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Robert Wood Johnson Foundation

Eight Million and Counting:
A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces

Monitoring the ACA's Health Insurance Marketplaces | May 2014

SUMMARY OF FINDINGS

In partnership with the Robert Wood Johnson Foundation (RWJF), Breakaway Policy Strategies has compiled and is making available to the public in open source a comprehensive dataset (HIX Compare) containing (1) premium information for all 7,027 Silver plans being sold through the new Affordable Care Act (ACA) health insurance exchanges (Exchanges) and (2) benefit design and cost sharing requirements for all 1,208 unique* Silver Exchange plans. HIX Compare is being released as part of RWJF's Reform by the Numbers initiative to make available timely and unique data about the impact of health reform.

Breakaway believes that HIX Compare will serve as a valuable resource to researchers, consumers and other health care stakeholders seeking to better understand the nature of health coverage offered through the ACA's Exchanges. In this report, for example, Breakaway has used HIX Compare to analyze premiums, deductibles and limits on out-of-pocket expenses under Exchange plans. Specific findings included:

- Exchange plan premiums vary widely between states and among rating areas within states. Across all Silver plans, the national average premium is $265 per month for a 27 year-old individual, $435 per month for a 50 year-old individual, and $878 for a family of four. The lowest and highest plan premiums are found in Minnesota and Virginia, respectively. Most premiums fall below the national average for self-only coverage under employer-sponsored insurance (ESI) plans, which was $491 per month in 2013, though Silver plans' actuarial value is about 15 percentage points below the average premium available through ESI plans.
- Many Exchange plans subject health care services such as primary care physician (PCP) visits and prescription drugs to a deductible, a benefit design feature which is not as common in ESI plans.
- Of the 1,208 unique Silver plans analyzed, approximately half (641) offer combined deductibles under which medical and prescription drug expenses accumulate to a single deductible. The average combined deductible for those plans is $2,267.
- Among the 1,208 unique plans, 1,150 had a combined out-of-pocket maximum (OOP Max), meaning that medical and prescription drug expenses accumulate to the same OOP Max.

**A unique plan is a plan with a specific benefit design offered by a particular insurer. Unique plans may be offered across multiple rating areas. Benefits and cost sharing remain constant but premiums may vary across areas.*

Implementation of the Affordable Care Act (ACA) has brought about a wave of changes to the way that health care coverage is provided in our country, affecting everything from the cost of health insurance to the way that insurers manage risk and cover certain health benefits. In addition to new regulations and consumer protections, the state-based health insurance marketplaces (Exchanges) through which much coverage is being sold stand to broadly influence how Americans obtain health insurance and the nature of the coverage in which they enroll/purchase.

To better understand the types of health insurance coverage available to consumers through the Exchanges, Breakaway Policy Strategies (Breakaway) partnered with the Robert Wood Johnson Foundation (RWJF) to compile and make available to researchers, health care stakeholders and the general public a comprehensive dataset (HIX Compare) detailing benefit design, premium and cost sharing information for the 7,027 Silver-level health plans being offered in the health insurance marketplaces of all 50 states plus the District of Columbia. Specifically, HIX Compare includes the following information:

- Premiums
- Deductibles
- Out-of-Pocket Maximums
- Copayments/Coinsurance for:
    - Primary Care Physician (PCP) Visits
    - Specialist Visits
    - Inpatient Hospital Stays
    - Emergency Room Services
    - Ambulatory Services
    - Prescription Drugs

Given the potential implications of the Exchange plans for the health insurance market as a whole, as noted above, Breakaway and RWJF are making HIX Compare available to researchers, consumers and other health care stakeholders in open source. HIX Compare data will be made available in an Excel format so that it is readily accessible to consumers and other health care stakeholders. HIX Compare will also be posted in .txt format for easy use in most statistical packages. This version will be coded to reflect 305 variables associated with various types of plan benefit design and cost sharing features. By providing HIX Compare in this format, we hope to provide researchers with a comprehensive source of information on Exchange plans to enable them to conduct their own market analyses. In addition, Breakaway intends to update HIX Compare on an annual basis so that researchers and others can examine emerging and historical trends in Exchange health coverage through longitudinal data.

