

MHBE Affordability Workgroup

Session 3 – July 6, 2022

Agenda

1:00 - 1:15 | Welcome

David Stewart and JoAnn Volk, Co-Chairs

1:15 - 1:30 | Survey Feedback

Johanna Fabian-Marks

1:30 - 1:45 | Standardized Plan Concepts Review and Q&A

JoAnn Volk

1:45 - 2:15 | Prescription Drug Affordability

Andy York, PDAB

2:15 - 2:25 | Follow-Up from Session 2

Johanna Fabian-Marks

2:25 - 2:50 | Discussion

2:50 - 3:00 | Public Comment

3:00 | Adjournment



Welcome

Members

Member	Affiliation
Brad Boban	MIA
Evalyne Bryant Ward	University of Maryland Charles Regional Medical Group
Matt Celentano	League of Life & Health Insurers of MD, Inc.
Steven Chen	Maryland Hospital Association
Lindsey Finne	HSCRC
Maya Greifer	United Health Care
Howard Haft	Maryland Primary Care Program
Emily Hodson	Chase Brexton
Stephanie Klapper	Maryland Citizens' Health Initiative
Michelle Livshin	On Our Own MD
Allison Mangiaracino	Kaiser Permanente
Jonathan McKinney	The Advocacy Factory

Member	Affiliation
Robert Metz	CareFirst
Kavita Patel	Mary's Center
Crystal Shivers-Lester	Seedco
Lisa Solomon	Senior Health Benefits Assistance
David Stewart	AHEC West
JoAnn Volk	Georgetown Center for Health Insurance Reforms
Crystal Watkins	MedStar Harbor Hospital
Andrew York	PDAB



Survey Feedback Summary

Should MHBE pursue standardized plans?

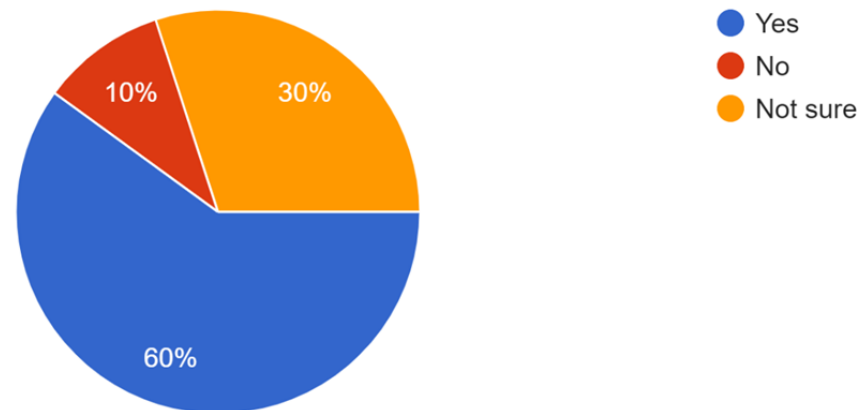
Yes (6/10)

Not sure (3/10) & No (1/10)

- Concerns that standardized plans could be less consumer friendly than Value Plans
- Need more information in general / specifically about the benefits of Standardized Plans

Are you interested in MHBE moving the Value Plans towards a Standardized Plan framework for Plan Year 2024 (while still allowing carriers to offer non-standard plans)?

10 responses



Pre-deductible and lowest-cost benefits

Preferences re: benefits that should be covered pre-deductible mirror what MHBE's Plan Certification Standards and Value Plan Standards already cover

- Most important: Primary care visits, diabetic supplies, generic drugs, mental health outpatient visits
- Important: Specialist, urgent care, lab tests

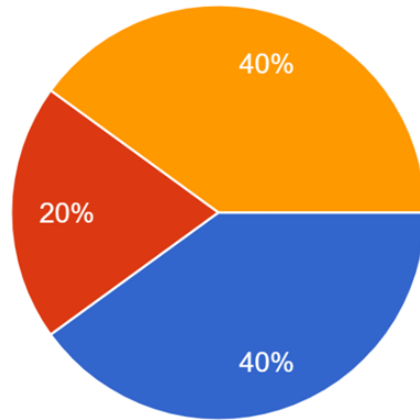
Preferences re: lowest-cost benefits

- Primary care visits
- Mental health outpatient visits
- Generic drugs
- Diabetes supplies, lab tests (to a lesser extent)

Controlling the Cost Balloon

Based on your professional experience, which trade-off is preferable to consumers?

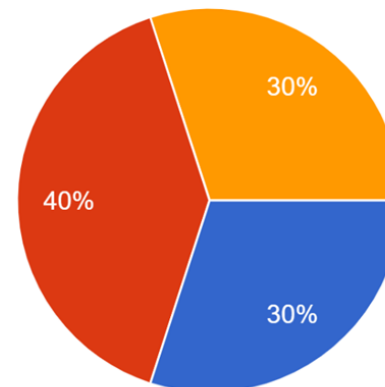
10 responses



- Higher deductible with more pre-deductible services
- Lower deductible with fewer pre-deductible services
- Not sure

Similarly, which plan design scenario do you think is more important to prioritize in Standardized Plans?

10 responses



- Higher premium and actuarial value at the higher end of the allowable range (richer benefits, higher premium)
- Lower premium and actuarial value at the lower end of the allowable range (less generous benefits, lower premium)
- Not sure

Other feedback

“...Consider creating a value/standard hybrid, where cost-shares for each service category are specified by the MHBE, but set as maximums.”

“[We] must use a data driven approach to designing plans that is specific to metal level, with consideration to premium and AV constraints.”

“Even though I support more standardized plans, I want Maryland to continue to create its own standards and not necessarily follow the feds.”

“These responses are based on my initial inclinations, but may change as I learn more over the course of the workgroup.”

In general, feedback conveys confusion/concerns that standardized plans will not promote affordability or consumer friendliness. Any policy pursued by MHBE would be in the interest of promoting affordability and simplifying the consumer shopping experience. The policy rationale for implementing Standardized Plans is to promote consumer understanding and selection of affordable, high-value plans.



Standardized Plan Review

Policy Options and Opportunities

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

MHBE Affordability Workgroup: Policies to Promote Prescription Drug Affordability

July 6, 2022

PDAB Staff



Agenda

- Overview of evidence of impact of cost-sharing on adherence
- Policies
 - Separate medical and drug deductible
 - Pre-deductible coverage of drugs
 - Formulary rules and design



Cost-Sharing and Adherence

- 2022 systematic review of literature published between January 2010 and August 2020; 79 articles included
- Increased patient cost-sharing is associated with worse patient adherence (84% of studies), lack of persistence (79% of studies), and medication discontinuation (58% of studies) across disease areas.
- Aggregate data reveals a **consistent inverse relationship between patient cost-sharing and medication adherence**
 - Greater the magnitude of patient cost-sharing → lower medication adherence
 - **Regardless of condition, patient population, or type of cost-sharing** (copays, coinsurance, deductibles)



Cost-Sharing and Adherence

- **“Dose-response” relationship between increased cost-sharing and decreased adherence**
 - Larger differences in cost-sharing are associated with worse adherence
 - Increased cost-sharing is associated with discontinuation of treatment
- Relationship may be stronger for patients being treated for cardiovascular disease compared with cancer or diabetes



Outcomes, Resource Utilization, and Total Costs

- Cost-sharing was associated with worse outcomes in 1 of 4 studies
- Higher cost-sharing was associated with **decreased outpatient and increased inpatient utilization of healthcare resources**
- Higher cost-sharing showed an overall **neutral to negative impact on total costs**
- Elimination of copayments revealed decreased or no impact in total costs



Consistent Cost-Sharing Increases

- From 2005 to 2016, the **annual deductible** for single-coverage beneficiaries in employee-sponsored U.S. health insurance plans **increased by 59%**.
- Cost-sharing has grown to 4 tiers: on average, \$11 for tier 1, \$35 for tier 2, \$62 for tier 3, and \$116 for tier 4.
- The 2020 coinsurance for **specialty** medications averaged at a patient contribution of 26%.
- In 2018, the average family in a large-employer plan paid \$5,000 in premium costs PLUS \$3,000 in OOP costs; for many families, OOP health care costs comprised **over 10%** of their annual income.



