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Mini-med Health Plans: Don't Call It Insurance

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SUMMARY

This issue brief uses the example of a health plan offered by McDonalds to their "crew" employees to illustrate the costs, coverage and policy dilemmas associated with mini-med health plans. Anecdotal evidence suggests that consumers don't realize how limited mini-med coverage is. With an actuarial value of just 16%, it is easy to argue that these plans shouldn't be called insurance. Consumers need better clarity on the limits of these plans and policymakers need to explore better alternatives.

What is a Mini-med Health Plan?

Mini-med health plans feature very limited benefits. These plans are offered by certain employers, unions and purchased by individuals who buy on their own. For example, the most popular plan offered by McDonalds to its "crew" (non-management) workers is a mini-med plan with an annual benefit limit of just $2,000 per year.[1] That's the maximum amount that the plan will pay. Once that limit is hit, remaining medical expenses have to be covered "out-of-pocket" by the enrollee. Other mini-med plans offered by other employers have somewhat higher benefit limits, for example $25,000 or $50,000 benefit maximums. However, according to Mercer's annual survey of employer health plans, the median annual cap for mini-med plans is $7,000.[2]

What Does a $2,000 Limit Mean for Consumers?

Many consumers don't realize how benefit limits affect their out-of-pocket costs.[3] They may not realize that many common medical conditions, such as having a baby (approximately $9,000)[4] or treatment for diabetes ($7,100 per year) would exceed a plan limit of $2,000, leaving substantial medical bills for the patient.[5] A more serious illness, such as a heart attack, could leave the enrollee with bills exceeding $75,000.[6]

Another way to think about the coverage offered by these plans is to look at their *actuarial value*. Actuarial value is the percentage of medical claims costs that the plan would pay across a standard population (see box).

The McDonalds plan would cover just 16% of the medical costs for a "typical" employee population of both high spenders and low spenders, leaving 84% for the enrollees to pay (Table 1).

In contrast, a "standard" employer plan featuring comprehensive coverage covers about 84% of the claims costs across a typical population of both high spenders and low spenders.[7]

Aside from the amount of coverage, a key difference between the mini-med plan and the comprehensive plan is that mini-med coverage is front loaded. More coverage is provided for smaller, commonplace medical expense (for example, a visit to the doctor for a cold) and much less for major illnesses or accidents. If a health plan featured a 16% actuarial value, but was designed to cover more of the major illnesses than the minor illnesses, it would feature an $85,000 deductible (Table 1)![8]

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Why Are Mini-meds Offered?

Although mini-med plans are rare overall, they are much more common among certain types of employers. Large companies and some unions often offer this type of product when they have a large, low-wage or part-time workforce. According to Mercer's annual employer benefit survey, 63 percent of "jumbo" retail or wholesale companies offer these plans, companies like Home Depot, CVS, Staples and Blockbuster.[9] Temp agencies also commonly offer these plans.

WHAT IS ACTUARIAL VALUE?

Actuarial value is a measure of financial protection provided by a health plan. In a typical covered population, most enrollees are low users and a few enrollees are high users. Actuarial value indicates the percent of medical expenses that a plan is likely to pay across ***all*** enrollees, reflecting the plan's cost sharing requirements (deductible, coinsurance, etc). For example, an actuarial value of .70 means that a health plan is estimated to pay 70% of medical expenses across this standard population, leaving 30% for enrollees to pay. Importantly, the percentage that an *individual* patient would pay could be very different from this average. For example, in a typical comprehensive plan, low users might pay a higher percentage because they haven't met the plan's deductible. Conversely, high users might pay a lower percentage because they've met their maximum out-of-pocket. In a mini-med plan, this is reversed. Enrollees with high expenses would pay *more* than the overall average, because they must pay all expenses that exceed the mini-med's benefit limits.

