What can I afford? Mini-med 2.0 and cost-coverage questions in a post-ACA world

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Although final details and timing for the post-Patient Protection and Affordable Care Act (ACA) health insurance market are still to be determined, one prominent theme in the policy discussions centers on the ability of consumers and their plan sponsors (e.g., employers, associations, and governments) to pay for coverage. Among approaches to address the cost-coverage conundrum facing policymakers, the phrase "What's old is new" comes to mind as questions develop around the role that mini-medical plans (i.e., "mini-med" plans as opposed to "major medical" plans with comprehensive coverage) could again play (call it "mini-med 2.0") to address the financial challenges faced by consumers and their plan sponsors. This paper's scope is limited to questions and issues related to a mini-med market in a post-ACA world. This paper does not address the policy or financial implications of how to provide the broader coverage required by the ACA nor does the paper address the economic implications for consumers accessing treatment that may not be covered by some mini-med policies.

ACA and Mini-Med background

Former Health and Human Services Secretary Sylvia Mathews Burwell shed light on the approach that led to the ACA's comprehensive benefit requirements as part of her recent speech at the National Press Club: [1,2]

- Plans without all of the ACA benefits and out-of-pocket limits were less expensive–but it was not clear what coverage such noncompliant plans offered or how the actuarial value of noncompliant plans compared to ACA plans.
- Concerns related to how people who need certain services can get them affordably in a world of a la carte healthcare coverage options where people do not know in advance what coverage they may need.

Prior to the ACA, mini-med plans had no standard meaning, though mini-med plans typically shared a few characteristics:

- In general, mini-med policies provided limited coverage that, depending on the level of benefits, could be exhausted quickly and/or result in significant out-of-pocket expenses if the enrollee needed comprehensive services.
- More specifically, the Centers for Medicare and Medicaid Services (CMS) defined mini-med plans as those with a total annual benefit of $250,000 or less with pre-ACA mini-med annual benefit limits as high as that $250,000 figure while more typically ranging in the market from perhaps $10,000 to $50,000.
- An expense-incurred basis for coverage as is used for traditional comprehensive health insurance (i.e., "traditional health insurance") with lower dollar-value benefit levels than traditional health insurance and accompanying lower premiums for the mini-med plans. In addition to mini-meds as defined in this paper, issuers may have also sold or continued to sell other forms of limited healthcare coverage before and after ACA implementation. Please see Appendix A for a more complete summary of the various limited healthcare coverage alternatives.

The ACA effectively eliminated the expense-incurred mini-med market in 2014 with the prohibition of annual limits on essential health benefits (EHBs). That elimination removed a coverage alternative that may have been particularly popular with certain employers and budget-sensitive, lower-wage workers due to its plan design customizability and low premiums in comparison to traditional health insurance. Industries in which mini-meds were particularly popular included, but were not limited to, industries employing higher proportions of part-time, hourly, seasonal, and/or temporary workers. Weekly payroll administration and deduction also helped spread out the costs for employers and workers to make the costs more manageable.

Mini-med supporters argued that the comprehensive coverage options mandated in the ACA resulted in an unaffordable combination of premiums and cost sharing (deductibles and copays) for a depth and breadth of protection that may not fit every consumer. Mini-med detractors countered that the low premiums stemmed from restrictive eligibility, benefit, and pre-existing condition limits that resulted in a lack of benefit understanding by enrollees, an inability of enrollees to access and use benefits, and/or disproportionately high numbers of rejections and delays on properly filed claims.

1 Burwell, S. (2017, January 9). The Reality of Repeal: Access, Quality and Affordability. Retrieved from http://www.press.org/sites/default/files/20170109_burwell.pdf

2 Hackman, M. (2017, January 9). Departing HHS Chief Makes Plea for Preserving Affordable Care Act. Retrieved from http://www.wsj.com/articles/departing-hhs-chief-makes-plea-for-preserving-affordable-care-act-1483995132

The question consumers ask – what can I afford?