Diabetes - Medicare Fee-For-Service Population

- June 2018 retrospective, observational cohort study; elderly patients with type 2 diabetes mellitus who use **generic versus branded antihyperglycemic agents** (Medicare fee-for-service population)
- 60,250 patients on anti-hyperglycemic agent monotherapy
- 131,594 prescribed **generic** drug with mean copay of **\$6**; 28,656 prescribed **branded** drug with mean copay of **\$41**
- Using administrative claims data, examined the relationship between medication copay, adherence, and discontinuation



Diabetes - Medicare Fee-For-Service Population

- Impact of copays on adherence and discontinuation significantly **varied between branded and generic** antihyperglycemic agents
- Medicare patients taking **branded** drugs: **higher risk of nonadherence and medication discontinuation with increasing copayments**
 - This association was NOT observed for those taking generic medications
- Overall: brand-name copays (mean value of \$41) resulted in lower adherence and higher discontinuation rates; this was not true if the drugs cost “\$10 or less”
 - 90% of the values for generic drugs were below \$10 (right skewed distribution)



Diabetes - Medicare Fee-For-Service Population

- Within the branded medication group, patients in the highest copayment subgroup (\$60) were **2.1 times more likely to be nonadherent** and 1.9 times more likely to discontinue medication therapy than patients having a copayment of \$10
- For the highest copayment group, patients taking branded drugs were **1.8 times more likely to be nonadherent**, versus 1.2 times in the generic cohort
- Relative risk of nonadherence was increased in the branded cohort for every copayment cutpoint greater than \$15
- **Linear model for branded cohort:** nonadherence would increase by 0.9% and risk of discontinuation by 0.8% for every dollar increase in copay



Medicare Fee-For-Service Population - Discussion

- **Higher brand copay price sensitivity can be more financially restrictive**
- Primary determinant of nonadherence is more likely to be the **final overall cost** to the patient than higher copayments alone
- Higher copayments for some drugs have little association with drug utilization by low-income subsidy recipients
- Potential explanation: low-income subsidy recipients have significantly lower copayments for both branded and generic medications compared to other populations covered under Medicare; these patients may have low **sensitivity to costs**



Copay Elimination

- June 2021 retrospective comparative study with 1,821 control group patients and 6,463 zero-dollar copay group members
- **Copay elimination** for high-prescription-volume drugs used to treat chronic conditions led to **increased medication adherence and decreased total cost of care**
- Increase in adherence was most pronounced for lower-income households (less than \$40K/year)



Copay Elimination

- **Medication adherence rose in the zero-dollar copay group** (relative increase of 2.1%) while it fell in the control group
- Relative to the control group, **medical spending in the zero-dollar copay group fell** by \$71/member
- There was no significant increase in drug costs between treatment and control groups, yet upon further characterization, there was a significant increase of \$8 per person per month for generic drugs and no significant difference for brand-name drugs



Publicly Insured Populations

- A 2013 meta-analysis of almost 200,000 publicly insured individuals found an **11% increase** in odds of nonadherence when copays were required for prescription medicines.



Community Pharmacy Setting

- In a study of the effect of zero copayments on medication adherence in a community pharmacy setting, patients with \$0 copayments had overall higher adherence rates than patients with copayments greater than \$0.
 - Significantly higher adherence for GERD patients with no copayments versus those with copayments
 - No statistically significant difference for hyperlipidemia and hypertension cohorts



Policy Options to Improve Patient Affordability in Exchange Plans

- Separate medical and drug deductibles
- Pre-deductible drug coverage
- Tier design, structure, and standardization



Separation of Medical and Drug Deductibles: Issue

- Beneficiary must meet the deductible before they receive the plan benefits
- This can cause patients to have a prohibitive OOP cost during the deductible phase



Separation of Medical and Drug Deductibles: Maryland Background

- 8 out of 64 individual plans on the Maryland exchange have a separate drug deductible above \$0
- Drug deductibles range \$50 - \$800
 - Silver base plan and 73% AV: \$800
 - Silver 87% AV: \$50
 - Gold: \$150 - \$250



Separation of Medical and Drug Deductibles: National Background

- **Combined** prescription deductibles: deductible includes medical and prescription; after deductible is met, patient still engages in cost-sharing
- On the Health Insurance Marketplace in 2021: 88% of bronze plans and 79% of silver plans offered combined deductibles



Separation of Medical and Drug Deductibles: National Background

- **Separate** prescription deductible: can be much lower than combined deductibles and therefore easier for patients to meet
 - Only prescription costs will count
 - On the Health Insurance Marketplace in 2021, 28% of gold plans and 55% of platinum plans offered separate deductibles



Separation of Medical and Drug Deductibles: Policy Option

- Plans can set separate, potentially lower deductibles for the drug benefit and for the medical benefit
- This would allow the beneficiary to enter the drug plan benefit with a lower OOP cost



Separation of Medical and Drug Deductibles: Example

- California has a separate medical deductible and drug deductible:
 - **2016:** Adjusted Covered California (state health exchange) rules
 - Capped monthly specialty drug cost sharing at \$250
 - **Created a separate pharmacy deductible**
 - Required at least one specialty drug per category to be included on a lower cost-sharing tier
- This allows the beneficiary to pay a lower OOP cost to get into the benefit phase



California - Separation of Deductibles

- Covered California Minimum Coverage plan has **no prescription deductible**
 - Members pay maximum out-of-pocket (\$7,150) before coverage applies; applies to all prescriptions regardless of tier
- Bronze level high deductible health plans have **integrated** deductibles - medical, pharmacy, and dental combined
- Covered California Platinum has **\$0 pharmacy** deductible



Covered California - Pharmacy Deductibles

- **Bronze (60% coverage)**
 - **Standard Bronze:** Individual - \$500 pharmacy deductible; Family - \$1,000 pharmacy deductible
 - **High Deductible Bronze Plan:** Individual - \$7,000 integrated medical and pharmacy deductible; Family - \$14,000 integrated medical and pharmacy deductible
- **Silver (70 to 94% coverage)**
 - Individual - \$0-\$10 pharmacy deductible; Family - \$0 to \$20 pharmacy deductible
- **Gold (80% coverage)**
 - \$0 pharmacy deductible for both individual and family
- **Platinum (90% coverage)**
 - \$0 pharmacy deductible for both individual and family



Separation of Medical and Drug Deductibles: Option for Maryland

- Maryland can develop rules around separate deductibles for the medical benefit and prescription drug benefit

Pre-Deductible Drug Coverage: Issue/Background

- Some plans cover the cost of prescription drugs before a patient meets the deductible



Pre-Deductible Drug Coverage: Policy Option

- Plans can increase coverage before patients meet their deductible
 - This can help lower out-of-pocket costs and eliminate financial barriers, thereby improving patient adherence and outcomes through increased utilization of drugs, devices, and medical testing
- Can be limited to certain drugs or classes



Pre-Deductible Drug Coverage: Example

- IRS Notice 2019-45, among other things, allowed employers to change high-deductible health plans to allow **pre-deductible prescription drug coverage** for chronic conditions
- 2021 Employee Benefit Research Institute survey revealed that 76% of employers added pre-deductible coverage in response
- Between 57%-69% of employers provide pre-deductible drug coverage for **both brand and generic drugs** in their classes
- Researchers estimate that expanding pre-deductible coverage will only have **0%-1.5%** impact on premiums



Tier Structure and Standardization: Issue/Background

- There is currently substantial variation between formularies, tiers, and copays/coinsurance
 - Provides important flexibility to plans to customize plan options and negotiate for the lowest costs and best benefits
 - May be confusing to beneficiaries, and beneficiaries may not select the best option



Tier Structure and Standardization: Policy Options

- Study/collect details on plan formularies and tiers
- Consider rules/guardrails for formulary and tiering design
- Evaluate policies around copay standardization
- Evaluate policies around no-waste formularies





MARYLAND

Prescription Drug Affordability Board

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Session 2 Follow-Up

State Law Limits on Cost-Sharing

Prescription Drugs

- §15-842(b) – Copay or coinsurance for a **prescription drug** may not exceed the **retail price** of the drug; Example – if a 30-day supply of generic Drug A were to have a retail price of \$5, the member can only be charged \$5 at the point of sale, even if their normal copay for generics is \$10 for a 30-day supply
- §15-852 – Copay or coinsurance for a partial supply of a **prescription drug** dispensed by a network pharmacy for purposes of **synchronizing** a member's prescriptions must be **prorated** to reflect the number of days dispensed
- §15-847 – **Specialty drugs** as defined in this section are subject to a copay or coinsurance **cap of \$150** for up to a 30-day supply; carriers are permitted to require members to obtain specialty drugs from a designated or in-network pharmacy
- §15-847.1 – Carves out drugs prescribed to treat diabetes, HIV, or AIDS from §15-847 and sets a **\$150 copay or coinsurance cap for these drugs**; unlike §15-847, this statute is not limited to designated or in-network pharmacies