TABLE 1 — HOW MUCH DOES A MINI-MED COVER?			
	Estimated 2011 Claims Costs per Member per Month	Estimated Actuarial Value of Plan	Percent of Claims NOT paid by this plan (across a standard population)
McDonald's Basic Plan ($2,000 benefit limit)	$66	0.164	83.7%
A Plan with an $85,000 Deductible	$66	0.164	83.7%

Source: Windsor Strategy Partners' analysis for Consumers Union.[10]

Insurers and employers say that mini-med plans, while not comprehensive, fill a niche and give some coverage to workers *who would otherwise have no insurance at all.*

Why is the alternative to have no coverage? Because the cost of a comprehensive health plan is considered prohibitive by these employers. Testimony by McDonalds showed that their contribution to health care for higher-wage corporate workers works out to about $574 per month, or $3.31 per hour.[11] Many employers feel that this is more than they can contribute to a worker whose hourly wage hovers around $7 to $10 in a job with high turn-over. In congressional hearings, McDonalds testified that they contribute just $10 per month to coverage for their first-year "crew" employees – about 6 cents per hour if we assume a 40 hour work week. Both management and crew workers also make contributions to their premiums. In the case of the $2,000 mini-med, the employee contribution is $13.09 per week (about 36 cents an hour) for a first-year, full-time employee.[12]

Citing these affordability concerns, more than 200 "mini-med" plans have notified the US Department of Health and Human Services (HHS) that raising benefit limits to meet the standard required by the new health care law would result in a "significant decrease in access to benefits or a significant increase in premiums." [13]

Many individuals shopping for coverage on their own buy these limited benefit plans for much the same reason – they don't feel they can afford more comprehensive coverage.[14] Indeed, McDonalds' crew workers have more comprehensive insurance options available to them but most take the $2,000 plan – the one with the lowest employee-paid premiums.

Improving Mini-med Offerings

Between now and 2014 (when comprehensive reforms are implemented), there is little that policymakers or employers can do to bring down the cost of comprehensive coverage so that it is affordable for low-wage workers and low income families. However, there are modest steps that can be taken to ensure that consumers understand what they are getting and so that the value of such plans is clearly identified.

DON'T CALL IT INSURANCE

Products featuring a $2,000 annual benefit limit and an actuarial value of .16 shouldn't even be called "insurance." The distinction matters. Enrollees in mini-med plans are basically "uninsured" for most of their potential medical expenses. Yet because these products are technically considered "creditable coverage," someone enrolled in a mini-med would not qualify for the new pre-existing conditions pool that is only open to individuals who have been uninsured for six months.[15] Similarly, the offer of a mini-med plan would disqualify a young adult from enrolling in his or her parent's coverage, potentially better and more comprehensive. Creating a separate benefit category for mini-med products would also clarify for consumers how different the policies are from true, comprehensive health insurance.

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If this proposal seems far fetched, consider these examples.

When a physician opens a "boutique" practice, charging a flat rate of $2,000 a year for unlimited access to the doctor, it isn't called insurance. One might call it pre-paid health care, even though different patients will derive different amounts of benefit. These arrangements aren't so different from the McDonalds' policy featuring a $2,000 limit and an emphasis on preventive care. The limits of the "plan" are more transparent with the concierge practice, however.

To take another example, many companies seek to cover employee health expenses out of their business revenues, as opposed to actually purchasing an insurance policy from a carrier. This is called being 'self-insured.' The company derives benefits from being self-insured such as being exempt from premium taxes and state benefit mandates. Yet companies are allowed to claim 'self-insured' status even if they actually use an insurance carrier to insure some of their employees' largest health claims. The National Association of Insurance Commissioners (NAIC) provides the following guidance: companies can purchase reinsurance for employee medical spending that exceeds $20,000 a year and still can claim "self-insured" status. Employing our standard population of employees again, this $20,000 threshold would mean that the company was covering 41% of expected claims, with the majority (59%) covered by the insurer.[16]

The bottom line: a *company* can purchase insurance to cover 59% percent of their employees' medical claims and still be considered "self-insured" (or "uninsured") and receive all the benefits that go with that status. Yet *individuals* can participate in a plan that covers just 16% of their medical expenses on average and be considered "insured" – a status that may prevent them from receiving certain benefits.

IMPROVE CONSUMER DISCLOSURE

...consumers see the term "health insurance" and expect more comprehensive coverage, consistent with the fundamental purpose of insurance

Many purchasers of mini-med plans don't realize just how limited their coverage is.[17] Most consumers are not just equipped to weigh hard-to-understand insurance fine print against the unknown cost of a potential illness or accident. In addition, many of these plans are marketed to prospective enrollees using reassuring phrases like "coverage when you need it."

