



Covered California's Standard Benefit Plan Designs

January 2022

OVERVIEW

This PowerPoint provides a high level overview of Covered California's approach to offering Patient-Centered Standardized Benefit Designs, which it has done since 2014. The material is organized in the following four sections:

- Federal Context: Essential Health Benefits, ACA, and Covered CA Requirements
- Covered California's philosophy and approach to standardized benefits
- Covered California's experience with standardized benefits (annual process for setting cost-sharing, guiding principles, etc.)
- Consumer and market impact of standardized benefits

FEDERAL CONTEXT: ESSENTIAL HEALTH BENEFITS, ACA, AND COVERED CA REQUIREMENTS

THE AFFORDABLE CARE ACT AND THE DRIVE TO CONSUMER-CENTERED HEALTH INSURANCE

The Patient Protection and Affordable Care Act (PPACA, or ACA) includes builds on design elements that are foundational to that collectively sought to limit the flexibility of health plans to craft products and benefit designs for the purposes of maximizing their returns through risk selection rather than to enhance consumer value. These include:

- Essential Health Benefits
- Standard metal tiers based on actuarial value
- Medical Loss Ratio requirements
- Risk adjustment

Standardization of benefit designs build upon and complement these efforts.

ESSENTIAL HEALTH BENEFITS (EHBS)

The Patient Protection and Affordable Care Act (PPACA, or ACA) requires that all health insurance plans offered in the individual and small-group markets must provide a comprehensive package of items and services, known as essential health benefits (EHBs). These benefits fit into the following 10 categories:

- Ambulatory (outpatient) services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease

STANDARD METAL TIERS & ACTUARIAL VALUE (AV)

The Affordable Care Act (ACA) requires individual and small group plans to meet actuarial value (AV) requirements for four levels of coverage.

Actuarial Value (AV) = The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits.*

NOTE: The percentage is based on total average costs for a population. A single member will not pay a flat 30% in this example – it depends on their utilization and the services they use



The Department of Health and Human Services (HHS) sets the AV “de minimis” range – the range of AVs allowed at a metal level. California has put the de minimis range into law: +/- 2%.‡ For example, the 2022 Silver plan has an AV of 71.07%.

*Definition is from www.healthcare.gov

‡ Expanded de minimis range starting in 2020 for Bronze HDHPs

COVERED CALIFORNIA'S PHILOSOPHY AND APPROACH TO STANDARDIZED BENEFITS

COVERED CALIFORNIA'S BENEFIT DESIGNS

Qualified Health Plan (QHP) issuers are required to offer products using Covered California's Board-approved Standard Benefit Plan Designs per the QHP Contract.

- California law authorized the Covered California Board to standardize products offered through the Exchange.
- Issuers must offer all four metal levels of coverage using the standard plan designs and offer “mirrored” products using these benefit designs off the Exchange.
- Plan-proposed alternative benefit designs are accepted in Covered California for Small Business (CCSB), which serves employers with up to 100 employees (California expanded the definition of Small Group to include employers with 100 or fewer employees).

The Standard Benefit Plan Designs are adjusted annually to meet actuarial value (AV) requirements, clarify benefit administration, and incorporate benefit design innovations.

ECONOMIC THEORY SUPPORTING STANDARD BENEFITS

Behavioral Economics and Consumer Decision-Making

- In high-stakes decision-making, too many options can discourage action or lead to sub-optimal choices.
- Health insurance jargon and cost-sharing concepts are confusing (coinsurance, copays, deductibles, etc.)
- Understanding how these features interact and weighing them against other plan features like monthly premiums, provider networks, and quality, is challenging for the average consumer.

Market Stability

- Increased choices in an insurance market can create more opportunity for adverse selection, either directly or indirectly.³

See Abaluck & Gruber, Bhargava et al., Ericson & Starc. in Appendix.

Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act, National Association of Insurance Commissioners (2011), p. 5, <https://naic.soutronglobal.net/Portal/Public/en-GB/RecordView/Index/179>

COVERED CALIFORNIA'S GOALS IN IMPLEMENTING STANDARD BENEFITS

Covered California requires all QHPs to offer patient-centered standard benefit plan designs to achieve the following goals:

- Enhance consumers' ability to compare plans and make decisions, resulting in higher satisfaction and less anxiety.
- Provide an apples-to-apples comparison of plan products, allowing consumer choice to be based on price (premiums), networks, and quality.
- Ensure consumer affordability and access to care are considered in all plan products offered on the individual market via a transparent policymaking process.
- Foster true competition among health plans to lead to lower prices.
- Avoid adverse selection stemming from benefit design differences between issuers (i.e., using benefits to attract or deter consumers based on risk).

