

Standard Plans

Presentation for Maryland Health Benefit Exchange
Affordability Workgroup
June 22, 2022

Georgetown University Center on Health Insurance Reforms (CHIR)

Nationally recognized team of private insurance experts

- Part of McCourt School of Public Policy
- Legal & policy analysis
 - Federal and state regulation
 - Market trends
- Published reports, studies, blog posts
- Technical assistance

Context: Marketplace Plans

- The ACA required some standardization of benefits
 - Metal “tiers” with actuarial value requirements
 - Essential Health Benefits (EHB)
 - Preventive services without cost-sharing
 - Limits on out-of-pocket spending
- Beyond these requirements plan design can vary widely
 - In 2022, there is no federally required cost-sharing design (other than no-cost sharing preventive care)
 - There are no federal limits the number of plans an insurer can offer

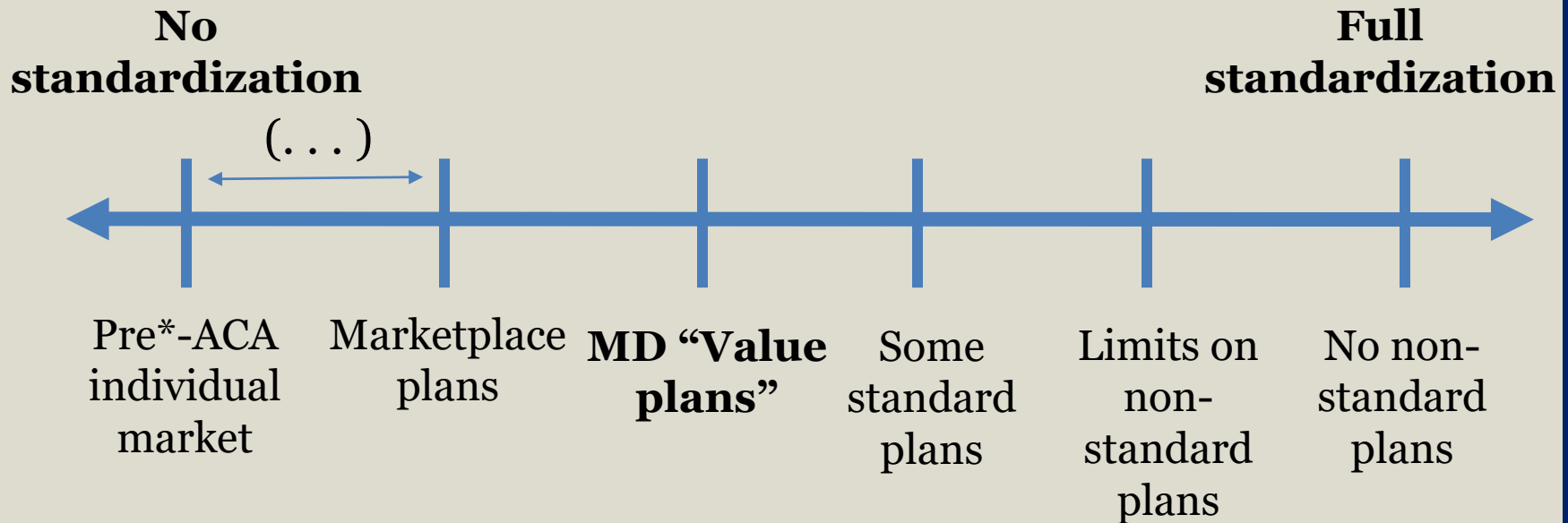
Context: Plan Choice Overload

- Between Plan Years 2019-2022 the average number of plans available to consumers on HealthCare.gov increased from 25.9 to 107.7 (Chu et al., 2021)
- Wide range of cost-sharing structures makes plan comparison difficult
- Too many plan options (“choice overload”) and difficulty understanding cost-sharing structures can lead to:
 - Suboptimal plan choice
 - Abandoning enrollment process

What are Standard Plans?