It is not surprising that consumers see the term "health insurance" and expect more comprehensive coverage, consistent with the fundamental purpose of insurance: "*[t]he purpose of health insurance is to help you pay for care. It protects you and your family financially in the event of an unexpected serious illness or injury that could be very expensive*" (Association of Health Insurance Plans *Consumer Guide*).[18]

HHS' new federal rules require mini-med insurers disclose the limitations of their coverage.[19] This is an important step forward; however, the model disclosure does little to provide the context needed by consumers. A bold statement that says "This is not insurance" – such as some states require for medical discount plans – would be better.[20] Similarly, a few medical scenarios showing the costs that the consumer would incur would also help clarify the value of the plan.

Companies like McDonalds provide brochures that include a description of the plan's benefits.[21] However, in the absence of information about medical expenses such as the cost of a hospital visit, the consumer may have too little context to understand the importance of the benefit descriptions. Furthermore, consumers may be lulled into a false sense of security by statements such as this one in the McDonalds' brochure: [m]edical insurance helps pay for the care you need when you're sick, injured or have an ongoing medical condition. They may skim over the harder-to-understand small print such as "This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits policy and is not intended to cover all medical expenses."

DON'T ASSUME IT'S A GOOD VALUE

Employers and unions that offer mini-med plans should make an honest assessment of their value. Some mini-med plans have argued that they need exemptions from the new requirements that large employer plans spend 85% of premium dollars on actual medical care and quality improvement activities.[22] These relaxed requirements allow mini-meds to devote as little as 43% of premiums to medical care in 2011. A plan featuring these high levels of administrative cost can't be the best deal for these low-wage employees (who pay

the preponderance of the premiums[23]) or individuals buying on their own. Plus, testimony from McDonalds indicates that some mini-med plans can devote a considerably higher proportion of the premium to medical care. The McDonalds' carrier showed that between 78% and 91% of premium dollars had been spent on medical care.[24]

Looking Ahead to 2014

Recent attention paid to mini-med policies drives home the need for the comprehensive reforms that come online in January 1, 2014. On this date, a much more comprehensive "floor" will be placed under all insurance products. Health insurance will cover at least a uniform set of essential benefits, annual dollar limits (such as these mini-meds) will be prohibited and patient cost-sharing can't exceed certain limits.

These changes will provide much needed clarity and consistency for consumers purchasing health insurance. Consumers will no longer encounter a mini-med option that poses as true health coverage.

Lower income individuals who buy on their own in the new health exchanges will have access to subsidies to help them afford this comprehensive coverage.

However, the challenge of providing employer-sponsored coverage to low-wage workers will remain. Employers with large, low-wage workforces and high turnover may still be reluctant to make the same health insurance contribution to their low-wage workers as their higher wage workers. State policymakers must anticipate this issue and begin *now* to craft creative solutions. Some states and localities have already piloted programs that target low-wage workers, albeit often those in smaller firms.[25] These state-based solutions should have several goals: retain or increase the employer contribution, avoid incentives to hire part-timers over full-timers, and work with providers to craft a lower-cost, comprehensive product featuring low administrative overhead. It is likely that policymakers will have to also explore how subsidies or tax breaks can be used to leverage contributions by employers, employees and providers so it all adds up to a reasonable insurance product.

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ENDNOTES

[1] Owing to the well documented nature of their coverage, this issue brief uses a plan offered by McDonalds to their "crew" workers to illustrate the pitfalls and policy dilemma's associated with mini-med plans. However, any number of large, low-wage employers could be substituted. Over 1.5 million employees are estimated to be in similar plans.

[2] Mercer's National Survey of Employer-Sponsored Health Plans, an annual survey of nearly 3,000 public and private employer health plan sponsors with 10 or more employees. Results have an error range of +/-3 percent.

[3] Quincy, *Consumer Confusion Over Health Insurance Cost-sharing*, Commonwealth Fund and Consumers Union, forthcoming January 2010.

[4] Thomson Healthcare, *The Healthcare Costs of Having a Baby*, June 2007 http://www.kff.org/womenshealth/upload/whp061207othc.pdf

[5] Testimony by American Cancer Society Cancer Action Network before Senate Commerce, Science and Transportation Committee, December 1, 2010. http://commerce.senate.gov/public/?a=Files.Serve&File_id=2205b1aa-bbcf-4079-922b-c95124104ab3

[6] Ibid.

[7] Peterson, *Setting and Valuing Health Insurance Benefits*, Congressional Research Service, April 6, 2009. http://opencrs.com/document/R40491/

[8] Estimating the deductible that corresponds to a plan with an actuarial value of .164 depends greatly on assumptions about the discounts negotiated with providers (doctors and hospitals). This estimate from Windsor Strategy Partners uses the same provider discount assumptions as were used to model the $2,000 benefit limit plan (see endnote 10).

[9] Mercer, op cit.

[10] Estimates of benefit cost and actuarial value were determined using Windsor Strategy Partners' proprietary healthcare rating model known as *Actuarial Advisor*. Actuarial Advisor is a sophisticated healthcare rating and underwriting tool that predicts the utilization and cost of healthcare. The model allows for a wide range of user inputs including plan design, trend, demographics, and provider network discounts. The Actuarial Advisor model is built on a database of over 3 million commercially insured lives, refreshed annually in order to capture and utilize the

most recent healthcare trends. The size and richness of the database yields robust estimates of healthcare claim costs. Windsor Strategy Partners, LLC, is a healthcare actuarial consulting firm specializing in product pricing, model building and data analysis, underwriting, strategic planning and business strategy.

[11] Chart comparing McDonalds Plans: http://commerce.senate.gov/public/?a=Files.Serve&File_id=c70daefe-006e-49b0-8039-4efffe7246d3

[12] McDonalds 2010 Brochure for Employees, http://commerce.senate.gov/public/?a=Files.Serve&File_id=58bf73ae-fbb6-48c2-b4f1-1856bbc518e9

[13] http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html. Note that McDonalds' health plan for management employees features no annual or lifetime benefit limits (endnote 11).

[14] "Hazardous Health Plans," *Consumer Reports,* May 2009. http://www.consumerreports.org/health/insurance/health-insurance/overview/health-insurance-ov.htm

[15] For purposes of the PCIP program, creditable coverage is defined as coverage under a group health plan, health insurance coverage, Medicare Part A or B, Medicaid, the Children's Health Insurance Program (CHIP), the TRICARE program, a medical care program of the Indian Health Service or a tribal organization, an existing state high-risk pool, the Federal Employee Health Benefits Plan (FEHBP), a public health plan (such as coverage through the Veterans Administration) or a health plan offered under the Peace Corps Act.

[16] Estimate by Windsor Strategy Partners. See endnote 10.

[17] *Consumer Reports*, op cit. See also: testimony by mini-med enrollee Eugene Melville (http://commerce.senate.gov/public/?a=Files.Serve&File_id=b6191754-3ed4-4305-b628-d449638d27a9)

[18] http://www.ahip.org/content/default.aspx?bc=41|329|20888

[19] http://www.healthcare.gov/center/regulations/guidance_limited_benefit_2nd_supp_bulletin_120910.pdf

[20] Medical discount plans don't pay any of your health care costs; instead, they require you to pay a fee for a list of health care providers and sellers of health-related products who are willing to offer discounts to members of the plan. These plans are not licensed insurance products but they are sometimes marketed to resemble insurance. http://www.iowapolicyproject.org/2010docs/101216-discountplans.pdf

[21] McDonalds 2010 Brochure for Employees, http://commerce.senate.gov/public/?a=Files.Serve&File_id=58bf73ae-fbb6-48c2-b4f1-1856bbc518e9

[22] HHS will allow mini-med plans – defined for this purpose as any plan with an annual limit of $250,000 or less – to multiply their medical care and health care quality improvement expenditures by a factor of 2 when calculating their "Medical Loss Ratio" (MLR) – that is, the percent of premium dollars spent on actual medical care and quality improvement activities. The MLR rules do not apply to self-insured, group health plans. *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act; Interim Final Rule* (December 1, 2010).

[23] Mercer, op. cit.

[24] Testimony by McDonalds before Senate Commerce, Science and Transportation Committee, December 1, 2010. http://commerce.senate.gov/public/?a=Files.Serve&File_id=1a2d6273-9810-4a27-8e6c-a0e13d6116b2

[25] L. Quincy, P. Collins, K. Andrews, C. Stone, *Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the Literature and a Synthesis of Stakeholder Views*, Mathematica Policy Research, December, 2008.