
Analysis of Benefit Design in Silver Plan Variations

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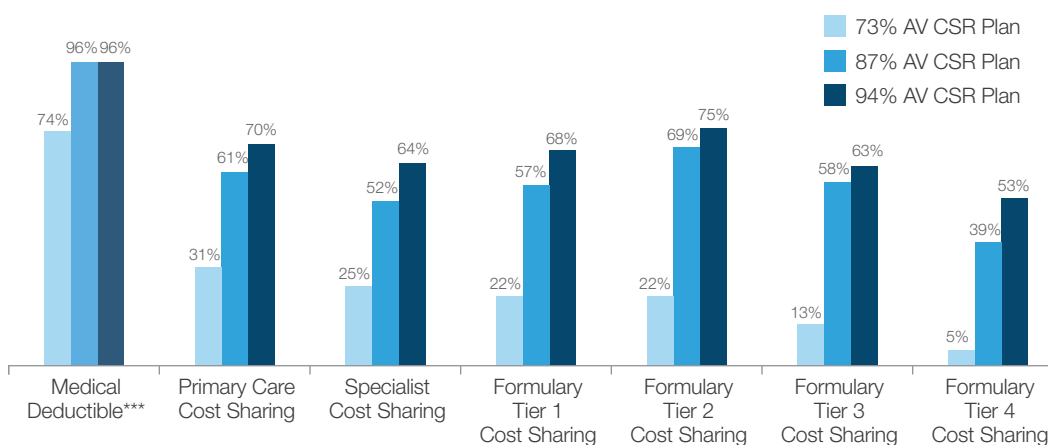
EXECUTIVE SUMMARY

Both state-based and federally-facilitated exchanges offer financial assistance for low-income enrollees. The assistance takes two forms: advanced premium tax credits and cost-sharing reductions (CSRs). This report focuses on CSR plans, which are available to individuals and families earning between 100% of the federal poverty level (FPL) and 250% FPL; this corresponds to individual income of \$11,670 to \$29,175 in 2014.ⁱ

CSR plans use federal subsidies to increase their actuarial value (AV) and lower cost-sharing for low-income exchange enrollees. Avalere Health conducted an analysis of the standard silver and CSR plans offered in the federally-facilitated exchange (FFE) that spans 34 states.ⁱⁱ While the Affordable Care Act (ACA) requires CSR plans to lower maximum out-of-pocket (MOOP) limits, health insurers have broad flexibility about how to adjust cost-sharing for other services to reach the required actuarial values. Notably, plans do not evenly reduce cost-sharing across all types of benefits; in fact, plans vary substantially in how they alter cost-sharing for each of the benefits examined in this analysis. Key findings from the analysis include:

Cost-sharing reductions are more often applied across multiple types of benefits in 94% and 87% AV plans compared to 73% AV plans. As expected, in comparison to the standard silver plans, most issuers are implementing moderate to high cost-sharing reductions for their 94% and 87% AV CSR plans across all types of benefits examined in this analysis; fewer issuers are reducing cost-sharing across all benefits for their 73% AV CSR plans.

Figure 1: Percent of Silver Plan Variations that Alter Cost-Sharing Structure* from the Standard Silver Plan**



* Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.

** For the purposes of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge, or no charge after the deductible was met were excluded. Amounts are rounded to the nearest dollar or percent.

*** For the purpose of this analysis, medical deductibles include combined deductibles as well as separate medical-only deductibles.

Source: Avalere PlanScape, updated March, 2014. Avalere collected plan information that was publically available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states.

AV = Actuarial Value

CSR = Cost Sharing Reduction

Many CSR plans have MOOP limits lower than the amount required by law. Across all CSR variations in this analysis, consumers will have access to plans with lower MOOPs than required, and the average MOOP is substantially lower than the mandated MOOP limit. For example, among 87% AV CSR plans, the average MOOP is \$450 lower than the required limit, while among 94% AV CSR plans, the average MOOP is \$1,140 lower.

Almost all CSR plans feature lower deductibles than the standard silver plans, though wide variation remains. Issuers reduce deductibles almost universally (96%) for their 87% AV and 94% AV CSR plans. Approximately three-quarters of 73% AV CSR plans have lower deductibles than the standard silver plan (Figure 1). On average, deductibles for the 73% AV CSR plans are \$688 lower than the standard silver plan deductibles, while average deductibles in the 94% AV CSR plans are \$2,813 lower than the average standard silver plan deductible. Even so, wide variation across plans remains; the highest deductible among 94% AV CSR plans is three times greater than the average deductible.

Consistent with standard silver plans, copays for specialist visits are higher than those for primary care visits. Exchange consumers visiting a specialist will encounter much higher, often double, copays in comparison to primary care physician (PCP) copays.

