



Standardized Benefit Plans: A Tool for Consumers?

National Academy for State Health Policy

Thursday, February 18, 2015

2:30 – 4:00 PM ET

Call-in # 1-877-717-9270

Presented with support from PhRMA

Webinar Agenda

2:30 p.m.	Introduction Kevin Lucia , Georgetown University Health Policy Institute
2:35-2:45 p.m.	Overview of Proposed Rule on Standardized Plans Sarabeth Zemel , NASHP
2:45–3:30 p.m.	Conversation on Standardized Plans <u>Moderator:</u> <ul style="list-style-type: none">• Kevin Lucia, Georgetown <u>Panelists:</u> <ul style="list-style-type: none">• Heather Cloran, Massachusetts Health Connector• M. Christopher Roebuck, RxEconomics• Wardell Sanders, New Jersey Association of Health Plans
3:30–4:00 p.m.	Question and Answer All Panelists and JoAnn Volk , Georgetown University Health Policy Institute <i>*Use the chat feature to submit your questions</i>
4:00 p.m.	Wrap-up

What are Standardized Benefit Plans?

- Health plans that have standardized (defined or identical) cost-sharing for covered health services
- All insurers who sell in the marketplace are required to offer standardized plans
- State-based marketplaces (SBMs) are not required to offer standardized plans, but many do, including:
 - California
 - Connecticut
 - Massachusetts
 - New York
 - Oregon
 - Vermont
 - Washington, DC

Proposed Rule's Rationale

- Experience in FFMs has shown that many consumers find the high number of plans and variety of cost sharing structures “difficult to navigate”
- Research from Medicare Advantage, Part D and Medigap plans has shown that an excessive number of health plan options results in consumers being:
 - Less likely to make any plan selection
 - More likely to make selection that won't match health needs
 - More likely to make selection that leads them to be less satisfied

Rationale cont'd.

- Standardized plans will allow consumers to focus on provider network, premiums, benefits and quality, and not have to make complex tradeoffs among cost sharing differences in a large number of plans

What Does Proposed Rule Say?

- Noting that ACA grants marketplaces “considerable flexibility” in certification and oversight of QHPs HHS proposes standardized plan options for 2017 in FFMs
 - To be offered at bronze, silver and gold levels, including all 3 cost sharing variations of silver plan
 - None to be offered at platinum level because “only a small proportion of QHP issuers in FFMs offered platinum plans in 2015

Proposed Rule's Approach

- To minimize market disruption, options are drawn from most popular plans in FFMs and from current SBM approaches
- Specific design elements focused on
 - Provider tiers: Single in-network provider tier
 - Drug formularies: no more than 4 tiers (generic, preferred brand, non-preferred brand and specialty tier)
 - standard copayments and coinsurance
 - deductible-exempt services

Approach cont'd.

- Standardized options would not vary across states
- Issuers may offer multiple standardized options within a service area, although must be meaningfully different (HMO v. PPO)
- Issuers encouraged (specifically at the “silver” level, in order to simplify for the greatest number of enrollees) but *not required* to offer standardized options

Other Aspects of Proposal

- Issuers would retain flexibility to offer non-standardized plans; however, HHS *may consider* limiting the number of plan options in future plan years
- Considering displaying in a way to readily allow consumers to identify standardized options

How are SBMs Offering Standardized Plans?

- **California**

- Does not allow non-standard plans in the individual marketplace.
- Plans exempt physician visits from the deductible; limits out-of-pocket costs for high-cost prescription drugs; minimizes use of co-insurance; low copays for primary care visits and generic drugs

- **Washington, DC**

- Standard silver and bronze plans exempt some services from deductible
- Separate deductible for prescription drugs
- Lower copays for primary care and generic drugs

Conversation on Standardized Plans

Moderator: Kevin Lucia

Research Professor
Georgetown University Health Policy Institute

Heather Cloran

Associate Director of Programs & Product Strategy
Massachusetts Health Connector

M. Christopher Roebuck

President & CEO
RxEconomics

Wardell Sanders

Former Executive Director, New Jersey Individual Health Coverage
Program Board and New Jersey Small Employer Health Benefits
Program Board
Current President, New Jersey Association of Health Plans

Can you describe the history and development of offering standardized benefit plans in your state?

New Jersey – History of Standardized Plans

- **Origins:** Standardization part of Governor Florio's 1992 individual and small group market reforms (including guarantee issue, guarantee renewal, rate factor and rate band limitations, pre-x limits, MLR standards) – in some ways a first draft of the ACA
- **Mission:** Stakeholder Boards develop 5 standard plans – a basic plan; and 4 comprehensive plans of “progressively greater actuarial values.”

New Jersey – History of Standardized Plans

- **Goals:** Make comparison shopping easier for consumers; focus competition on something other than plan design; remove perception of “hidden exclusions.”
- **Initial Execution:**
 - Review of existing products; stakeholder input; promulgated as regulations
 - Plan A: 30-day hospitalization plan (aim for \$ a day)
 - Plans B through E: comprehensive medical plans covering the same medical and hospital services, but at different rates of coinsurance. Plan B has a 60 percent coinsurance rate, Plan C 70 percent, Plan D 80 percent, and Plan E 90 percent.

Massachusetts

- Origin: Chapter 58 of the Acts of 2006 instituted health care reform creating the Health Connector in 2006
- Beginning July 1, 2007 6 carriers were approved to sell a total of 42 plans
- Plans were minimally standardized at inception, but increased standardization was introduced in 2010 based on consumer feedback

Can you describe your state's framework for offering standardized plans today and how has it evolved over time?

New Jersey – Framework and Evolution

- **1992 laws:** 5 standard plans; no non-standard plans; no riders; forced conversion
- **1994 amendments:** Grandfathering of pre-reform plans; small group riders of increasing and decreasing value.
- **2001 amendments:** Added a new individual market limited benefits plan called “Basic and Essential”
- **2009 amendments:** Reduced required plan options from 5 to 3; allows individual market riders of increasing value.

New Jersey – Framework and Evolution

- **Cost sharing:** Originally prescribed options then moved to permissible ranges of cost-sharing to allow carriers to reach price points desired by consumers; all subject to state's minimum benefit limitations (e.g., maximum deductible of \$2500).
- **Variable text:** Allows for variations in cost-sharing and terminology variation.
- **Rider examples:** Altering cost-sharing; adult vision; limitations on ED drugs; Rx changes like vacation overrides.
- **Value-based provision:** Specialty case management provision allows for coverage flexibility for disease states.

Massachusetts

- Although the Health Connector's product strategy has evolved since inception in 2006, the core goal of the product shelf remains to provide consumers high value plans, a user friendly shopping experience, and encourage carrier innovation
- The Seal of Approval Process, comparable to the ACA plan certification, has been used since 2006 to engaged the market and refresh policy goals each year
 - Plans were developed with input and engagement from consumers, carriers, and other stakeholders
 - The Health Connector standardizes 9 of the most commonly utilized benefits and permits cost-sharing flexibility on other benefits

Massachusetts

- In 2013, the Health Connector invited carriers to provide non-standard plan designs and standard plans on narrower networks in the hopes of fostering plan innovation
- The Health Connector encourages carriers to freeze plans to new membership, rather than discontinue them entirely, in order to minimize member disruption

How does plan design affect consumer utilization of health care services?

Plan Design = Cost-Sharing

- There are many elements of plan design, but it's largely about cost-sharing
- Not just sharing cost burden, but optimizing efficient healthcare use
 - More generous coverage may induce moral hazard and overuse of services
 - Less generous coverage decreases risk protection and may prompt underuse
- RAND Health Insurance Experiment (HIE) concluded the sweet spot was \$200 individual deductible; 25% coinsurance; \$1500 stop-loss (in 1983\$)
- These levels are less relevant today due to health care cost inflation, as well as advances in prevention and treatment since the 1970s
- To “get it right”, we need to measure with precision
 - How members respond to cost-sharing (i.e., elasticity of demand)
 - Economic costs and benefits of specific health services

References

Manning, W.G., J.P. Newhouse, N. Duan, E.B. Keeler, A. Leibowitz, and M.S. Marquis. 1987. “Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment.” *American Economic Review* 77(3): 251-277.

Newhouse, J.P. and the Insurance Experiment Group. 1993. “Free for All? Lessons from the RAND Health Insurance Experiment.” Cambridge, MA: Harvard University Press.



Deductibles and CDHP

- Consumer-Directed Health Plans (CDHP) with Health Savings Accounts are intended to promote more efficient use of health services
- Much research suggests deductibles are blunt tools
- In a series of 5 papers, the Employee Benefit Research Institute studied a large employer that replaced all of its plans with a CDHP
- The new \$2150/\$4300 deductible was associated with
 - Lower total healthcare costs (-25% after 1 year; -6% after 4 years)
 - Persistent decreases in the number of physician visits
 - Fewer prescriptions filled, which was linked to worsening medication adherence for hypertension, dyslipidemia, diabetes, and depression
 - A slight (but significant) increase in emergency department visits
 - Marked reductions in quality measures, such as lower likelihoods of receiving breast, cervical, and colorectal cancer screenings

References

Fronstin, P., M-J. Sepulveda, and M.C. Roebuck. 2013. "Consumer-Directed Health Plans Reduce the Long-Term Use of Outpatient Physician Visits and Prescription Drugs." *Health Affairs* 32(6): 1126-1134.

Fronstin, P., M-J. Sepulveda, and M.C. Roebuck. 2013. "Medication Utilization and Adherence in a Health Savings Account-Eligible Plan." *American Journal of Managed Care* 19(12): e400-e407.

And other publications available at www.EBRI.org.



