MILLIMAN WHITE PAPER

Will Repeal and Replace of the ACA cause pent-up demand to occur?

Kimberley K. Hiemenz, FSA, MAAA
Michelle Klein, ASA, MAAA

Milliman

The only constant is change

Changing the future of healthcare in the United States is a top priority for the Trump administration. Americans can be sure change is coming, though the details of those changes are still emerging.

The uncertainty started on Election Day and will continue until new healthcare legislation is enacted and likely through a transition period as well. President Trump's move to repeal and replace the Patient Protection and Affordable Care Act (ACA) has led many Americans to believe their future healthcare coverage may be in danger. Particularly, many Americans are worried about the future affordability of healthcare if current subsidies are not available in the future.

This paper considers the impact of pent-up demand—that is, when the demand for a service is unusually strong.[1] Specifically, this paper analyzes the impact of insureds utilizing more elective services in 2017 out of fear of losing or having reduced coverage with the repeal of the ACA.

"Repeal and Replace" may cause an increase in elective services

Between the enactment and effective date of the ACA, pent-up demand was a widely discussed concept. Specifically, would newly insured individuals under the ACA utilize more services than individuals with continuous healthcare coverage? It has been widely touted that the ACA expanded access to affordable healthcare coverage for millions of Americans.[2] With this newfound access to healthcare coverage, many newly insured individuals sought out healthcare services previously postponed or denied to them because of a lack of previous coverage. A study by the Society of Actuaries noted that, in the first quarter of 2014, newly insured members utilized 50% more services and were 90% more expensive than those who maintained continuous coverage.[3]

With the future of American healthcare in flux, a wave of a pent-up demand may be starting in 2017. Specifically, Americans worried about losing access to affordable healthcare or having benefits more limited in the future may seek out healthcare services now. Preventive services are particularly susceptible due to two main reasons:

1. Pent-up demand in healthcare applies primarily to elective services, such as a doctor's visit or a diagnostic screening, because the individual can control this utilization.
2. Preventive services are covered under the ACA without any member cost sharing.

Preventive service utilization increased after implementation of the ACA

From 2012 to 2013, utilization of preventive services[4] in the commercial individual insurance market trended at approximately a 3% higher rate than the utilization of non-preventive services. The introduction of the ACA widened the utilization trend gap between preventive and non-preventive services in the commercial individual insurance market. Specifically, utilization of preventive services during 2014 trended at roughly a 4% higher rate than non-preventive services (i.e., the gap widened 1%) compared with 2013 levels.[5] It is difficult to identify and quantify the exact drivers of this additional utilization of preventive services in 2014, particularly since utilization data is not available on previously uninsured members in 2012 and 2013. However, pent-up demand is likely a contributing factor.

Figure 1 on page 2 shows the additional utilization in preventive services from 2013 to 2014 in excess of trend (rounded to the nearest 5%). The impact varied by service category, but ranged from no impact (excluded from Figure 1) to a 570% increase in utilization.[6] While different data sets may produce somewhat

1 http://www.investopedia.com/terms/p/pent-up-demand.asp

2 http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

3 Owen, R. & Maeng, D. (April 2015). Indications of Pent-Up Demand: New ACA Enrollee Use of Preference-Sensitive Services. Society of Actuaries.

4 Preventive services as defined by the U.S. Preventive Services Task Force.

5 Based on an analysis of the nationwide commercial individual insured market in Milliman's Consolidated Health Cost Guidelines™ database. The data covers over 1.2 million lives. Utilization was normalized for age and gender variables.

6 We calculated the increase in utilization in excess of trend by comparing the relative differential between the preventive trend and non-preventive trend from 2013 to 2014 to the same differential from 2012 to 2013.

varying results, we expect the results for a credible population to fall within + /-10% of the estimates in Figure 1.