Low-income consumers may face very high coinsurance for drugs on tiers three and four, which is least likely to be reduced in CSR plans. Over half of the 87% AV and two-thirds of 94% AV CSR plans reduce cost-sharing for tier one (generic) prescription drugs, while only 39% and 53% of such plans, respectively, reduce cost-sharing for tier four drugs (Figure 1). As such, despite receiving cost-sharing subsidies, low-income consumers may face barriers accessing brand-name drugs due to high cost-sharing requirements, which are particularly prevalent on higher formulary tiers. For example, among 94% AV CSR plans—which enroll individuals earning less than 150% FPL (\$17,505 for a single person in 2014)—of the plans utilizing coinsurance, one-third of plans have coinsurance greater than 30% for tier three drugs, and one-fifth of these plans require such coinsurance for tier four drugs.

Based on our analysis, it is evident that issuers are selective when applying cost-sharing reductions across different benefits in CSR plans. For example, there is a trend among issuers to consistently reduce medical deductibles, while at the same time only slightly more than half of the plans alter cost-sharing for tier four prescription medications in the 94% AV CSR plans. Given the continued flexibility granted to issuers designing CSR plans and the high proportion of enrollees eligible for financial assistance, stakeholders may wish to identify trends in benefit design of CSR plans and assess consumer affordability heading into the 2015 plan year.

BACKGROUND ON COST-SHARING REDUCTION PLANS

Health plans offered in the individual and small group markets, including those offered on the exchange, must meet one of four actuarial values, known as “metal levels.” Plans with the lowest AV are bronze plans with an AV of 60%, followed by silver plans (70% AV), gold plans (80% AV), and platinum plans (90% AV). Actuarial value is the percentage of total covered healthcare costs that the plan would pay for an average population. A high AV means that the plan pays a larger portion of covered costs, while the consumer pays a smaller portion. Conversely, a low AV means that the plan pays a smaller portion of covered costs, and the consumer pays a larger portion.

Both state-based and federally-facilitated exchanges offer two forms of financial assistance: advanced premium tax credits (APTC) and cost-sharing reductions (CSRs). Individuals and families eligible for APTCs receive tax credits, on a sliding scale, that limit the amount they must pay toward their health insurance premium to a percent of income. APTCs are available for individuals and families with incomes between 100% and 400% of the federal poverty level (FPL).ⁱⁱⁱ APTCs are calculated based on the premium of the second-lowest cost silver plan available, but may be used to purchase any exchange plan.

CSRs allow individuals and families with incomes between 100% and 250% FPL to enroll in silver plans with increased AVs and reduced out-of-pocket costs. Qualifying individuals and families are eligible for “silver variation plans” that have, on average, lower deductibles, coinsurance, and copayments. The law requires issuers participating in the exchange to offer CSR plans based on each of the issuer’s standard silver plans.^{iv}

For each standard silver plan offered on the exchange, issuers must offer three CSR plans with increasing AVs: 73%, 87%, and 94%. To meet the required AV for each CSR plan, issuers must first reduce the maximum out-of-pocket (MOOP) limit of the CSR plan. If this change does not increase the AV to the required level, issuers must then lower cost-sharing for covered services. Mandated AV levels and out-of-pocket spending caps associated with each bracket of income are included in Figure 2.^v

Figure 2: Cost-Sharing Reduction Plan Overview

Actuarial Value	Household Income	OOP Cap for 2014	Individual Income Range	Family of Four Income Range
94%	100 – 150% FPL	\$2,250	\$11,670 – \$17,505	\$23,850 – \$32,197.50
87%	150 – 200% FPL	\$2,250	\$17,505 – \$23,240	\$32,197.50 – \$47,700
73%	200 – 250% FPL	\$5,200	\$23,240 – \$29,175	\$47,700 – \$59,625

Based on the 2012 American Community Survey, it is estimated that nearly 16 million uninsured individuals have incomes between 100% and 250% FPL, which is the qualifying income range for CSR plans on the exchange.^{vi} It is important to note that this data point includes individuals with incomes from 100% to 138% FPL in states that are not expanding Medicaid, who otherwise would have been eligible for Medicaid coverage.^{vii}

Trends from the most recent HHS Enrollment Report indicate that 85% of exchange enrollees who have selected a plan are eligible for financial assistance.^{viii} This figure includes eligibility for both APTCs and CSRs; therefore, the large proportion of enrollees eligible for financial assistance who chose to enroll in a silver plan suggests that many may be eligible for CSR plans.

Notably, four states (CA, CT, NY, and VT) opted to limit plan variability by mandating standardized benefit structures for the CSR plans offered on their state-based exchanges. For example, in California, standard silver plans must charge \$45 for a primary care office visit copay, while 94% AV CSR plans must charge \$3 for a primary care office visit copay.^{ix} In FFM states, the federal government has afforded issuers a substantial amount of flexibility when designing the CSR plans, provided they meet required AV levels and the lower MOOPs. Plans are under no obligation to reduce cost-sharing for all covered benefits or to do so evenly across benefits. Federal regulations require that CSR plans may not increase cost-sharing for any service as the value of the cost-sharing subsidy (and resulting plan AV) increases.^x Thus, consumers are assured that they receive the most generous benefits by enrolling in the CSR plan for which they are eligible.

SILVER PLAN VARIATION DATA ANALYSIS

Data Sources, Methodology, and Limitations

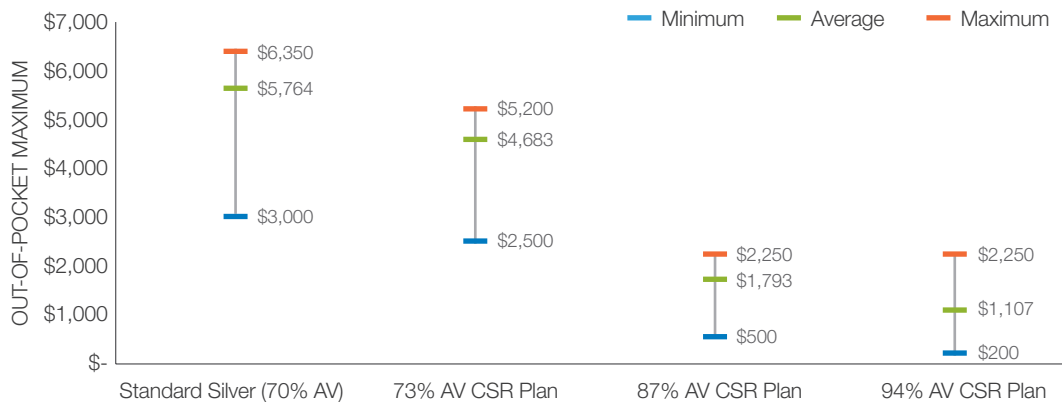
Avalere analyzed the most recent version (11th volume) of the Department of Health and Human Services (HHS) Landscape file available on HealthCare.gov.^{xi} The file contains details on individual and family premiums and benefit designs for plans across the 34 states in the FFE.^{xii} This analysis focuses solely on this data file and, therefore, does not reflect plans offered in any state-based exchange. The file contains 5,800 total silver plans, including standard silver plans as well as the required “silver plan variations.” Drug coverage data in the HHS Landscape file are structured into four formulary tiers; therefore, for plans that have fewer or more than four formulary tiers, the data in this file may not align with the plan’s true formulary structure. The accuracy of all analysis is limited by the accuracy of the data included in the Landscape file itself.

FINDINGS

Maximum Out-of-Pocket (MOOP)

Maximum out-of-pocket (MOOP) limits are capped at \$6,350 for all standard metal level plans. Issuers offering silver plan variations are required to reduce this standard MOOP to no greater than \$2,250 for individuals between 100% and 200% FPL and \$5,200 for individuals between 200% and 250% FPL. Some plans, however, have lowered the MOOPs below those limits. Average MOOPs for standard silver, 73% AV CSR, and 87% AV CSR plans are between \$450 and \$600 lower than the maximum allowed MOOPs for these plan types. The average MOOP in 94% AV CSR plans is approximately half of the required MOOP of \$2,250 (Figure 3).

Figure 3: Out-of-Pocket Maximums by Silver Plan and Silver Plan Variations



Source: Avalere PlanScope, updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states. AV = Actuarial Value
CSR = Cost-sharing Reduction

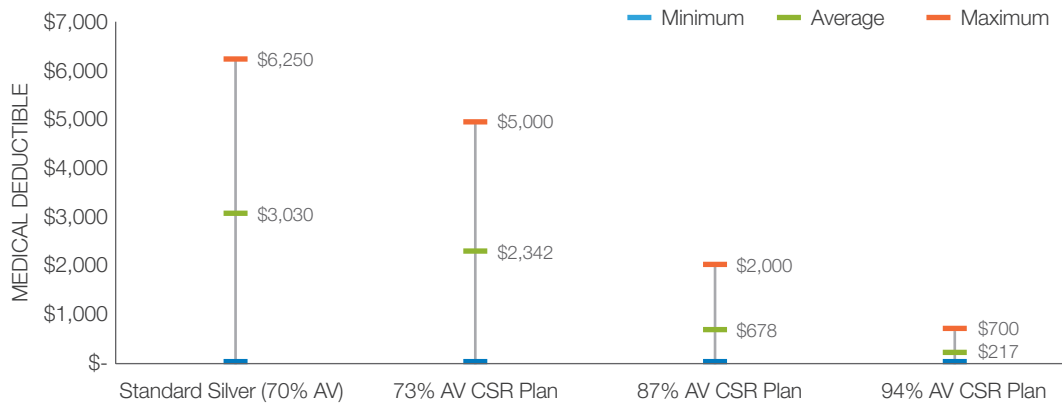
Medical and Drug Deductibles

Medical deductibles in the standard silver and CSR plans vary considerably across plans. Across all types of silver plans, the maximum deductibles are two to three times higher than average deductibles. For example, the average medical deductible for the 94% AV CSR plan is \$217 as compared to the maximum deductible of \$700.^{xiii} That said, only 26 plans in Ohio and Wisconsin include the \$700 deductible. However, approximately 1,500 (26%) of the 94% AV CSR plans have deductibles at or above \$400, which is nearly twice the average deductible.

The HHS Landscape file indicates that over one-third of silver plans have a \$0 drug deductible, signifying that drugs are not subject to any deductible in those plans. We further reviewed a sample of plan summary of benefits and coverage documents to

confirm that these plans do in fact exempt drugs from the deductible altogether versus including drugs in a combined, but not drug-specific, deductible. Through our review, we confirmed that two-thirds of these plans do exempt drugs from the deductible.^{xiv} We could not confirm this for the remaining one-third of plans, meaning that data from the Landscape file alone may not be enough to determine whether these plans allow first dollar coverage of drugs.

Figure 4: Medical Deductibles* by Silver Plan and Silver Plan Variations



* For the purpose of this analysis, medical deductibles include combined deductibles as well as separate medical-only deductibles.
 Source: Avalere PlanScape, updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states.
 Note: The analysis in this graph includes plans with \$0 medical deductibles.
 AV = Actuarial Value
 CSR = Cost-sharing Reduction

Some standard silver and CSR plans have separate, non-zero dollar drug deductibles. Notably, the number of plans with a separate drug deductible decreases as the plan's AV level increases. More specifically, 16% of standard silver plans, 15% of 73% AV CSR plans, 12% of 87% AV CSR plans, and 8% of 94% AV CSR plans have separate non-zero dollar drug deductibles. These deductibles average \$730 for standard silver plans; \$490 for 73% AV CSR plans; \$200 for 87% AV CSR plans; and \$150 for 94% AV CSR plans.

Cost-Sharing for Primary Care Physician and Specialist Visits

For primary care physician (PCP) and specialist visits, the maximum and minimum copayment and coinsurance amounts are relatively stable across standard silver and CSR plans; however average cost-sharing steadily decreases as the AV level increases.

Across standard silver and CSR plans, the maximum copays for PCP visits range from \$50 to \$60, while minimum copays are consistently \$0. Furthermore, the average copay for a PCP visit drops by more than half from the standard silver plan to the 94% AV CSR, falling from \$32 in standard silver plans to \$12 in 94% CSR plans (Figure 5).

Similarly, the average coinsurance rate for a PCP visit drops from 23% in standard silver plans to 14% in 94% AV CSR plans (Figure 6). For each type of silver plan, the average coinsurance rates for PCP and specialist visits are nearly identical (Figures 6 & 8). However, the cost of a specialist visit may be higher than that for a PCP visit, meaning that a patient's out-of-pocket cost (in dollars) could be higher when visiting a specialist.

Coinsurance maximums are consistently 50% for both PCP and specialist visits, across the standard silver plan and all CSR plans, while the minimum coinsurance ranges from 0% to 5% (Figures 6 & 8). Notably, only 71 of the 5,800 standard silver and CSR plans charge 50% coinsurance for a PCP or specialist visit; these outliers are plans in Kansas, North Carolina, and Tennessee.

In comparison to the standard silver plans, 31% of 73% AV CSR plans, 61% of 87% AV CSR plans, and 70% of 94% AV CSR plans lower cost-sharing amounts for PCP visits (Figure 1). However, on average, plans do not substantially reduce the required cost-sharing for PCP visits in 73% AV CSR plans.

Figure 5: PCP Copayments

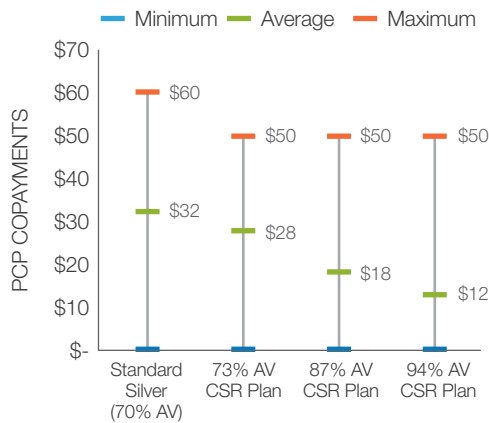
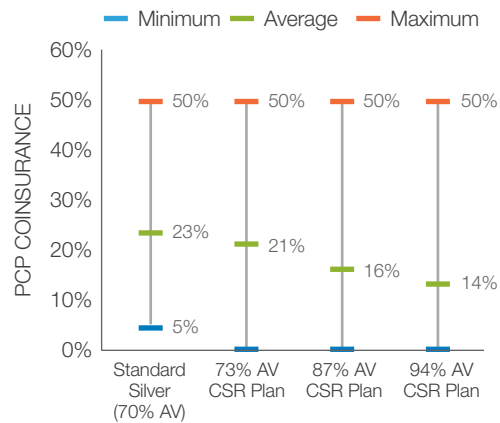


Figure 6: PCP Coinsurance



Source: Avalere PlanScope, updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states.

Note: For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge after the deductible for the standard option were excluded. When plans indicated no charge for the standard option, Avalere assumed a \$0 copay. For other CSRs, when no charge was indicated, Avalere used a \$0 or 0% based on any cost-sharing structure for the lower AV level.

AV = Actuarial Value

CSR = Cost-sharing Reduction

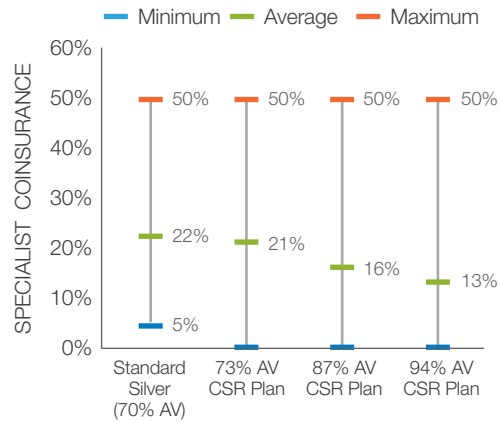
Specialist visits have much higher copays, often double, than PCP visits; coinsurance rates, however, as discussed above, are comparable for specialist and PCP visits. Similar to PCP cost-sharing trends, minimum copay and coinsurance amounts for specialist visits vary by only \$10 or 5 percentage points, respectively, across silver plan types. Average cost-sharing for specialist visits declines as AV increases (Figures 7 & 8).

Fewer issuers reduce cost-sharing for specialist visits in CSR plans relative to the standard silver plan than do for PCP visits. In comparison to standard silver plans, 25% of 73% AV CSR plans, 52% of 87% AV CSR plans, and 64% of 94% AV CSR plans lower cost-sharing for specialist visits (Figure 1).

Figure 7: Specialist Copays



Figure 8: Specialist Coinsurance



Source: Avalere PlanScope, updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states. Note: For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge after the deductible for the standard option were excluded. When plans indicated no charge for the standard option, Avalere assumed a \$0 copay. For other CSRs, when no charge was indicated, Avalere used a \$0 or 0% based on any cost-sharing structure for the lower AV level. AV = Actuarial Value CSR = Cost-sharing Reduction

Cost-Sharing for Prescription Drugs

Among analyzed plans, the range of copay and coinsurance amounts for each formulary tier is similar across the standard silver and all CSR plans. In general, issuers use copayments for lower tier drugs and shift to coinsurance rates for higher tier drugs.

As expected, average cost-sharing increases along with formulary tier and decreases with increasing AV level among the CSR plans. The average copay for a tier one drug in a 94% AV plan is \$6—less than half the average cost-sharing in the standard silver plans. The majority of all silver plans (84%) utilize copays for tier one drugs, while only 12% of plans have coinsurance.^{xv}

Figure 9: Average Copayments and Coinsurance Amounts Across Silver Plan Variations

	Standard Silver Plan (70% AV)	73% AV CSR Plan	87% AV CSR Plan	94% AV CSR Plan
Average Copayments**				
First Tier Drugs*	\$13	\$11	\$8	\$6
Second Tier Drugs*	\$49	\$46	\$31	\$22
Third Tier Drugs*	\$87	\$84	\$59	\$49
Fourth Tier Drugs*	\$165	\$160	\$124	\$98
Average Coinsurance**				
First Tier Drugs*	29%	28%	17%	14%
Second Tier Drugs*	30%	29%	20%	15%
Third Tier Drugs*	36%	35%	27%	24%
Fourth Tier Drugs*	31%	31%	26%	23%

* Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.

** For the purposes of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there no charge after the deductible was met were excluded. For plans that noted no charge for the standard plan on a tier, Avalere used \$0 copays for tiers 1-3 and 0% coinsurance for tier 4. For analyzing the no charge for the CSRs, Avalere assigned a \$0 or 0% based on the type of cost sharing used for that tier by the standard plan. Amounts are rounded to the nearest dollar or percent.

Source: Avalere PlanScape, updated March, 2014. Avalere collected plan information that was publically available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states.

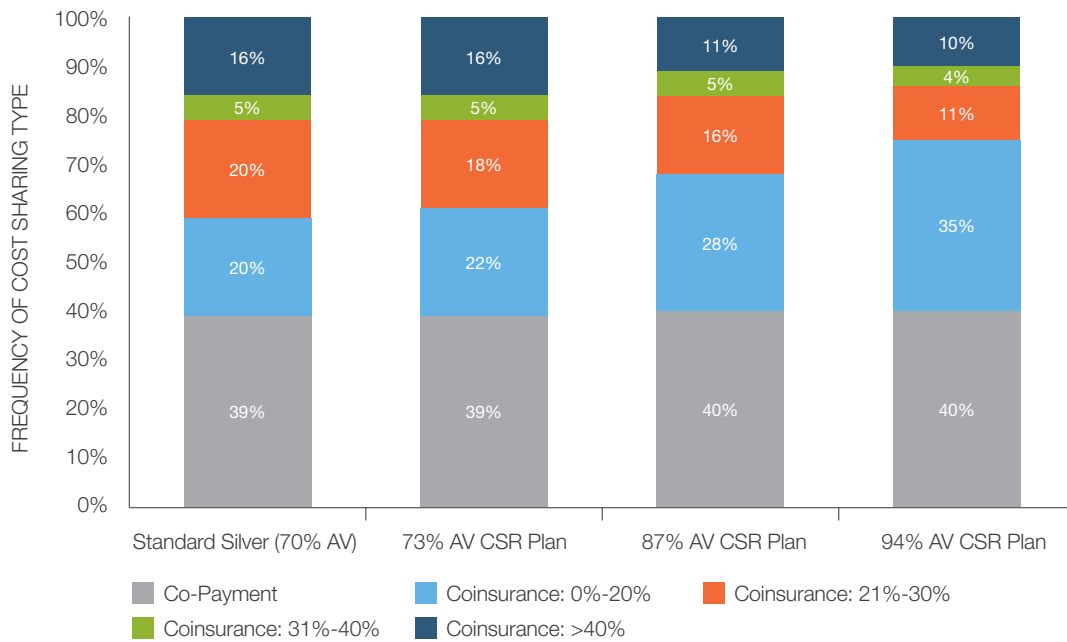
AV = Actuarial Value

CSR = Cost Sharing Reduction

At the other end of the spectrum, copayments on tier four range from \$0 to \$395 for standard silver plans, and from \$0 to \$300 for CSRs, while coinsurance ranges from 0% to 75% for all types of silver plans. The 75% coinsurance rate is an outlier limited to 26 silver and CSR plans in Michigan. The average copay for tier four drugs is \$165 among standard silver plans and \$98 among the 94% AV CSR plans. The average coinsurance rate for tier four drugs is 31% in standard silver plans and drops to 23% in the 94% AV CSR plans. Across all standard silver and CSR plan types, plans use coinsurance for tier four in approximately 60% of plans, while the remaining 40% of plans use copayments.

Use of coinsurance is quite common for higher formulary tiers; in comparison, of all standard silver and CSR plans, only 12% use coinsurance on tier one, and 20% use it on tier two. Of the nearly third of plans utilizing coinsurance for tier three drugs, more than half of the standard silver and 73% AV CSR plans require at least 30% coinsurance, while about one-third of the 87% AV and 94% AV CSR plans do.

Figure 10: Tier Four Cost Sharing in FFM States, By Silver and Silver CSR Plans



*Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.

**For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans were excluded that noted that there was no charge after the deductible was met.

Source: Avalere PlanScape, updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states.

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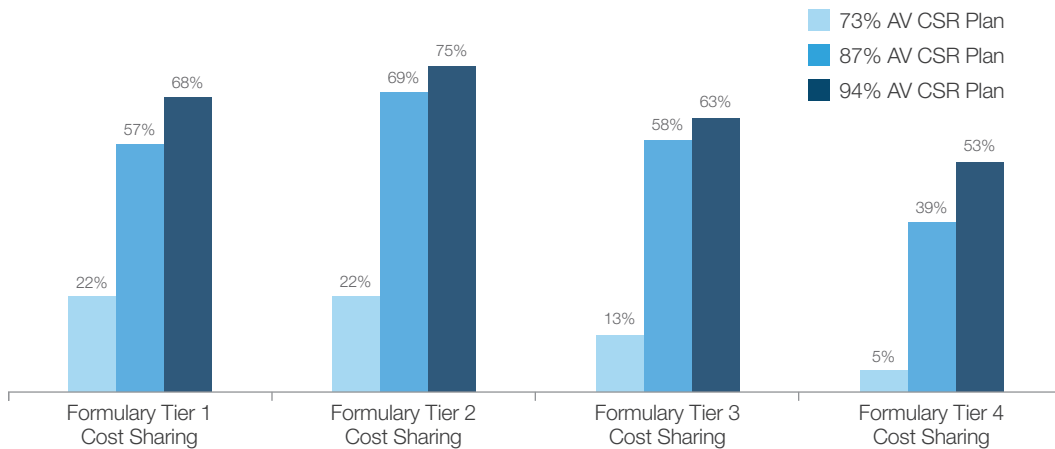
CSR = Cost-sharing Reduction

As noted above (Figure 10), on tier four 21% of standard silver and 73% AV CSR plans have more than 30% coinsurance, while roughly 15% of the 87% AV and 94% AV CSR plans do. High coinsurance amounts on the standard silver and 73% AV CSR plans is not the only factor leading to high out-of-pocket costs on tier four—higher copays also are a contributor. More specifically, of the 2,151 plans with copays for tier four, approximately 92% of standard silver plans and 90% of 73% AV CSR plans charge over \$150. As AV increases, use of lower coinsurance (i.e., up to 20% coinsurance) is more common than higher coinsurance. Around 10% of 94% AV and 87% AV CSR plans have coinsurance of more than 40% on tier four; this figure rises to 16% of standard silver and 73% AV CSR plans (Figure 10).

Plans vary in whether and how they alter cost-sharing across formulary tiers. Less than one-quarter of 73% AV CSR plans reduce cost-sharing from the standard silver plan for any formulary tier, and only 5% of 73% AV CSR plans reduce cost-sharing on tier four (Figure 11). The 87% AV and 94% AV CSR plans were more likely to have reduced

cost-sharing for all formulary tiers. For example, 39% of 87% AV CSR plans reduce cost-sharing on tier four and 69% do so on tier two. Additionally, 53% of 94% AV CSR plans reduce cost-sharing on tier four, and 75% reduce such costs for tier two. Generally across all CSR variations, more CSR plans reduce cost-sharing for tier two drugs, typically preferred brand drugs, than for other formulary tiers. Across all formulary tiers, fewer CSR plans reduced cost-sharing for tier four drugs, typically specialty drugs, than any for other formulary tier.

Figure 11: Percent of Silver Plan Variations that Alter Cost-Sharing Structure* From the Standard Silver Plan**



* For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge after the deductible was met were excluded.
 Source: Avalere PlanScape, updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: <https://www.healthcare.gov/>. The file contained 5,800 silver plans spanning 34 FFM states.
 ** Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.
 AV = Actuarial Value
 CSR = Cost-sharing Reduction

The large variation in co-payments, co-insurance, and deductibles required by CSR plans may not be clear to exchange enrollees with limited income. An individual at 200% FPL (\$23,340 annually) would be eligible for an 87% AV CSR plan.^{xvi} A large portion of the 87% AV CSR plans in this analysis do not reduce cost-sharing for any prescription drugs; for example, only 39% of plans alter cost-sharing from the standard silver plan on tier four. Therefore, consumers who qualify for financial assistance could pay the same cost-sharing for a prescription drug as higher income consumers who do not qualify for such assistance. While low-income enrollees will be protected by a lower MOOP, consumers who rely on brand or specialty medications may meet a CSR plan's MOOP on the first drug fill. Consumers with limited incomes at or below 200% FPL may not have the means necessary to pay the full out-of-pocket costs to meet the cap, up to \$2,250, upon the first drug fill. For individuals with incomes 200% to 250% FPL,

the out-of-pocket cap is raised to \$5,200. A recent Kaiser Family Foundation study found that individuals from 100% to 250% FPL have an average of just \$670 in liquid assets, which means that even with a reduced OOP cap, these consumers may still face difficulty affording their cost-sharing.^{xvii}

DISCUSSION

Across all CSR plans, there is broad variation in how issuers reduce cost-sharing across benefit categories relative to the standard silver plans. Because issuers have a high level of flexibility in designing these CSR plans, cost-sharing amounts vary across services and in some cases mirror the cost-sharing in standard silver plans. Therefore, consumers with limited income have a great deal of financial incentive to review plan cost-sharing requirements given the variable application of cost-sharing reductions across services.

The large variation in how plans apply the cost-sharing reductions across covered benefits may not be clear to consumers while they are shopping and comparing plans. Exchange websites, including HealthCare.gov, may not clearly explain the different cost-sharing amounts of the qualifying CSR plans in comparison to other available plans on the exchange, and it may be difficult for consumers to understand how the reductions apply to specific services. Further, the federal government did not require issuers to create unique Summaries of Benefits and Coverage (SBCs) for CSR plans, and as a result consumers may not be able to access accurate CSR plan SBCs.

Notably, consumers with the lowest income who qualify for the highest level of financial assistance (100% to 150% FPL) could encounter some 94% AV CSR plans with cost-sharing requirements for specific services that are identical to standard silver plans. Even for CSR plan cost-sharing that is reduced, out-of-pocket costs could still serve as a barrier to accessing care. For example, among 94% AV CSR plans, the average deductible is \$217, the average coinsurance for tier four drugs is 23%, and the average MOOP is \$1,107. For an individual with income at 100% FPL (or \$970 monthly), a single high cost service or drug could be unaffordable. Patients at this income level who reach the average of \$1,107 MOOP will have spent 9.5% of their annual income on out-of-pocket costs.

Aside from states with standardized CSR plans, all regulations and guidance issued from the federal government indicate that for the 2015 plan year, issuers will continue to maintain flexibility to adapt non-uniform cost-sharing reductions in the benefit designs for CSR plans on the exchange. Consumers and stakeholders should pay close attention to plan benefits and cost-sharing to ensure they are picking the option that best meets their needs.

This research was supported by the Pharmaceutical Research and Manufacturers of America®.

NOTES

- i Annual income for a family of four at 100% FPL is \$23,850 and at 250% FPL is \$59,625, accessed at ASPE 2014 Poverty Guidelines: <http://aspe.hhs.gov/poverty/14poverty.cfm>
- ii The 34 states in the federally-facilitated marketplace include: Alaska, Alabama, Arkansas, Arizona, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Kansas, Louisiana, Maine, Michigan, Missouri, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, and Wyoming.
- iii The eligibility threshold for individuals receiving subsidies in states expanding their Medicaid programs is higher (138% FPL).
- iv ACA Sec. 1402
- v 2014 Poverty Guidelines accessed at: <http://aspe.hhs.gov/poverty/14poverty.cfm>
- vi Avalere examined the uninsured population by income from the American Community Survey for coverage in 2012, accessed at: <https://www.census.gov/acs/www/>. This data point does not take into account individuals with prior sources of insurance that may enroll into exchange plans, those with affordable offers of employer coverage, or those who may not qualify for coverage due to citizenship requirements.
- vii To date, 28 states and DC have committed to expanding Medicaid under the ACA. Nineteen of the remaining states rejected expansion for 2014 and three states (TN, UT, VA) remain undecided.
- viii *ASPE Issue Brief, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period"* accessed at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf
- ix Covered California, "Health Insurance Companies for 2014: Making the Individual Market in California Affordable," October 2013, accessed at: <https://www.coveredca.com/coverage-basics/PDFs/CC-health-plans-booklet-rev3.pdf>.
- x *HHS Notice of Benefit and Payment Parameters for 2015* released on March 11, 2014 and accessed at: <http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>
- xi "Health plan information for individuals and families," accessed at: <https://www.healthcare.gov/health-plan-information/>
- xii Ibid.
- xiii 2014 Poverty Guidelines accessed at: <http://aspe.hhs.gov/poverty/14poverty.cfm>
- xiv Note: A portion of silver plans in the HHS Landscape file indicated a zero dollar drug deductible. An examination of a subset of the Summary of Benefits and Coverage (SBC) documents from these plans confirmed that two-thirds of the sample of plans did not actually require drugs to be subject to a deductible, and the remaining third could not be validated with the data from the plan's SBC. If this rate holds true, two-thirds of the plans in the HHS Landscape file with the zero dollar drug deductible designations do, in fact, exempt drugs from the deductible, and approximately 1,360 standard silver plans are likely to have no drug deductible. Therefore, one-quarter of standard silver plans allow access to drugs without an enrollee meeting the deductible.
- xv Avalere excluded plans that noted no charge after the deductible; therefore, data will not round to 100%.
- xvi 2014 Poverty Guidelines accessed at: <http://aspe.hhs.gov/poverty/14poverty.cfm>
- xvii See Table 3 on Page 8 of the Kaiser Family Foundation, "Medical Debt among People with Health Insurance," January 2014; accessed via <http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf>

About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. We partner with stakeholders from across healthcare to help improve care delivery through better data, insights, and strategies. For more information, please contact Kelly Brantley at kbrantley@avalere.com. You can also visit us at www.avalere.com. We look forward to working with you.

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