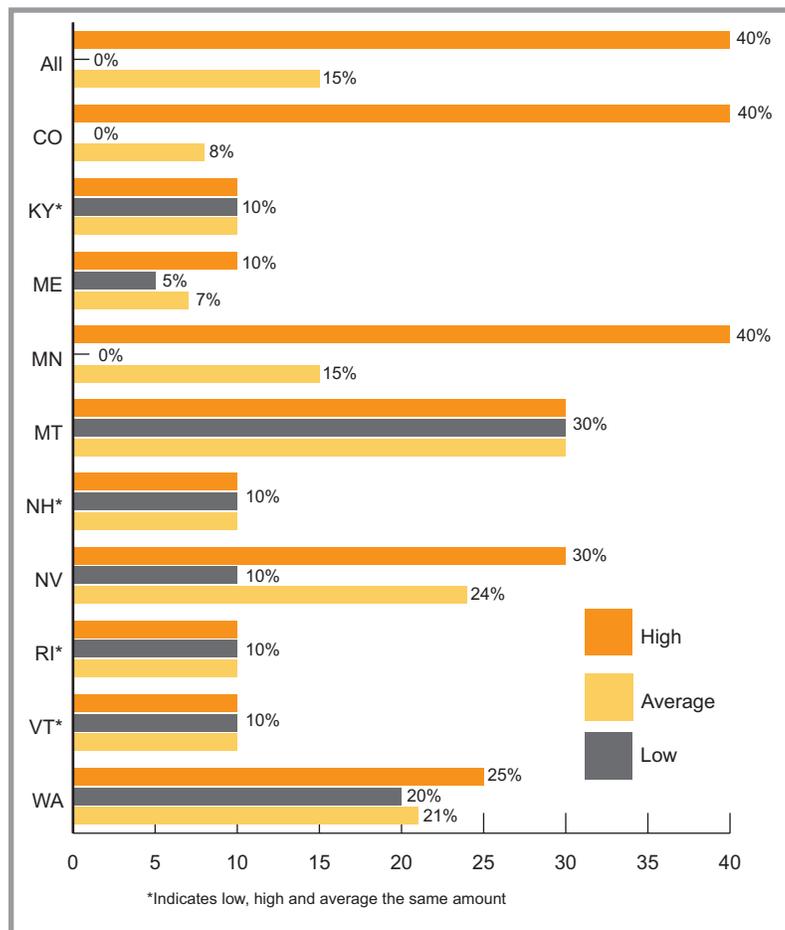


7). Coinsurance ranges from 0 to 40 percent with an average of 17 percent.

In reviewing the copayments and coinsurance for PCP and specialist visits, we noted that some carriers have taken completely different tactics with respect to cost sharing for physician visits. For example:

- In Vermont, one carrier does not charge for the first 3 PCP visits and then imposes a \$30 copay for each visit thereafter.
- In New Hampshire, one carrier applies a \$40 copay to the first 3 PCP visits

Figure 6: High, Low, and Average Coinsurance for PCP Visits



but does not indicate what will be charged for subsequent visits.

