MILLIMAN REPORT

Analysis of Texas Senate Bill 1765: Evaluation of combined out-of-pocket max accruals

Commissioned by the Texas Association of Health Plans

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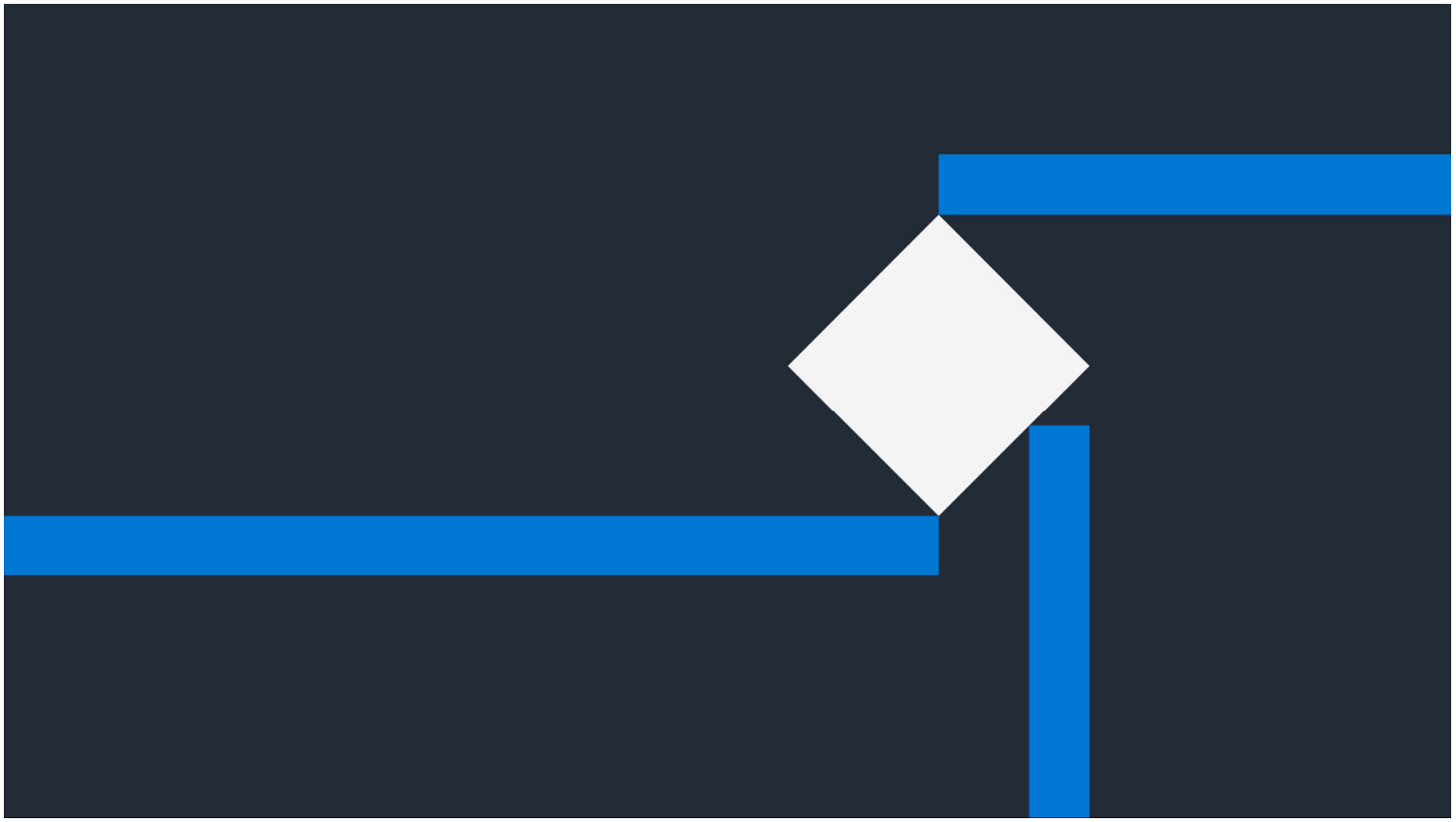

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Background

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, Medicaid plans, Medicare Advantage plans, and other related healthcare entities operating in the state of Texas. The 88th Texas Legislature is currently in session and TAHP engaged Milliman to provide actuarial support in evaluating a subset of the proposed bills that could impact the commercial health insurance market in Texas.

