Benefit Design Considerations for SB 2

Supplement B to the Report:

Challenges and Alternatives for Employer Pay-or-Play Program Design: *An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2)*

For the
California Health Care Foundation
and the
California Managed Risk Medical Insurance Board

Project Team Led by the
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Lynn Taylor, senior policy analyst with the Institute for Health Policy Solutions, was the principal author of this supplement on the benefit design considerations surrounding SB 2, the pay-or-play legislation that was passed by the California legislature in 2003 but subsequently overturned by referendum. The lead organizations for the overall study were the Institute for Health Policy Solutions and the RAND Corporation. Rick Curtis, of the Institute for Health Policy Solutions, served as the project director. Please see the main report for a detailed discussion of the study process.

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Supplement B:

Benefit Plan Design Considerations

Background

The California Health Insurance Act of 2003 (also known as SB 2) adopted a "pay-or-play" mandate aimed at reducing the size of the state's uninsured population. This law required employers over a certain size to either: (a) "pay" a fee to the state so that their workers and, for employers with 200 or more workers, dependents could be covered through a State Health Purchasing Program established under the Act, or (b) "play" by directly providing health coverage for specified workers and dependents. Although SB 2 was overturned by a narrow margin in a November 2004 referendum, the passage of legislation intended to expand employment-based coverage provides a unique opportunity to assess and to evaluate the implementation issues and challenges presented by a "pay-or-play" program.

The Act directed California's Managed Risk Medical Insurance Board (MRMIB) to design and operate the program. As discussed below, they were given very general guidelines as to the type of coverage that should be offered by the State Health Purchasing Pool (SHPP). This report supplement examines the considerations that a pay-or-play administrator might want to take into consideration in the design of the benefits to be offered.

What Constitutes Minimum Coverage Under SB 2?

The *Health Insurance Act of 2003* envisioned that the same covered services would be required in the pool (for employer paying the fee) and in the market (for employers who provide "qualifying" coverage directly to their workers). These covered services included "hospital, surgical and medical care expenses" as well as prescription drug coverage. Limited-coverage plans such as vision-only, disease-only and hospital-indemnity-only are ineligible for a credit and could not be offered by the pool.

The Act did not provide much guidance regarding cost-sharing levels. MRMIB was tasked with detailing the cost-sharing levels that should be offered within the health insurance pool. For coverage in the pool, the Act specified the following:

- MRMIB was to establish deductibles, coinsurance or copayment levels and total annual out-of-pocket costs.
- No out-of-pocket costs other than copayments, coinsurance, and deductibles in accordance with this section were to be charged to enrollees and dependents for health benefits (plans in the pool cannot include any benefit limits).
- MRMIB should "take into consideration" the impact of enrollee cost-sharing on the patient's access to services *and* the employer's ability to pay the fee (affordability considerations).

- MRMIB was also charged with "developing and utilizing appropriate cost-containment measures to maximize the cost-effectiveness of health care coverage offered under the program."[1]

Regarding coverage in the market that would qualify for a credit against the fee, the Act specified:[2]

- For indemnity/PPO plans governed by the insurance code, the maximum out-of-pocket costs could not exceed the maximum allowed for "health care service plans providing benefits under a preferred provider organization policy."[3] (In other words, they could not be higher than would be approved by the Department of Managed Health Care for a PPO plan.)
- An employer "may purchase health care coverage that includes additional out of pocket expenses, such as copayments, coinsurance or deductibles." (The cost-sharing amounts can be higher than those specified by MRMIB for the pool.)
- Yet, in approving the coverage, the DMHC or DOI (as appropriate) shall "consider" the cost-sharing limits established by MRMIB for coverage in the pool.

What We Modeled

The scenarios for simulation examined the viability of a pool offering a "mainstream" benefit package (under various fee-setting strategies) as well as a "lean" benefit package. These PPO plan designs are described in the exhibit below. These plan designs represent (approximately) the 75th and 10th percentile of all plans if the plans in the simulation database were distributed by richness of plan design.[4]

[1] For a discussion of cost-containment and patient cost-sharing please see *Supplement C*.

[2] Anticipating an ERISA challenge to the specification of a benefits standard for self-insured plans, the Act also included a "fallback" provision that is more likely to survive an ERISA challenge: an employer would qualify for a full credit if the amount spent on health insurance equaled or exceeded the lower of (a) the cost of Healthy Families (California's SCHIP program) or 150% of the cost of Medi-Cal (California's Medicaid program).

[3] Patricia Butler points out that these cost-sharing limits are not specified in Knox-Keene or in its regulations but DMHC "apparently ... would disapprove a PPO product that allows unreasonably high out of pocket costs." (See footnote 4 in: Butler, Patricia, *ERISA Implications for SB 2: Full Report*, March 2004, California HealthCare Foundation, www.chcf.org.) Hence, we don't know what these limits are but do know that DMHC has approved plans that include deductibles up to $1,000.

[4] Given some of the very high deductible plans being introduced in California's small employer market place ($3,000 and $5,000) and the results of our expert interviews, some felt that a $1,000 deductible plan might be more generous than the 10th percentile of plans by the time SB 2 was implemented (in 2006). The simulation is constrained, however, because the 2003 plan distribution underlying the simulation database doesn't yet include very many of these extremely lean plans. On the other hand, the project team feels that the *relative* positioning of a plan with a $1,000 deductible in 2003 may be a realistic proxy for the positioning of a higher deductible plan in 2006.

Exhibit B-1: Plan Design Comparison

	Mainstream	Lean
Deductible	$100	$1,000
Coinsurance	20%	20%
Drug Copay	$10	$12
Out-of-Network coinsurance	30%	40%
Out-of-Pocket Max	$1,250	$5,000
Average Percent of Spending Covered Overall	91%	84%

Source: RAND Corp.

As the table below shows, the "leanness" of the plan design weighs more heavily on those with low health care spending (a much smaller percent of expected services are covered). The highest quartile of spenders is more similar in terms of the percent of spending covered by the two plans.

Exhibit B-2: Percent of Expected Health Spending Covered by Each Plan, by Health Spending Quartile

Health Spending Quartile	Mainstream Plan	Lean Plan
Lowest	50%	10%
Medium-low	69%	35%
Medium-high	83%	68%
Highest	94%	88%

Source: RAND Corp.

For simulation purposes, the "lean" plan described above was also designated as the leanest plan that qualified for a credit in the market. In other words, it is the plan that non-offering employers are expected to "have in mind" when deciding whether or not to participate in the pool. This plan would meet the requirements of the SB 2 legislation for receiving a credit because it includes prescription drug coverage and contains cost-sharing levels that have been approved for the large employer market by the California Department of Managed Health Care (and hence is compliant with the Knox-Keene Act).

The Impact of Benefit Design on Pool Composition

The results of the simulation show that whether the pool offers a "lean" or a "mainstream" plan does not materially affect the size of the pool but does impact the composition of the pool. (See section 2.8.2 of the main report and Figures A-16 and A-18 in Supplement A.) Moving from a

"lean" plan to a "mainstream" plan decreases the number of previously non-offering employers in the pool. However, they are replaced with employers who had previously offered—keeping the total about the same. This reflects the new positioning of the pool offering relative to the market.

Not surprisingly, the share of low-wage workers in the pool decreases when the minimum benefit standard is increased.

The simulation analysis demonstrates how the relative coverage standard between the pool and market significantly impacts the expected distribution of employers between these two purchasing venues. However, as discussed in the main report, the benefit standard used in a pay-or-play design will not conclusively predict anything about program viability without also knowing the fee structure and subsidy availability (if any).

Affordability Considerations

Positioning the coverage "floor" at the "lean" end of the market may facilitate the "pay-or-play" goals of increasing employer provided coverage (while minimizing labor market effects), but such an approach invites controversy for other reasons. A lean plan may be characterized as inadequate if one of the goals of the legislation is comprehensive coverage for all.

The SB 2 Act requires MRMIB to take into consideration whether the proposed deductibles, coinsurance and copayments associated with pool coverage might "deter enrollees and dependents from receiving appropriate and timely care." It also tasks the board with taking into consideration the employer's ability to pay the fee. These are potentially conflicting goals.[5]

The Impact of Cost-Sharing on Service Use

The most thorough investigation of the impact of cost-sharing on the use of services was the RAND Health Insurance Experiment (HIE) which took place in the 1970's and early 80's. This study looked at the impact of various deductible and coinsurance levels on the use of services and on the health status of the study participants. The study found that increasing cost-sharing did impact the use of services. These shifts are small, however, implying that any premium savings associated with increases in cost-sharing are mostly due to cost-shifting to the enrollee and not a reduction in service use.[6] The effect is stronger for the very low income than for those with higher incomes. The study also found that the reductions in service use did not negatively impact the health status of study participants *except for those who were below poverty and in poor health*.

[5] Setting aside, for the moment, the more general goal of enabling employers to comply with the mandate. This goal can be satisfied even if the fee for purchasing coverage from the pool is high if qualifying coverage can purchased cheaply in the market.

[6] While the strength of the response varies with the type of service, on average a 10% increase in cost-sharing reduced service use by 2%. In contrast, most research finds that people are more sensitive to differences in premium levels.

There is general agreement that the largest effect of cost-sharing is on the probability of accessing any care rather than a change in the number of visits once care has been accessed.[7] Sensitivity to price changes also varies across different health care services. Prescription drugs have been identified as the most responsive, followed by preventive services and other physician services, with inpatient hospital use being the least responsive. This hierarchy reflects that fact that the more "urgent" the care, the less sensitive the demand is to price.

Importantly, increasing cost-sharing "across the board" was found to cause a reduction in both necessary services and discretionary care. As such, it is a "blunt instrument" for steering patients to consume the "correct" mix of health services.[8] Based on a review of such efforts, several authors have concluded that it is very difficult to design benefit plans so that they induce only beneficial service use.[9]

How Much Can The Low-Income Afford?

Closely related to the issue of cost-sharing's impact on service use is the question of affordability for the low-income. While premium sharing is capped at 5 percent of wages for workers whose annual wages are less than 200% of federal poverty guidelines, the Act contains no such cap for point-of-service cost-sharing.[10]

The impact of point-of-service cost-sharing falls disproportionately on those enrollees with heavier service use and with lower incomes. A study from 2003 illustrates the disproportionate impact by income and by service use.

[7] Ringel, Jeanne, Susan D. Hosek, Ben A. Vollaard, and Sergej Mahnovski. "The Elasticity of Demand for Health Care, A Review of the Literature and Its Application to the Military Health System," RAND, 2002.

[8] These studies do not speak to the effectiveness of differential cost-sharing for different services (which does seem to impact purchasing behavior).

[9] Ku, Leighton and Teresa A. Coughlin. "The Use of Sliding Scale Premiums in Subsidized Insurance Programs," Urban Institute, March 1997.

[10] Under all implementation scenarios, children continue to be eligible for Medi-Cal and Healthy Families, which does cap out-of-pocket expenses. As discussed in the main report, alternative pay-or-play scenarios could be implemented with low-cost sharing plans targeted to the low-income.

Exhibit B-2: The Distribution of Out-of-Pocket Costs, by Benefit Design

	Baseline Plan: $0 deductible $10 copays $1,500 OOPM	**Mainstream Plan:** $100 deductible 10% in-network coinsurance; 20% out-of-network coinsurance $1,600 OOPM	**Lean Plan:** $1,000 deductible 20% in-network coinsurance; 30% out-of-network coinsurance $2,500 OOPM
Average Annual Out-of-Pocket Costs	$52	$321	$763
Percent of People Exceeding $500	1%	19%	49%
Percent of People Exceeding $1,000	0%	9%	36%
Out-of-Pocket Costs Exceeding 10% of Income, by Family Income:			
Below Poverty	8%	32%	47%
100%-124% FPL	2%	11%	33%
125%-199% FPL	1%	5%	16%
200%-399% FPL	1%	2%	6%
All Incomes	1%	3%	7%

OOMP=out-of-pocket maximum
Note: These plan designs are close but do not exactly match those used in our simulations.

Source: Trude, Sally. "Patient Cost Sharing: How Much is Too Much?," Issue Brief from Center for Studying Health System Change, no. 72, December 2003.

Under the "mainstream" plan, the typical enrollee will face $321 in annual out-of-pocket costs. However, 19 percent of enrollees will have expenses exceeding $500 and 9 percent will have expenses exceeding $1,000. Whether or not this burden is "unaffordable" depends, in part, on the enrollee's income level. On average, only 3% of enrollees will face expenses exceeding 10% of family income. However, the poor and near poor are much more likely to have their out-of-pocket costs exceed 10% of income. This burden increases greatly when the deductible and out-of-pocket max are increased by $900 and coinsurance is raised. Based on the results of this analysis, it would be very difficult for many low-income workers to afford the out-of-pocket costs associated with our "lean" plan.[11]

Some Benchmarks:

2.5% of income: total annual OOP costs allowed under SCHIP for families <150% FPL

5% of income: total annual OOP costs allowed under SCHIP for families >150% FPL

7.5% of income: IRS permits OOP expenses exceeding this threshold to be deducted from taxable income

There is no agreed upon standard as to what constitutes an affordable level of health expenditures. Different plans and

[11] Which is not to say that they would be worse off compared to having no insurance coverage at all.

states have adopted some benchmarks. For example, the State Children's Health Insurance Program (SCHIP) requires that combined premium and point-of-service cost sharing not exceed 2.5% of family income for those under 150% of the federal poverty level. For those at higher incomes, these expenses cannot exceed 5% of family income.

The cost sharing for California's SCHIP program falls well below these Federal guidelines. In *Healthy Families*, premium cost-sharing is limited to a maximum of $14 per month for families under 150% of FPL and $27 a month for families with higher incomes. Certain services have a $5 copay, but there is an out-of-pocket cap of $250 per year per family.

The table below translates 2.5% and 5% of income into dollars for selected low-income families. In light of their expected contribution to the premium (up to 5% of income), these guidelines suggest there is little room for extensive point-of-service cost sharing, particularly for those under 150% of poverty.[12]

Exhibit B-4: Maximum Total Annual Out-of-Pocket Costs Allowed under Federal SCHIP Rules, by Family Size and Income

	Family Size			
	1	**2**	**3**	**4**
2.5% of Income for Families at 100% 2004 FPL	*$ 233*	*$ 312*	*$ 392*	*$ 471*
2.5% of Income for Families at 150% 2004 FPL	*$ 349*	*$ 468*	*$ 588*	*$ 707*
5% of Income for Families at 200% 2004 FPL	*$1,047*	*$1,405*	*$1,763*	*$2,121*

Source: Author's calculation.

This suggests that for low-income workers in the pool (who are ineligible for public programs such as Medicaid and SCHIP), there may need to be a low-cost sharing plan or a plan with cost-sharing that "slides" with income.[13] The evidence is persuasive that "mainstream" cost sharing may deter needed service use for those under 150% of poverty.

Sliding-scale cost-sharing (as opposed to premium sharing) is rare in both public and private programs.[14] Nonetheless, according to a Hewitt survey of large employers, 7% of very large

[12] The premium cap is set at five percent of *wages* for those that qualify. If the worker has no other source of family income, then he or she will effectively pay 5% of income. If there is other income, they will pay less as a percentage of total family income.

[13] See Section 2.6.1 of the main report for a discussion of SB 2 and the Medi-Cal/Healthy Families population.

[14] Massachusetts' Children's Medical Security Plan has sliding-scale copayments based on family income guidelines. The proposed Dirigo health plan in Maine has sliding-scale deductibles based on family composition and income. New Mexico's adult expansion proposal included sliding-scale cost-sharing. Safety net clinics often have sliding-scale payment schedules. Premium Assistance programs in several states have cost-sharing based on

employers have cost-sharing levels based on employee pay.[15] Such a design might help MRMIB resolve the conflicting goals of affordability for patients (low cost sharing) and affordability for employers (high cost sharing). It is difficult to administer, however, and the potential for adverse selection against the pool would have to be carefully considered.

Should There Be A Choice Of Plans?

As noted in our *Market Context* report, most employees in firms of 200 or more workers have a choice of benefit packages and health plans. A choice of plans is one of the key predictors of employee plan satisfaction.

California's SB 2 legislation seemed to envision that the pool would have multiple insurers all offering a standard benefit package:

> *The board shall negotiate contracts with those health care service plans and health insurers that choose to participate for the benefit package described in this part…*

The legislation did not, however, specifically address whether or not plan-design upgrades would be available within the pool. Offering such benefit "upgrades" within the pool might increase the attractiveness of the pool to employers whose employees don't all value health insurance equally.

A variety of benefit designs, however, implies a variety of premiums. A variety of premiums, in turn, make administration of pay-or-play more difficult. A key concept underlying pay-or-play is that employers are not required to offer coverage ("sponsor a health benefit plan") directly. (Such a requirement would clearly violate ERISA). Thus, paying the pool fee is intended not to involve employer sponsorship of the plan in the pool. But this argument becomes more difficult to make if the fee charged to employers fluctuates with the benefit plan selected by their employees. (Furthermore, if the employer's share of fee did vary with the selection of the plan, then it may be necessary to let the employer limit the plans to which the employee has access.)

If the fee charged to employers does not vary, then the cost of selecting a benefit upgrade must be born by the employees. As discussed in section 3.2 of the main report, the employer should probably not be involved in the collection of the additional amount from the employee. The pool could perform this function, but doing so would be administratively burdensome. A better option might be to have the plan administer and collect the premium difference associated with employee purchase of benefit upgrades.[16]

Charging the employee the full amount of the benefit upgrade has the added benefit of emulating a "defined contribution" approach to the determination of the employee's total cost of coverage.

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income. New York has proposed modest cost-sharing measures on a sliding scale according to income for their Family Health Plus program.

[15] Hewitt, 2003. In addition, their study found that eighteen percent of surveyed employers base the employee premium contribution on employee pay.

[16] A similar role is played by health care plans in California in the administration of Cal-COBRA (California's COBRA law for employers with 2-19 employees).

Such an approach removes the incentive for employees to "over-insure" because they face the entire cost of purchasing the upgrade.

Even if the plans administer any benefit upgrades offered, the pool will still have to establish program rules governing these upgrades in order to minimize adverse selection against the plans and to prevent risk skimming by the plans. To ensure a "level playing field," these rules would have to specify the benefit level or levels and perhaps require that all participating carriers offer them.