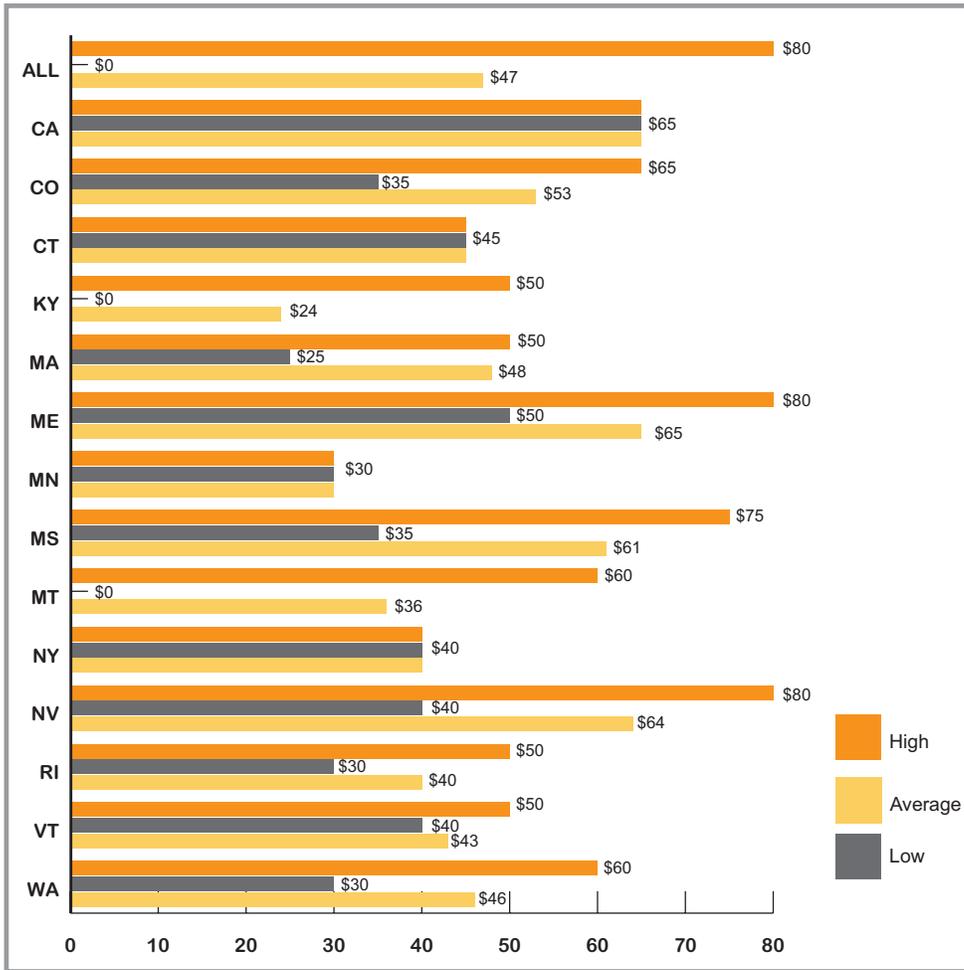
- In Montana, one carrier applies a \$30 copay for the first 3 PCP visits and 30 percent coinsurance for each visit thereafter.

### Impact of Cost Sharing Reductions

Under the ACA, individuals with incomes up to 250 percent of the federal poverty level (FPL) who purchase a silver-level plan through an exchange can receive cost sharing reductions (CSRs) that will lower their out-of-pocket spending. Especially for individuals with lower incomes, these CSRs can substantially reduce cost sharing amounts by effectively increasing the plan's actuarial value. As previously noted, the cost sharing amounts outlined above do not reflect amounts that eligible individuals will pay after the application of CSRs.

To illustrate the impact of CSRs on out-of-pocket spending, we have provided the cost sharing amounts for New York's standard silver plan<sup>13</sup>, (i.e., the amounts that would be paid by an individual who is not eligible for CSRs) along with the amounts that would be paid by individuals eligible for CSRs. As shown in the chart in Figure 8, the actuarial value of the plans available to these individuals varies by income. For example, coverage for a 27 year-old individual with an income of \$30,000, which is greater than 250 percent of the FPL (\$11,490 for 2013)<sup>14</sup>, would be subject to a deductible of \$2,000, whereas the same coverage for an individual with an income at or below the FPL would not be subject to any deductible.

Figure 7: Copayments for Physician Specialist Visits



### Initial Takeaways, Future Work

When it comes to benefit design features of plans offered through the marketplaces, early attention has been focused on premiums, which vary significantly both across states and among rating areas within individual states. Premiums alone, however, do not give a complete picture of the potential out-of-pocket health costs that consumers may face when purchasing coverage offered through the exchanges. For that complete picture, consumers also will need to consider cost sharing.

This preliminary analysis shows that some silver-level plans offered through health insurance exchanges have adopted a number of cost sharing features that may add to the total amount of out-of-pocket costs consumers enrolling in such plans experience. For example, in Nevada and Minnesota, at least one plan requires an \$80 copay for a specialist visit. In California and Maine, the average specialist visit copayment is \$65. Even with an out-of-pocket maximum, for individuals who do not qualify for CSRs, the higher cost sharing may present challenges in accessing services. It will be important for consumers to look beyond premiums when determining which plan best meets their needs.

Breakaway is expanding this preliminary snapshot by compiling premium and cost sharing data for all 50 states, expanding the metal level of plans to be examined, and analyzing trends related to a range of additional health benefits. We will be releasing additional reports based on these more comprehensive analyses over the coming months.