Proposed bill S.B. No. 1765[1] would, among other things, require insurers in Texas to credit all insured cost sharing to a single out-of-pocket maximum (OOPM), prohibiting insurers from having separate in-network and out-of-network OOPMs. TAHP seeks to understand the impact this change would have on commercial premiums and how it might affect insurers and insureds in the near term (in 2024) and how it might change the health insurance landscape going forward.

There are two main types of plans in the commercial health insurance market:[2] preferred provider organizations (PPOs) and health maintenance organizations (HMOs).[3] Due to the more open network structure that accompanies them, this bill primarily affects PPOs because it removes the ability for insurers to offer PPOs with separate in-network and out-of-network OOPMs. In the Texas commercial market, the individual Patient Protection and Affordable Care Act (ACA) market is made up entirely of HMOs, meaning that the impact of this bill will be primarily seen in the employer-sponsored group market.

Executive Summary

The impact of combining in-network and out-of-network (OON) maximums will vary by benefit plan design across all insurers offering coverage in Texas, as the impact is influenced by a number of factors: the original plan's cost-sharing levels (deductibles, copays, coinsurance), the proportion of services that insureds currently receive from out-of-network providers, and, over time, changes in where insureds choose to receive their care. Moreover, these factors will vary by health plan.

Our analysis is centered on the potential impact that this bill will have on premiums. Combining the in-network and out-of-network maximums represents an increased benefit for insureds and will result in an increase in premium. To quantify the possible range of increases, we have studied three varying plan designs (a leaner-than-average plan, a richer-than-average plan, and one in the middle), with different levels of insured cost sharing. It is important to note that because the in-network OOPM is often lower than the out-of-network deductible, combining the in-network and out-of-network OOPM at the in-network level will also result in the out-of-network deductible being capped at the in-network OOPM. For instance, for a plan design that has an out-of-network deductible of $18,900 but the new combined OOPM is $9,450, the out-of-network deductible will also be capped at $9,450. See Appendix A for more detail on the assumptions underlying each of the three plan designs tested.

By removing the separate out-of-network OOPM and potentially capping the out-of-network deductible, this bill will also remove an incentive for insureds to seek in-network care, potentially resulting in an increase in out-of-network utilization over time. We analyzed several scenarios with in-network utilization ranging from 95% to 80% to illustrate how a potential change in behavior leading to more out-of-network utilization would impact premiums.

Our estimates show that commercial insurance premiums for PPOs could rise as little as 0.4%, assuming no change in out-of-network utilization, up to potential increases of 32.1% if out-of-network utilization were to increase by 15%. If the bill passes, it is possible that the first-year impact is at the lower end of these ranges, but as consumers change their behavior and network leakage increases over time costs can increase quickly.

[1] The full text of the bill is available at https://capitol.texas.gov/BillLookup/History.aspx?LegSess=88R&Bill=SB1765.
[2] The commercial health insurance market is comprised of insurance provided by nongovernmental entities, typically to a population under age 65.
[3] The most significant difference between the two types of plans is the provider network; a PPO allows the insured to visit any provider he or she chooses whether they are in-network or out-of-network. However, for out-of-network (OON) care, the insured may be required to pay a higher portion of cost sharing or have cost sharing accrue to separate OON deductibles and OOPMs. An HMO plan limits insureds to using providers within the network or they will have to pay the full cost of the treatment. HMOs tend to require referrals for specialist visits.

