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Draft, for policy discussion

Background Analysis

Plan Offerings and Benefit Standardization

February 2013

Introduction

The Affordable Care Act (ACA) imposes a certain amount of standardization by mandating that each plan cover a set of benefits, known as Essential Health Benefits (EHB), and by establishing categories of "actuarial equivalence" among QHPs -- the four "metal" tiers (bronze, silver, gold, platinum) plus catastrophic coverage. In addition, standardizing cost-sharing across qualified health plans (QHPs) offered on the Exchange may make it easier for consumers to compare health plans and ultimately purchase the plan best suited to meet their health coverage needs.

Would the standardization of cost sharing (co-pays, co-insurance, deductibles, and maximum out of pocket expenses) reduce confusion and allow consumers to make better "apples-to-apples" comparisons among plans? Conventional wisdom and classical economics suggest that more choice is better for consumers. However, behavioral economics and applied psychology suggest that consumers can be overwhelmed by too much choice.[i] In particular, consumers dislike shopping for health insurance and find it hard to understand insurance jargon, let alone compare differences in cost-sharing details and hold these differences in their heads as they sort through options. This report summarizes the relevant literature on consumer choice, provides the experience of other health insurance Exchanges with choice, and describes how other State Exchanges established under the ACA are approaching standardization.

Standardization and the Affordable Care Act

QHPs will be designed and offered in the D.C. Exchange at overall levels of coverage prescribed by the ACA. The ACA does this by setting four different "actuarial values" for non-grandfathered health plans in the non-group and small-group market(s). Actuarial value is defined as the portion of the total medical expenses that the carrier will be responsible for paying, i.e. for a Bronze plan with 60% AV, on average the carrier is responsible for 60% of the total medical expenses expected for a typical commercial

population. The member is responsible for the remaining 40%, known as cost-sharing. Therefore, the higher the AV of a plan, the less out-of-pocket expenses the member will have to pay for cost-sharing. These categories of AV are commonly referred to as metal tiers or levels , which can vary +/-two percentage points from the following values:

Bronze	Silver	Gold	Platinum
(60% AV)	(70% AV)	(80% AV)	(90% AV)

While the metal levels establish a rough equivalence among QHPs in overall value or richness of coverage, carriers can mix and match different levels of co-payments, co-insurance, annual deductibles, and maximum out-of-pocket expenditures to achieve a given actuarial value. As a result, carriers can design numerous plan variations within a metal tier using different cost-sharing features. For example, a high annual deductible combined with a relatively low coinsurance level can achieve the same actuarial value as a low deductible combined with relatively high coinsurance. Varying service-specific coinsurance and copayments generates an almost limitless set of actuarially equivalent plan designs.

Consumer Choice Dynamics and the Number of QHPs Offered on the Exchange

Research into consumer choice, with particular reference to health insurance, strongly suggests the need to simplify choice. Otherwise, in the face of complex choices, consumers can be overwhelmed and tend to resort to familiar concepts that make the decision easier, often sacrificing thoroughness and ending up with a plan that may not be in their best interest. A second problem occurs when people struggle to discern any difference across their available choices. Options may vary in ways that are hard for consumers to understand or evaluate, or differences may be inconsequential even if they are being marketed as substantial. [ii]

By and large, consumers do not enjoy shopping for health insurance. (This is a "grudge buy," sorting through complex financial arrangements to protect self and family, rather than "playing" with a consumer good or service that generates pleasure.) Studies on consumer decision-making regarding health insurance have shown that the primary objective of consumers is to exert the least amount of cognitive effort in order to reach a quality decision.[iii] For example, a study for the California HealthCare Foundation found that, "too many choices can lead to an inability to make decisions; people experience a kind of decision overload where they become incapable of acting upon any information."[iv]

Recent consumer testing by Consumers Union (the advocacy and policy arm of *Consumer Reports*) confirms the widely held perception that people struggle to understand their health insurance choices.[v] Consumers Union conducted three studies between September 2010 and May 2011 to explore consumer understanding of health insurance. They found that consumers are challenged to assess the "value" of health plans and need a "manageable" number of choices. Consumer Union also found that consumers do not necessarily want the cheapest plan, but instead want the plan that has the best value they can afford. In addition, it was determined that cost-sharing terms created the greatest source of confusion. Confusing cost-sharing terms may cause consumers to misconstrue a plan's actual out-of-pocket expenses and they may choose a plan that does not meet their value or affordability standards.