Figure 8: New York Standardized Silver Plan and CSR Variations

	Standard Silver Plan 68-72% Actuarial Value	200-250% FPL 72-74% Actuarial Value	150-200% FPL 86-88% Actuarial Value	100-150% FPL 93-95% Actuarial Value
Deductible	\$2,000	\$1,750	\$250	\$0
Maximum Out-of-Pocket Limit	\$5,500	\$4,000	\$2,000	\$1,000
PCP Visit	\$30	\$30	\$15	\$10
Specialist Visit	\$50	\$50	\$35	\$20

## Notes

- 1 It is our hope that the stepped up efforts of federal and state governments to resolve exchange website problems will improve both the accuracy and accessibility of plan data. Regardless, Breakaway will continue to verify data integrity and accuracy and provide updates to our reports as necessary.
  - 2 The ACA requires that each state have a set number of geographic rating areas that all issuers in the state must uniformly use as part of their rate setting. CCHIO, Market Rating Reforms, State Specific Geographic Rating Areas, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html>.
  - 3 As has been widely reported, SBE websites have experienced fewer glitches than healthcare.gov, thereby making data for SBEs more accessible. For this reason, 11 of the 15 state marketplaces surveyed in this initial report are SBEs.
  - 4 Kaiser Family Foundation Issue Brief, Quantifying Tax Credits For People Now Buying Insurance on Their Own, August 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8469-quantifying-tax-credits-for-people-now-buying-insurance-on-their-own.pdf>.
  - 5 In its August 2013 report, the Kaiser Family Foundation projects that in the portion of the population it studied (people currently buying individual insurance) qualifying for premium tax credits, the credits would reduce the premium for the second lowest cost silver plan by an average of 66 percent. The reduction will vary by income. The Kaiser report also notes that the premium would subsidize a greater share of a bronze plan premium.
- Bronze plans, however, have a lower actuarial value than silver plans, so more costs will be passed to the consumer – most likely in the form of higher cost sharing.
- 6 The total number of silver plans offered in the 15 states surveyed was actually 198, but information was unavailable for 2 plans in Maine.
  - 7 The 196 plans surveyed were distributed among the states as follows: California - 16, Colorado - 43, Connecticut - 4, Kentucky - 8, Maine-7, Massachusetts - 19, Minnesota - 16, Mississippi - 9, Montana - 8, Nevada – 22, New Hampshire - 3, New York - 15, Rhode Island - 3, Washington - 17 and Vermont – 6
  - 8 “Health Plan Information for Individuals and Families,” <https://www.healthcare.gov/health-plan-information/>. This analysis is based on data available as of October 11, 2013.
  - 9 Premium tax credits are determined by calculating the maximum percentage of income that an individual must pay toward health insurance, which is based on a sliding scale for people earning up to 400 percent of the federal poverty level (FPL) – \$45,960 for an individual and \$94,200 for a family of four in 2013. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2013 Federal Poverty Guidelines, <http://aspe.hhs.gov/poverty/13poverty.cfm>. That amount is then subtracted from the cost of the SLCSP offered in the individual’s rating area.
  - 10 Premium tax credits are set based on the premium charged by the SLCSP, but can be used to pay the premium for any bronze, silver, gold or platinum plan offered on an exchange.
  - 11 Plans on each “metal level” or benefit tier must meet an “actuarial value”, or share of covered health spending paid by the insurer rather than out of pocket by the patient, set by statute. However, except for federal limits on out-of-pocket spending and the standardized cost sharing imposed in some states, plans generally have discretion in how they set specific deductible, copayment, and coinsurance amounts.
  - 12 As previously noted, since the SCLSP in an individual’s rating area is used as the benchmark for determining the amount of his or her premium tax credit, Breakaway examined the premiums and deductibles for those plans.
  - 13 To participate in their exchanges, a number of states require issuers to offer a minimum number of “standardized” plans per metal level which contain uniform cost sharing provisions. To allow for some variation and innovation in the insurance market, most of these states also permit insurers to offer a limited number of non-standard plans (usually 1-3) per metal level. States with standardized plans include: California, Connecticut, Massachusetts, New York, Oregon, and Vermont.
  - 14 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2013 Federal Poverty Guidelines, <http://aspe.hhs.gov/poverty/13poverty.cfm>.

---

### ***About Breakaway Policy Strategies***

Breakaway Policy Strategies is a health policy firm that provides research, analysis, practical advice and strategic solutions to a wide range of health care stakeholders. Breakaway's health care experts offer creative, sophisticated guidance to help hospitals, health plans, physicians, employers, consumers, patients, government agencies, biopharmaceutical and device companies, foundations and investors successfully navigate the transformative changes taking place in the American health care system. Learn more at [www.breakawaypolicy.com](http://www.breakawaypolicy.com)

### ***About the Robert Wood Johnson Foundation***

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, [visit www.rwjf.org](http://www.rwjf.org). Follow the Foundation on Twitter [www.rwjf.org/twitter](http://www.rwjf.org/twitter) or Facebook [www.rwjf.org/facebook](http://www.rwjf.org/facebook).