FIGURE 1: PREMIUM IMPACT SUMMARY – COMMERCIAL MARKET

PLAN DESIGN	% IMPACT TO CONSUMER PREMIUM
Plan 1 $9,450 Deductible / OOPM High-Deductible Health Plan (HDHP)	2.7% to 32.1%
Plan 2 $2,000 Deductible / $6,000 OOPM	1.0% to 22.8%
Plan 3 $500 Deductible / $1,000 OOPM	0.4% to 22.9%

* The low-end estimate assumes no change to in-network utilization (95%); the high-end estimate assumes a 15% decrease in in-network utilization (80%).

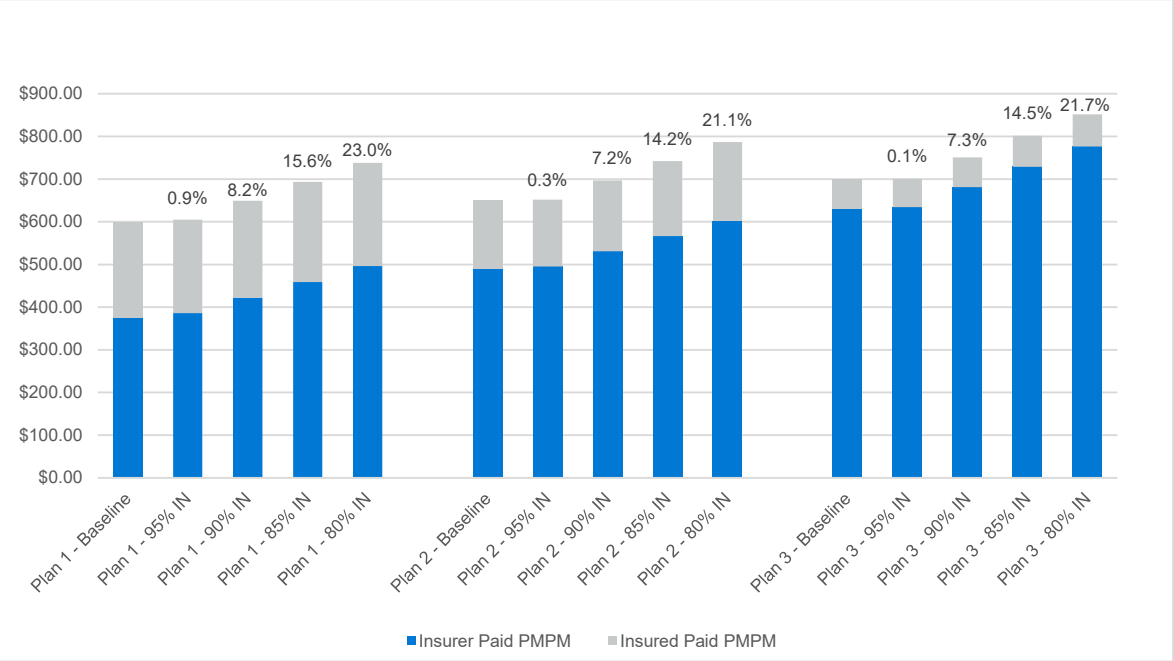
As a result of the potential premium increases shown in Figure 1, it is possible that the proposed bill would materially change the characteristics of PPOs in Texas. The extent of that change will depend on how much purchasers value the option to receive services out-of-network. Today, premiums for a PPO plan are slightly higher than for an HMO plan with the same in-network benefits, for two reasons. First, the out-of-network utilization on the PPO plan is reimbursed at a higher non-negotiated rate, increasing the average cost of services. Second, HMO plans typically have higher degrees of cost containment achieved through care coordination and managing patients within the network. Insured premiums reflect such differences, but some people still purchase the more expensive PPO plan because they value the choice or because they have a relationship with a provider that is not in the HMO network. With that background, the primary impact of this bill on PPOs will likely be twofold:

1. PPO premiums will increase, raising the cost for insureds who value choice. The increase in PPO premium may drive insureds to look for alternatives, including HMOs. The tipping point will be when the additional premium for the PPO plan exceeds the perceived value of the choice or the value of staying with an out-of-network provider.
2. In the PPOs that remain, it is the minority of claimants who drive up costs due to out-of-network care. Our data set shows that, in the 2019 Texas commercial market, only approximately 16% of claimants in PPO plans utilized out-of-network services, and their out-of-network spend equated to 5% of total allowed claims. While all insureds choosing a PPO plan would be paying the increased premiums resulting from this bill, only those who utilize out-of-network care would be taking advantage of the additional benefit.