One month after the Exchanges launched, in November 2013, Breakaway and RWJF issued a joint report, *Looking Beyond Technical Glitches: A Preliminary Analysis of Premiums and Cost Sharing in the New Health Insurance Marketplaces* (Report I), the first in a series called "Monitoring the ACA's Health Insurance Marketplaces." In that report, we provided a snapshot of averages and ranges of premiums and deductibles associated with the second-lowest cost Silver plans (SLCSPs) across 96 rating areas in 15 states, 11 state-based exchanges (SBEs) and four federally facilitated exchanges (FFEs)[1]. Report I also provided the averages and ranges of copayment and coinsurance amounts applicable to in-network PCP and specialist visits.

In this more in-depth report, we analyze data for all 7,027 Silver-level plans and cost sharing data for all 1,208 unique Silver plans in the more than 500 rating areas[2] across all 50 states (plus the District of Columbia), focusing on premiums, deductibles and out-of-pocket maximums. Future reports will take a closer look at:

- Cost sharing for PCP and specialist physician visits, prescription drugs and hospital services;

- Discrepancies between the cost sharing information in the summaries of benefits and coverage (SBCs) published by insurance carriers and the information in the individual market landscape file posted by the Centers for Medicare & Medicaid Services (CMS Data); and

- Differences in average premiums, deductibles and physician visit cost sharing between states with standardized benefits and a number of states with non-standardized benefits.

Beyond the ACA Exchanges

Implications for Employer-Sponsored Insurance and Private Exchanges

On April 17, the Obama administration announced that 8 million people had signed up for health insurance coverage through the Exchanges. The announcement came just days after the Congressional Budget Office (CBO) released its latest report on the budgetary effects of the ACA's insurance coverage provisions in which CBO estimated that six million individuals will have insurance coverage through the Exchanges in 2014. (See Figure 1.) The discrepancy between the two figures may be attributable, at least in part, to the fact that CBO's estimate, unlike the Administration's, is an average for 2014 that accounts for variations in exchange plan enrollment throughout the year—such as increases during special enrollment periods and drops in exchange plan coverage from individuals who later shift to Medicaid or employer plans. CBO's estimate also does not include individuals who fail to pay their initial plan premiums or lose coverage at any point in 2014 for not continuing premium

payments. In contrast, the Administration's current enrollment numbers include both individuals who have paid their premiums and those who have not.

Whether the actual number of enrollees turns out to be 6 or 8 million individuals, it is a small population compared to the roughly 149 million people covered in the employer-sponsored insurance (ESI) market.[3] CBO estimates, however, that enrollment in Exchange plans will increase substantially in 2015 and 2016, and then gradually increase and level off from 2017 to 2024. In fact, in its latest report, CBO estimates a more rapid increase in enrollment in 2016 and 2017 than previously projected. In addition, the cost sharing and benefit designs of the new Exchange plans, which have the government's seal of approval as having met ACA requirements, may influence cost sharing and benefit design in ESI (including ESI offered through new private exchange markets) over time.

