January 14, 2016

Proposed Exchange Standardized Benefit Designs Expand First-Dollar Coverage for Services and Drugs

As the government considers rules for 2017 insurance plans offered through exchanges, a new analysis by Avalere finds that proposed 2017 benefit designs could increase coverage of certain services and drugs, while lowering out-of-pocket costs for many consumers. Specifically, in recently issued regulations, the federal government proposes establishing "standardized" benefit designs wherein all cost-sharing features (i.e. deductibles, out-of-pocket limits, etc.) are the same for plans within a metal level. While these benefit designs would be optional for plans, the government is strongly encouraging plans to sell at least one standard silver plan.

Importantly, unlike how most plans on HealthCare.gov currently elect to structure their benefits, these new, optional plan designs would provide first-dollar coverage for physician visits, and all tiers of prescription drugs in silver and gold plans. First-dollar coverage means that consumers pay cost sharing for services (i.e. copayment, coinsurance) immediately, rather than having to pay the full cost of care until meeting their deductible. While first-dollar coverage reduces overall consumer cost sharing, it may also result in higher utilization and thereby increase premiums. Health plans have largely opposed standardized benefits, which can limit consumer choice, reduce geographic variation, and constrain plans' ability to evolve benefit designs over time in response to consumer preferences.

"Standardized benefit designs might increase access to care for certain services and drugs by providing first-dollar coverage," said Caroline Pearson, senior vice president at Avalere. "In particular, first-dollar coverage may be appealing to some healthier consumers who are paying a monthly premium but never meet their deductible and therefore are not seeing the value of their insurance."

For plans sold on HealthCare.gov, silver-level exchange plans, which are the highest-enrollment plans, have routinely featured high deductibles, averaging $2,889 in 2016 (Figure 1). This means many consumers must first spend close to $3,000, in addition to their premiums, before their plan starts to share in the cost of their care. While most plans (66 percent) in 2016 cover primary care visits without requiring consumers to fulfill their deductible, specialist visits and prescription drugs typically do apply to the deductible (Figure 2). As shown below, 64 percent of silver plans cover specialist visits only after the deductible is met, and 74 percent of plans similarly subject specialty drugs to the deductible.

Notably, many state-based exchanges (CA, CT, DC, DE, MA, NY, OR, and VT) already use standardized plan designs for some or all products sold in 2016. For instance, California's plans exempt physician visits from the deductible and apply non-generic drugs to a separate, low drug deductible.

"Introducing standardized benefit designs into the federal exchange builds on the existing approach of many states," said Elizabeth Carpenter, vice president at Avalere. "While standard benefits limit flexibility for plans and could increase costs, the structure may appeal to some consumers by making it easier to compare plans and choose insurance."

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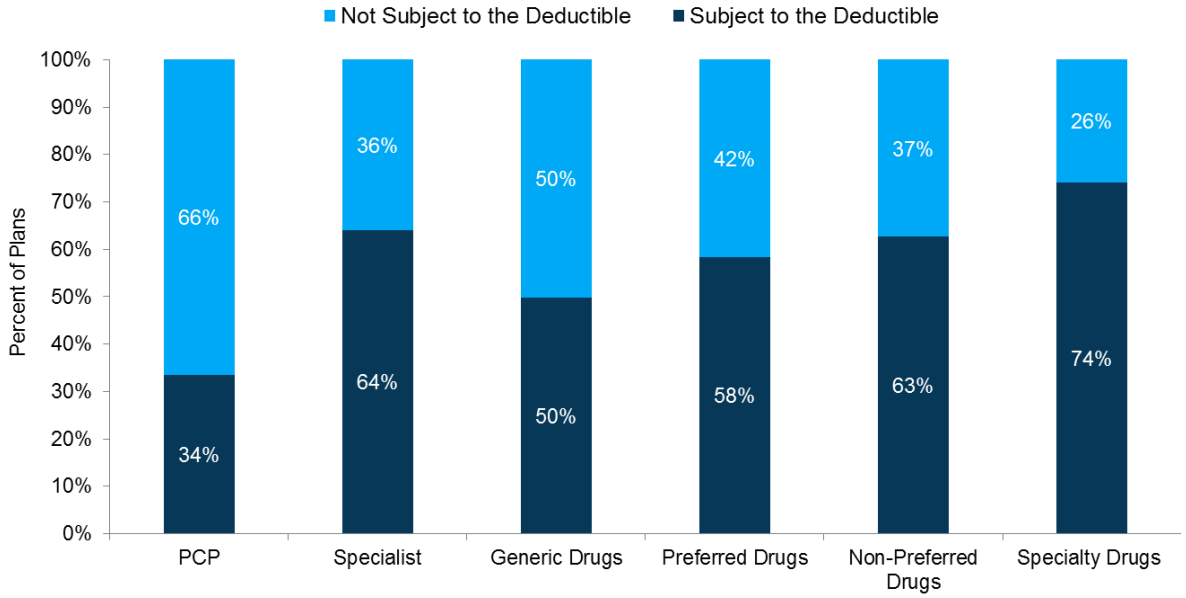
The federal government is currently working to finalize rules for the 2017 plan year, with comments on the annual Letter to Issuers due on Sunday, January 17.

Figure 1. Comparison of Average HealthCare.gov Cost-Sharing Levels (2016) to Proposed Standardized Silver Cost-Sharing (2017)[1]

	Deductible	MOOP	Primary Care Visit	Specialist Visit	Prescription Drugs			
					Generic Drugs	Preferred Drugs	Non-Preferred Drugs	Specialty Drugs
HC.gov Average (2016)	$2,889	$6,172	$27	$59	$10.60	$43.58	$73.62	31%
Proposed Silver Standard Design (2017)	$3,500	$7,150	$30 (*)	$65 (*)	$10 (*)	$50 (*)	$100 (*)	40% (*)

(*) indicates exemption from deductible
HC.gov: HealthCare.gov; MOOP: Maximum Out-of-Pocket Limit; ER: Emergency Room

Figure 2. Applicability of Benefit Categories to the Deductible in Silver Plans, 2016[2]



1 HealthCare.gov averages based on unique benefit designs included in the Individual Landscape file released October 2015.
2 HealthCare.gov plans only. Centers for Medicare & Medicaid Services. Health Insurance Marketplace Public Use Files (Marketplace PUF). November 2015. https://www.cms.gov/cciio/resources/data-resources/marketplace-puf.html.

Methodology

Data in this analysis is based on the benefit designs for 2016 exchange plans sold on HealthCare.gov, the Individual Landscape file released October 2015, and the Public Use Files released November 2015. To compare the "HC.gov Average" to the standardized benefit designs, Avalere took the average of the cost sharing for unique benefit designs by state. Cost sharing may be copayments in some plans and coinsurance in other plans. Data displayed in this release reflects the cost-sharing method (copay or coinsurance) proposed for the 2017 standard plan. For example, if the 2017 FFM standard silver benefit design includes copayments for preferred brand drugs, Avalere calculated the average of those silver plans that implemented copayments for their preferred band drugs. In all cases, the implementation of coinsurance or copays by the proposed 2017 standardized silver benefit design was the same as the majority of plans in the FFM.

The proposed 2017 standardized silver benefit design was proposed in the HHS Notice of Benefit and Payment Parameters for 2017 proposed rule. This rule has yet to be finalized and HHS has accepted comments on the proposals.

An important caveat to the analysis is that it ignores the cost of the premiums. As this proposal has not been finalized and no plans have submitted rates for these benefits designs, it is impossible to know whether the premiums for a standardized silver plan will be higher or lower than the market average, which would factor into the estimates of savings for the consumer.

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