



# Oregon Essential Health Benefits Advisory Committee Meeting

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May 18, 2015

# Objectives

- **Understand constraints for plan design development**
- **Review 2016 standard designs and most popular 2015 plan designs**
- **Discuss preferences for 2017 designs**

# Oregon SB 91 (2011)

- DCBS has authority to design the form, level and coverage of standard Bronze and Silver plans that must be offered by all issuers in the individual and small group markets
- The marketplace defines a standard gold plan for on exchange only and was historically developed to have a similar cost sharing structure to silver and bronze
- The standard plans define in-network cost sharing (deductibles, coinsurance, copayments, etc.) for each EHB
- Issuers can define out-of-network cost sharing

# Plan design constraints

- Actuarial value requirements
- Maximum out-of-pocket (MOOP) requirements
- Cost sharing is prohibited for certain preventive services
- Mental health parity
- Successive cost sharing for cost-sharing reduction plans
- Requirements for HSA-enabled HDHP

# Actuarial Value (AV) requirements

- AV is the average percent of claims that are covered by the plan for a standard population

<b>Metal Level</b>	<b>AV Range</b>
Platinum	88 – 92%
Gold	78 – 82%
Silver	68 – 72%
Bronze	58 – 62%

- Eligible individuals with incomes below 250% FPL are eligible for cost sharing reduction subsidies if they purchase a silver level plan

<b>Household FPL</b>	<b>CSR AV Range</b>
< 150%	93 – 95%
150 – 200%	86 – 88%
200 – 250%	72 – 74%

# AV requirements

- Only in-network cost sharing is considered
- AV is generally calculated using the standard federal calculator in which cost sharing features for a defined set of services are input
  - As examples, urgent care and pediatric vision/dental cost sharing are not included as inputs
- Federal AV calculator (AVC) may be updated on an annual basis to reflect updated claims trends and distributions
  - AVC changes will generally increase plan AVs, in some cases requiring carriers to increase cost sharing to remain within required AV levels

# Maximum out-of-pocket (MOOP)

- The maximum out-of-pocket for 2016 is \$6,850 for self-only coverage and \$13,700 for family coverage
  - These amounts are indexed annually
  - Self-only amount applies to each individual covered under a family contract (new in 2016)
- Cost-sharing reduction (CSR) plan variations available to those with household incomes below 250% FPL have lower MOOPs

Household FPL	AV Range	Self-only MOOP	Family MOOP
< 150%	93 – 95%	\$2,250	\$4,500
150 – 200%	86 – 88%	\$2,250	\$4,500
200 – 250%	72 – 74%	\$5,450	\$10,400

# Successive cost sharing for CSR plans

- Each silver plan offered through the Exchange must be accompanied by each of the three CSR variations
  - For each increase in CSR level from the non-CSR silver plan, consumer cost sharing must decrease for each covered benefit
  - Any specific element in a given plan variation must have equal or more generous cost sharing features compared to each less generous variation
  - Changes in cost sharing structures are not allowed if there are situations in which the consumer in the higher AV variation may be worse off and pay increased cost sharing, for example 20% coinsurance may produce lower cost sharing than a \$20 copay

# Requirements for HSA-enabled HDHPs

- There are separate rules, defined by the IRS, governing whether a high deductible health plan (HDHP) can be combined with a tax-favored health savings account (HSA)
  - Minimum deductible: \$1,300 for self-only coverage / \$2,600 for family coverage for 2016
  - Maximum out-of pocket: \$6,550 for self-only coverage / \$13,100 for family coverage for 2016
  - Deductible must apply to all non-preventive benefits, including Rx and primary care
  - Family policies cannot provide coverage to any individual until the minimum family deductible has been met

# Pros and cons of cost sharing features

Feature	Pros	Cons
Copayments	<ul style="list-style-type: none"><li>• Predictable for consumers</li><li>• Can vary to help steer consumers (e.g., primary care provider vs. ED)</li></ul>	<ul style="list-style-type: none"><li>• Lack of cost transparency</li><li>• No incentive for “consumerism”</li></ul>
Deductibles	<ul style="list-style-type: none"><li>• Cost transparency</li><li>• Increased “consumerism” (assuming availability of information)</li></ul>	<ul style="list-style-type: none"><li>• May present barrier to seeking care</li><li>• Unpredictable costs</li><li>• Complex</li></ul>
Coinsurance	<ul style="list-style-type: none"><li>• Cost transparency</li><li>• Increased “consumerism” (assuming availability of information)</li></ul>	<ul style="list-style-type: none"><li>• Unpredictable / unknown costs</li></ul>

# Plan design review overview

- Handout summarizes the 2016 standard plans and most popular 2015 standard plans in the individual and small group markets
- 2015 plans may no longer meet 2016 AV requirements
- In the small group market, some of the most popular plans for 2015 are not ACA compliant; we included these in the summary for closest metal level based on AV reported by the carrier
- 2015 standard plans are not shown

# Striking a balance

Simplicity /  
consumer  
understanding



Targeted to meet  
policy objectives

# Discussion questions

- Should standard designs be the same in the individual and small group markets?
- Should target AVs be at the lower or upper end of de minimis range?
  - Higher end: richer benefits/higher premium, may require more frequent changes to design to keep up with changes to AV calculator
  - Lower end: less rich benefits/lower premium, may be more stable
- How should the plan balance the needs of the many (generally healthy) vs. the few (generally sick)?
- Should bronze option continue to be HSA-compliant?
- Are there different considerations for medical vs. Rx cost sharing?

# Discussion questions

- Which benefits should have the lowest cost sharing to incentivize use?
- How should deductibles and MOOPs be applied for family policies?
  - Deductibles can be applied as aggregate, where only the family amount applies, or stacked, where the per individual amount applies in addition to the family amount
  - Similarly, MOOPs can be applied as aggregate or stacked, however, each individual enrolled in family coverage cannot be subject to a deductible of more than the federal maximum for self-only coverage
  - The stacked approach provides greater consumer protection, but increases premiums

# Discussion questions

- For which services should the deductible apply at each metal level? Should the number of services covered before the deductible be limited (note less flexibility on bronze HSA)?
  - Primary care
  - Specialty care
  - Emergency department
  - Lab
  - Imaging
  - Rehab/hab services
  - Outpatient
  - Inpatient
  - Rx at which tiers?

# Discussion questions

- For which services do you prefer copayment or coinsurance?
  - Primary care
  - Specialty care
  - Emergency department
  - Lab
  - Imaging
  - Rehab/hab services
  - Outpatient
  - Inpatient
  - Rx at which tiers?
- Is there a preference for copayment or coinsurance after the deductible?
- If coinsurance applies, do you want to cap amount for any benefits? E.g., specialty drugs

# Pediatric dental background

- Pediatric dental is a required Essential Health Benefit (EHB)
- Carriers can exclude from on-exchange plans IF a stand-alone dental plan (SADP) covering pediatric dental EHB is available on the exchange
- Carriers can exclude from off-exchange plans ONLY IF they have reasonable assurance that the individual purchasing the medical plan has enrolled in an exchange-certified SADP
- When covered under medical, the cost of pediatric dental benefits are spread across children and adults, whereas SADP premiums impose full cost of pediatric dental on families with covered children

# Pediatric dental cost sharing

- **SADPs have cost sharing requirements**
  - **68 - 72% AV for low option**
  - **83 – 87% AV for high option**
  - **\$350 MOOP for single child / \$700 MOOP for more than one child**
- **There is no standardized AV calculator for SADPs**
- **SADP cost sharing requirements do not apply to pediatric dental benefits covered through medical plan**
- **Pediatric dental cost sharing is not an input in the AVC**

# Pediatric dental discussion

- **Pediatric dental benefits are not included in the current standard plan designs**
- **The state may not be able to legally require coverage of pediatric dental EHB on the exchange**
- **Outside of the Marketplace, should pediatric dental benefits be embedded in the standard medical plan, or should issuers be able to offer the standard plan without pediatric dental when allowed?**
- **Are there other suggested approaches?**

# Next Steps

- **Develop options for 2017 standard designs based on discussion**

# Questions