Diabetes

- §15-822(d)(3) – Except for in high deductible health plans (HDHPs), **diabetes test strips** may not be subject to deductible, copay, or coinsurance; in HDHPs, the deductible may apply
- §15-822.1, HB 1397, Chapter 405, Acts of 2022, effective Jan. 1, 2023 – Copay or coinsurance for **insulin** may not exceed \$30 for a 30-day supply

State Law Limits on Cost-Sharing

Contraception

- §15-826.1(c)(2)(ii) – Copay or coinsurance may not be applied to FDA-approved **contraceptive drugs or devices** prescribed by an authorized prescriber; this applies to in-network and out-of-network benefits; there is an exception at §15-826.1(c)(3) for a contraceptive drug or device that is therapeutically equivalent to another contraceptive drug or device available under the contract without a copayment or coinsurance
- §15-826.1(e)(1)(ii) – Copayment or coinsurance for FDA approved **contraceptive drug** dispensed without a prescription and available by prescription or over the counter may not exceed the copayment or coinsurance for the contraceptive drug when dispensed under a prescription
- §15-826.2(b) – Except for in high deductible health plans (HDHPs), **male sterilization** may not be subject to deductible, copay, or coinsurance; in HDHPs, the deductible may apply

Miscellaneous

- §15-825(c) – Deductible, copay, or coinsurance not permitted for **prostate cancer screenings**
- §15-812(g)(1) and (2) – Except for in high deductible health plans (HDHPs), **home visits** for mothers and newborns following childbirth may not be subject to deductible, copay, or coinsurance; in HDHPs, the visit may be subject to the deductible



Discussion

Discussion

- Should MHBE move toward standard plans?
 - What do you think is most important to keep in mind as we shape standard plans?
- How should we differentiate Value/Standard Plans from other plans?
 - Currently, Value plans must include “Value Plan” in the plan name
 - Use an icon by the plan name or popup/banner etc. to indicate/educate users?
 - Do you like the “Value Plan” moniker? Would a different name be better, or not?

We've located **32** matching health plans

Edit Health Care Use

Filters 


Add to Compare

APPLY









KP MD Gold Value 0/20/Vision

METAL LEVEL:
GOLD

QUALITY RATING:
★★★★★ 

[Details](#)

ESTIMATED MONTHLY PREMIUM 	ANNUAL DEDUCTIBLE 	ANNUAL OUT-OF-POCKET MAX 	PRIMARY CARE CO-PAY 	URGENT CARE CENTER 	H.S.A. Qualified
\$210.31 Price after estimated \$116.00 tax credit	\$0 per person \$0 per group	\$6950 per person \$13900 per group	\$20.00 Copay	\$40.00 Copay	No

YOUR TOTAL YEARLY COST ESTIMATE  **\$2,848 per household** (Select the "Edit Health Care Use" button to change the yearly cost estimate.)

[Find a Doctor](#)

[Important Plan Information](#)

[Plan Costs & Benefits](#)

[Drug Search](#)


Add to Compare

APPLY









UHC Gold Saver+ (Free Primary & Virtual Visits)

METAL LEVEL:
GOLD

QUALITY RATING:
Not yet rated 

[Details](#)

ESTIMATED MONTHLY PREMIUM 	ANNUAL DEDUCTIBLE 	ANNUAL OUT-OF-POCKET MAX 	PRIMARY CARE CO-PAY 	URGENT CARE CENTER 	H.S.A. Qualified
\$211.89 Price after estimated \$116.00 tax credit	\$2900 per person \$5800 per group	\$8100 per person \$16200 per group	No Charge	\$50.00 Copay	No

YOUR TOTAL YEARLY COST ESTIMATE  **\$2,899 per household** (Select the "Edit Health Care Use" button to change the yearly cost estimate.)

[Find a Doctor](#)

[Important Plan Information](#)

[Plan Costs & Benefits](#)

[Drug Search](#)

Add to Compare

APPLY

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Public Comment

Next Steps

Next meeting: Wednesday, July 20, 1 - 3PM

Questions to consider in advance:

Promoting Equity: Cost-Sharing for Services/Drugs to Manage Diabetes

- Should MHBE extend current Value Plan cost sharing protections for diabetic management (\$0 preferred brand insulin and glucometers) to all MHC plans in PY24?*
- Should MHBE reduce/eliminate cost sharing in Value Plans for other standard services/drugs used to manage diabetes?

Balancing AV requirements and affordability:

- Which specific services should have zero cost-sharing?
- Are there specific services that are low-value and could have higher cost-sharing?

**Cost-sharing can be waived for HSA compatible, high deductible health plans only to the extent permitted by federal law.*

