



# State Efforts to Lower Cost-Sharing Barriers to Health Care for the Privately Insured

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## Introduction

Consumer cost-sharing for covered health plan services has been growing over time and is likely to increase under proposals to repeal and replace the Affordable Care Act (ACA), many of which would encourage enrollment in high-deductible health plans.<sup>1</sup> High deductibles can help lower premiums, in part by reducing the use of health care services, but they can also encourage consumers to delay or forgo necessary care.<sup>2</sup> This can lead to poorer health outcomes and greater financial liability for policyholders. As a result, some health care experts have called for more nuanced health benefit plan designs that cover certain services, such as primary care and generic drugs, before the deductible.<sup>3</sup> This is sometimes called value-based insurance design (VBID).

States have historically been, and are likely to remain, the primary regulators of health insurance in the individual and small-group markets. As such they have authority to require insurers to cover certain benefits or to adjust cost-sharing to lower financial barriers to care. We find, however, that very few states currently use their authority to establish cost-sharing standards for specific services. Only six states and the District of Columbia do so, largely through standardized plan designs that insurers must offer. However, other state and federal policymakers may wish to learn from the experiences of these six states and DC as consumers increasingly enroll in high-deductible health plans and face higher out-of-pocket costs to obtain needed health care services. This paper discusses findings from our review of laws and policies in 50 states and the District of Columbia that regulate cost-sharing for consumers in individual and small-group health plans, as well as from interviews with officials and health care stakeholders about the development and implementation of these policies.

# Background

Cost-sharing is a common feature in private health insurance and refers to the amount that a consumer is responsible for paying when accessing covered services. Cost-sharing generally includes deductibles, copayments, and coinsurance.<sup>4</sup>

- **deductible:** a fixed dollar amount that a consumer must pay before the health plan provides its share of payment for covered services under the health plan
- **copayment:** a fixed dollar amount that a consumer must pay at the point of service
- **coinsurance:** a percentage of the cost of services that a consumer must pay at the point of service

Cost-sharing allows insurers to keep monthly premiums low by shifting costs to consumers when they use health care services. Increased cost-sharing has also been shown to lower consumers' use of covered services and overall health care spending.<sup>5</sup> Although more people have private health insurance now than ever before, the share of costs that privately insured individuals shoulder, via deductibles, copayments, and coinsurance, has risen steadily. In particular, health plans with high deductibles—amounts that consumers must meet before services are covered—have become increasingly popular among insurers and plan sponsors.<sup>6</sup> However, several surveys of consumer satisfaction with high-deductible health plans indicate lower satisfaction compared with consumers enrolled in plans without high deductibles.<sup>7</sup>

Enrollment in high-deductible plans is growing. For the estimated 155 million people enrolled in coverage through their employer, the percentage of people with a deductible of \$1,000 or more has grown from 10 percent in 2006 to 51 percent in 2016.<sup>8</sup> For 43 percent of those enrolled in an individual market plan without reduced cost-sharing through the ACA's Marketplaces, the average deductible for the most popular level of coverage was \$3,064 in 2016, an increase of 17 percent from the previous year. However, more than half of Marketplace enrollees receive subsidies to reduce their cost-sharing.<sup>9</sup> Approximately half of consumers enrolled in the Marketplaces report increased dissatisfaction with higher deductibles under their coverage.<sup>10</sup>

Cost-sharing obligations can be a barrier to accessing health care services. According to one survey, one-third of Americans with private health insurance report postponing medical treatment because of cost.<sup>11</sup> This number jumps to more than half for families with chronic conditions and those with low incomes.<sup>12</sup> Delayed or postponed care often leads to worse health outcomes. Many who receive care struggle to pay their cost-sharing charges, leading to financial insecurity and medical debt, particularly for those enrolled in high-deductible health plans.<sup>13</sup>