Data Sources

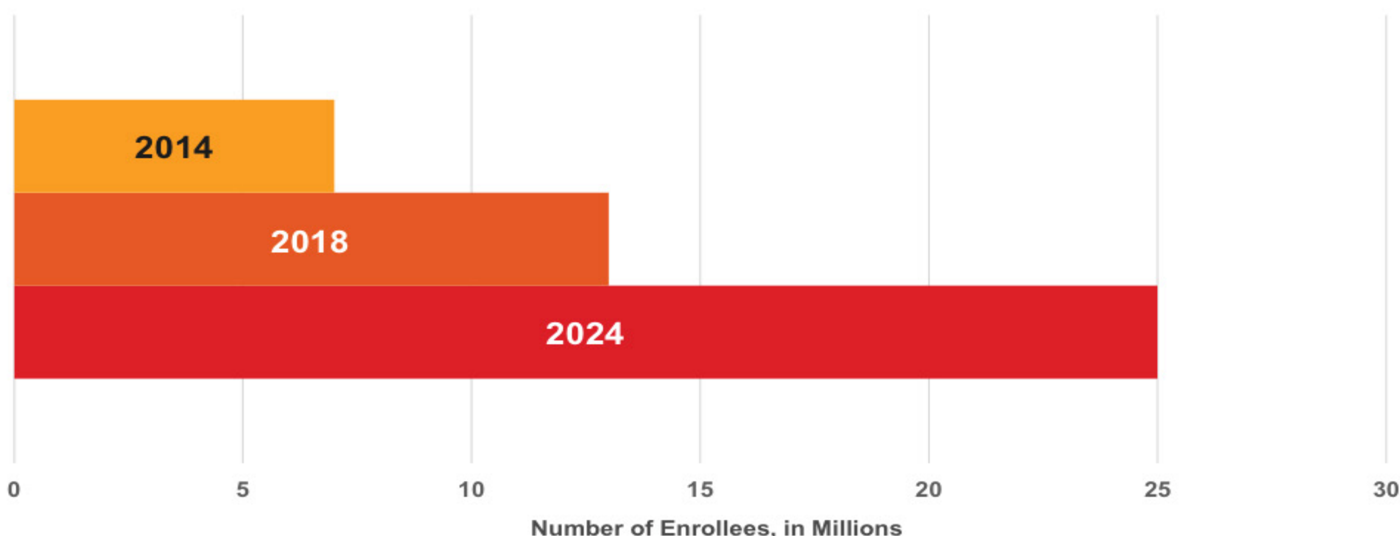
From October 1, 2013 through January 1, 2014, Breakaway collected premium and in- and out-of-network cost sharing information for: a 27 year-old individual, a 50 year-old individual, a single parent with two children and a family of four. For SBEs, Breakaway obtained all benefit design and cost sharing data from the state health insurance Exchange websites. In cases where information was not available through the state Exchange website, Breakaway obtained the necessary data directly from SBCs posted on the insurance carriers' websites (SBC Data). If a carrier did not post the SBC for a plan(s), Breakaway used other plan information posted by the carrier. Where information in the SBC conflicted with other plan information posted by the carrier, Breakaway utilized the information provided in the SBC.

For FFEs and partnership exchanges, Breakaway obtained all premium and cost sharing information from the individual market landscape file posted by CMS.[5]

In the course of compiling the data, Breakaway found that some cost sharing information varied by source. Specifically, Breakaway observed that the CMS Data and SBC Data sometimes contain conflicting information on deductibles, prescription drug cost sharing, and other variables. To better understand the magnitude of these discrepancies, Breakaway reviewed 25 percent of all of the unique Silver plans in each of the 50 states, plus the District of Columbia. To ensure that a sufficient number of issuers were accounted for in the sample, we supplemented the sample to include at least one plan offering from each distinct issuer in each state. Breakaway also included a mix of plan types in its comparative analysis (i.e., HMO, PPO, HSA). This methodology yielded a sample of 344 Silver-level plans. This review revealed that approximately 40 percent of the plans studied have at least one discrepancy between the CMS Data and the SBC Data. Given the potential implications of these inconsistencies for consumers and other stakeholders, Breakaway is continuing to study their scope.

When the cost sharing information provided on an Exchange or carrier website was incomplete or unclear, Breakaway made an effort to obtain the information by contacting the carrier directly. If the carrier was unable to clarify or provide the information, the data was not included in the analysis. In the limited cases where insurance premiums were not available through the state Exchange website or carrier website, Breakaway did not include the plans in HIX Compare.