Detailed results and methodology

We developed paid claim estimates under two sets of OOPM scenarios: (1) a baseline scenario where in-network and out-of-network cost sharing accrues to separate OOPMs and in-network utilization is fixed at 95%, and (2) a second set of scenarios where in-network and out-of-network cost sharing accrues to a single OOPM. For the second set of scenarios, we developed paid claim estimates that assume in-network utilization ranging from 80% to 95%. Figure 2 shows the impact to insurer and insured paid claims under various scenarios for each of the three plans tested. The detailed values underlying this chart are shown in Appendix B.

FIGURE 2: CHANGE IN EXPECTED ALLOWED COSTS VS. BASELINE



In addition to insurer costs increasing, the average cost to the insured also increases in most scenarios due to the increase in allowed charges that results from increased out-of-network utilization. Allowed costs increase as more care leaks out of the network and insureds utilize providers who do not have negotiated discounts or fee schedules with the insurer. Insured out-of-pocket costs are slightly lower with the combined OOPM if the percentage of out-of-network care remains the same. However, as more out-of-network care takes place, insured cost sharing begins to increase as well.

While the claim costs paid by the insurer increase more sharply than insured cost sharing, it is important to note that those increased claim costs will be passed on to the insured, in this case employers and their employees, in the form of increased premiums. In many cases, insureds would be paying greater premiums and greater cost sharing despite the fact that the combined OOPM is seemingly favorable to insureds.

PLAN DESIGNS

For this analysis, we tested the impact of combining the in-network and out-of-network OOPM for three plan designs that were chosen to represent a wide range of insured cost-sharing levels. The low plan starts at an estimated paid-to-allowed[4] ratio of 62.6% and the high plan has an estimated paid-to-allowed ratio of 90.3%. There is also a middle plan with an estimated paid-to-allowed ratio of 75.4%. All baseline plan designs assume an out-of-network deductible and OOPM equal to two times the respective in-network value.

For each of the plan designs, we developed a baseline claim estimate that assumes that the insured cost sharing accrues separately from the in-network and out-of-network OOPM, with 95% in-network utilization. We then modified the baseline plan designs to assume that both in-network and out-of-network cost sharing would be credited to a single in-network OOPM.

It is also important to note that, because the in-network OOPM is often lower than the out-of-network deductible, combining the in-network and out-of-network OOPM at the in-network level will result in the out-of-network deductible being capped at the in-network OOPM. For instance, if the baseline plan has an out-of-network deductible of $18,900 but the new combined OOPM is $9,450, then the out-of-network deductible must also be capped at $9,450.

[4] The ratio of the dollars paid by the insurer (after insured cost sharing) to the total dollars charged by the provider (after applying the negotiated reimbursements). The complement of this is the percentage of the dollars paid by the insured.

OUT-OF-NETWORK UTILIZATION

A key assumption of this analysis is the impact that this bill would have on out-of-network utilization. Because a combined OOPM removes some of an insured's incentive to choose in-network providers for their services, we developed claim estimates for these modified plan designs under a range of in-network utilization assumptions to illustrate the impact of insureds receiving more out-of-network services over time.

TREND ASSUMPTIONS

We assumed the annual trend values shown in Figure 3 to adjust our results to calendar year 2024. These values are based on the 2023 Milliman Health Cost Guidelines™, which provide secular trend factor guidelines.

FIGURE 3: ANNUAL TREND ASSUMPTIONS

SERVICE CATEGORY	ANNUAL TREND
Inpatient Facility	5.00%
Outpatient Facility	9.50%
Professional	5.75%
Radiology	5.75%
Pathology/Lab	5.75%
Prescription Drugs	4.00%
Other	5.75%

DATA

Milliman maintains the Milliman Health Cost Guidelines (HCGs), which incorporate more than 60 years of research and consulting practice and are considered the industry gold standard for modeling detailed healthcare utilization. We developed the paid claim per member per month (PMPM) values using the HCGs adjusted to Texas statewide average costs and reimbursements for a commercial population. The HCGs allow us to estimate the relative differences in expected claim costs under the different plan design and network scenarios described in this report.

Caveats

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate future claims under varying plan design and network scenarios. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models, including all input, calculations, and output, may not be appropriate for any other purpose.

Differences between projections and actual amounts will depend on the extent to which future experience conforms to the assumptions used for the projections. There is a substantial amount of uncertainty, including but not limited to: morbidity of the markets, provider payments, insured utilization, and changing regulations. It is certain that actual experience will not conform exactly to assumptions made for these items.

This report is intended to estimate the impact of certain portions of Texas Senate Bill 1765. It may not be appropriate and should not be used for other purposes. Milliman does not intend to benefit or create a legal duty to any recipient of this work.

This information is subject to the existing Consulting Services Agreement between TAHP and Milliman dated March 27, 2023.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

The authors would like to thank Fritz Busch for his peer review of this material.

Appendix A

FIGURE 4: BASELINE PLAN DESIGNS

PLAN PARAMETER	PLAN 1	PLAN 2	PLAN 3
Deductible	$9,450 IN / $18,900 OON	$2,000 IN / $4,000 OON	$500 IN / $1,000 OON
OOPM	$9,450 IN / $18,900 OON	$6,000 IN / $12,000 OON	$1,000 IN / $2,000 OON
Coinsurance	0% IN / $0% OON	20% IN / $50% OON	20% IN / $50% OON
Emergency Room	0% IN / $0% OON	$150 IN / $150 OON	$150 IN / $150 OON
Primary Care Physician	0% IN / $0% OON	$20 IN / 50% OON	$20 IN / 50% OON
Estimated Paid-to-Allowed Ratio	**62.6%**	**75.4%**	**90.3%**

Appendix B

FIGURE 5: SCENARIO DETAIL

PLAN DESIGN	SCENARIO	ALLOWED PMPM	INSURED PAID PMPM	PLAN PAID PMPM	% DIFFERENCE VS. BASELINE (PLAN PAID)
$9,450 HDHP	**Baseline: Separate OOPM – 95% IN**	**$600.00**	**$224.26**	**$375.74**	
	Combined OOPM – 95% IN	$605.14	$219.26	$385.88	2.7%
	Combined OOPM – 90% IN	$649.28	$227.29	$421.99	12.3%
	Combined OOPM – 85% IN	$693.58	$234.53	$459.04	22.2%
	Combined OOPM – 80% IN	$738.03	$241.73	$496.30	32.1%
$2,000 Deductible/ $6,000 OOPM	**Baseline: Separate OOPM – 95% IN**	**$650.00**	**$159.61**	**$490.39**	
	Combined OOPM – 95% IN	$652.06	$156.67	$495.38	1.0%
	Combined OOPM – 90% IN	$697.05	$166.28	$530.77	8.2%
	Combined OOPM – 85% IN	$742.08	$175.69	$566.39	15.5%
	Combined OOPM – 80% IN	$786.98	$184.87	$602.12	22.8%
$500 Deductible/ $1,000 OOPM	**Baseline: Separate OOPM – 95% IN**	**$700.00**	**$68.21**	**$631.79**	
	Combined OOPM – 95% IN	$700.66	$66.46	$634.20	0.4%
	Combined OOPM – 90% IN	$750.96	$69.66	$681.30	7.8%
	Combined OOPM – 85% IN	$801.40	$72.72	$728.69	15.3%
	Combined OOPM – 80% IN	$851.91	$75.60	$776.32	22.9%

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