The ACA evolved with the triad of access, affordability, and quality used to develop and assess the legislation. While the ACA improved access and reduced the number of uninsured, the objectives of expanding access and increasing affordability (i.e., reducing healthcare costs) have often conflicted. Even with premium subsidies, the affordability question has lingered in cases where ACA-compliant coverage may remain outside of some consumers' budgets, especially when cost sharing (deductibles and copays) is included in consumers' evaluations. Analyses of HealthCare.gov exchange plan data for 2015 and 2016 indicates that ACA public exchange plan enrollees focus mainly on their own discounted out-of-pocket price when shopping for health coverage.[3]

Further reform may want to consider the budgetary constraints of price-sensitive consumers. For such consumers with limited budgets for monthly premiums and/or out-of-pocket expenses at the point of service, the start to the decision-making process may be the price point that answers the question of "What can I afford?" Upon answering that question, the decision-making process for consumers may then continue in assessing any trade-offs between the benefits/services available and their accompanying cost.

Thoughtful expansion of healthcare coverage options to answer consumers' "What can I afford" question may help address the ongoing economic challenges that consumers from different socioeconomic classes and incomes face.[4] In such an expansion, future reform may again need to consider the potential for enrollee "paralysis by analysis." Like the balance that ACA developers faced, reform may need to strike a balance between making a sufficient number of options available to consumers and facilitating decision-making that does not overwhelm those consumers making healthcare decisions.

Mini-Med 2.0 – intersection of cost and coverage to meet consumer needs?

In restarting the development of healthcare legislation from the consumer view of "what can consumers afford," an array of important questions may require answers:

1. How does reform redefine, prioritize, and/or eliminate EHBs? Such a question may need to start by addressing what, if any, coverages/benefits remain mandatory. Questions related to the role that current, emerging, and/or future healthcare crises play in recrafting coverage mandates (e.g., emerging proposals tied to addressing opioid addiction)[5] may also be important.

Early research tied to issues of coverage indicates stronger support for mandatory coverage for hospitalizations, lab tests, and emergency care over other benefits.[6] Additional research shows particular interest in having the ability to buy lower-cost plans to fit their needs more generally with an emphasis on reducing out-of-pocket costs and affordable drug coverage.[7]

Various post-ACA proposals indicate significant changes to EHBs if not the outright elimination of EHBs. If post-ACA reform should instead retain a significant number of current EHBs, such a result would likely dampen the development of a mini-med 2.0 market.

2. Will an expansion of limits in some form facilitate a mini-med 2.0 market? With answers to the following questions, issuers may then just need to balance their administrative capacity with their creativity in finding the right blend of services needed, at the premium level and out-of-pocket exposure needed, to answer the question "what can consumers afford?":

- Will dollar and/or use limits apply? If so, what will the frequency of such limits be–daily, annual, and/or lifetime?[8] Will mini-med 2.0 annual benefit limits increase from the legacy definition of a total annual benefit of no more than $250,000 to find more of a middle ground between that legacy and the unlimited benefits of the ACA? In addition to the ceiling just mentioned, will there be a floor for annual benefits below which no plans may go? Will limits apply to all or just some benefits? If limits apply to just some benefits, what benefits have those limits?

3 Bell, A. (2017, January 19). Net Price Drives ACA Health Plan Sales, Feds Say. Retrieved from **http://www.lifehealthpro.com/2017/01/19/net-price-drives-aca-health-plan-sales-feds-say**

4 Bagley, N. and Frakt, A. (2016, December 5). The Problem with One-Size-Fits-All Health Insurance. Retrieved from **https://www.nytimes.com/2016/12/05/upshot/the-problem-with-one-size-fits-all-health-insurance.html**

5 Hutchins, R. and Jennings, K. (2017, January 10). In Annual Speech, Bruised Christie Lays Out Plan to Attack Drug Addiction. Retrieved from **http://www.politico.com/states/new-jersey/story/2017/01/in-annual-speech-bruised-christie-lays-out-plan-to-attack-drug-addiction-108613**

6 Bell, A. (2016, December 26). A Look Back at our 2016 Health Insurance Predictions. Retrieved from **http://www.lifehealthpro.com/2016/12/26/a-look-back-at-our-2016-health-insurance-predictio?eNL=586182d0160ba06476074bb9&utm_source=LHPro_HCRW&utm_medium=EMC-Email_editorial&utm_campaign=12262016&page=11**

7 Altman, D. (2017, January 5). The Health Care Plan Trump Voters Really Want. Retrieved from **https://www.nytimes.com/2017/01/05/opinion/the-health-care-plan-trump-voters-really-want.html?ref=business**

8 Different proposals under consideration suggest various approaches to allowing/prohibiting limits on the coverage provided to individuals. As three examples specific to limits, the Paul proposal permits limits on plans; the Ryan proposal supports an end to lifetime limits; and the Cassidy/Collins proposal supports bans on annual and lifetime benefits limits, among other reforms:
Paul, R. (2017, January 24). S. 222, the Obamacare Replacement Act. Retrieved from **https://www.paul.senate.gov/news/press/dr-rand-paul-unveils-obamacare-replacement-act**
Ryan, P. et al (2016, June 22). A Better Way. Retrieved from **https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf**
Cassidy, B.; Collins, S.; Isakson, J.; and Moore Capito, S. (2017, January 24). Patient Freedom Act of 2017. Retrieved from **http://www.cassidy.senate.gov/imo/media/doc/PFA%20Bill%20Text.pdf**

Figure 1 below summarizes a potential simplified sample range of mini-med 2.0 benefit plans and their actuarial values and estimated premium ranges alongside an ACA-compliant silver plan.

- What sort of minimum coverage terms/durations and renewals may be allowed? Will the durations of plans be limited to or capped at certain periods? Will enrollees be restricted in their ability to renew such plans? For example, recently published rules[9] limited short-term health insurance to terms of three months or less with no option for the issuer to renew.
- What other plan design and operational considerations may reform need to consider? Issuer protections such as use of waiting periods or other protections to mitigate "enroll-use-disenroll" scenarios will need to balance the importance of ensuring value to the enrollee. Where gaps in coverage exist, how issuers and the market respond to address costs in those gaps will be important–issuers in the pre-ACA mini-med market sometimes made discount cards and/or provider negotiation services available to help enrollees reduce their bills in those gaps.

3. Will minimum loss ratio (MLR) requirements change in the mini-med 2.0 market and with what timing? In revisiting the challenges that existed prior to the ACA, reform will need to strike a balance between:

- **Issuer questions** related to higher anticipated administrative costs relative to benefits paid/incurred claims and higher potential enrollee turnover with shorter average enrollment periods
- **Consumer demands** for lower costs and greater efficiency from mini-med 2.0 issuers and consumer needs for benefit plan understanding

One idea within the MLR calculation could exclude agent commissions to facilitate greater agent participation. Congressional support and proposals for such an adjustment to the MLR calculation existed in the 112th and 113th Congress.[10]

Alternatively, mini-med 2.0 could include MLR transitional rules. One option could transition to a lower target MLR (e.g., 65% like Medigap) over multiple years. Another alternative could reverse the transitional multipliers available to mini-med issuers in the development of the ACA, so multiply the MLR numerator by factors of 1.25, 1.50, 1.75, and 2.00.

4. How will a mini-med 2.0 market address consumer needs for transparency, protection, and education? As noted earlier, a primary criticism of pre-ACA mini-meds was the lack of enrollee understanding of the plans and their limits. With the goal of helping consumers understand what they are getting with mini-med 2.0 coverage, several questions may need answers to make mini-med 2.0 benefit plans transparent and optimize consumers' education:

- Could a consumer evaluation framework evolve to clearly categorize the mini-med 2.0 plans and describe their relative value to allow consumers to distinguish among those plans? Such a framework may need minimum plan baselines with varying benefits for hospitalization, doctor visit, prescription drug, and/or other services with issuers and/or consumer groups providing input into the setting of those baselines.

9 Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance (2016, October 31). Retrieved from https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance

10 Kirchhoff, S. (2014, August 26). Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act (ACA): Issues for Congress. Retrieved from https://fas.org/sgp/crs/misc/R42735.pdf

FIGURE 1: SAMPLE RANGE OF MINI-MED 2.0 BENEFIT PLAN DESIGNS AND VALUES

CHARACTERISTIC	MINI-MED 2.0 "PEARL"	MINI-MED 2.0 "EMERALD"	MINI-MED 2.0 "DIAMOND"	ACA SILVER PLAN
Plan design overview and simplifying assumptions	Mini-med plans cover the same broad range of services as the ACA silver plan; mini-med plans embed no inside limits/service-specific limits or maximums			
Deductible/Coinsurance	$0 / 30%	$250 / 30%	$1,000 / 30%	$1,700 / 30%
Out-of-pocket maximum	N/A	N/A	N/A	$7,150
Annual maximum benefit	$10,000	$25,000	$250,000	N/A
Estimated actuarial value	38%	48%	60%	70%
Estimated premium as a percent of ACA Silver Plan*	43% to 46%	62% to 66%	87% to 92%	100%

*Mini-med 2.0 plans assume 75% loss ratios for additional anticipated issuer expenses in comparison to 85% for the sample ACA plan. Mini-med 2.0 premium range estimates also assume reduced discretionary use of services because of benefit limits and improved morbidity. Different assumptions for plan design (service exclusions or service-specific limits or maximums), issuer expenses, utilization, morbidity, and other factors will result in different estimates. Affected parties should monitor claim and expense experience as it emerges and adjust rates and assumptions as needed to align actual experience with projections.