Figure 1[4]



It should be noted that the premiums and cost sharing figures reported here do not reflect the premium tax credits[6] or cost sharing reductions (CSRs) for which many enrollees are eligible. According to one recent analysis,[7] as of the end of February, 83 percent of Exchange plan enrollees were eligible for premium subsidies, with 21 percent of those eligible actually applying for assistance. While total and average subsidies were found to vary by state, the analysis estimated that 3.5 million people had qualified for a total of about $10.0 billion in annual premium subsidies, an average of about $2,890 per person. To date, there are no comprehensive statistics on the total number of Exchange plan enrollees eligible for CSRs but at least two states have looked at the percentage of enrollees in their Exchanges who are eligible for subsidies and CSRs (all individuals eligible for CSRs also are eligible for premium subsidies). In its December 2013 Enrollment Report, NY State of Health reported that 50 percent of its enrollees (75,516 individuals) were eligible for subsidies and CSRs.[8] In its February 2014 Enrollment Report, Washington Health Plan Finder reported that 58 percent of Exchange enrollees (60,352 individuals) were eligible for CSRs.[9]

Exchange Plan Premiums

As we noted in our initial report, premiums vary from state to state and among rating areas within individual states. Across all 7,027 Silver plans, the national average premium is $265 per month for a 27 year-old individual, $435 per month for a 50 year-old individual, and $878 for a family of four. Under many plans, the family deductible is roughly twice the amount of the individual deductible. The lowest and highest plan premiums are found in Minnesota and Virginia, respectively. For a 27 year-old individual, premiums range from a low of $126 in Minnesota to a high of $1,858 in Virginia. For a 50 year-old, premiums range from a low of $215 in Minnesota to a high of $3,167 in Virginia. For a family of four, premiums range from a low of $452 in Pennsylvania to a high of $1,848 in Colorado.[10] (See Figure 2.) While these variations across and within states are important for understanding overall cost patterns, it should be noted that individual consumers are selecting from among plans within a given rating area, where the range and average will be based on local circumstances.

The national average and ranges of premiums for a 27 year-old individual and 50 year-old individual, as well as the averages and ranges for the ten states with the highest expected Exchange enrollment are shown in Figure 3, on the next page. As was expected, most premiums fall below the national average of self-only coverage under ESI plans, which was $491 per month in 2013. (See Figure 3.)

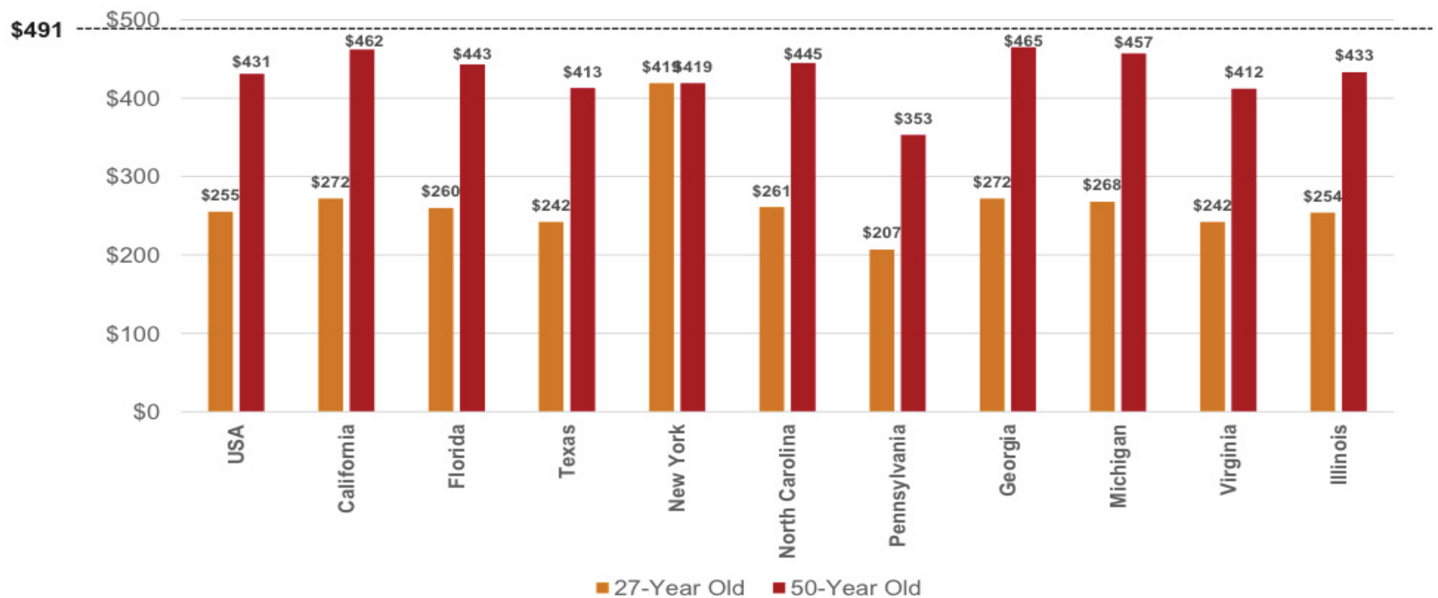
In this report, we make some comparisons between the premiums and cost sharing requirements of Exchange plans and ESI plans. Many of the new Exchange plan enrollees previously were uninsured or were insured through the individual market, not through ESI plans. The pre-ACA individual market looked fundamentally different from the ACA Exchanges. According to one study, more than half of the plans sold through the individual market would not have