COVERED CALIFORNIA'S EXPERIENCE WITH STANDARDIZED BENEFITS (ANNUAL PROCESS FOR SETTING COST-SHARING, GUIDING PRINCIPLES, ETC.)

STRATEGY FOR STANDARD BENEFIT PLAN DESIGNS

Organization Goal

Covered California should have benefit designs that are standardized, promote access to care, and are easy for the consumer to understand.



Principles

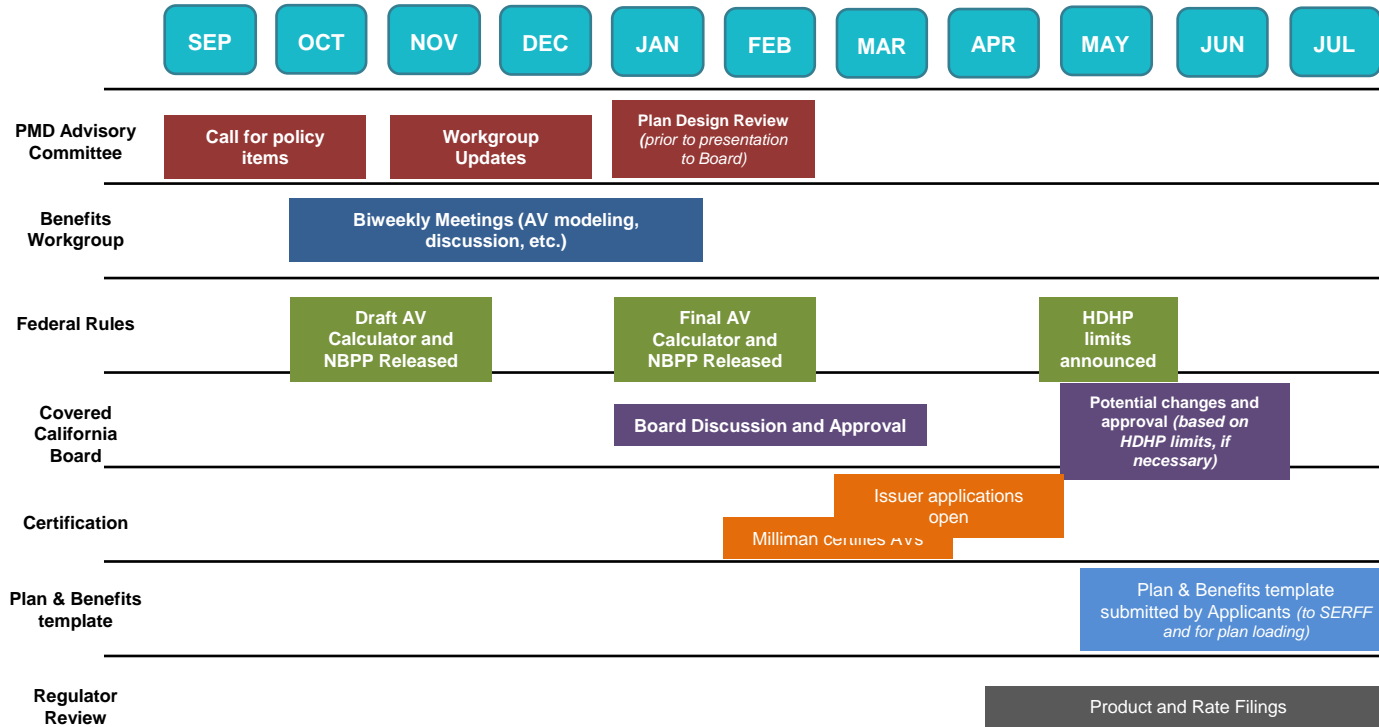
- Multi-year progressive strategy with consideration for market dynamics: changes in benefits should be considered annual based on consumer experience related to access and cost.
- Adhere to the principles of value-based insurance design by considering value and cost of clinical services.
- Set fixed copays as much as possible and utilize coinsurance for services with wide price variation to encourage members to shop for services.
- Apply a stair-step approach for setting member cost shares for a service across each metal level; e.g., in 2022, a primary care visit is \$35 in the Silver and Gold tiers, and \$15 in Platinum.

ANNUAL PROCESS FOR ASSURING INNOVATION AND UPDATING STANDARDIZING BENEFITS

The Plan Management Division (PMD) leads an annual benefit design workgroup to determine consumer cost-sharing and benefit design policies for the following plan year.