Under the ACA, consumers in individual and employer group health plans have several protections that limit enrollees' cost-sharing liability. First, insurers and plan sponsors must cover preventive services and screenings without cost-sharing. Second, the law places an annual limit on the out-of-pocket cost-sharing an individual or family must pay for covered items and services. In 2017, that

amount is \$7,150 for an individual and \$14,300 for a family.<sup>14</sup> Third, health plans are no longer allowed to impose annual or lifetime dollar limits on benefits. Fourth, individual and small-group market health plan designs, both on and off the health insurance Marketplaces, must fit within five specified levels of coverage: catastrophic, bronze, silver, gold, and platinum. Each of these actuarial value (AV) levels corresponds to the percentage of costs an insurer must pay for covered services versus the percentage in cost-sharing a consumer must pay. Bronze level plans cover, on average, 60 percent of enrollees' costs for covered services. On the other end are platinum level plans, which cover, on average, 90 percent of enrollees' costs. Within each AV level, insurers have flexibility to set deductibles, copayments and coinsurance for covered services, but they must stay within the parameters for each AV level.<sup>15</sup>

VBID is a more nuanced approach to cost-sharing that policymakers and plan sponsors have encouraged in recent years as part of efforts to simultaneously lower health care costs and cost-sharing for consumers. Under a VBID health plan, a consumer may have access to certain “high-value” services pre deductible, meaning the consumer does not need to exhaust his or her deductible before a health plan pays for the service or drug. High-value services are those known to promote or maintain good health. A VBID health plan may also eliminate or lower copayment or coinsurance amounts to encourage consumers to obtain these high-value services. For example, lowering cost-sharing for blood pressure or diabetes medication has been shown to increase patient compliance with treatment regimens that help manage chronic conditions, which then may save insurers money on more costly and preventable health care services in the future.<sup>16</sup> Other versions of VBID also work to lower health care spending by imposing higher enrollee cost-sharing for services whose benefits do not justify the cost, based on available evidence.<sup>17</sup> Policymakers critical of the negative incentives under a VBID approach often cite the challenges of determining which services are “low-value” and designing appropriate plans accordingly. They also cite the lack of reliable data as a challenge to applying VBID to low-value services, particularly because affected populations may have varying characteristics that make comparison difficult.<sup>18</sup>

The use of VBID has gained traction among insurers and plan sponsors. In one survey of large employers in 2014, 59 percent indicated interest in adopting VBID for medical benefits and 57 percent for prescription drug benefits in the next three to five years.<sup>19</sup> Medicare is also piloting a VBID initiative for its Medicare Advantage health plans for specific chronic conditions.<sup>20</sup> In the individual market, as many as one-third of policies sold on the federally facilitated Marketplaces (FFM) have gone beyond the law's requirement to cover preventive services without cost-sharing and voluntarily cover commonly needed health care services, such as primary care visits and generic drugs, before the deductible.<sup>21</sup>

## Methodology

To determine whether states have policies to lower consumers' financial barriers to services through cost-sharing standards in the individual and small-group market, we conducted a survey of laws and policies in 50 states and DC. We excluded from our review state policies that mandated coverage or parity of coverage for certain goods or services, even if they include cost-sharing limits. For example, we

excluded state-mandated cost-sharing limits or parity for oral chemotherapy compared with intravenous chemotherapy. We also excluded state policies that limit cost-sharing for out-of-network providers—for example, capping coinsurance at a certain percentage for nonpreferred providers.<sup>22</sup> In our analysis, we focused on policies directed at the individual insurance market; however, standards for individual and small-group plans were similar if not identical in most of these states.

We supplemented our research with in-depth interviews of stakeholders in four study states (California, Connecticut, DC, Massachusetts) about their respective state policies. Stakeholders included state-based Marketplace (SBM) officials, state regulators, insurance company representatives, and consumer advocates. We conducted 10 interviews between November 2016 and December 2016.