Copays and VBID

- RAND HIE estimated price elasticity of demand to be -0.17 for both inpatient and outpatient services
- Prescription drug copay elasticities vary by therapeutic class from -0.03 to -0.21
- A large body of literature recognizes the value of medication adherence in chronic disease, and medical cost offsets from prescription drug utilization
 - In 2012, the Congressional Budget Office changed its methodology for estimating the impact of legislation affecting prescription drug utilization among Medicare beneficiaries. CBO now assumes that a 1.0% increase in the number of prescriptions filled will cause a 0.2% decrease in spending on other medical services
- Value-Based Insurance Design (VBID) has been offered as a solution to encourage optimal use of high-value services by reducing or eliminating copays, but the math may not always work out

References

Roebuck, M.C. Dissertation. "Price Elasticity of Demand for Prescription Drugs: Therapeutic Class-Specific Estimates and Implications for Value-Based Insurance Design." RxEconomics LLC.

Congressional Budget Office. "Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services." Washington, DC: CBO; 2012 [cited 2013 March 23]. Available from:

<http://www.cbo.gov/sites/default/files/cbofiles/attachments/43741-MedicalOffsets-11-29-12.pdf>.

VBID Example

- An employer is considering VBID: Free (100% reduction in copays) ARBs for all hypertension patients because 50% of its patients are non-adherent
- The plan sponsor will lose \$180 in copays per patient per year
 - \$0.65 per day; \$240 for fully adherent; \$120 for partially adherent; averaged
- They will gain \$3,908 in annual medical cost offsets for each new adherent
- Assuming adherence maps to utilization, how price elastic must ARB demand be for plan to break even?
- Answer: at least **-0.092** ($-\$180 \div \$3908 \div 0.50$)
- Estimate of ARBs elasticity
 - **-0.071** intensive margin
- All else equal, this plan sponsor would not adopt this VBID policy, but it's a close call highly dependent on the equation inputs

References

Roebuck, M.C. Dissertation. "Price Elasticity of Demand for Prescription Drugs: Therapeutic Class-Specific Estimates and Implications for Value-Based Insurance Design." RxEconomics LLC.

Roebuck, M.C., J.N. Liberman, M. Gemmill-Toyama, and T.A. Brennan. 2011. "Medication Adherence Leads to Lower Health Care Use and Costs Despite Increased Drug Spending." *Health Affairs* 30(1):91-99.

Implications for Standardized Benefit Plans

- Standardized Benefit Plans are designed to simplify choice
- But, flexibility in cost-sharing structure is still important to maintain
- Yet, the most efficient plan design may be too complex
- Deductibles are made less blunt by exempting preventive services, but members must also be educated
- Exactly what can be excluded from the deductible is up to the IRS

Proposed Rule's Approach

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*Has offering standardized plans
simplified plan choice in your state?
What do you see as the benefits of
standardized benefit plans in your
state?*

Massachusetts

- Consumers are able to compare the same set of standardized benefits across carriers in the shopping experience
- Standardization allows for the Health Connector to control consumer cost sharing and benefit simplicity
 - Since the advent of the Federal AV calculator, the Health Connector has standardized plans the on the higher end of the AV value

New Jersey – Perceived Benefits of Standardization

Pre-ACA: Riders made it a true hybrid model. To relieve rigid plan choices, there are lots of nonstandard options.

- **Shopping:** In theory, standardization was to make shopping easier. However, the need for flexibility and riders made true comparison shopping difficult.
- **State Guidance:** Standardized contract language made it easier for State officials to provide guidance to consumers on contract coverage.
- **Carrier compliance:** Carrier's did not need to submit true form filings, but rather a certification of compliance with the standardized contracts.
- **Brokers:** Standardized contracts simplified the work of brokers, who had to educate themselves on one standard set of forms.

What have been some drawbacks to, or where has there been pushback on, standardized plans?

Massachusetts– Perceived Drawbacks of Standardization

- In 2010, there was been some moderate carrier pushback with plan standardization. A few carriers felt it impeded innovation.
 - To combat this fear, the Health Connector mixes standardization and non-standard plan design on the product shelf
 - For 2016, the Health Connector invited carriers to develop bronze plans

Massachusetts– Perceived Drawbacks of Standardization

- The Federal AV Calculator has caused some constraints in plan design

New Jersey – Perceived Drawbacks of Standardization

- **National models:** National carriers like common platforms
- **Politics:** Political pushback of “government mandated” coverage requirements
- **AV constraints:** NJ regulations of standard plans left it nearly impossible to get to a Bronze plan (e.g., \$2500 max deductible)
- **Nimbleness:** Standardized contracts set through regulation may be slow to change. NJ has special rulemaking standards for these contracts
- **Innovation:** Standardization makes innovation more difficult
- **Change is hard:** Example of NJ of out-of-network payment levels and unlimited home health care – difficult to change original provisions even if the markets are outliers

In your state, are issuers required to offer standardized products? Why did you take that approach?

Q&A Discussion

Use the chat box on the left of your screen to type in your question.



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