- Will enhanced disclosure requirements emerge related to plan limits? Perhaps summaries of benefits and coverage (SBCs), as used in the traditional health insurance market, can serve as a starting point for such disclosure. Such requirements may help consumers have a better understanding of what they are buying and that reduced premiums are the result of benefit gaps/trade-offs. What language and examples will help those enhanced disclosures make the coverage more understandable? Will regulators collaborate with issuers to eliminate legalese and simplify disclosure documents?
- What other consumer protections are important? Post-election focus group research[11] indicates a need for consumer education related to provider networks and out-of-network care. As part of a solution, mini-med 2.0 plans may also need to improve provider network disclosure and adequacy communications and be clear about the cost trade-offs for limited and expanded networks. Regarding out-of-network care, information to help enrollees better understand their out-of-pocket exposure and reduce the chances for surprise out-of-network bills appears to be important.

Market consequences – traditional and self-insured markets

While reducing the cost of healthcare coverage and optimizing consumer understanding of the cost-coverage trade-off may be concurrent goals at the forefront of the potential mini-med 2.0 market, such a market would not exist in a vacuum. A potential mini-med 2.0 market may need to mitigate the risk of anti-selection and subsequent upward pressure on traditional health insurance premium rates, prompting the following questions:

1. Does a mini-med 2.0 market create coverage that a new market can afford at the expense of the traditional health insurance market? Once again, herein lies the conflict of consumer choice, affordability, and access. Questions related to specific issues, protections, and/or incentives may need to be answered to help protect the integrity of both risk pools:

- How would mini-med 2.0 plans satisfy continuous coverage requirements for traditional health insurance, if at all? While no credit for mini-med 2.0 enrollment would maximize protection of the traditional health insurance risk pool, consumers and consumer groups may view such an approach as imbalanced. Estimates of actuarial values for prior enrollment in mini-med 2.0 plans would be an option to assign partial credit for such enrollment, relative to traditional plans, with consumer understanding of the rules being a critical related component.
- For issuers in one or both of the mini-med 2.0 and traditional space, how will pricing, benefits, and experience compare and change between the products in these key markets? It will be critical for legislators, issuers, consumers, and other affected stakeholders to assess how the markets develop initially and evolve over time. Issuers may also direct some of their focus to how selection emerges and where the greatest exposure exists.
- For issuers and consumers, could incentives or penalties develop to balance the risk profile of those enrolling in traditional or mini-med 2.0 pools? Financial subsidies or penalties, and liberal or restrictive enrollment or movement rules, may just be part of reform efforts to encourage sufficient enrollment and/or retain healthcare coverage that both risk pools can afford.

2. How would a mini-med 2.0 market influence the self-insured market, both employers that self-insure their benefit plans and issuers of employer stop-loss insurance? Self-insuring employers and issuers of employer stop-loss insurance replacing coverage with mini-med 2.0 plans would expect savings from potential benefit caps, with those savings magnified by emerging large claim experience in traditional health insurance (the number of $1 million or more claims continues to increase[12] with more patients also emerging with $10+ million in medical costs[13]).

3. In considering the impact on the self-insured market, what accompanying trade-offs may also need to be considered? In the presence of mini-med 2.0 plans, to whom are the costs for catastrophic claims transferred–the consumer, the provider, a risk pool or government sponsor, or someone else?

Affordability - Questions beyond mini-med 2.0

As healthcare reform discussions continue, a renewed focus on consumer affordability may extend well beyond consideration of a mini-med 2.0 market. As healthcare reform evolves, issues beyond the scope of this paper that may also be an important part of addressing affordability include:

- Coverage mandates and continuous coverage provisions
- Enrollment periods and requirements/restrictions/late enrollment surcharges
- Underwriting and pre-existing condition exclusions
- Risk adjustment programs (efficacy, modifications, monitoring, etc.)

11 Altman, D. (2017, January 5). The Health Care Plan Trump Voters Really Want.

12 Top Ten Catastrophic Claims Conditions Report Explores Costliest Medical Conditions and Emerging Trends (2016, July 11). Retrieved from http://www.sunlife.com/us/News+and+insights/Press+releases/2016/Top+Ten+Catastrophic+Claims+Conditions+report+explores+costliest+medical+conditions+and+emerging+trends?vgnLocale=en_CA

13 Bell, A. (2016, December 26). A Look Back at our 2016 Health Insurance Predictions.

- High-risk pools (funding, rules/mechanisms, etc.)
- Premium and cost-sharing subsidies (funding, structure, etc.)
- Tax treatment of premiums and accounts/tax code revisions
- Incentives/rewards for participation in health-contingent wellness programs
- Age/gender/other pricing flexibility
- Policies related to selling across state lines
- Quality measures and requirements
- Alternative payment models (CMS programs/models or otherwise)
- Medical liability reform

Conclusion - questions becoming answers

The unique economic circumstances of consumers and plan sponsors seeking to answer the question "What can I afford?" may drive the selection of healthcare coverage. Though more questions than answers may exist now, issuers and their policyholders should keep a keen eye on emerging legislation as answers emerge to the questions raised in this article and as more questions arise. The answers to current and emerging questions related to the critical issue of cost-coverage balance facing the healthcare market will help issuers and policyholders better understand the role mini-med 2.0 plans may play in a post-ACA healthcare world.

Limitations/biography

Nick Ortner, FSA, MAAA is a consulting actuary with the Milwaukee office of Milliman, Inc. Nick is also a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to issue this report and render the actuarial opinion contained herein. Readers of this report should not interpret this report as an endorsement of any particular legislation by Milliman or the author. The report reflects the author's findings and opinions. Different assumptions for mini-med 2.0 benefit plan designs, issuer expenses, and other factors will result in different estimates. Affected parties should monitor emerging experience and make adjustments to align experience with expectations. The report reflects a current understanding of the ACA and the questions emerging from potential changes to current regulations. As regulations develop and change, answers may emerge that prompt new questions. We ask that readers of this report only distribute this report in its entirety because extracts of this report taken in isolation can be misleading.

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Appendix A
Summary of Characteristics of ACA and Limited Healthcare Coverage Plans

		LIMITED HEALTHCARE COVERAGE PLANS			
PLAN CHARACTERISTIC	ACA / TRADITIONAL	MINI-MED	FIXED INDEMNITY / LIMITED BENEFIT MEDICAL	SHORT-TERM MEDICAL / HEALTH	DEDUCTIBLE GAP / GAP-FILLER
Primary Features	Comprehensive coverage of minor, major, and chronic condition service needs	Lower premium; covers smaller common expenses; provides network access	Lower premium; may provide network access; may be useful supplement to help cover high deductible costs	Lower premium; immediate coverage; often used in transitional periods (new graduates, between jobs, or prior to an open enrollment period)	Lower premium; strictly fills in the gap before a high deductible
Benefit Basis	Expense-incurred	Expense-incurred	Cash benefit	Expense-incurred	Expense-incurred, coordinating with the ACA plan
Enrollee Cost-Sharing	Deductibles and copays / coinsurance	Typically copays / coinsurance	Provider charge less cash benefit	Deductibles and copays / coinsurance	Separate deductible and coinsurance inside the high deductible
Dollar Limits	None	Lower lifetime and/or annual limits; service-specific limits may also apply	Lifetime, annual, and/or service-specific limits may apply	Limits based on the term of the coverage	Limit is the high deductible around which this coverage wraps
Utilization Limits	Specified by service	Specified by service	Specified by service	Specified by service	
Network	Yes, with reduced or no coverage out of network	Yes, with reduced or no coverage out of network	Coverage anywhere, a network (if present) helps reduce out-of-pocket expense	Yes, with reduced or no coverage out of network	Coordinates with ACA plan
Term	12 months	12 months	12 months	Historically, less than 12 months and typically 1 to 6 months; 3 month federal limit implemented prior to the election on policies sold after 3/31/2017	12 months
Coverage of Pre-Existing Conditions	Yes	Typically yes; may vary	Typically yes; may vary	Usually no; new term resets pre-ex clause	Yes
Benefit Exclusions	Few, if any	Varies	Varies	Several exclusions often apply	Tied to ACA plan
Market Type	Individual or Group	Typically sold to groups; contracts may be owned at the individual or group level	Typically sold to groups; contracts may be owned at the individual or group level	Typically individual	Typically sold to groups; contracts may be owned at the individual or group level