- Also called “standardized plans,” “standardized benefit design,” “Simple Choice Plans” (fed. marketplace), “Patient-Centered Benefit Design” (CA), “Clear Choice Plans” (ME)
- Standardized cost-sharing
 - Identical deductibles, copayments, and coinsurance (typically within a metal tier; can have multiple plans per tier)
 - Standardize services subject/not subject to plan deductible
 - Promote apples-to-apples comparison
 - *Optional*: limit/prohibit non-standard plans
 - *Optional*: differential display

Spectrum of Standardization



*NJ and MA had standardization requirements predating the ACA



2022 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	\$25,761 to \$32,200 (>200% to ≤250% FPL)	\$19,321 to \$25,760 (>150% to ≤200% FPL)	up to \$19,320 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Visit	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	\$65*	\$35	\$35	\$15	\$5	\$35	\$15
Urgent Care		\$65*	\$35	\$35	\$15	\$5	\$35	\$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	\$95*	\$70	\$70	\$25	\$8	\$65	\$30
Emergency Room Facility		40% after deductible is met	\$400	\$400	\$150	\$50	\$350	\$150
Laboratory Tests		\$40	\$40	\$40	\$20	\$8	\$40	\$15
X-Rays and Diagnostics		40% after deductible is met	\$85	\$85	\$40	\$8	\$75	\$30
Imaging			\$325	\$325	\$100	\$50	\$150 copay or 20% coinsurance***	\$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	\$18**	\$15**	\$15**	\$5	\$3	\$15	\$5
Tier 2 (Preferred Drugs)		40% up to \$500 per script after drug deductible is met	\$55**	\$55**	\$25	\$10	\$55	\$15
Tier 3 (Non-preferred Drugs)			\$85**	\$85**	\$45	\$15	\$80	\$25
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250** per script	15% up to \$150 per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible	N/A	Individual: \$6,300 Family: \$12,600	Individual: \$3,700 Family: \$7,400	Individual: \$3,700 Family: \$7,400	Individual: \$800 Family: \$1,600	Individual: \$75 Family: \$150	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$500 Family: \$1,000	Individual: \$10 Family: \$20	Individual: \$10 Family: \$20	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$8,700 individual \$17,400 family	\$8,200 individual \$16,400 family	\$8,200 individual \$16,400 family	\$6,300 individual \$12,600 family	\$2,850 individual \$5,700 family	\$800 individual \$1,600 family	\$8,200 individual \$16,400 family	\$4,500 individual \$9,000 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.

Actuarial Value

- **Actuarial value (AV)** = Share of total costs* (on average) paid by the plan
- The ACA requires plans to fall within metal “tiers” defined by AV
 - Statute: Bronze = 60%, Silver = 70% (and cost-sharing reduction variations of 73%, 87%, and 94%), Gold = 80%, Platinum = 90%**
 - Limited deviation from AV allowed (“de minimis” range)
 - In 2023, de minimis ranges are narrowing (generally +2/-2%, with some exceptions)

*Costs calculated based on provision of EHB to the general population

**“Catastrophic” plans available to some consumers (fed. premium subsidies don’t apply)

Actuarial Value, Cont.

- AV is determined by federal AV Calculator
 - Published annually by CMS
- “Squeezing the balloon”
 - AV requirements act as a limit on both imposing and lowering cost-sharing amounts
 - To stay within AV limits, lowering cost-sharing for one service/category may require raising it in another

Policy Options and Opportunities

- Increase health care access
- Promote insurer competition
- Simplify plan choice
- Set a coverage “floor”

Increasing Health Care Access

- Cover more services pre-deductible
- Favor copayments over coinsurance
 - Coinsurance: fixed percentage of charges (less predictable)
 - Copayments: fixed dollar amount (more predictable)
- Reduce discriminatory benefit design
- Promote health equity through cost-sharing structures
 - Target conditions disproportionately impacting people of color (e.g., diabetes, asthma)