Figure 2[11,12]

Premium Ranges and Averages Across the Nation and the Top 10 States by Expected Exchange Enrollment

	Lowest Premium		Highest Premium		Average Premium	
State	*27 Year Old*	*50 Year Old*	*27 Year Old*	*50 Year Old*	*27 Year Old*	*50 Year Old*
USA	$126 (MN)	$215 (MN)	$1,858 (VA)	$3,167 (VA)	$265	$435
California	$184	$313	$394	$672	$272	$462
Florida	$167	$285	$395	$674	$261	$445
Texas	$153	$260	$354	$602	$240	$410
New York	$270	$270	$553	$553	$416	$416
North Carolina	$215	$367	$322	$549	$262	$447
Pennsylvania	$134	$228	$355	$606	$224	$382
Georgia	$188	$321	$410	$699	$273	$465
Michigan	$156	$266	$395	$674	$266	$454
Virginia	$188	$321	$1,858	$3,167	$528	$899
Illinois	$157	$268	$334	$570	$257	$438

Figure 3

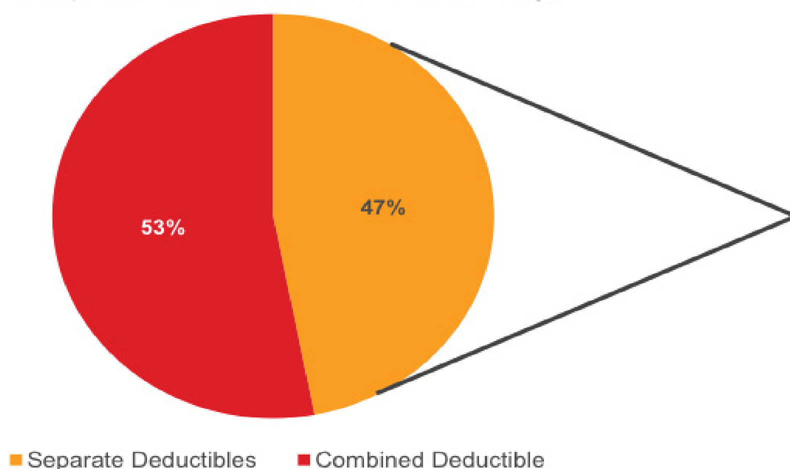


satisfied ACA requirements.[13] Although most new enrollees were not previously covered by ESI plans, we do believe that comparisons between the Exchange marketplace and ESI marketplace help provide some important context for our findings. Moreover, the ESI figures are relevant because there is likely to be more crossover between the two markets in the coming years. As this crossover continues to occur, and as benefit design and cost sharing features of Exchange plans possibly migrate into the ESI market, the comparisons become even more relevant.