- Members and attendees from the Plan Management Advisory Group Committee, which meets monthly to discuss policy and program issues, participate in the benefits workgroup.
- Workgroup membership includes representatives from health and dental plans, consumer advocacy groups, and state regulators.
- The workgroup meets for 5-6 meetings starting in the fall (when the draft Notice of Benefit and Payment Parameters and AV Calculator are released).
- The workgroup and the broader Plan Management Advisory Group Committee advise PMD on benefit design changes before the plan designs go the Board for approval in March.

ANNUAL CYCLE OF STANDARD BENEFITS



STANDARDIZATION INCLUDES THE FLEXIBILITY AND THE OPPORTUNITY FOR INNOVATION

Since 2014, Covered California has provided a process for issuers to propose alternative plan designs.

- In the past eight years, only two proposals were submitted, and both were withdrawn after careful consideration of the pros and cons.
- However, Covered California brainstorms actively with QHP Issuers to pursue innovative new designs, such as proposals involving Value-Based Insurance Design (VBID)

Standard benefit designs allows for variation and innovation on the part of QHP issuers' consumer incentive programs. QHP issuers' programs vary with the following guardrails:

- They must demonstrate that they are focused on closing gaps in care, promote and encourage utilization of high-value services, and promote healthy behaviors.
- Information about consumer incentives used to promote health behaviors, however, cannot be used as marketing inducement for enrollee recruitment and can only be promoted to existing enrollees.

CALIFORNIA'S APPROACH TO COST SHARING IN STANDARD BENEFIT PLAN DESIGNS

Covered California plan designs are distinguished by several key approaches to member cost-sharing to ensure the right care at the right time:

Deductibles and Member Cost Shares

- Platinum and Gold plans do not have a deductible.
- In the Silver plan, all office visits, labs, emergency room visits, and x-rays are NOT subject to the medical deductible. Only inpatient admissions and skilled nursing facilities are subject to the medical deductible.
- In the Bronze plan, the first three office visits are NOT subject to the deductible, and the member pays a flat-dollar copay. At the fourth visit, the member pays the full cost until the deductible is met.

Maximum Out-of-Pocket (MOOP) Limits

- All member cost-sharing, excluding premiums, is subject to a MOOP limit for in-network services. In 2022, the individual MOOP ranges from \$800 to \$8,200, depending on metal tier.

CALIFORNIA'S APPROACH TO COST SHARING IN STANDARD BENEFIT PLAN DESIGNS

Covered California plan designs are distinguished by several key approaches to member cost-sharing to ensure the right care at the right time:

Drugs

- All drugs, including specialty drugs, are capped at a maximum amount per 30-day script (\$150/ \$250/ \$500). This means a consumer will not pay thousands of dollars for a single script in any given month.
- In Silver and Bronze, drugs are subject to a separate deductible that is much lower than the medical deductible.

Primary and Emergency Care

- Primary care copays are lower than specialist visit copays.
- Urgent care copays are set at the same amount as a primary care visit.
- Lab tests are not subject to any deductible in any plan (except Health Savings Account (HSA)-eligible High-Deductible Health Plans (HDHPs)).



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.

CONSUMER AND MARKET IMPACT OF STANDARDIZED BENEFITS

MARKET IMPACT OF STANDARDIZED BENEFITS

Market Impacts of Standard Benefit Designs

- Streamlines evaluation of health plan bids (i.e., simplifies review of complex rate filings and provides clarity of what drives premium differences).
- Potentially contribute to a better risk mix (i.e., patient-centered designs do not have deductibles on most services and thus deductibles are rarely an impediment to getting needed routine care)
- Potential driver of enrollment (easier for consumers to understand products).
- Potential driver of lower prices as QHPs must compete on core market elements that consumers understand and value (i.e., network composition and premium)

TALE OF THREE CITIES & THE DANGER OF CHOICE OVERLOAD

In 2021, Los Angeles had nine unique Silver 70 plans available to consumers, whereas consumers in Miami and Houston faced 46 and 25 different Silver options, respectively. Because of standard benefit designs, consumers in LA face a more limited set of factors in making plan choice, whereas Miami and Houston consumers must also consider varying deductibles, MOOPs, and copays.