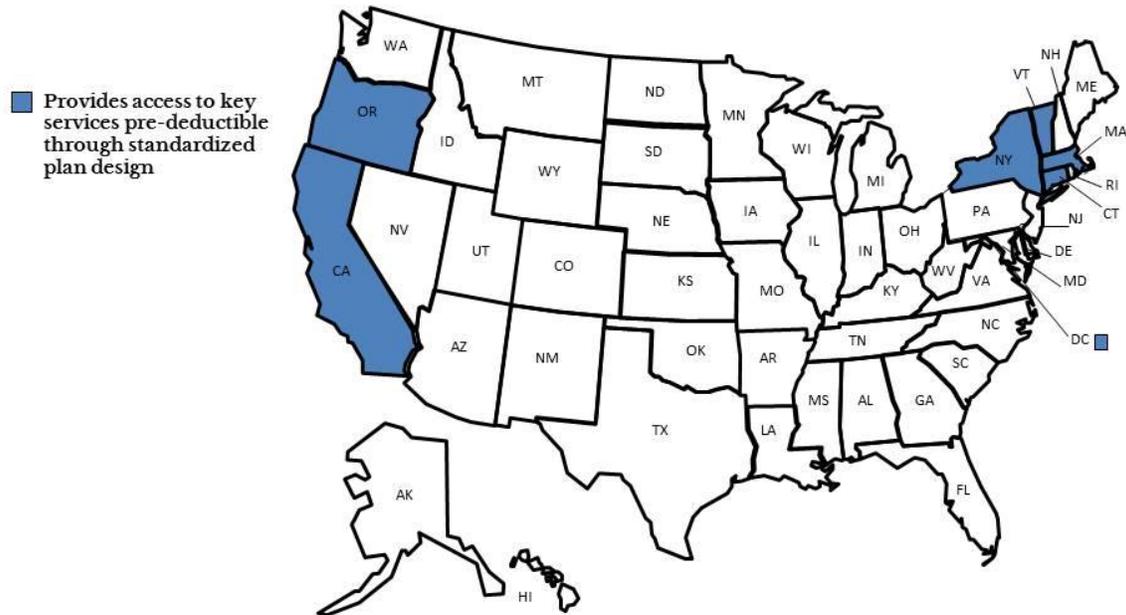
## Findings

### 50-State Analysis: Results

We find that six states have policies aimed at lowering cost-sharing for specified health care services in the individual and small-group markets through state-prescribed standardized plan designs: California, Connecticut, Massachusetts,<sup>23</sup> New York, Oregon, and Vermont. In most cases, standardized plans for the individual and small-group markets are similar, if not identical. The District of Columbia has pursued a similar policy through standardized plan designs but applies it only to the individual market; DC is considering extending standardized plans to the small-group market in the future (see figure 1). It is no coincidence that all of these states also established their own health insurance Marketplaces under the ACA. Decisions to standardize benefit designs in these states were largely driven by Marketplace officials, even though insurers are required to offer these plans inside and outside the Marketplaces. And except in California, insurers can offer nonstandardized plans on their Marketplaces.<sup>24</sup> New Jersey also has standard plans, but these plans predate the ACA and explicitly waive the deductible for immunizations and lead screening for children, preventive care, maternity care, and second surgical opinions. New Jersey's approach reflects legislated state benefit mandates rather than an intentional, government-led effort to develop standardized cost-sharing that reflects VBID principles.<sup>25</sup> The federally facilitated market (FFM) also developed standardized benefit plans for 2017 but does not require insurers to offer them.<sup>26</sup>

FIGURE 1

States That Have Lowered Cost-Sharing for Health Services



Source: Authors' analysis of state law and guidance, based on data as of November 2016.