Exchange Plan Deductibles

To be offered through the Exchanges, plans must provide all ten categories of essential health benefits (EHB) and have an actuarial value sufficient to satisfy one of the metal levels established by the ACA. To meet these requirements while still keeping premiums low enough to attract enrollees, some insurers have, among other things, increased cost sharing, including copayments, coinsurance and deductibles. Deductibles take on a new significance in Exchange plans. As will be examined in future reports, many Exchange plans subject health care services such as PCP visits and prescription drugs to the deductible, a benefit design feature which is less common in ESI plans.[14] In addition, as detailed below, Exchange plan deductibles are relatively high as compared to ESI plan deductibles. Accordingly, even some individuals who qualify for CSRs may find it difficult to afford the amounts that they will have to pay out-of-pocket before their Exchange plans begin to pay benefits.

Figure 4



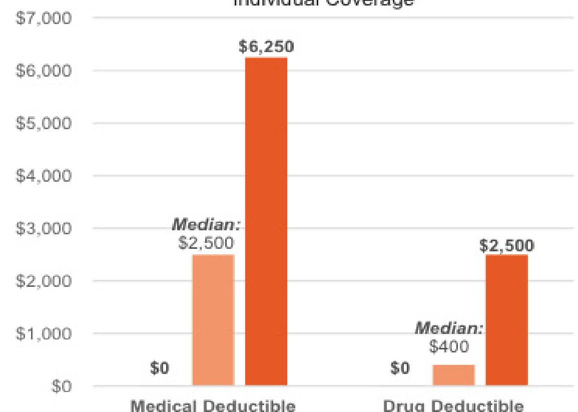
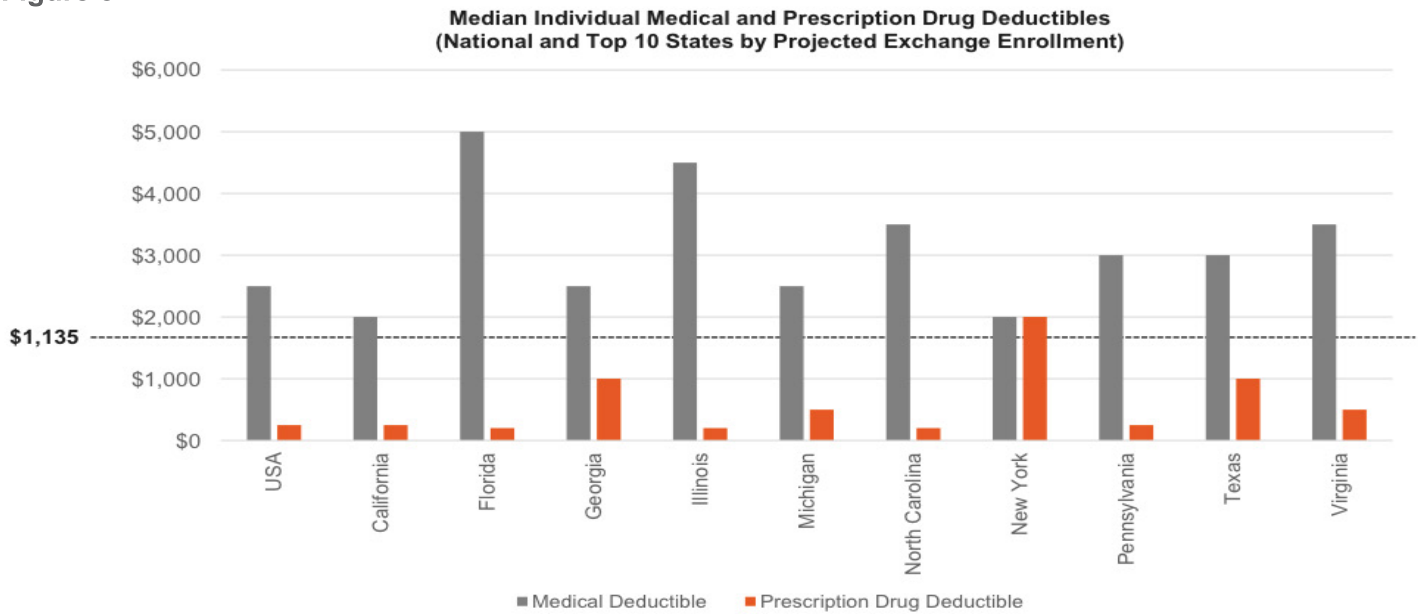
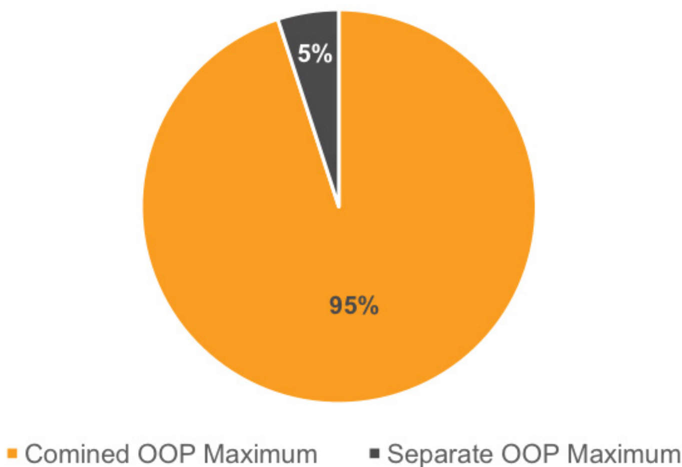