FIGURE 1: PREVENTIVE UTILIZATION INCREASE IN EXCESS OF NON-PREVENTIVE UTILIZATION TREND 2014 COMMERCIAL INDIVIDUAL INSURANCE MARKET

PREVENTIVE SERVICE CATEGORY	2013 TO 2014 ADDITIONAL UTILIZATION TREND INCREASE
Dental	570%
Cardiovascular	320%
Depression	235%
Tobacco use	230%
Obesity	205%
Sickle cell	75%
Substance abuse	50%
Diabetes	45%
STI[7] syphilis	40%
Breastfeeding	35%
STI HIV	35%
Abdominal aortic aneurysm	30%
Child screen	25%
Contraception	25%
STI gonorrhea	20%
Lung cancer	20%
STI chlamydia	20%
Iron deficiency	15%
STI hepatitis	15%
Colorectal cancer	10%
Prenatal	10%
Cholesterol	10%
Path/lab	5%
Cervical cancer	0%
Total	**1%**

It is notable that increases shown in Figure 1 correlate fairly strongly with the fact that the ACA mandates coverage of pediatric dental services and mental health and substance abuse treatment services, which typically had only very limited benefits in the pre-ACA individual market. Also, as mentioned earlier, the ACA requires no cost sharing for preventive services, where pre-ACA plans required cost-sharing and often limited benefits.

7 STI is an abbreviation for sexually transmitted infection.

We project demand of preventive services to increase healthcare costs in 2017

The most single-day sign-ups for ACA coverage on HealthCare.gov occurred the day after the presidential election.[8] This suggests many Americans see the need for insurance coverage in 2017. While newly insureds may "stock up" on preventive services, reenrolling members may be inclined to do the same if they fear losing healthcare coverage or preventive services benefits after the repeal and replacement of the ACA. Utilization of preventive services may increase in 2017 if the experience in 2014 with the introduction of the ACA is indicative of the potential impact of the repeal of the ACA.

The impact of an increase in preventive services utilization in 2017 may vary by region, population health status, and demographics.

If pent-up demand occurs, the impact has the potential to be even higher in services that are elective in nature but not defined as preventive by the U.S. Preventive Services Task Force. Examples of these types of services include diagnostic imaging, physical therapy, and chiropractic services. This paper does not examine the potential change in utilization for these services as it is difficult to determine the portion of utilization that is truly elective.

As of now, there has been no substantial legislation regarding the removal of Essential Health Benefits (EHBs). However, their removal is an item that could reduce the cost of insurance and may be subject to change in the future. Additionally, there are several classes of preventive services, which are overseen by multiple government bodies. The status of these services is subject to change as well.

Contraception may be particularly impacted by pent-up demand as coverage remains uncertain

Contraception coverage has been one of the most highly publicized issues surrounding the Trump administration's healthcare plan. Women who use short-term contraception methods like the pill, patch, injectable shot, or vaginal ring may consider a long-term contraception method now while contraceptives have no cost sharing under the ACA. One such long-term contraception method is the intrauterine device (IUD). With the full details of the ACA replacement plan unknown, some women may seek an IUD in 2017 to obtain a long-term contraception method while IUDs are a preventive service with no cost sharing. In fact, recent media reports included several articles about healthcare providers (e.g., Planned Parenthood[9]) reporting a large spike in IUD appointments after the election.

8 https://twitter.com/SecBurwell/status/796759995530563585

9 Schenker, L. (December 1, 2016). After Trump's win, Planned Parenthood of Illinois reports big spike in IUD appointments. Chicago Tribune. Retrieved February 16, 2017, from http://www.chicagotribune.com/business/ct-trump-birth-control-demand-spike-1202-biz-20161201-story.html.

FIGURE 2: POTENTIAL IMPACT IN 2017 OF SHIFT FROM SHORT-TERM CONTRACEPTION METHODS[10] TO IUDS IN COMMERCIAL INDIVIDUAL INSURED MARKET

METHOD	2014 ALLOWED COST PMPM (TRENDED TO 2017)	PROJECTED 2017 ALLOWED COST PMPM WITH ASSUMED SHIFT
Short-term methods – 10% shift to IUD assumed		
Emergency contraception and the pill	$1.41	$1.25[11]
Injection	$0.54	$0.49
Patch	$0.00	$0.00
Vaginal ring	$0.00	$0.00
Long-term methods – 10% shift of short-term methods assumed		
IUD	$0.57	$3.29[12]
Implant	$0.09	$0.09
Immediate methods – no shift assumed		
Cervical cap	$0.00	$0.00
Diaphragm	$0.00	$0.00
Male condom	$0.00	$0.00
Spermicide	$0.00	$0.00
Female condom	$0.00	$0.00
Permanent methods – no shift assumed		
Female sterilization, tubal blockage	$0.27	$0.27
Female sterilization, tubal blockage or ligation	$0.01	$0.01
Female sterilization, tubal ligation	$0.90	**$0.90**
Total	$3.79	$6.31
Impact of 10% shift of short-term methods to IUDs		**$2.51**

If the number of women switching from short-term contraception methods to IUDs increases in 2017, there is potential for a cost impact to insurers in 2017. Although spikes in IUD appointments have been reported across the country, the number of women seeking IUDs will vary significantly based on many variables—including age, income level, marital status, and geography.

If 10% of the 2014 utilization for short-term contraception methods shift to IUDs, the cost impact would be around $2.51 per member per month (PMPM), or about 0.75% of projected 2017 allowed claims for the commercial individual market.[13] This assumes no change in utilization for immediate and permanent contraception methods. Figure 2 details the projected results by contraception method.

Some states, including New York, Illinois, and California, proposed legislation to keep contraception coverage free to consumers.[14] If this legislation passes, we expect insurers in these states will not experience a utilization shift across contraception methods in 2017.

10 Note the definition of contraceptive methods differs slightly between Figure 1 and Figure 2. Figure 2 includes medical claims as well as pharmacy claims associated with contraceptive pills while Figure 1 refers strictly to medical claims.

11 The utilization shift applied to the emergency contraception and the pill line is dampened slightly so that the shift is only applied to the pill, not emergency contraception.

12 Because the IUD can last for up to 12 years, the associated allowed costs may be zero starting in year two, which would effectively spread the full cost over several years if the member remains with the same carrier throughout the life of the IUD. For this analysis, we only look at year one costs because members may switch carriers, and we are quantifying the immediate cost impact of a utilization shift.

13 The data source and methodology used to develop Figure 1 apply here as well. We assumed a 3% annual utilization trend and a 6% annual cost trend based on Milliman's *Health Cost Guidelines*. For simplicity, we assumed short-term and long-term contraception methods are equally effective at preventing pregnancy, so there is no change in downstream claim costs associated with pregnancy.

14 Mincer, J. (January 12, 2017). U.S. states mull contraception coverage as Obamacare repeal looms. Reuters. Retrieved February 16, 2017, from **http://www.reuters.com/article/us-usa-obamacare-contraception-idUSKBN14W1CD**.

Insurers can only wait and see

Based on our current understanding of the ACA and the state of healthcare legislation through the publication date of this paper, some amount of pent-up demand will likely occur, but the timing is unknown. Depending on the timing associated with the ACA replacement plan, this could be only a 2017 concern or it could continue beyond 2017.

The premium rates for 2017 individual commercial policies are already in place and cannot change. Insurers should monitor their emerging claims to ensure reserves are sufficient to withstand an uptick in claims. Further, insurers may want to consider the potential impact of various pent-up demand scenarios in their 2018 pricing. The expected pent-up demand effect may occur entirely in 2017 or span multiple years depending on the transition to new legislation.

Further, insurers should monitor the legislative environment in their states to determine any potential cost implications from state-specific legislation (e.g., contraception coverage).

Caveats and limitations

Kim Hiemenz is a Principal and Consulting Actuary with Milliman, Inc. Michelle Klein is an Associate Actuary with Milliman. Both are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to issue this paper and render the actuarial analysis contained herein. The paper reflects the authors' findings and opinions, which are not necessarily representative of the views of Milliman and its other employees. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the prior written consent of Milliman.

This paper should not be interpreted as an endorsement of any particular legislation by Milliman or the authors. The paper reflects a current understanding of the ACA and the questions emerging from potential changes to current legislation and regulations. As legislation develops and regulations change, answers may emerge that prompt new questions and considerations. We ask that this paper be distributed only in its entirety because extracts of this paper taken in isolation may be misleading.

FOR MORE ON MILLIMAN'S PERSPECTIVE ON HEALTHCARE:
Visit milliman.com/insight/healthcare
Visit our blog at healthcaretownhall.com
Or follow us on Twitter at twitter.com/millimanhealth

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Kimberley K. Hiemenz
kim.hiemenz@milliman.com

Michelle Klein
michelle.klein@milliman.com