In all these states except New York, standardized benefit plans include the following predeductible services with low to moderate copayment amounts: doctor's visits for nonpreventive primary care, specialty care, mental health and substance use disorder (MH/SUD) treatment, and urgent care, as well as generic prescription drugs in the popular metal categories of silver and bronze (table 1). Other predeductible services or services available without any cost-sharing include outpatient habilitative and rehabilitative services, home health services, and hospice care. Routine pediatric care such as eye exams and dental exams are available predeductible with little or no copayments in California, Connecticut, DC, and Vermont. California, Connecticut, DC, and Oregon also ensure easier access to laboratory and diagnostic testing by including them as predeductible services. New York's standardized plan design differs from the other states' because it only provides access to prescription drugs (generic and brand-name) predeductible and does not require coverage of any medical services predeductible. New York, however, allows insurers to offer a version of its standardized plan design that provides three nonpreventive primary care visits predeductible in the silver and gold levels.<sup>27</sup> Massachusetts's

ConnectorCare program, available to people with incomes below 300 percent of the federal poverty level, eliminated cost-sharing for opioid addiction treatments in its standardized plans.<sup>28</sup>

Partly because of the constraints on the federally prescribed metal plan levels, more services are available predeductible in silver level plans than bronze level plans. Though fewer services are available predeductible at the bronze level, nonpreventive primary care visits and urgent care must be covered predeductible by standard plans in California, Connecticut, DC, and Oregon. In California, however, enrollees are limited to three visits before the deductible applies. Only DC and Oregon provide access to generic drugs in the standard bronze plan without meeting a deductible.

TABLE 1

**Required Predeductible Services in 2017 Individual Silver Standard Plans, with State-Prescribed Copayments\***

State	Deductible	Primary Care	Specialist	Mental Health/Substance Use Disorder	Urgent Care	Generic Drugs
California	\$2,500	\$35	\$75	\$35	\$35	\$15
Connecticut	\$4,000	\$35	\$50	\$35	\$50	\$5
DC	\$2,000	\$25	\$50	\$25	\$90	\$15
Massachusetts**	\$2,000	\$30	\$50	\$30	\$50	\$20
New York***	\$2,000	None	None	None	None	\$10
Oregon	\$2,500	\$35	\$70	\$35	\$70	\$15
Vermont	\$2,150	\$25	\$65	\$25	\$60	\$15

**Sources:** 2017 Patient-Centered Benefit Designs and Medical Costs. Covered California. <http://www.coveredca.com/PDFs/2017-Health-Benefits-table.pdf>. 2017 Standard Benefit Plan Designs Redline. California Health Benefit Exchange, Board Meeting, June 16, 2016. <http://board.coveredca.com/meetings/2016/6-16/index%20-%20Copy.shtml>. Plan Designs, 2017 Standard Silver Plan—70%, Health Access CT, [http://agency.accesshealthct.com/wp-content/uploads/2016/10/Health-Plans-2017-Ind-Standard\\_Silver\\_Plan70.pdf](http://agency.accesshealthct.com/wp-content/uploads/2016/10/Health-Plans-2017-Ind-Standard_Silver_Plan70.pdf). Standard Plans Advisory Working Group Report 4-4-16. DC Health Benefit Exchange Authority, Executive Board Meeting April 6, 2016, Meeting Materials. <https://hbx.dc.gov/event/executive-board-meeting-54>. All Assister Conference Call: Health Connector 2017 Seal of Approval Process and Results. Massachusetts Health Connector. Sept. 21, 2016. [http://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review\\_FINAL.pdf](http://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review_FINAL.pdf). 2017 Invitation for Participation in NY State of Health. New York State of Health. April 11, 2016. <https://info.nystateofhealth.ny.gov/resource/2017-invitation-participation-ny-state-health>. Recommendations for NY State of Health 2017 Plan Invitation. Health Care for All New York. March 8, 2016. <http://hcfany.org/wp/wp-content/uploads/2016/03/HCFANY-comments-on-plan-invitation-1.pdf>. Accessed Jan. 2017. Oregon standardized health plans: Summary of Coverage. Oregon Div. of Financial Regulation of the Dept. of Consumer and Business Services, June 2016. [http://dfr.oregon.gov/healthrates/Documents/plan\\_summary.pdf](http://dfr.oregon.gov/healthrates/Documents/plan_summary.pdf). Summaries of Benefits and Coverage, Silver BCBSVT and MVP. Vermont Health Connect. <http://info.healthconnect.vermont.gov/healthplans#PCB>.