Promoting Insurer Competition

- Promotes transparency
- Apples-to-apples comparison means insurers compete based on premiums, network, quality
- Simplifying plan choice reduces inertia, helps consumers make informed choices
- Policies that further promote competition include differential display and limits on non-standard plans

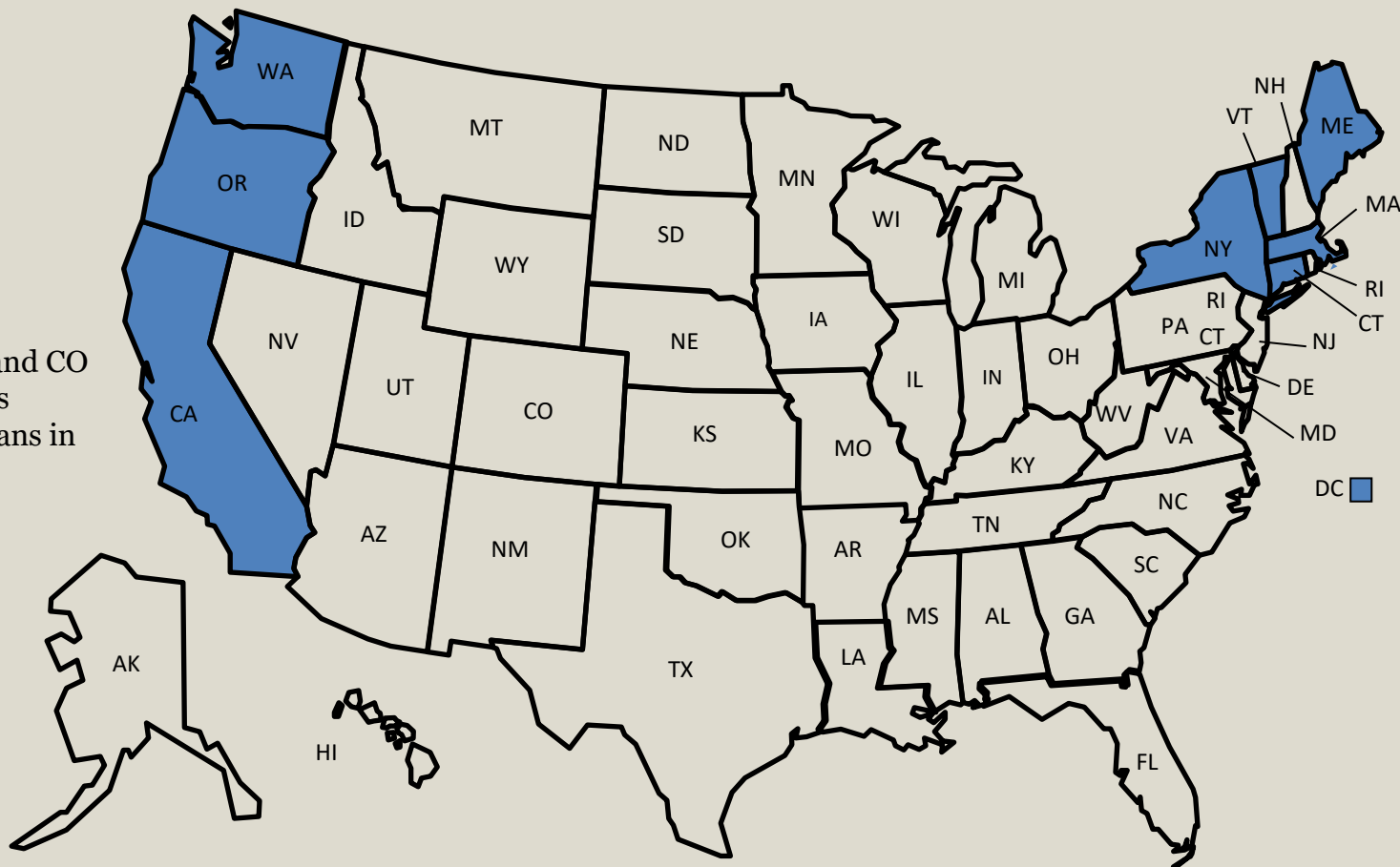
Simplifying Plan Choice

- Limiting non-standard plans
 - Quantity limits
 - Meaningful difference standard
 - Complete ban
- Differential display
 - Naming conventions
 - Special branding/graphics
 - Sorting/filtering function

Setting a Coverage “Floor”

- Marketplaces can make standard silver plans the “floor” for all silver plans
 - Maximizes federal premium tax credits
 - Federal premium subsidies are tied to second-lowest cost silver plan (setting minimum value of a silver plan can help ensure robust subsidies)
 - Also promotes standard plans (consumers can “buy down” to the lowest-cost silver)

States Requiring Marketplace Insurers to Offer Standard Plans in 2022*



*The FFM and CO will require standard plans in 2023

Source: Justin Giovannelli, Rachel Schwab, and Kevin Lucia, *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities*, Commonwealth Fund, July 2021.

State Landscape

- Limits on non-standard plans
 - Currently, only one state bans non-standard plans (CA)
 - Most states requiring standard plans limit, but do not ban non-standard plans (CT, ME, MA, NY, OR, and WA in 2023)
- Health equity initiatives (CO, DC, MA, MD Value Plans)
- Some states tie public option plan design to standard plans (WA, CO in 2023)
- Most states requiring standard plans have some differential display (naming, graphic/brand, filtering)

Maryland: Value Plans

- Achievements
 - Lowered out-of-pocket costs with standardized deductibles and pre-deductible coverage
 - Aligned plan design with population health priorities

For 2022:

- Insurers offering marketplace plans must offer at least one bronze, silver, and gold value plan
- Limits on deductibles for silver and gold
- Pre-deductible services
 - Metal tier variation; all value plans cover primary care, MH/SUD services, and generic drugs pre-deductible
- Differential display (naming convention, sorting tool)

Federal Marketplace Plans: 2023

- Beginning in 2023, insurers selling on HealthCare.gov must offer standard plans for every product network type (e.g., HMO, PPO), metal level, and service area that they offer non-standard qualified health plans
- Federal design across states that use HealthCare.gov*
 - Standard deductibles
 - Prescribed drug tiering system
 - Generic tiers use copayments rather than coinsurance
 - Pre-deductible services
 - Differential display
- No limits on non-standard plans

*Exceptions for some states (e.g., OR already has standard plans; different fed. design for DE and LA due to state drug cost-sharing laws)

Sources

Covered California, “2022 Patient-Centered Benefit Designs and Medical Cost Shares,” available at <https://www.coveredca.com/pdfs/2022-Health-Benefits-table.pdf/>.

Johanna Fabian-Marks, “Evolution and Focus of Value Plans,” Maryland Health Benefit Exchange (Presentation, Jan. 19, 2021), available at <https://www.marylandhbe.com/wp-content/uploads/2021/01/Evolution-and-Focus-of-Value-Plans.pdf>.

Justin Giovannelli, Rachel Schwab, and Kevin Lucia, *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities*, Commonwealth Fund, July 2021, available at <https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans>.

Maryland Health Benefit Exchange, “Final 2022 Letter to Issuers Seeking to Participate in Maryland Health Connection,” Mar. 18, 2021, available at <https://www.marylandhbe.com/wp-content/uploads/2021/06/2022-Letter-to-Issuers-Seeking-to-Participate-in-Maryland-Health-Connection.pdf>.

Sources, Cont.

“Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023,” 87 Fed. Reg. 27208, 27314–15 (May 6, 2022).

Rose C. Chu, Jacquelyn Rudich, Aiden Lee, Christie Peters, Nancy De Lew, and Benjamin D. Sommers, *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces*, December 2021, available at <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

Questions?

CHIR Publications:

www.chir.georgetown.edu

CHIRblog:

www.chirblog.org

Rachel Schwab

Senior Research Associate

rachel.schwab@georgetown.edu