Figure 5



Of the 1,208 unique Silver plans analyzed, approximately half (641) offer *combined deductibles* under which medical and prescription drug expenses accumulate to a single deductible. The average combined deductible for those plans is $2,267 for a 27 year-old individual. The other approximately half of plans (567) have two *separate deductibles*, a medical deductible towards which expenses for medical services accumulate and a drug deductible towards which expenses for prescription drugs accumulate. (See Figure 4.) Among the plans having separate medical and prescription drug deductibles, separate medical deductibles range from $0 to $6,250, with the median amount being $2,500, approximately twice the amount of the average separate medical deductible for ESI plans ($1,135). Separate prescription drug deductibles range from $0 to $2,500, with a median of $400. (See Figure 5.) Figure 6 below, shows the median individual medical and prescription drug deductibles nationwide as well as for the ten states having the highest expected Exchange enrollment.

Figure 6

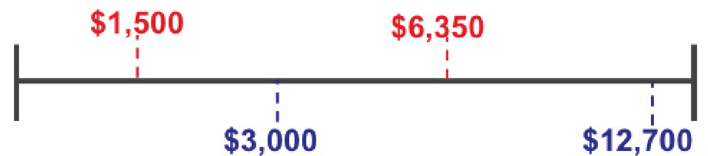


Out-of-Pocket Maximums

The ACA limits the amount that plans can require people to pay out-of-pocket each year for *in-network* deductibles, copayments and coinsurance on covered services to $6,350 for individuals ($12,700 for a family). Among the 1,208 unique

Figure 7

Combined OOP Maximums:
Range for Individual and Family Coverage



Separate OOP Maximums:
Range for Medical and Drug OOP Maximums

plans, 1,150 had a *combined out-of-pocket maximum* (OOP Max), meaning that medical and prescription drug expenses accumulate to the same OOP Max. (See Figure 6.) The OOP Max for those plans ranges from $1,500 to $6,350, with a median of $6,350 for individuals. The range for combined OOP Max for families is $3,000 to $12,700, with a median of $12,700.

The remaining plans had *separate limits on out-of-pocket medical expenses and prescription drug expenses*. For those plans, the OOP Max on medical expenses ranged from a low of $1,500 to a high of $6,350, with the median also being $6,350. The OOP Max on prescription drug expenses ranged from a low of $950 to a high of $2,350, with a median of $1,500. (See Figure 7.)

Looking Back—and Ahead

Prior to the launch of the Exchanges, most of the attention regarding the new insurance marketplaces centered on premiums. In Report I, we emphasized that premiums alone do not provide consumers with a complete picture of their potential out-of-pocket costs and that consumers should look beyond premiums and also consider other cost sharing requirements in determining which Exchange plan best meets their needs.