\*Although these services are available predeductible, copays are required at the time of service

\*\* The information shown here refers to the Massachusetts Health Connector, available for individuals with income above 300 percent of the federal poverty level. The deductible is a combined medical and prescription drug deductible (\$4,000 for family coverage).

\*\*\*New York gives insurers an option to provide a standardized benefit design that includes 3 non-preventive primary care visits predeductible, but the required standardized benefit design that insurers must offer on the silver level does not include any predeductible services except for prescription drugs, see table 2.

California, Connecticut, DC, and Vermont have mandated separate prescription drug deductibles, but Massachusetts limits prescription drug deductibles if they are present. In Massachusetts, all three tiers of prescription drugs are available predeductible with copayments of \$20, \$60, and \$90. Similarly, Connecticut makes the first three tiers of prescription drugs available predeductible with copayments of \$5, \$35, and \$60, and places out-of-pocket limits on the fourth tier. There are no deductibles applicable in New York and Oregon for prescription drugs in their silver standard plans. In New York, copayments of \$10, \$35, and \$70 correspond to the first three tiers; the state does not allow a fourth tier. In Oregon, copayments are \$15 for tier 1, \$50 for tier 3, and 50 percent coinsurance for the last two tiers.

TABLE 2

**Prescription Drugs Available Predeductible in 2017 Individual Silver Standard Plan**

State	Deductible	Tier 1/ Generic	Tier 2	Tier 3	Tier 4
California	\$250	Yes	No	No	No
Connecticut*	\$150	Yes	Yes	Yes	No
DC	\$250	Yes	No	No	No
Massachusetts**	\$250	Yes	Yes	Yes	N/A
New York	N/A	Yes	Yes	Yes	N/A
Oregon***	N/A	Yes	Yes	Yes	Yes
Vermont	\$150	Yes	No	No	No

**Sources:** 2017 Patient-Centered Benefit Designs and Medical Costs. Covered California. <http://www.coveredca.com/PDFs/2017-Health-Benefits-table.pdf>. 2017 Standard Benefit Plan Designs Redline. California Health Benefit Exchange, Board Meeting, June 16, 2016. <http://board.coveredca.com/meetings/2016/6-16/index%20-%20Copy.shtml>. Plan Designs, 2017 Standard Silver Plan—70%, Health Access CT, [http://agency.accesshealthct.com/wp-content/uploads/2016/10/Health-Plans-2017-Ind-Standard\\_Silver\\_Plan70.pdf](http://agency.accesshealthct.com/wp-content/uploads/2016/10/Health-Plans-2017-Ind-Standard_Silver_Plan70.pdf). Standard Plans Advisory Working Group Report 4-4-16. DC Health Benefit Exchange Authority, Executive Board Meeting April 6, 2016, Meeting Materials. <https://hbx.dc.gov/event/executive-board-meeting-54>. All Assister Conference Call: Health Connector 2017 Seal of Approval Process and Results. Massachusetts Health Connector. Sept. 21, 2016. [https://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review\\_FINAL.pdf](https://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review_FINAL.pdf). 2017 Invitation for Participation in NY State of Health. New York State of Health. April 11, 2016. <https://info.nystateofhealth.ny.gov/resource/2017-invitation-participation-ny-state-health>. Recommendations for NY State of Health 2017 Plan Invitation. Health Care for All New York. March 8, 2016. Accessed Feb. 2017. Oregon standardized health plans: Summary of Coverage. Oregon Div. of Financial Regulation of the Dept. of Consumer and Business Services, June 2016. [http://dfr.oregon.gov/healthrates/Documents/plan\\_summary.pdf](http://dfr.oregon.gov/healthrates/Documents/plan_summary.pdf). Summaries of Benefits and Coverage, Silver BCBSVT and MVP. Vermont Health Connect. <http://info.healthconnect.vermont.gov/healthplans#PCB>.