During the Consumer Union studies, participants were typically asked to compare just two health plans at a time. Most struggled with this exercise due to a large number of variables and differences across the two plans. The author concluded that making a decision amongst a large number of choices with multiple differences across plans is beyond the cognitive ability of many people. Research performed by the Pacific Business Group on Health confirms this conclusion: a greater number of choices demands more time and effort by consumers, and one study showed that increasing from two plan options to three reduced the likelihood that consumers make the "right choice" for the health coverage needs.[vi] One recommendation Consumers Union makes to improve customers' choice and decision-making abilities is to increase the standardization of health plan designs.

Previous developments in the Medicare market also show the effect of minimal standardization on consumer choice dynamics. Following the introduction of Medicare Part D (prescription drug coverage) in 2006, the number of Medicare Advantage plans offered (and variations across plans) increased, including variations in premiums, cost-sharing, extra benefits, and provider networks[vii]. The Centers for Medicare and Medicaid Services (CMS) was concerned that the large number of available plans and variations overwhelmed some beneficiaries. In 2009, CMS implemented new rules that encouraged a reduction in low enrollment and duplicative plans and as a result the number of Medicare Advantage plans decreased by about a third. [viii] Prior to this decrease, a 2007 Kaiser Family Foundation study found that nearly all States had 50 stand-alone drug plans to choose from, and when combined with Medicare managed care plans, seniors often faced over 100 choices for drug coverage. [ix] Studies on this increase in the number of Medicare plans offered have shown that decision quality deteriorated as the number of plans increased.[x] Interestingly, due to the complex variations across plans, even educated physicians had trouble choosing the highest overall value Medicare Part D plan for their patients.[xi]

Experience from the Massachusetts Health Connector provides further insight into the effect that standardization (or lack of standardization) has on consumer decisions. The Connector's Commonwealth Choice program had originally (2007) solicited plans that each carrier designed to reach an overall actuarial value, and as a consequence plans of similar AV offered different deductibles, copayments and coinsurance levels. User focus groups conducted by the Connector in 2009 discovered considerable confusion among enrollees about the different plan options. Consumers had trouble translating and giving full credence to the concept of "actuarial equivalence" across a metal tier level. Ironically, many thought the most expensive premiums among actuarially equivalent plans indicated the richest coverage. As a result, price was sometimes being interpreted as a proxy for coverage and even quality, instead of simply a measure of cost.

Interestingly, results from a survey of Connector enrollees conducted about the same time, and published in January 2013, quantify the same general findings.[xii] During enrollment, 42 percent of respondents thought the information presented on the Connector site was difficult to understand, and 28 percent believed that choosing a plan would have been easier with fewer plan options. After enrollment, 23 percent of respondents thought the benefits of their plan were hard to understand and 45 percent stated that their out-of-pocket expenses were higher than originally expected.

Consumers in the focus groups told the Connector that they wanted "apples-to-apples" comparisons. They wondered why similar benefits were not offered across plans on the same actuarial tier, so that price for the same coverage could be compared more easily. In response to these findings, the Health Connector selected the most popular plans already being offered on the Exchange, based on enrollment and "meaningful differences" in cost-sharing designs. The selection resulted in three Bronze plan designs, three Silver plan designs, and one Gold plan. (Subsequently, the Connector has reduced the number of Silver plan designs to two.) The Health Connector then solicited bids for all seven plan designs from all eight carriers, so that every carrier offered the same seven benefit designs. As a result, consumers were first able to select the cost-sharing design of their choice, and then focus on a comparison of price, brand, and network across carriers.

Pros and Cons of Standardization

The research cited above clearly demonstrates that reducing the number of different plan designs on each actuarial tier to a "manageable level" decreases consumer confusion, allowing the consumer to effectively compare plans and choose one that meets her coverage needs. In addition, standardization's effect on minimizing confusion may reduce administrative burden for the Exchange and issuers by decreasing the number of inquiries and complaints made by consumers. However, exactly what a "manageable" number of plan designs is, let alone how to determine which ones the Exchange should prescribe is far from obvious.

The literature on health plan choice also tends to ignore or minimize the negative implications of limiting the number of QHPs available from each issuer and prescribing their cost-sharing. First, prescription of designs will pre-empt carrier- or purchaser-driven innovation. For example, in a prescribed choice environment, it is doubtful that an Exchange would have developed and imposed on employers and insurers 3-tier Rx formularies in the 1990's, when they were being introduced and adopted gradually by private initiatives? Similarly, account-based health plans might never have been developed had exchanges prescribed plan designs in the last decade. If the Exchange is the only market in DC, the impact of standardization of plan design on blocking innovation is even more acute than in other jurisdictions where there will be non-Exchange options.

Second, to implement standardization, the Exchange will be required to develop criteria for the number of plans a carrier can offer and the specific allowed cost-sharing designs. These may be seen as arbitrary and may ignore incipient market trends. The entire burden of explaining to small employers why their choices are now so limited will fall on the Exchange.

Third, exceptions to standardized cost-sharing for "systems issues" may be required and must then be evaluated to ensure they meet the Exchange's standardization criteria and are not unfair to competitors. For example, were the Exchange to require coinsurance for some services, Kaiser might not be able to comply because it does not pay externally-generated claims, but uses copayments instead for point-of-service cost-sharing. This places administrative burdens on both the Exchange and particular carriers.

Fourth, a negative aspect of standardization specifically for small employers is that they often increase cost-sharing year-to-year, as an alternative to, or a way of dampening premium increases. So, allowing more flexibility and more QHP options in SHOP than the individual market may be desirable. Of course, with the small-group and non-group markets merged and SHOP the only option for small employers in D.C., the need for variation is all the greater, but it will affect the non-group options as well.

The following list summarizes the potential benefits and downsides of standardization:

PROs of Standardization	*CONs of Standardization*
• Reduces consumer confusion. Consumers can more effectively compare plans and choose one that meets their coverage needs • Increase overall consumer satisfaction with health plans and the Exchange • Reduce administrative burden due to fewer inquiries or complaints by consumers to the Exchange and carriers	• Exchange has the responsibility to pick standardized plan designs and has to develop a methodology to do so. This is an administrative burden, which can seem arbitrary • Does not account for carrier-specific ways of operating and may impose undue burdens on particular health plans • May restrict employers in adjusting year-to-year to premium increases • May reduce health plans' ability to be innovative, to test innovations in the market, and to introduce them gradually

Standardization Decisions of State-based Exchanges

Most states implementing state-based Exchanges have grappled with the issue of standardization. Virtually all of the 12 states we have examined are limiting the number of plans offered on their Exchanges and half of them have decided to standardize cost-sharing designs to some extent. The table below shows the standardization decisions State-based Exchanges have made in relation to cost-sharing designs.

Exchange requires that all or some QHPs have standardized, prescribed cost-sharing designs	Exchange will NOT require standard cost-sharing designs, but allows issuers to propose their own designs that meet AV requirements
1. Massachusetts 2. California 3. Oregon 4. New York 5. Connecticut 6. Vermont	1. Washington 2. Colorado 3. Minnesota 4. Maryland

Among states which are requiring some standardization, most are still allowing issuers to offer some unique plan designs, in addition to the standardized design requirements. Including the states which have settled on a "hybrid" approach, which prescribes some plans and allows issuers to propose others

of their own design, the majority of states are allowing issuers to propose unique designs. This approach may generate a further issue: should issuers proposing unique designs be required to demonstrate "meaningful differences" among the plan designs and, if so, how to define "meaningful difference"?

Maryland deserves special attention, due to its close proximity to Washington DC and overlapping health insurance market factors. Based on current information, Maryland is not requiring cost-sharing standardization, but may place a limitation on the number of plans carriers can offer. A detailed examination of Maryland's standardization policies may be appropriate, if the DC Health Benefits Exchange wishes to make standardization decisions based on Maryland's approach, or to take it into account in making its own decisions.

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[i] Payne, J.W.; Bettman, J.R.; Johnson, E.J. *"The Adaptive Decision Maker"*. Cambridge University Press, May 1993

[ii] Shaller, Dale. "Consumers in Health Care: The Burden of Choice". California HealthCare Foundation. October, 2005.

[iii] Payne, J.W.; Bettman, J.R.; Johnson, E.J. "*The Adaptive Decision Maker".* Cambridge University Press, May 1993.

[iv] Shaller, Dale. "Consumers in Health Care: The Burden of Choice". California HealthCare Foundation. October, 2005.

[v] "*What's Behind the Door: Consumers' Difficulties Selecting Health Plans".* Health Policy Brief. January 2012. www.consumersunion.org.

[vi] Von Glahn, Ted. "Consumer Choice of Health Plan, Decision Support Rules for Health Exchanges, Installments 1 and 2". Pacific Business Group on Health. July 2012.

[vii] Damico, A.; Gold, M.; Jacobson, G.; Neuman, T. "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums". (Kaiser Family Foundation, October 2010), http://www.kff.org/medicare/upload/8117.pdf.

[viii] Damico, A.; Gold, M.; Jacobson, G.; Neuman, T. "Medicare Advantage 2011 Data Spotlight: Plan Availability and Premiums". (Kaiser Family Foundation, October 2010), http://www.kff.org/medicare/upload/8117.pdf.

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