	Los Angeles, CA	Miami, FL	Houston, TX
Number of Carriers	7	6	6
Number of Unique Silver 70 Plans	9	46	25
Median Number of Plans per Carrier	1	7	4
Monthly Gross Premium*	\$266 - \$358	\$365 - \$806	\$312 - \$476
Integrated	N/A	\$2,750 - \$8,450	\$1,250 - \$8,550
Deductibles			
Medical	\$4,000	\$0 - \$6,200	\$0
Drug	\$300	\$0 - \$4,000	\$0 - \$4,000
Maximum Out-of-Pocket	\$8,200	\$4,800 - \$8,550	\$4,800 - \$8,550
Projected share of Silver 70 enrollment at bottom of de minimis range**	0%	31%	28%

*Gross premiums are for a 27-year-old individual. LA premiums are from Region 15.

**Represents projected share of Silver 70 enrollees who are enrolled in a plan with an AV under 67%, using projected enrollee member months from 2021 URRT files.

Sources: 2021 HIX Compare for plan attributes, and 2021 URRT filings for AV and projected enrollment.

CONSUMER IMPACT OF STANDARDIZED BENEFITS

Consumer Impact of Standardized Benefit Plan Designs

- Lower exposure to deductibles and other cost-sharing compared consumers in other states.
- Consumers choosing the right plan for their health needs (risk scores are higher for individuals enrolled in plans with higher actuarial value)
- Improved customer satisfaction.
- Consumers in all plan tiers see value by having the opportunity to get some services (e.g., PCP services) without high deductibles.

IMPACT OF STANDARD BENEFIT DESIGNS – COVERED CALIFORNIA CLAIMS DATA

Few medical claims in the Silver tier have deductible amount greater than \$0, although the share increases to 17% of medical claims in Bronze.

	Bronze	Silver
Medical claims that show deductible greater than \$0	17%	0.4%
Drug scripts that show deductible greater than \$0	72%	18%
Office visits with deductible greater than \$0	34%	0.5%

Source: Covered California claims database, aggregated by IBM, from plan year 2019. Totals omit data from certain QHP issuers as Covered California works to improve data quality.

HIGH DEDUCTIBLES AND THEIR IMPACT ON CARE SEEKING BEHAVIOR

- However, Covered California's claims data only show what we know about those who accessed coverage.
- By designing plans that exclude services from the deductibles that results in a high deductible amount, which only applies to inpatient admissions, two groups are missing from the data that may be harmed by this approach:
 - Consumers who deferred care because of perceived high deductibles (even if care wouldn't have been subject to it)
 - Consumers who don't take up coverage because of perceived low plan value with a high dollar deductible.

NEED FOR FURTHER RESEARCH – LEARNING WHAT WORKS BEST FOR CONSUMERS

The academic literature is clear about the value of informed competition and the dangers to consumers of choice overload. More research, however, is needed to inform the best possible development of standardized designs, including on subject such as:

- How to effectively communicate when some services are not subject to a deductible while other are;
- The value of competition in promoting lower prices through higher MLRs and lower plan profits;
- What specific structures of standard designs lead to the highest value and lowest barriers to accessing care for consumers.

RESEARCH APPENDIX

For a complete literature review, please see [“Implications of Different Approaches to Offering Standard or Non-Standard Benefit Designs.”](#)

Abaluck J, Gruber J. [Less Is More: Improving Choices by Limiting Choices in Health Insurance Markets](#). NBER Working Paper. 2019.

- In a study among Oregon school district employees, the foregone savings from not choosing the best plan available to employees fell from an average of \$1,118 when facing seven plan choices to \$352 in foregone savings when choosing among two plans. However, authors demonstrate that enrollees are not necessarily better at choosing an optimal plan among a limited plan choice set, but that larger plan choice sets feature worse plan choice options.

Bhargava S, Lowenstein G, Sydnor J. [Choose to Lose: Health Plan Choices from a Menu with Dominated Option](#). The Quarterly Journal of Economics. 2017; 132(3):1319-72.

- In a study of large-firm employees, when faced from a menu of health plan options that differed only in cost-sharing and premium, the majority of enrollees chose plans that were financially dominated, leading to excess spending. Authors conclude that the choice of dominated plans is mainly driven by individuals’ lack of understanding of health insurance.

Ericson KMM, Starc A. [How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange](#). Journal of Health Economics. 2016; 50:71-85.

- In Massachusetts, which introduced standard benefit design to its individual marketplace prior the passage of the Affordable Care Act, consumers ended up in plans with higher actuarial value and lower out-of-pocket costs, when compared to plan selection prior to standardization

Handel BR, Kolstad JT. [Health Insurance for “Humans”: Information Frictions, Plan Choice, and Consumer Welfare](#). American Economic Review. 2015; 105(8):2449-2500.

- Using a combination of administrative and survey data from individuals enrolled in a large employer health plan, authors find that individuals make suboptimal health insurance decisions due to information gaps and plan complexity.