Appendix



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

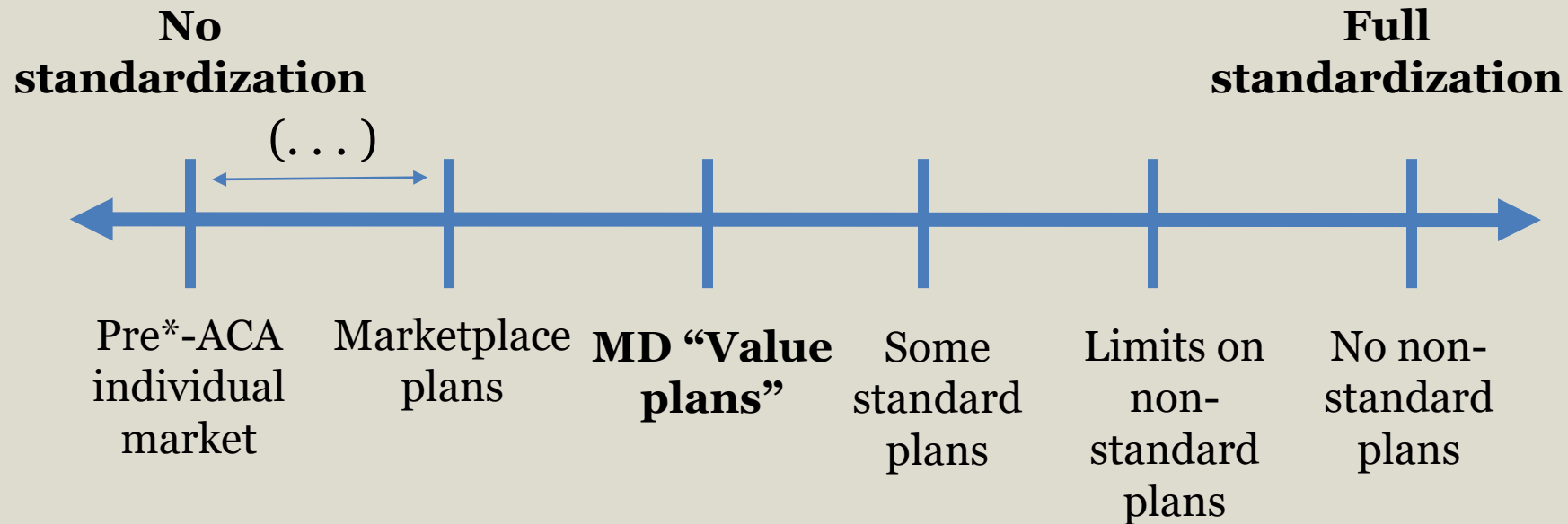
Context: Plan Choice Overload

- 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

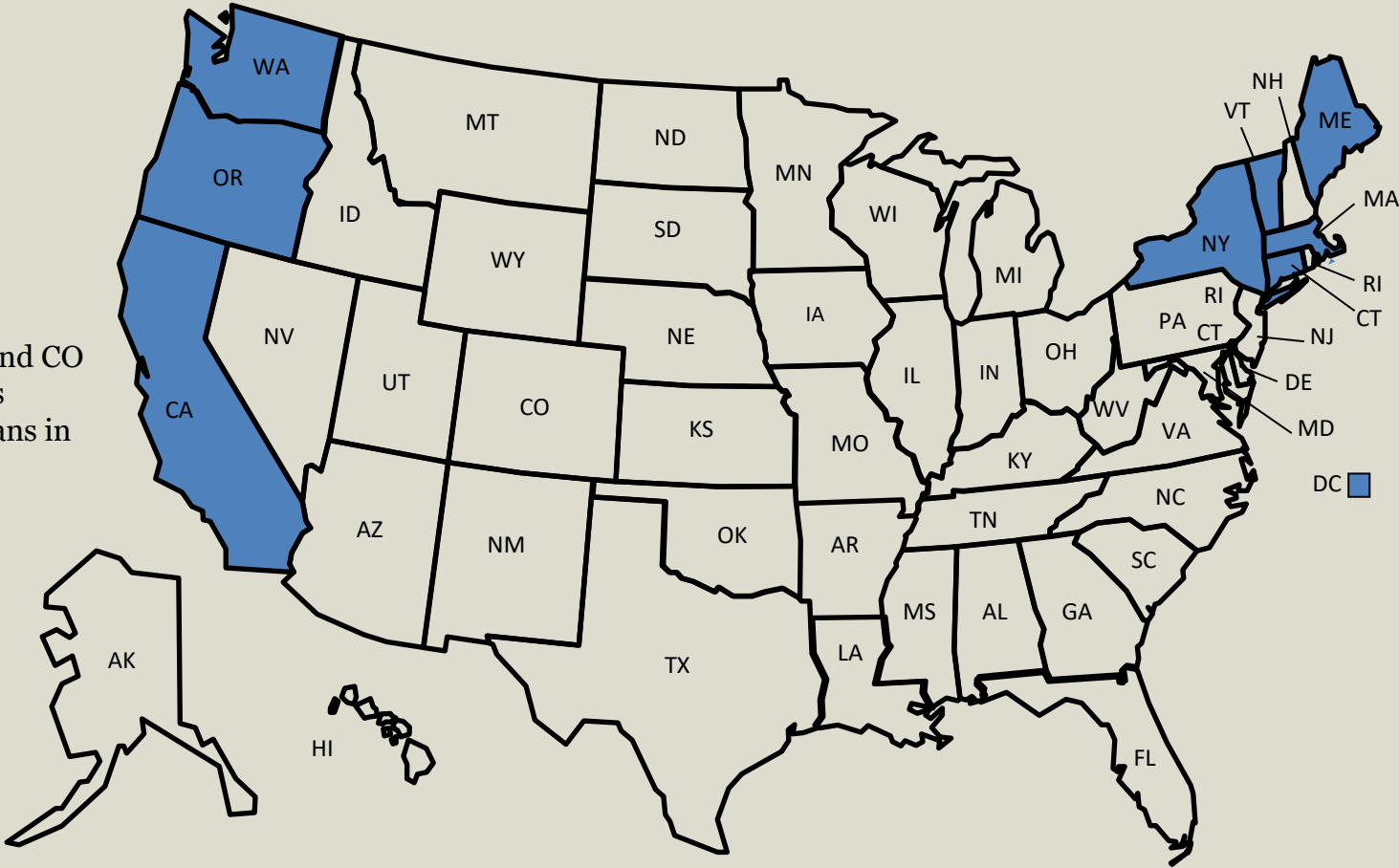
- Limiting non-standard plans
 - Quantity limits
 - Meaningful difference standard
 - Complete ban
- Differential display
 - Naming conventions
 - Special branding/graphics
 - Sorting/filtering function

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 requires 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

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Sources, Cont.

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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?

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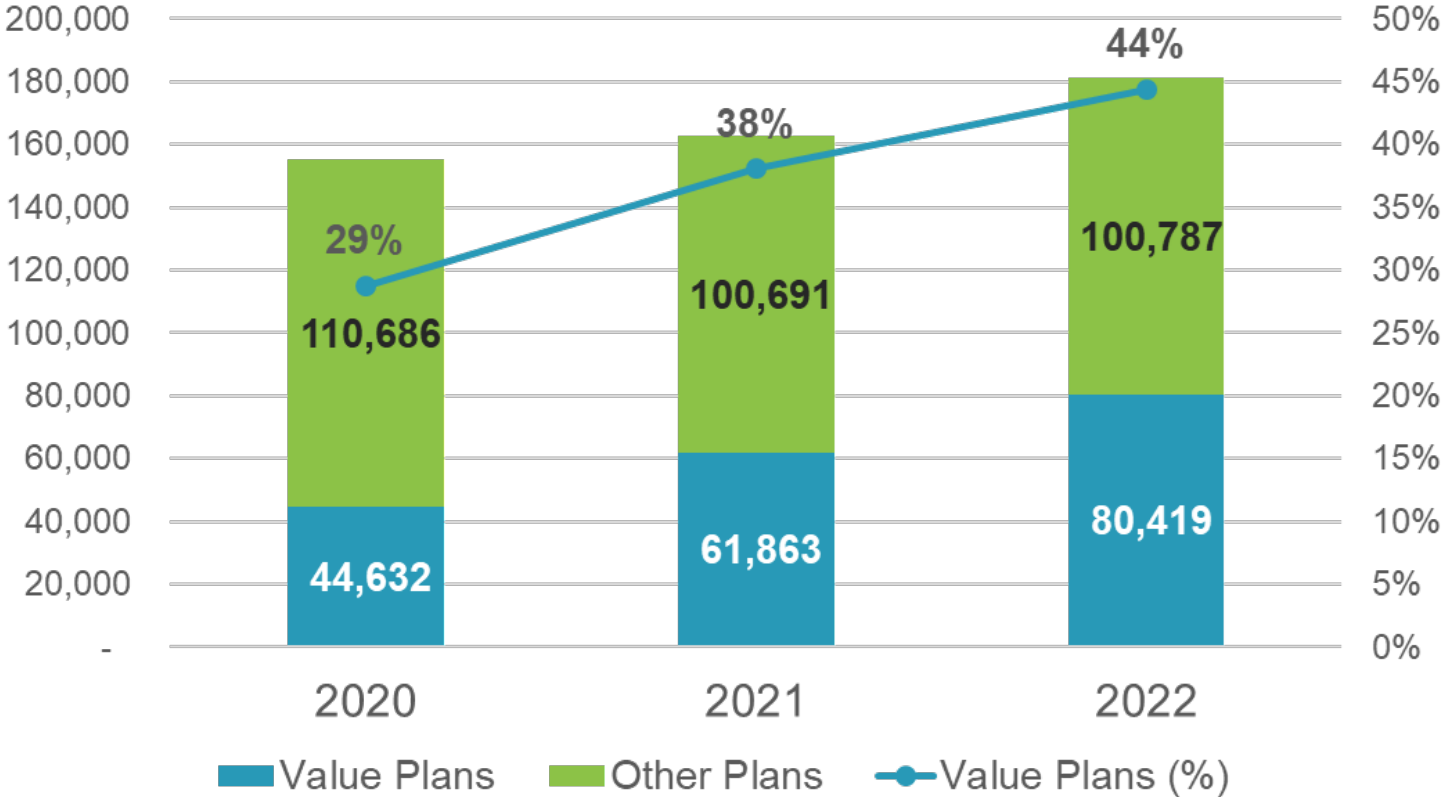
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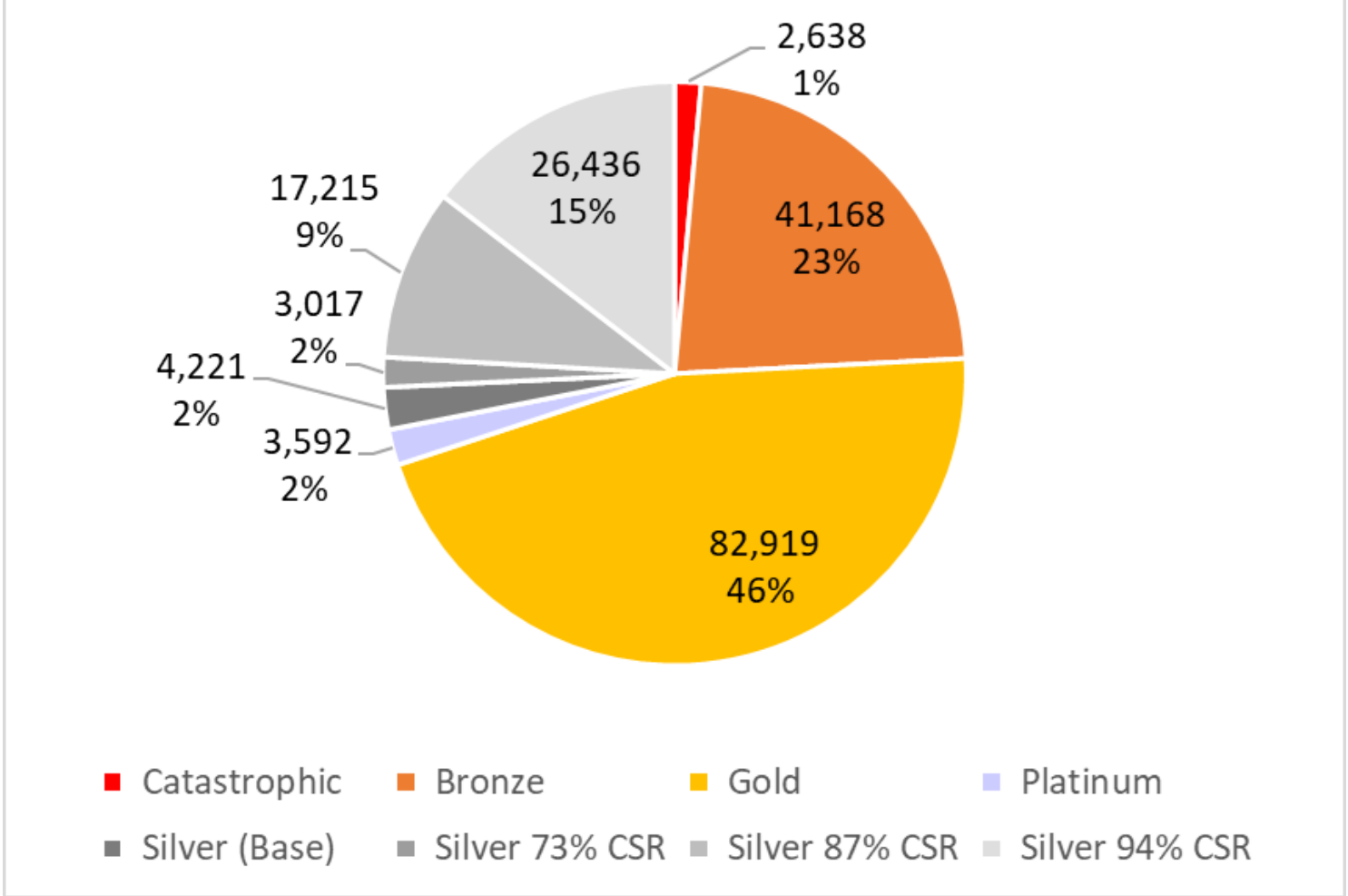
Value Plan Enrollment, 2020-2022