Our more exhaustive review of the cost sharing requirements in over 1,200 unique Silver plans underscores the importance of examining Exchange plan details beyond premiums. It also shows that cost sharing under the new Exchange plans varies, in some cases considerably, from cost sharing under traditional ESI plans.

Recognizing that evaluating and comparing Exchange plans would be somewhat of a challenge, Breakaway and RWJF believe it is important to make HIX Compare available in open source. By providing HIX Compare in this format, we hope to provide researchers with a comprehensive source of information on Exchange plans to enable them to conduct their own market analyses. In addition, Breakaway intends to update HIX Compare on an annual basis so that researchers and others can examine emerging and historical trends in Exchange health coverage through longitudinal data.

The applicability, use and amount of deductibles in Exchange plans may be particularly important for consumers and other stakeholders to understand. In addition to being relatively high as compared to the ESI market, deductibles under Exchange plans are being applied to products and services not generally subject to the deductible in ESI plans, such as prescription drugs and physician visits. This could further complicate enrollees' task of evaluating plans' cost sharing provisions, as they will not only have to consider the amount of deductibles but also the way they are applied. Application of deductibles, and other cost sharing requirements will be examined in future reports.

Using HIX Compare, Breakaway is currently examining cost sharing requirements for specific benefits under Exchange plans and will be releasing additional reports in the coming weeks and months.

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.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national culture of health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

Notes

1 For the first report, Breakaway chose to examine premiums and cost sharing for SLCSPs since the SLCSP in an individual's rating area is used as the benchmark for determining the amount of his or her premium tax credit.

2 The ACA requires that each state have a set number of geographic rating areas that all issuers in the state must use to set their rates. CCIIO, Market Rating Reforms, State Specific Geographic Rating Areas, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html.

3 Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2013 Annual Survey, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf, citing Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, The Uninsured: A Primer: Key Facts About Americans Without Health Insurance, October 2012, http://www.kff.org/uninsured/issue-brief/the-uninsured-a-primer/.

4 Congressional Budget Office. "Effects of the Affordable Care Act on Health Insurance Coverage." April 2014. http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

5 QHP Landscape – Individual Market Medical, https://data.healthcare.gov/dataset/QHP-Landscape-Individual-Market-Medical/b8in-sz6k.

6 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. That amount is then subtracted from the second lowest cost Silver plan (SLCSP) in the individual's rating area.

7 Kaiser Family Foundation, Issue Brief, "How Much Financial Assistance Are People Receiving Under the Affordable Care Act?" March 27, 2014, http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8569-how-much-financial-assistance-are-people-receiving-under-the-affordable-care-act1.pdf.

8 NY State of Health: The Official Health Plan Marketplace, December 2013 Enrollment Report, http://info.nystateofhealth.ny.gov/sites/default/files/December%202013%20Enrollment%20Report_Jan%2013%202014.pdf.

9 Washington Health Plan Finder, Health Coverage Enrollment Report, February 2014, http://wahbexchange.org/files/1813/9568/0206/February_Data_Report_FINAL.pdf.

10 The extremely high premiums listed for Virginia are not necessarily representative of the entire Exchange plan marketplace in that state. Rather, they most likely are associated with plans having a rider covering bariatric surgery. Virginia does not mandate coverage of bariatric surgery but does require that bariatric treatment be offered as an option for consumers. Kaiser Health News, "Why Some Virginia Health Plans Cost So Much," October 13, 2013, http://www.kaiserhealthnews.org/stories/2013/october/13/why-some-virginia-health-plans-cost-so-much.aspx.

11 The state of New York still requires full community rating which explains why the premiums for a 27 year-old individual and 50 year-old individual are identical.

12 Top 10 states by expected exchange enrollment based on Kaiser Family Foundation analysis of state marketplace statistics. March 2014. http://kff.org/health-reform/state-indicator/state-marketplace-statistics/.

13 Health Affairs, "More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014," May 2012, http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.

14 The majority of workers covered by ESI plans having a deductible do not have to meet that deductible before certain services, such as physician office visits or prescription drugs, are covered. Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2013 Annual Survey, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf.