McKinsey&Company

McKinsey Center for U.S. Health System Reform

Exchange product benefit design: Consumer responsibility and value consciousness

Over the past several months, we have closely examined the new individual exchange market landscape from several perspectives: which carriers are offering what products at what price points, the composition of hospital networks attached to these products, and how consumers are responding to the initial exchange product offerings. In this Intelligence Brief, we examine the benefit designs (e.g., deductibles, maximum out-of-pocket (MOOP) requirements, co-pays, and co-insurance) of the new exchange products and their potential impact on consumers, carriers, and providers.

We have based our research and findings on an analysis of the benefit designs used in all 19,484 exchange products across bronze, silver, gold, and platinum metal tiers offered across the 501 exchange rating areas in 50 states and the District of Columbia. We derived our comparisons with the 2013 individual market from an analysis of over 31,000 products offered during that year in 495 of those rating areas[1]. Some of our data (i.e., co-pay design for urgent care, out-patient, and prescription drug) was obtainable only from the state-run exchanges and thus is based on 2,068 bronze- and silver-tier products. (See the Appendix for more detail on our methodology.) Most of our data reflects national averages, and may vary significantly from those found in individual rating areas. However, at points in the brief, when noted, we do delve into market-specific data.

There are five key observations from our analyses:

- Average level of coverage of individual exchange products is higher than in 2013, as required by actuarial value (AV) and Essential Health Benefits (EHB)
- Exchange product benefit designs reveal considerable cost-sharing (e.g., through deductibles, co-pays, MOOPs) with enrollees, and this may make them value-conscious consumers
- Product designs differ significantly even within the same tier, and the selection of an economically optimal vs. non-optimal product can have a significant impact on total out-of-pocket obligations across income groups; premium differences alone account for only part of this potential economic impact
- By utilizing levers making consumers financially responsible, carriers are encouraging them to select lower cost types of service
- Deductible levels for various provider services may lead to realized reimbursements lower than negotiated; some reimbursement realization will be enhanced by cost-

[1] Our source for 2013 data was eHealth; no carriers in Maine or Rhode Island participated in e-health in 2013.

sharing subsidies available to lower-income (250 percent federal poverty level (FPL)) silver product enrollees

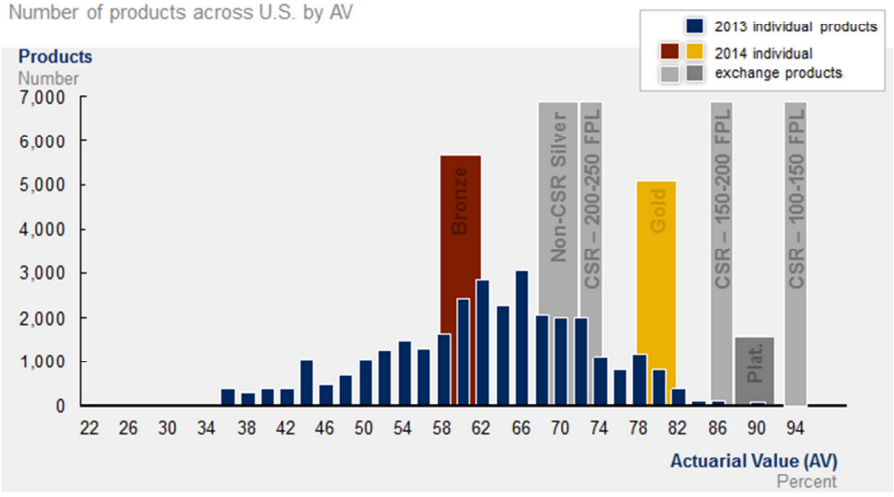
Average level of coverage of individual exchange products is higher than in 2013, as required by actuarial value and Essential Health Benefits

The Affordable Care Act (ACA) established several key product changes that increase the average actuarial value of individual products compared to those available in 2013. For example, 2014 individual market products are required to cover ten EHBs, including several benefits not offered by many 2013 products, such as maternity and mental health. Cost-sharing requirements are in place for some EHBs but not all, e.g., certain preventive services must be free. In addition, ACA established standards for maximum out-of-pocket limits and minimum AVs, and eliminated annual and lifetime limits on coverage.

Comparing the distribution of actuarial values of 2013 with 2014 products in the individual and exchange markets shows a narrower distribution of product value and an overall shift toward higher AV offerings *(Exhibit 1)*. In 2013, while the median AV was 62 percent, there was a wide range of AVs across markets, from less than 25 percent to over 90 percent. In 2014, the range among standard exchange products (excluding catastrophic) is 58 to 92 percent. As of February 1st, as reported by Health and Human Services (HHS), 62 percent of exchange enrollees had purchased silver products, many of whom are subsidy-eligible and receiving cost-sharing subsidies that increase the product's underlying AV).

EXHIBIT 1

Distribution of 2013 individual products and 2014 individual exchange products by Actuarial Value



Note: 2014 individual exchange products must fall within set AV ranges: bronze 58-62%, silver 68-72%, gold 78-82%, platinum 88-92%; cost-sharing reduction silver-tier products are available to individuals below 250% FPL and must fall within AV ranges of 72-74% AV, 86-88% AV, and 93-95% AV

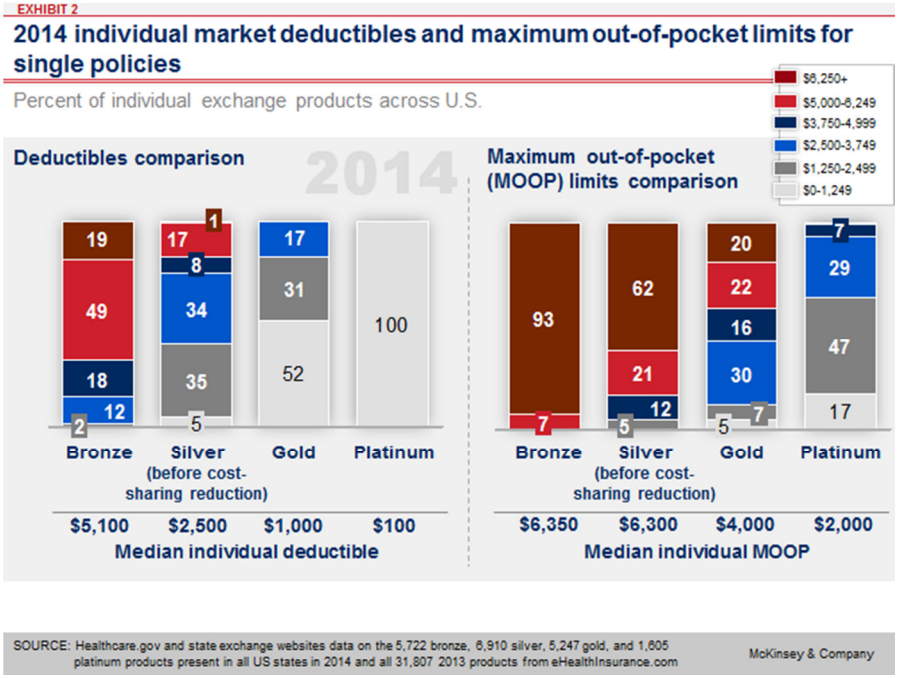
SOURCE: Healthcare.gov and state exchange websites data on the 5,722 bronze, 6,910 silver, 5,247 gold, and 1,605 platinum products present in all US states in 2014 and all 31,807 2013 products from eHealthInsurance.com

McKinsey & Company

Exchange product benefit designs reveal considerable cost-sharing with enrollees, and this may make them value-conscious consumers

In our analysis of 2014 individual exchange products, we observed the use of benefit design levers (e.g., co-pays, deductibles, MOOPs) comparable to many high-deductible

health plans (HDHP) in the market today. Specifically, 76 percent of exchange products have deductibles equal to or greater than the $1,250 minimum deductible for HDHPs[2], including all bronze products, almost all (95 percent) silver products, and close to half (48 percent) of gold products. The vast majority of bronze and silver tier products have MOOPs above $5,000 (100 percent and 83 percent respectively), as do 42 percent of gold products *(Exhibit 2)*.



Product designs differ significantly even within tier, and selection of an economically optimal vs. non-optimal product can have a significant impact on total out-of-pocket costs; premium differences alone accounts for only part of this impact

Premium price, frequently considered a benchmark of affordability for consumers, may not represent the majority of the potential annual financial obligations for consumers. Given the structure of the benefit designs we analyzed, many people who are relatively frequent consumers of health services may pay more in the form of deductibles, co-pays, and co-insurance than in premium. We also observed that a person's aggregate annual financial obligation (premium and any cost-sharing) as a percent of gross annual income varies greatly across income levels and is highly sensitive to the product design selected.

For each individual, there is an economically optimal product depending on household income and expected healthcare utilization, defined as the product with the lowest annual total out-of-pocket cost across premium and cost-sharing *(Exhibit 3)*. Based on an analysis of all lowest-price product offerings in Atlanta, Georgia for a range of different individual

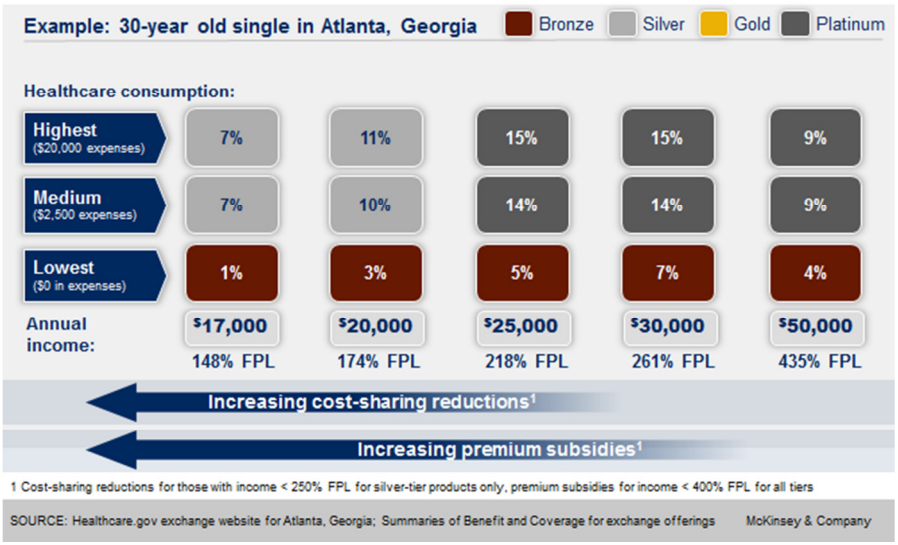
[2] 2014 regulation establishes $1,250 as the minimum HDHP deductible

income levels, we found significant variation in a consumer's financial exposure[3]. For many consumers, selecting the economically optimal product will limit healthcare expenses to less than 10 percent of gross income. Yet, for the middle income, middle morbidity individuals (~200-300 percent FPL range, $2,500 in annual medical expenses on average), this financial obligation is much higher relative to their utilization. In this example, a 30-year old earning $25,000 and having $2,500 in annual healthcare expenses is paying nearly the same amount as a percent of his income then if he had expenses far exceeding his out-of-pocket limit. Specifically, with a deductible of $1,000 and co-insurance of 20 percent, he pays $1,300 on his $2,500 of expenses; but, with an out-of-pocket maximum of $1,500 on the same product, even if he incurs $20,000 or more of healthcare expenses, he will only pay at most an incremental $200. If this individual had not selected the economically optimal product (in this case, the platinum product), but had selected the cost-sharing subsidized silver product, he would face expenses totaling 25 percent of his gross income.

EXHIBIT 3

Economically optimal product choice based on individual's FPL and expected healthcare consumption

Percent of gross income



1 Cost-sharing reductions for those with income < 250% FPL for silver-tier products only, premium subsidies for income < 400% FPL for all tiers

SOURCE: Healthcare.gov exchange website for Atlanta, Georgia; Summaries of Benefit and Coverage for exchange offerings McKinsey & Company

In many cases, consumers may not be fortunate enough to select the economically optimal product, which could result in much higher financial exposure than illustrated. For example, while the bronze product may offer the lowest total cost option across income levels for those who do not utilize healthcare services during the year, it also carries the largest uncertainty, with consumers' maximum potential liabilities in excess of 35 percent of gross income for the lowest-income consumers.

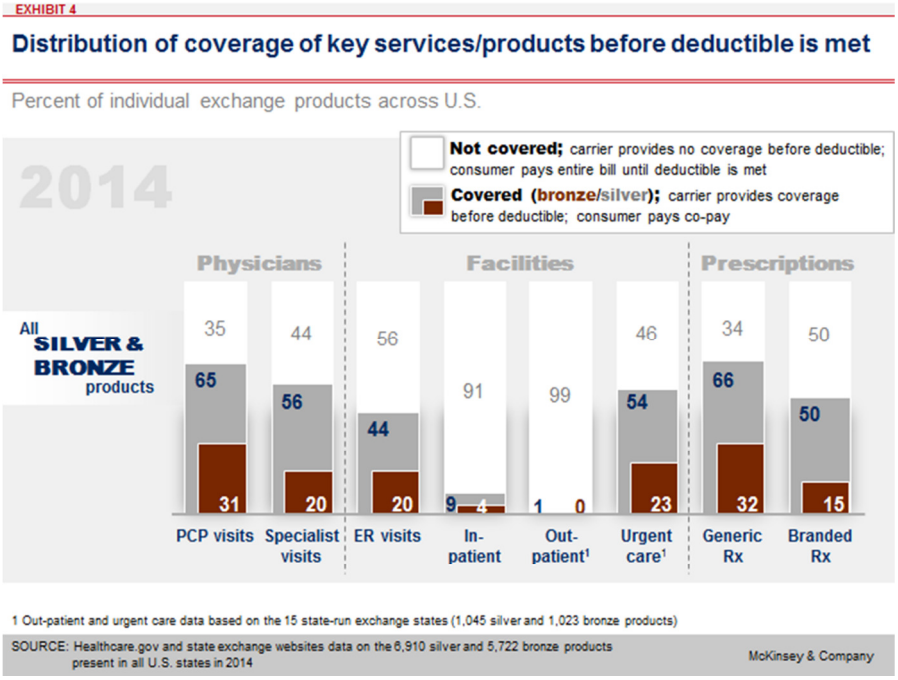
By utilizing levers making consumers financially responsible, carriers are encouraging them to use lower cost types of service

In the 2014 individual exchange market, carriers are using benefit-design levers that impose financially consequences for consumers' healthcare decisions. Accordingly, carriers may affect consumers' primary demand for healthcare services, as well as their selection of care

3 Atlanta's lowest-price premiums are below the national median, implying consumer's financial exposure could be higher as a percent of gross annual income depending on the market.

venues. The use of deductibles, co-pays, and MOOPs in many products this year likely contributed to lower premiums than would have been offered, and may contribute to the sustainability of more affordable products over time.

In our recent analysis of exchange hospital network designs, we associated broad network access with higher premiums, encouraging consumers to more explicitly evaluate the benefits and costs of one provider over another. High deductibles, co-pays, and MOOPs may have a similar effect (although at the point of service delivery rather than at the point of product purchase). The benefit design of most exchange products is such that many key services and products (including some EHBs) are not covered until after the consumer fully meets his deductible *(Exhibit 4)*. Accordingly, the consumer pays the full cost of services, and therefore bears any price difference between providers, or sites, of care below the annual deductible.

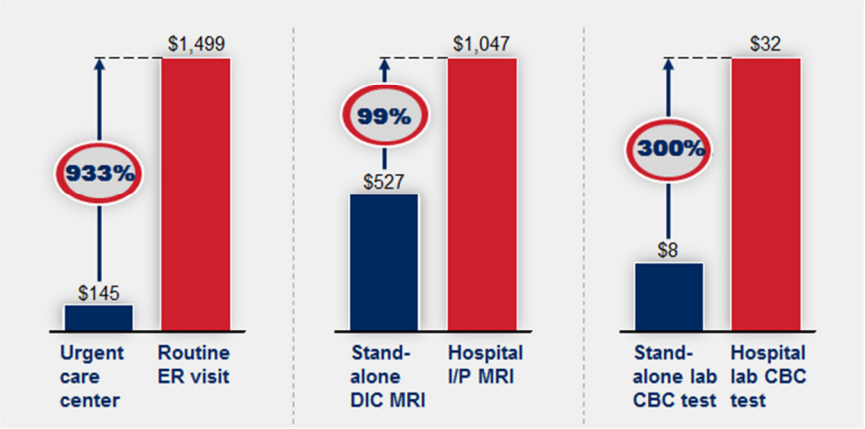


For services performed in many different care venues (e.g., ER vs. urgent care center for non-emergency visit, hospital vs. stand-alone facility for an MRI or lab test), the consumer's selection has a substantial impact on out-of-pocket obligation and may encourage him to closely evaluate his site of care *(Exhibit 5)*.

EXHIBIT 5

Actual healthcare cost by site of venue (amount consumer faces before deductible, when no co-pay coverage exists)

USD



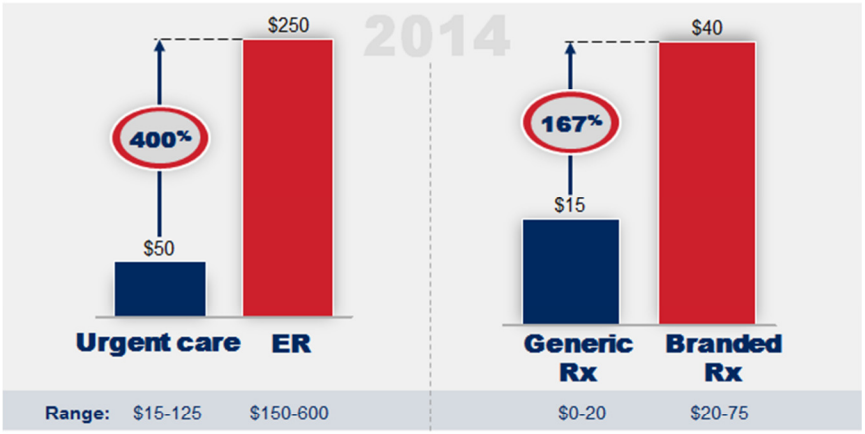
SOURCE: Truven Marketscan Data, Truven Healthcare Analytics — McKinsey & Company

Even in exchange products offering some coverage before deductible, we observed the use of co-pays that similarly results in a higher level of consumer financial responsibility. In our analysis of all silver-tier exchange products across state-run exchanges, the median consumer co-pay for an ER visit was $200 higher (400 percent more) than an urgent care center visit *(Exhibit 6)*; for the 20 percent[4] of non-emergency ER visits that could otherwise be treated in urgent care, this price difference may encourage those consumers to utilize the lower-cost urgent care setting. This difference also appears in pharmaceutical products; the median co-pay for a preferred branded drug was $25 higher than generic (160 percent more).

EXHIBIT 6

Median co-pays before deductible for silver-tier single policies, across all state-run exchange states

USD



SOURCE: State exchange websites data on the 1,045 silver products in 2014 — McKinsey & Company

[4] Truven Marketscan Data; percent of visits under $800 to estimate routine visit that could have been treated in urgent care.

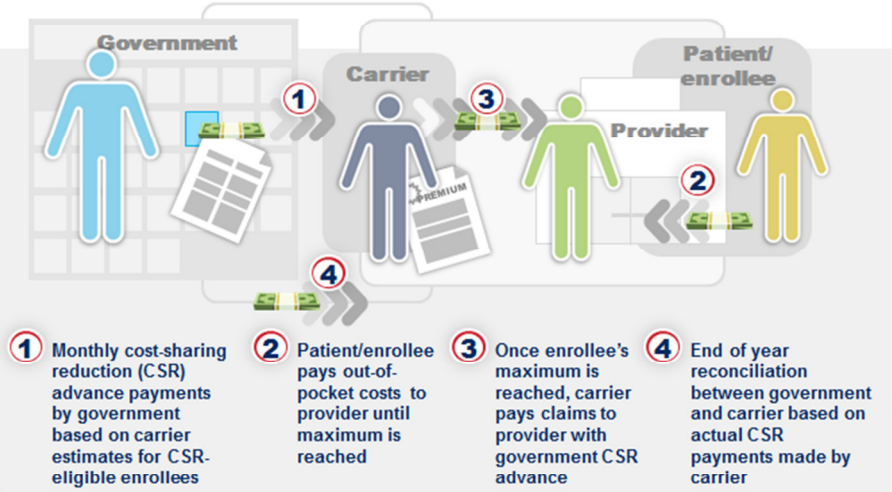
Deductible levels for various provider services may lead to lower reimbursement realization than negotiated; some reimbursement realization will be enhanced by cost-sharing subsidies of lower-income silver enrollees

As previously uninsured individuals enroll in exchange products, providers are expected to experience a decrease in overall demand for charity care, with a beneficial impact on uninsured bad debt. However, enrollees with high deductibles could lead to a situation where providers are not realizing the reimbursement they negotiated. In our analysis, this consumer financial responsibility is particularly prevalent in inpatient and outpatient hospital procedures, for which over 90 percent of all bronze- and silver-tier products do not include any third-party payments until the enrollee meets his full deductible[5] *(Exhibit 4)*. For ER visits, this figure exceeds 50 percent for both bronze- and silver-tier products. For physician office visits and generic drug prescriptions, the percentages are much lower.

However, cost-sharing subsidies may enhance the reimbursement realization from those individuals below 250 percent FPL purchasing silver-tier products. Specifically, these lower-income enrollees will be partially indemnified by cost-sharing subsidies (their MOOPs will not exceed $2,250 for those with incomes under 200 percent FPL and $5,200 for those with incomes 200 to 249 percent FPL[6]). More important perhaps is that when cost-sharing subsidies are dispensed, they will flow from the government to the carrier (not the enrollee) and then to the provider *(Exhibit 7)*.

EXHIBIT 7

Flow of cost-sharing subsidies for low-income enrollees (under 250 percent of federal poverty level)



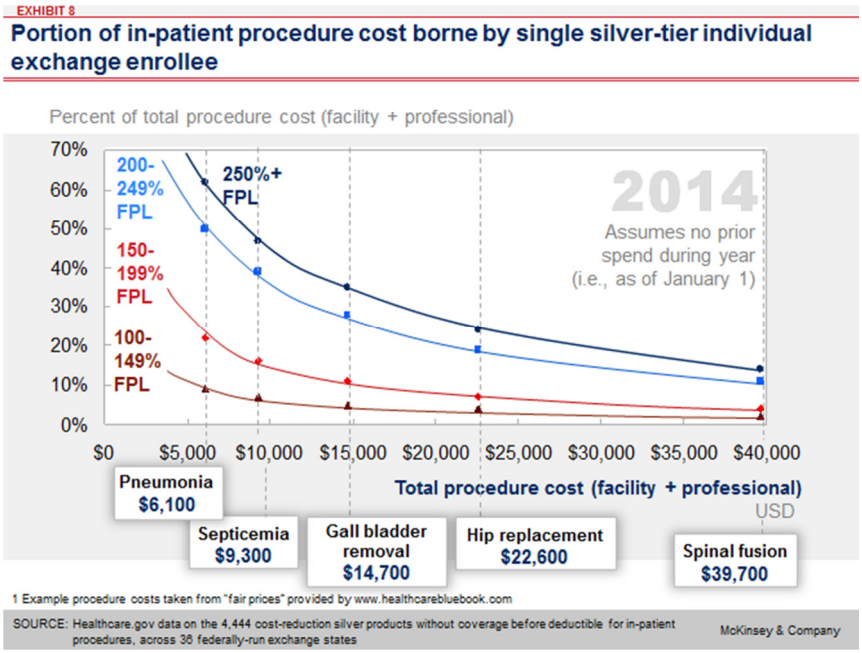
SOURCE: https://www.regtap.info/reg_library.php McKinsey & Company

The structure and flow of the cost-sharing subsidies are such that a much lower percentage of a given procedure's reimbursement comes from a lower-income enrollee selecting a silver-tier product than is the case with higher-income enrollees; instead, the majority of the reimbursement to the provider comes from the carrier. To illustrate this effect, we analyzed all silver-tier exchange products without coverage before deductible for in-patient

[5] Data on out-patient benefit design based on 2,068 bronze- and silver-tier products in state-run exchange states

[6] Based on single policies; see appendix for adjusted MOOP of family policies

procedures, across federally-run exchange states (4,444 products, totaling 17,776 cost-sharing reduction variations). An enrollee with income over 250 percent FPL is responsible for an over six times higher percent of total procedure cost than the lowest income enrollees *(Exhibit 8)*. In addition, there is a marked difference in total cost exposure at the 200 percent FPL threshold. An enrollee whose income is just below 200 percent FPL ($22,000) needs to pay only ~$1,300 out-of-pocket for a pneumonia in-patient episode (~22 percent of the total cost), while an enrollee whose income is just above 200 percent FPL ($24,000) would need to pay ~$3,000 (~50 percent) for the same episode. For a hip replacement, the numbers may rise to ~$1,600 and ~$4,300, respectively *(Exhibit 8)*. The implication for providers may seem counterintuitive: they may be able to realize a higher total percentage of reimbursement from lower-income patients enrolled in silver-tier products than from many patients with higher incomes.



□ □ □

The preliminary findings presented in this Intelligence Brief provide a perspective of the product benefit designs being offered on the public exchanges, and their implications to consumers, carriers, and providers. These findings are directional indicators only that are representative of nation-wide observations. Given benefit designs can vary significantly across states and even across markets within a state, it is important to evaluate product benefit design at a local level.

Erica Coe, Jim Oatman, Mahi Rayasam, Tom Bowen Wright

Appendix

Additional background on the underlying research

The analyses supporting this Intelligence Brief are informed by a new McKinsey Health Systems and Services Practice asset that has been developed jointly by the Center for U.S. Health System Reform and McKinsey Advance Healthcare Analytics (MAHA). Instead of estimates and projections, this tool offers a real-time view of what has actually been filed on the exchanges—over 21,000 qualified health products—for 2014. The Reform center/MAHA tool can compare individual and small-group rate filings, pre- to post-ACA trends, pricing across product types and actuarial value tiers by consumer characteristics, exchange network trends, predictions of market share based on filings and consumer-predicted dynamics, benefit designs across carrier types and metal tiers, and more. Specific analyses are available upon request from the Reform Center/MAHA team; we look forward to helping our clients achieve success in the post-ACA market through the use of data-driven analysis on specific market trends.

Please contact reformcenter@mckinsey.com with any inquiries.

Methodology

The major analyses and other data sources used to develop this Intelligence Brief include:

Data analyzed. For 2014 individual market exchange observations, we based our analyses all benefit designs of the 5,722 bronze, 6,910 silver, 5,247 gold, and 1,605 platinum products across the U.S. In addition, we analyzed product detail for the cost-sharing subsidy product variations of silver-tier products. We accessed the product benefit design data from the public exchanges as of January 30th, 2014, by shopping directly on all exchanges and by analyzing datasets released by the federal exchange. In addition, details about products' underlying benefit designs were obtained directly from carrier sites. We focused our analyses on exchange silver and bronze products for three reasons. First, they constitute 80 percent of enrollment on the exchanges as of February 1, 2014 as reported by HHS. Second, all carriers are required to offer a silver product to compete on the exchanges, so this analysis includes all exchange carriers across the U.S. Third, the silver tier is the only tier for which income-eligible consumers can receive both federal premium and cost-sharing subsidies.

For pre-reform 2013 individual market observations, we based our analyses on product data accessed from ehealthinsurance.com, for which data was available in all but two states (Maine and Rhode Island), totaling 31,807 products. We did however include data from both Maine and Rhode Island in our 2014 analyses, totaling 85 products.

Key benefit design fields used in the analyses

Co-pays	Co-insurance	Other benefit design features
Primary care (PCP)	Primary care (PCP)	Deductibles
Specialist (SPC)	Specialist (SPC)	Medical maximum out-of-pocket
Emergency care (ER)	Emergency care (ER)	Premiums
Urgent care (UC)	Urgent care (UC)	Cost-sharing subsidy designs
Generic drugs (Tier 1)	Generic drugs (Tier 1)	
Prescription drugs (Tier 2)	Prescription drugs (Tier 2)	
Inpatient care (I/P)	Inpatient care (I/P)	
Outpatient care (O/P)	Outpatient care (O/P)	

Actuarial value analysis. For 2013 products, we used the standard AV Calculator (provided by HHS) to approximate the actuarial value of each of the 31,807 individual products. All 2013 AVs were reduced to reflect the impact of non-covered Essential Health Benefits (in particular, maternity and mental health were not covered in many products). The population used for this calculation is the same standard population that HHS provided for 2014 actuarial value estimations. For 2014 products, actuarial values are standardized for each metal tier with products required to be within 2 percent of the standard, resulting in the following ranges: bronze 58-62 percent AV; silver 68-72 percent AV; gold 78-82 percent AV; platinum 88-92 percent AV. For silver-tier cost-sharing subsidy products, AVs are required within 1 percent of the standard, with the following ranges: 72-74 percent AV for 200-250 FPL, 86-88 percent AV for 150-200 FPL, and 93-95 percent AV for 100-150 FPL.

Affordability analysis. We selected the lowest-price bronze, silver, gold and platinum products in Atlanta, Georgia, for a 30-year old single, as given in table below:

	Annual Premium (30 year old)							
	$17,000	$20,000	$25,000	$30,000	$50,000	Deductible	MOOP	I/P Coinsurance
Platinum	$1,140	$1,500	$2,208	$2,988	$3,144	$1,000	$1,500	20%
Gold	$780	$1,140	$1,848	$2,628	$2,784	$2,500	$3,500	20%
Silver - ≥250% FPL				$2,283	$2,441	$4,600	$6,300	20%
Silver - 200-249% FPL			$1,500			$3,250	$4,750	20%
Silver - 150-199% FPL		$793				$900	$1,450	20%
Silver - 138-149% FPL	$431					$500	$750	20%
Bronze	$143	$505	$1,212	$1,995	$2,152	$6,300	$6,300	0%

We selected Atlanta as it was a major metropolis in which lowest price products in all four metal tiers (and CSR products) used coinsurance for inpatient services, enabling a straightforward comparison of potential consumer cost-sharing liability. We calculated premium subsidies based on the second lowest-price silver product with a 30-year single policy premium of $222 per month. To calculate cost-sharing for the medium level of healthcare consumption, we calculated expected consumer cost-sharing liability if he was to visit an I/P facility and incur $2,500 worth of expenses, as a percent of his gross income. Since none of the products provided coverage before deductible for in-patient procedures, consumer cost-sharing liability was calculated as the out-of-pocket the consumer would pay once he paid his deductible (if it were less than $2,500), then paid 20 percent coinsurance on

the remainder up to their maximum out-of-pocket. We assumed that gross income was equivalent to modified adjusted gross income, which is used to calculate subsidy eligibility.

Cost-sharing of key services. We compared insurance coverage of key health care services before deductible is met across exchange products nationwide. Four of the eight services/products illustrated are EHBs (emergency services, hospitalization, ambulatory patient services, prescription drugs). Covered service is defined as when a co-pay is required for the service, even if deductible has not yet been met. Non-covered service is defined as when the consumer must pay for the entire amount of the service until they hit their deductible. Key services analyzed include: primary care visit, specialist visit, emergency care, inpatient care, generic prescription, branded prescription.

Actual procedure cost by site of care. To compare the procedure cost across venues of emergency room vs. urgent care, hospital I/P MRI vs. stand-alone facility MRI, and hospital lab test vs. stand-alone lab test, we used Truven Marketscan Data for the 2012 estimated national average cost.

Emergency room, urgent care, preferred branded drug and generic drug cost-sharing comparison. For 2014 observations, our analysis focuses on states where the benefit design fields were directly obtainable from the exchange, which includes all state-run exchanges (1,045 silver products in total).

Inpatient cost-sharing. To compute consumer cost-sharing for inpatient procedures, we calculated the expected expense that the consumer would bear as a portion of the total procedure cost. We analyzed all silver-tier exchange products without coverage before deductible for in-patient facility costs, across all federally-run exchange states. This totals 4,444 products, with 17,776 cost-sharing reduction variations. To calculate consumer liability, we considered the products use of co-insurance, deductible and out-of-pocket maximum for in-network inpatient procedures. To determine how the cost-sharing between the carrier and the consumer varies by the cost of the procedure, we selected 5 higher volume I/P services from HCUPnet site of HHS that offered a range of medical expenses. The costs for these procedures were taken from the 'fair values' provided by HealthcareBlueBook.com.

Glossary

Actuarial value. Percent of total average costs for covered benefits that insurer is expected to cover (based on a standard set of claims that spans all states).

Coinsurance. Variable payment (percent of cost of respective product/service) borne by individual, typically after the deductible is covered. Carriers may use different levels of coinsurance for different types of expenses, e.g., physician visits, ER visits, O/P surgery, specialty/generic Rx costs.

Co-pay. Fixed payment for respective product/service borne by individual, typically before the deductible is covered, but not always. Carriers may use different co-payments for different types of medical or Rx expenses, e.g., physician visits or Rx prescription costs.

Cost-sharing subsidy. Also referred to as cost-sharing reduction, a federal subsidy that is eligible for silver-tier products only, that offsets out-of-pocket expenses for consumers with incomes up to 249 percent FPL, on a sliding scale of adjusted actuarial value: 100-149 percent FPL have 94 percent AV; 150-199 percent FPL: 87 percent AV; 200-249 percent FPL: 73 percent AV. Adjusted maximum out-of-pocket limits are also set as follows: 200-249 percent FPL: $5,200 individual, $10,400 family; 100-199 percent FPL: $2,250 individual, $4,450 family.

Covered service before deductible. A medical service or prescription for which the carrier shares in the cost before the consumer meets his deductible. The consumer pays a fixed co-pay (can be tied to length of stay for I/P visits) and the carrier covers remainder of the cost.

Deductible. Amount of expenses paid by individual out of pocket before insurer pays for any covered but non-preventative services. Carriers may offer separate deductibles for Rx and medical. Higher deductibles are often used to lower premiums.

Essential Health Benefits (EHB). EHBs are required to be offered by all 2014 individual products. They include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services.

Federal poverty level (FPL). As defined by the Department of Health and Human Services, the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. The Affordable Care Act set premium subsidy and cost-sharing subsidy amounts off of federal poverty level thresholds.

Maximum out-of-pocket (MOOP). The maximum annual cost-sharing contribution (not including premium payments) an individual could make (including deductibles, co-pays and co-insurance payments). Once out-of-pocket limit is reached, carrier assumes 100 percent of the risk for individual's expenses. ACA mandated limit for 2014 maximum out-of-pocket is $6,350 for individuals and $12,700 for families. Exceptions are made for out-of-network expenses that may not be covered under the maximum out-of-pocket. For individuals and families below 250 percent FPL, MOOPs are adjusted down; see 'Cost-sharing subsidy' glossary entry for details.

Not-covered service before deductible. A medical service or prescription for which the carrier does not share in any of the cost until the consumer meets his deductible. Consumer is then responsible for paying for 100 percent of the cost until he meet s his deductible.

Obtaining previous Intelligence Briefs

Previous Intelligence Briefs on exchange dynamics can be obtained online at: www.mckinsey.com/client_service/healthcare_systems_and_services/latest_thinking

- "Individual market enrollment: Early assessments" (January 2014)
- "Hospital networks: Configurations on the exchanges and their impact on premiums" (December 2013)
- "Exchanges go live: Early trends in exchange dynamics" (October 2013)
- "Emerging exchange dynamics: Temporary turbulence or sustainable market disruption?" (September 2013)