Value plans enrollment has steadily increased, both in absolute numbers and as a percent of total enrollment.



Enrollment data as of January 31 of each year.

Total MHC Enrollment by Metal Level, 2022



MHBE Affordability Initiatives: 2023 Value Plan Standards

Requirements	Bronze	Silver	Gold
Minimum offering	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.	Issuer must offer at least 1 “Value” plan.
Branding	Required.	Required.	Required.
Medical Deductible Ceiling	No requirement. Lower deductibles are encouraged.	\$3,000 or less.	\$1,000 or less.
Services Covered with Copay Before Deductible	<ul style="list-style-type: none"> • Primary Care Visits with copay of not more than \$40 • Mental Health and Substance Use Disorder Outpatient Visits with copay ≤\$40 • Generic Drugs with copay ≤\$20 	<ul style="list-style-type: none"> • Primary Care Visit • Urgent Care Visit • Specialist Care Visit • Mental Health and Substance Use Disorder Outpatient Visits • Generic Drugs • Laboratory Tests • \$0 Diabetic Supplies (insulin, glucometers, test strips) 	<ul style="list-style-type: none"> • Primary Care Visit • Urgent Care Visit • Specialist Care Visit • Mental Health and Substance Use Disorder Outpatient Visits • Generic Drugs • Laboratory Tests • X-rays and Diagnostics • \$0 Diabetic Supplies (insulin, glucometers, test strips)

California - 2022

	Deductible (M/D)	MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital	Generic Rx	Preferred Rx
Bronze HSA	\$7,000	No Charge AD							
Bronze	\$6,300/\$500	\$8,200	\$65	\$95	\$65*	40% AD	40% AD	\$18	40% up to \$500 per script AD
Silver	\$3,700/\$10	\$8,200	\$35	\$70	\$35	\$400	20% AD	\$15 AD	\$55 AD
73.4% AV Silver	\$3,700/\$10	\$6,300	\$35	\$70	\$35	\$400	20% AD	\$15 AD	\$55 AD
87.8% AV Silver	\$800/\$0	\$2,850	\$15	\$25	\$15	\$150	15% AD	\$5	\$25
94.7% AV Silver	\$75/\$0	\$800	\$5	\$8	\$5	\$50	10% AD	\$3	\$10
Gold	\$0	\$8,200	\$35*	\$65	\$35	\$350	\$600/Day up to 5 days	\$15	\$55

- *Deductible applies after first 3 non-preventive visits
- Gold Plan has two designs: copay and coinsurance

Colorado - 2023

	Deductible	MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital	Rx Tier 1**	Rx Tier 2	Rx Tier 3
Bronze	\$7,000	\$9,100	\$0*	50% AD	50% AD	50% AD	50% AD	\$0	\$30	\$200
Silver	\$5,000	\$8,550	\$0	\$80	\$80	40% AD	40% AD	\$0	\$20	\$125
73.4% AV Silver	\$3,500	\$7,250	\$0	\$80	\$80	40% AD	40% AD	\$0	\$20	\$125
87.9% AV Silver	\$800	\$2,800	\$0	\$60	\$60	30% AD	30% AD	\$0	\$0	\$60
94% AV Silver	\$100	\$1,000	\$0	\$40	\$40	20% AD	20% AD	\$0	\$0	\$20
Gold	\$1,600	\$7,800	\$0	\$50	\$50	30% AD	30% AD	\$0	\$10	\$50

- Gold/silver plans - \$0 PCP, MH/SUD, prenatal and postnatal visits
- Bronze - No charge for first 3 visits for PCP, MH/SUD, prenatal and postnatal visits
- All CO standard plans include:
 - Diabetic supplies and continuous glucose monitors at no charge
 - Diabetes education for \$5

* First 3 visits \$0, then deductible, then \$50

** Tier 1: The prescription drug tier which consists of drugs used for preventive purposes.

Tier 2: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic.

Tier 3: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand-name prescription drugs.

Washington D.C. - 2023

	Deductible (M/D)	MOOP	PCP*	Specialist	Urgent Care	Emergency Room	Inpatient Hospital	Generic Rx**	Preferred Rx
Bronze HSA	\$6,350	\$6,900	20% AD	20% AD	20% AD	20% AD	20% AD	20% AD	20% AD
Bronze	\$7,500/\$850	\$9,100	\$45	\$105	\$100	40% AD	40% AD	\$25	\$75 AD
Silver	\$4,850/\$350	\$8,850	\$40	\$80	\$90	\$400	20% AD	\$20	\$50 AD
Gold	\$500	\$5,800	\$25	\$50	\$60	\$300	\$600/Day (up to 5 days) AD	\$15	\$50

- Preventive care visits (screening & immunization) are \$0 and not subject to the deductible in all plans
- *PCP visits, dilated retinal exam (1x per year), diabetic foot exam (1x per year), and nutritional counseling visits (unlimited) with a primary diagnosis of Type 2 diabetes are provided with no cost-sharing
- **A select list of diabetes supplies and medications within the diabetic agents drug class, as defined by the carrier, are provided with no cost-sharing. A carrier is not required to change the drugs that are on the carrier's formulary.
- For a person with a primary diagnosis of Type 2 diabetes, the following lab services are provided with no cost-sharing:
 - Lipid panel test (1x per year)
 - Hemoglobin A1C (2x per year)
 - Microalbumin urine test or nephrology visit (1x per year)
 - Basic metabolic panel (1x per year)
 - Liver function test (1x per year)

2022 Plan Summary - Bronze

Carrier	Plan Marketing Name	Individual Deductible	Individual MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital Services	Generic Drugs	Preferred Brand
CF HMO	BlueChoice HMO Bronze \$8,250	\$8,250	\$8,700	No Charge AD*						
CF HMO	BlueChoice HMO HSA Bronze \$6,150	\$6,150	\$8,700	\$30 AD*	\$40 AD	\$60 AD	\$300 AD	\$500/Day AD	\$10 AD	\$50 AD
CF HMO	BlueChoice HMO Value Bronze \$6,100	\$6,100	\$8,700	\$40*	\$50 AD	\$70	40% AD	40% AD	\$20	\$50 AD
CF PPO	BluePreferred PPO Bronze \$8,250	\$8,250	\$8,700	No Charge AD*						
KP	KP MD Bronze 6900/0%/HSA/Vision	\$6,900	\$8,700	No Charge AD*						
KP	KP MD Bronze 7500/40%/Vision	\$7,500	\$8,700	40% AD*						
KP	KP MD Bronze Value 6700/40%/Vision	\$6,700	\$8,700	\$40*	\$50 AD	\$50 AD	40% AD	40% AD	\$20	40% AD
OCI	UHC Bronze Essential+ (Low Premium)	\$8,700	\$8,700	No Charge AD*						
OCI	UHC Bronze Saver+ (HSA)	\$5,900	\$8,700	30% AD*	30% AD	30% AD	30% AD	30% AD	\$5 AD	25% AD
OCI	UHC Bronze Value+	\$8,700	\$8,700	\$40*	\$40 AD	\$80	\$500 AD	No Charge AD	\$10	No Charge AD
<i>AD = After Deductible</i>		<i>* Equal to Mental Health & Substance Use Disorder Cost-Sharing</i>								
<i>Indicates Value Plan</i>										

- Value plans are the only plans with pre-deductible coverage
- Some value plans cover Urgent Care pre-deductible (not required)
- Federal comparison: In addition to MD required pre-deductible coverage, plans cover urgent care, ST/OT/PT, specialty visits
- CA comparison: Pre-deductible services same as federal + labs; all pre-deductible services limited to 3x except generics and labs are unlimited
- CO comparison: Pre-deductible services - 3x \$0 PCP, pre-natal & postnatal visits; unlimited \$0 MH/SUD outpatient and generics, \$5 Diabetes self-management education; other drug tiers with \$30-\$700 copays
- DC comparison: Pre-deductible services - PCP & MH/SUD office visits and outpatient services, specialist, urgent care, generics, prenatal

2022 Plan Summary - Silver

Carrier	Plan Marketing Name	Individual Deductible	Individual MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital Services	Generic Drugs	Preferred Brand
CF HMO	BlueChoice HMO Value Silver \$2,250 VisionPlus	\$2,250	\$8,050	\$30*	\$40	\$60	30% AD	30% AD	\$15	\$50 AD
CF PPO	BluePreferred PPO HSA Silver \$3,000 VisionPlus	\$3,000	\$6,650	\$30 AD*	\$40 AD	\$60 AD	\$300 AD	\$500/Day AD	\$10 AD	\$50 AD
KP	KP MD Silver 3200/20%/HSA/Vision	\$3,200	\$6,650	20% AD*	20% AD	20% AD	20% AD	20% AD	\$20 AD	\$55 AD
KP	KP MD Silver 6000/40/Vision	\$6,000	\$8,500	\$40*	\$60	\$60	35% AD	35% AD	\$30	\$60
KP	KP MD Silver Value 2500/35/Vision	\$2,500	\$8,250	\$35*	\$55	\$55	35% AD	35% AD	\$20	\$60
KP	KP MD Silver Virtual Forward 4000	\$4,000	\$8,550	\$55 AD*	\$75 AD	\$75 AD	30% AD	30% AD	\$20	\$50 AD
OCI	UHC Silver Base+ (3 Free Virtual Visits)	\$3,750	\$8,700	\$25	\$40*	\$60	\$500 AD	30% AD	\$5	\$75 AD
OCI	UHC Silver Extra+ (6 Free Visits)	\$4,000	\$8,700	\$30	\$60*	\$75	\$500 AD	30% AD	\$10	\$75 AD
OCI	UHC Silver Saver+ (6 Free Visits)	\$6,500	\$8,700	\$40	\$65*	\$60	\$500 AD	30% AD	\$10	\$75 AD
OCI	UHC Silver Value+	\$2,500	\$8,700	\$40	\$70*	\$60	\$500 AD	40% AD	\$5	\$75 AD

- Value plans have lowest deductibles; Not shown - labs have \$25-\$60 copays and X-rays/Diagnostic imaging have \$55-\$70 copays
- One carrier matches MH/SUD outpatient copays to specialist copay rather than PCP copay
- **Federal comparison:** \$5,800 deductible, \$9,000 MOOP; pre-deductible coverage doesn't include labs, imaging, does include preferred brand drugs
- **CA comparison:** \$3,700 med deductible, \$10 Rx deductible, \$8,200 MOOP; Pre-deductible services same as MD plus all Rx, ER, medical transport, home health, outpatient hab/rehab, \$0 hospice and prenatal, child eye exam/glasses/contacts, child dental diagnostic and preventive
- **CO comparison:** \$5,000 deductible, \$8,550 MOOP; pre-deductible coverage doesn't include labs, imaging, does include all drugs, \$0 PCP, MH/SUD outpatient, generics, pre-natal & postnatal visits, \$5 Diabetes self-management education
- **DC comparison:** \$4,850 med deductible, \$350 Rx deductible, \$8,850 MOOP; Pre-deductible services same as MD plus home health, outpatient hab/rehab, \$0 hospice and prenatal, child eye exam/glasses/contacts, child dental; DME with coinsurance

73% AV Silver

Carrier	Plan Marketing Name	Individual Deductible	Individual MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital Services	Generic Drugs	Preferred Brand
CF HMO	BlueChoice HMO Value Silver \$2,250 VisionPlus	\$2,050	\$6,400	\$30*	\$40	\$60	30% AD	30% AD	\$15	\$50 AD
CF PPO	BluePreferred PPO HSA Silver \$3,000 VisionPlus	\$1,150	\$6,300	\$30 AD*	\$40 AD	\$60 AD	\$300 AD	\$550/Day AD	\$10 AD	\$50 AD
KP	KP MD Silver 3200/20%/HSA/Vision	\$2,000	\$6,650	20% AD*	20% AD	20% AD	20% AD	20% AD	\$20 AD	\$55 AD
KP	KP MD Silver 6000/40/Vision	\$3,500	\$6,500	35*	\$55	\$55	35% AD	35% AD	\$25	\$60
KP	KP MD Silver Value 2500/35/Vision	\$2,200	\$6,500	30*	\$55	\$55	35% AD	35% AD	\$20	\$60
KP	KP MD Silver Virtual Forward 4000	\$2,000	\$6,950	\$45 AD*	\$65 AD	\$65 AD	20% AD	20% AD	\$20	\$50 AD
OCI	UHC Silver Base+ (3 Free Virtual Visits)	\$3,500	\$6,800	\$20	\$40*	\$60	\$500 AD	25% AD	\$5	\$75
OCI	UHC Silver Extra+ (6 Free Visits)	\$2,250	\$6,950	\$20	\$50*	\$75	\$500 AD	20% AD	\$10	\$75
OCI	UHC Silver Saver+ (6 Free Visits)	\$3,750	\$6,800	\$30	\$60*	\$60	\$500 AD	20% AD	\$10	\$75
OCI	UHC Silver Value+	\$2,500	\$6,950	\$30	\$60*	\$60	\$500 AD	40% AD	\$5	\$75

AD = After Deductible

* = Equal to Mental Health & Substance Use Disorder Cost-Sharing

Indicates Value Plan

Indicates coverage before deductible

87% AV Silver

Carrier	Plan Marketing Name	Individual Deductible	Individual MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital Services	Generic Drugs	Preferred Brand
CF HMO	BlueChoice HMO Value Silver \$2,250 VisionPlus	\$0	\$2,350	\$10*	\$40	\$40	15%	15%	\$15	\$50
CF PPO	BluePreferred PPO HSA Silver \$3,000 VisionPlus	\$0	\$2,700	\$10*	\$40	\$40	\$200	\$200/Day	\$10	\$50
KP	KP MD Silver 3200/20%/HSA/Vision	\$600	\$2,700	10% AD*	10% AD	10% AD	10% AD	10% AD	\$15 AD	\$50 AD
KP	KP MD Silver 6000/40/Vision	\$0	\$2,700	\$15*	\$40	\$40	30%	30%	\$15	\$60
KP	KP MD Silver Value 2500/35/Vision	\$0	\$2,700	\$10*	\$40	\$40	30%	30%	\$10	\$60
KP	KP MD Silver Virtual Forward 4000	\$750	\$2,500	\$35 AD*	\$55 AD	\$55 AD	10% AD	10% AD	\$10	\$30 AD
OCI	UHC Silver Base+ (3 Free Virtual Visits)	\$950	\$2,900	\$10	\$30*	\$60	\$500 AD	15% AD	\$5	\$50 AD
OCI	UHC Silver Extra+ (6 Free Visits)	\$900	\$2,500	\$10	\$30*	\$75	\$250 AD	10% AD	\$5	\$50 AD
OCI	UHC Silver Saver+ (6 Free Visits)	\$775	\$2,750	\$15	\$50*	\$60	\$250 AD	10% AD	\$5	\$50 AD
OCI	UHC Silver Value+	\$900	\$2,500	\$10	\$40*	\$60	\$250 AD	20% AD	\$5	\$75 AD
<i>AD = After Deductible</i>		<i>* = Equal to Mental Health & Substance Use Disorder Cost-Sharing</i>								
	<i>Indicates Value Plan</i>									
	<i>Indicates coverage before deductible</i>									

- One carrier matches MH/SUD outpatient copays to specialist copay rather than PCP copay
- **Federal comparison:** \$800 deductible, \$3,000 MOOP; pre-deductible coverage doesn't include labs, imaging, does include preferred brand drugs
- **CA comparison:** \$800 med deductible, \$0 Rx deductible, \$1,600 MOOP; Pre-deductible services same as MD plus all Rx, ER, medical transport, home health, outpatient hab/rehab, \$0 hospice and prenatal, child eye exam/glasses/contacts, child dental diagnostic and preventive
- **CO comparison:** \$800 deductible, \$2,800 MOOP; pre-deductible coverage doesn't include labs, imaging, does include all drugs, \$0 PCP, MH/SUD outpatient, generics, pre-natal & postnatal visits, \$5 Diabetes self-management education

94% AV Silver

Carrier	Plan Marketing Name	Individual Deductible	Individual MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital Services	Generic Drugs	Preferred Brand
CF HMO	BlueChoice HMO Value Silver \$2,250 VisionPlus	\$0	\$1,300	\$10*	\$15	\$20	10%	10%	No Charge	\$10
CF PPO	BluePreferred PPO HSA Silver \$3,000 VisionPlus	\$0	\$1,300	\$10*	\$15	\$20	\$100	\$100/Day	No Charge	\$10
KP	KP MD Silver 3200/20%/HSA/Vision	\$100	\$2,300	5% AD*	5% AD	5% AD	5% AD	5% AD	\$10 AD	\$15 AD
KP	KP MD Silver 6000/40/Vision	\$0	\$2,000	\$5*	\$15	\$15	10%	10%	\$5	\$15
KP	KP MD Silver Value 2500/35/Vision	\$0	\$1,800	\$5*	\$15	\$15	10%	10%	\$5	\$10
KP	KP MD Silver Virtual Forward 4000	\$100	\$1,000	\$25 AD*	\$45 AD	\$45 AD	5% AD	5% AD	\$3	\$20 AD
OCI	UHC Silver Base+ (3 Free Virtual Visits)	\$75	\$2,850	\$10	\$20*	\$60	\$100	10% AD	No Charge	\$25 AD
OCI	UHC Silver Extra+ (6 Free Visits)	\$50	\$2,000	\$5	\$10*	\$75	\$100 AD	5% AD	No Charge	\$15 AD
OCI	UHC Silver Saver+ (6 Free Visits)	\$0	\$2,000	\$10	\$20*	\$60	\$75 AD	5% AD	No Charge	\$15 AD
OCI	UHC Silver Value+	\$75	\$2,500	\$5	\$20*	\$60	\$100 AD	5% AD	No Charge	\$25 AD
<i>AD = After Deductible</i>		<i>* = Equal to Mental Health & Substance Use Disorder Cost-Sharing</i>								
<i>Indicates Value Plan</i>										
<i>Indicates coverage before deductible</i>										

- One carrier matches MH/SUD outpatient copays to specialist copay rather than PCP copay
- **Federal comparison:** \$0 deductible, \$1,700 MOOP; pre-deductible coverage doesn't include labs, imaging, does include all drugs
- **CA comparison:** \$75 med deductible, \$0 Rx deductible, \$800 MOOP; Pre-deductible services same as MD plus all Rx, ER, medical transport, home health, outpatient hab/rehab, \$0 hospice and prenatal, child eye exam/glasses/contacts, child dental diagnostic and preventive
- **CO comparison:** \$100 deductible, \$1,000 MOOP; pre-deductible coverage doesn't include labs, imaging, does include all drugs, \$0 PCP, MH/SUD outpatient, generics, pre-natal & postnatal visits, \$5 Diabetes self-management education

2022 Plan Summary - Gold

Carrier	Plan Marketing Name	Individual Deductible	Individual MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital Services	Generic Drugs	Preferred Brand
CF HMO	BlueChoice HMO Gold \$1,750	\$1,750	\$6,650	No Charge*	\$30	\$50	\$300 AD	\$450/Day AD	No Charge	\$50 AD
CF HMO	BlueChoice HMO Value Gold \$1,000	\$1,000	\$6,650	No Charge*	\$30	\$50	30% AD	30% AD	No Charge	\$50 AD
CF PPO	BluePreferred PPO Gold \$1,750	\$1,750	\$6,650	No Charge*	\$30	\$50	\$300 AD	\$450/Day AD	No Charge	\$50 AD
KP	KP MD Gold 1750/20/Vision	\$1,750	\$6,950	\$20*	\$40	\$40	35% AD	35% AD	\$15	\$55 AD
KP	KP MD Gold Value 0/20/Vision	\$0	\$6,950	\$20*	\$40	\$40	\$500	35%	\$10	\$55
KP	KP MD Gold Value 1000/20/Vision	\$1,000	\$6,950	\$20*	\$40	\$40	\$500	35% AD	\$10	\$55
KP	KP MD Gold Virtual Forward 2000	\$2,000	\$5,000	\$50 AD*	\$70 AD	\$70 AD	\$200 AD	\$300/Day AD	\$10 AD	\$50 AD
OCI	UHC Gold Advantage+ Extra (Dental + Vision)	\$2,250	\$7,500	\$30	\$50*	\$50	\$500 AD	30% AD	\$5	\$50 AD
OCI	UHC Gold Base+ (\$3 Walgreens + 6 Free Visits)	\$1,500	\$7,500	\$30	\$40*	\$50	\$500 AD	30% AD	\$3	\$50
OCI	UHC Gold Saver+ (Free Primary & Virtual Visits)	\$2,900	\$8,100	No Charge	\$35	\$50	\$500 AD	20% AD*	\$5	\$50 AD
OCI	UHC Gold Value+ (3 Free Virtual Visits)	\$1,000	\$7,500	\$20	\$40*	\$50	\$500 AD	30% AD	\$5	\$50 AD

AD = After Deductible

* = Equal to Cost-Sharing for Mental Health & Substance Use Disorder Outpatient Services

- Value plans have lowest deductibles; Not shown - labs have \$15-\$40 copays and X-rays/Diagnostic Imaging have \$65-\$70 copays
- Some plans cover ER, preferred brand drugs, Imaging (CT/PET, MRI) before deductible
- One carrier matches MH/SUD outpatient copays to specialist copay rather than PCP copay
- **Federal comparison:** \$2,000 deductible, \$8,700 MOOP; pre-deductible coverage doesn't include labs, imaging, does include all drugs
- **CA comparison:** \$0 med deductible, \$0 Rx deductible, \$8,200 MOOP (all services are pre-deductible because the deductible is \$0)
- **CO comparison:** \$1,600 deductible, \$7,800 MOOP; pre-deductible coverage doesn't include labs, imaging, does include all drugs, \$0 PCP, MH/SUD outpatient, generics, pre-natal & postnatal visits, \$5 Diabetes self-management education
- **DC comparison:** \$500 med deductible, \$0 Rx deductible, \$5,800 MOOP; Pre-deductible services same as MD plus home health, outpatient

2022 Plan Summary - Platinum

Carrier	Plan Marketing Name	Individual Deductible	Individual MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital Services	Generic Drugs	Preferred Brand
KP	KP MD Platinum 0/15/Vision	\$0	\$4,000	15*	\$20	\$20	\$300	\$350/Day	\$5	\$35
<i>AD = After Deductible</i>		<i>* = Equal to Mental Health & Substance Use Disorder Cost-Sharing</i>								
<i>Indicates Value Plan</i>										
<i>Indicates coverage before deductible</i>										

Value Plan Cost Sharing Summary

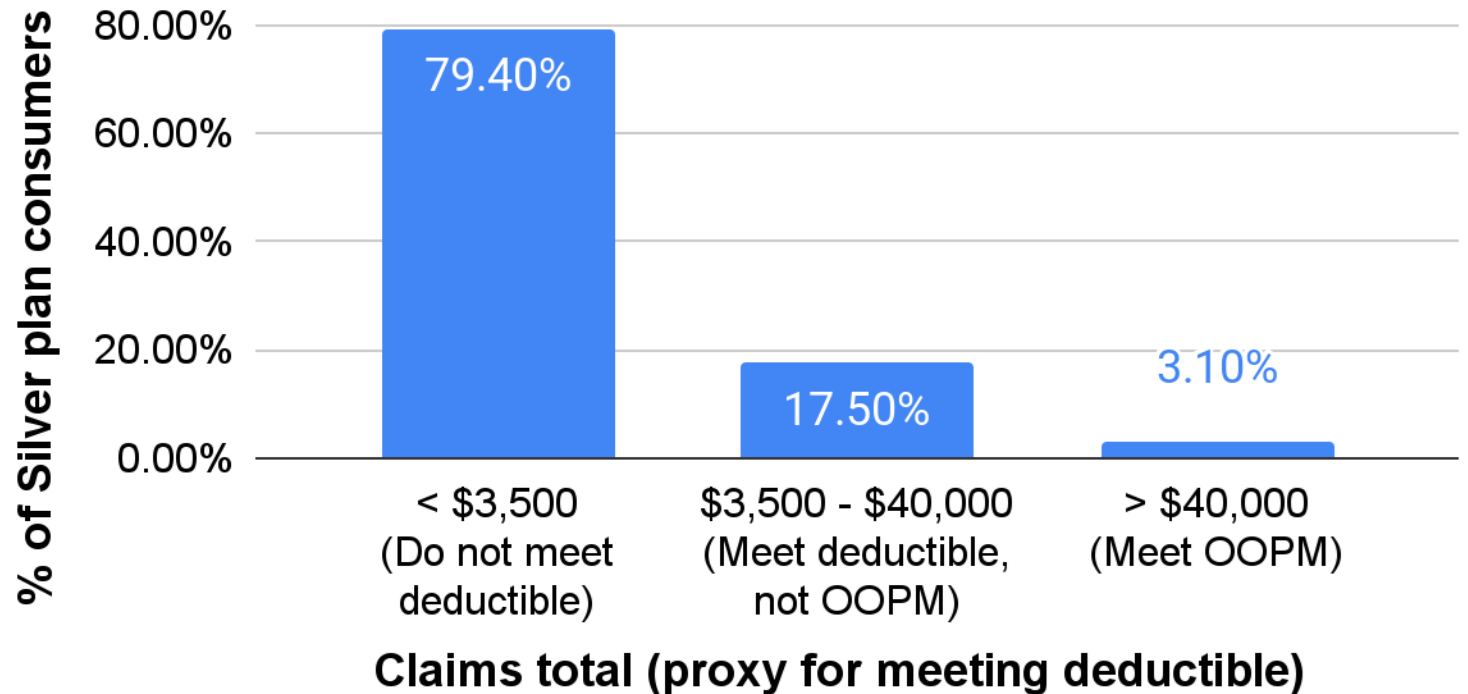
	Deductible	MOOP	PCP	Specialist	Urgent Care	Emergency Room	Inpatient Hospital
Bronze	\$6,100-8,700	\$8,700	\$40	\$40-50 AD	\$70-80	\$500 AD - 40% AD	0-40% AD
Silver	\$2,250-2,500	\$8,050-8,700	\$30-40	\$40-70	\$55-60	\$500 AD - 30-35% AD	30-40% AD
73% CSR	\$2,050-2,500	\$6,400-6,950	\$30	\$40-60	\$55-60	\$500 AD - 30-35% AD	30-40% AD
87% CSR	\$0-900	\$2,350-2,700	\$10	\$40	\$40-60	15-30%; \$250 AD	15-30%; 20% AD
94% CSR	\$0-75	\$1,300-2,500	\$5-10	\$15-20	\$15-60	10%; \$100 AD	10%; 5% AD
Gold	\$0-1,000	\$6,650-7,500	\$0-20	\$30-40	\$40-50	\$500; \$300-500 AD	30-35%; 30-35% AD

	Generic Drugs	Preferred Brand	Non-Preferred Brand	Specialty Drugs
Bronze	\$10-20	\$0-50 AD; 25% AD	0-50% AD; \$70 AD	0-50% AD; \$150 AD
Silver	\$5-20	\$50-75 AD; \$60	35-40% AD; \$70 AD	35-40% AD; \$150 AD
73% CSR	\$5-20	\$60-75; \$50 AD	35-40% AD; \$70 AD	35-40% AD; \$150 AD
87% CSR	\$5-15	\$50-60; \$75 AD	30% AD; \$70	30-35% AD; \$150
94% CSR	\$0-5	\$10; \$25 AD	5% AD - 10%; \$25	5% AD - 20%; \$75
Gold	\$0-10	\$55; \$50 AD	25-35% AD; \$70 AD	30-35% AD; \$150 AD

Deductible & Out-of-Pocket Max (OOPM) Impacts

- 3.4% of Silver plan enrollees met OOPM**
 - 3.0% of base plan enrollees
 - 3.1% of 73% CSR enrollees
 - 4.7% of 87% CSR enrollees
 - 2.7% of 94% CSR enrollees

Consumers impacted by deductible vs. by out-of-pocket maximum*



HHS Standardized Plans

Metal Level	Deductible	MOOP	Pre-Deductible Coverage	Other Coverage	AV
Non-Expanded Bronze	\$9,100	\$9,100	None	N/A	59.86%
Expanded Bronze	\$7,500	\$9,000	\$50 - PCP, MH/SUD, ST/OT/PT \$100 - Specialty visits \$75 - Urgent care \$25 - Generics	50% coinsurance AD - ER, Inpatient, Labs, Imaging, SNF, Outpatient surgery	64.18%
Base Silver	\$5,800	\$9,000	\$40 - PCP, MH/SUD, ST/OT/PT \$80 - Specialty visits \$60 - Urgent care \$20 - Generics \$40 - Preferred Brand	40% coinsurance AD - ER, Inpatient, Labs, Imaging, SNF, Outpatient surgery	70.06%
Gold	\$2,000	\$8,700	\$30 - PCP, MH/SUD, ST/OT/PT \$60 - Specialty visits \$45 - Urgent care \$15 - Generics \$30 - Preferred Brand \$60 - Non-Preferred Brand \$250 - Specialty Drugs	25% coinsurance AD - ER, Inpatient, Labs, Imaging, SNF, Outpatient surgery	78%

HHS Standardized Plans

Acronyms: PCP = Primary Care Provider; MH/SUD = Mental health and substance use disorder outpatient visits; ST/OT/PT = speech therapy, occupational therapy, and physical therapy; AD = After deductible; ER = Emergency room; SNF = Skilled nursing facility

Metal Level	Deductible	MOOP	Pre-Deductible Coverage	Other Coverage	AV
Base Silver	\$5,800	\$8,900	\$40 - PCP, MH/SUD, ST/OT/PT \$80 - Specialist visits \$60 - Urgent care \$20 - Generics \$40 - Preferred Brand	40% coinsurance AD - ER, Inpatient, Labs, Imaging, SNF, Outpatient surgery	70.06%
Silver 73%	\$5,700	\$7,200	\$30 - PCP, MH/SUD, ST/OT/PT \$60 - Specialist visits \$45 - Urgent care \$20 - Generics \$40 - Preferred Brand	40% coinsurance AD - ER, Inpatient, Imaging, Labs, X-ray, SNF, Outpatient surgery	73.11%
Silver 87%	\$800	\$3,000	\$20 - PCP, MH/SUD, ST/OT/PT \$40 - Specialist visits \$30 - Urgent care \$10 - Generics \$20 - Preferred Brand	30% coinsurance AD - ER, Inpatient, Imaging, Labs, X-ray, SNF, Outpatient surgery	87.05%
Silver 94%	\$0	\$1,700	Deductible N/A: \$0 - PCP, MH/SUD, ST/OT/PT \$10 - Specialist \$5 - Urgent care \$0 - Generics \$15 - Preferred Brand drugs	Deductible N/A: \$50 - Non-preferred drugs \$150 - Specialty drugs 25% coinsurance - ER, Inpatient, Labs, Imaging, X-rays, SNF, Outpatient surgery	94.02%

HHS Standardized Plans vs. MHBE Value Plans

Federal standardized plan requirements that differ from MHBE's Value Plans:

- Higher deductibles
- Standardized coinsurance for post-deductible cost sharing
- Specified pre-deductible copays for generic drugs, primary care, MH/SUD, specialist, ST/OT/PT, and urgent care; silver adds preferred drugs and gold adds non-preferred and specialty drugs
- Lab services and x-rays/diagnostic imaging not required pre-deductible
- MOOP limits, but nearly/fully maxed out
- No pre-deductible coverage in standardized Bronze plan
- No diabetes cost sharing requirements