\*In Connecticut's 2017 standardized silver plan, Tier 4 drugs are subject to the deductible and then a 20% coinsurance is required, but the out-of-pocket cost is limited to \$200 per prescription.

\*\*The information shown here refers to Massachusetts Health Connector, available to individuals with income above 300 percent of the federal poverty level. The deductible is a combined medical and prescription drug deductible (\$4,000 for family coverage).

\*\*\*Oregon has no deductible for prescriptions under its standardized silver plan.

## Stakeholder Observations

In the four study states, Marketplace officials and stakeholders alike viewed the ACA's Marketplaces and insurance reforms as opportunities to deliver a better shopping experience and greater value to health insurance consumers. Despite numerous initial challenges in standing up their Marketplaces and

operationalizing key functions, they continued to pursue this goal through benefit design standardization and the principles of VBID. Their efforts to implement these policies highlight the importance of policy transparency and public input. States had to be willing to create “winners” and “losers” depending on which services receive lowered cost-sharing. But although California, Connecticut, and Massachusetts have had standardized plans for several years, none of the study states had yet reviewed data to help them assess the effectiveness of these policies, particularly with regard to consumers’ access to services, customer satisfaction, and enrollee retention.

## CREATING VALUE FOR THE CONSUMER:

### MAKING SERVICES AVAILABLE PREDUCTIBLE

Several state officials noted that although the original policy objective of adopting standardized plan designs was to promote a simplified, streamlined consumer shopping experience, they quickly realized they could use their authority over benefit design to improve the value of coverage available to Marketplace consumers. For example, one Marketplace official noted, “While the policy wasn’t implemented per se to make plans better, it is also a vehicle to do that.” The official added that such standardized plans “create a consumer-centric baseline with a good balance of coverage richness and simplicity of design.” Another official said that the standard plans were about “apples-to-apples comparison, but in doing so, we really did try to create the best value for consumers and try to design our plans to at least help people get services.”

Indeed, state Marketplace officials in California and Connecticut assert that creating better value for their customers was the primary reason they decided to require standardized plan designs.<sup>29</sup> In particular, they hoped the designs would appeal to healthy consumers, many of whom may only see a primary care clinician or fill a prescription once or twice a year. Because these healthy enrollees are more likely to stop paying their plan premiums midyear if they are required to pay the full cost of these services out-of-pocket, Marketplace officials believe that providing some predeductible coverage is an important enrollment retention tactic. Insurer respondents shared similar views, but not all supported the Marketplace’s control over plan design. One respondent said insurers “have to convince [consumers] that they want this” by “putting some services before the deductible.”

Some consumer advocates view standardized plan designs not only as a way to generate better value for consumers, but also as a “policy vehicle” to reduce out-of-pocket costs for vulnerable enrollees, particularly those with chronic conditions. One respondent stated, “The goal of the policy was minimizing the liability people are faced with when they need coverage.” One consumer advocate said that coverage of drugs and primary care services predeductible was important for patients with chronic conditions, who may need multiple prescriptions and a few physician visits to control their condition. Consumer advocates also noted that lowering cost-sharing or providing predeductible coverage specifically for drugs would improve medication adherence for consumers with chronic conditions, thereby improving health outcomes over the long term.

Consumer advocates in Massachusetts see VBID as the next logical step to lower out-of-pocket costs for consumers. In particular, Massachusetts Marketplace officials noted that they were exploring

ways to expand VBID use in the future, citing their experience eliminating cost-sharing for opioid addiction treatment under ConnectorCare plans.

At the same time, some stakeholders in California and Connecticut indicated reluctance to use standardized designs to impose higher cost-sharing on services deemed to have low or uncertain value. They cited concerns about the lack of effectiveness data specific to their Marketplace population and disagreement over what services should be considered high- versus low-value. One insurer respondent said, “No one has ever come up with a list of what the low-value things that we’re going to charge more for are. The people who get and provide those services think they’re high-value.” District of Columbia stakeholders also noted that they lacked the expertise and resources to conduct the kind of medical evidence review needed to make value judgments about which services should be subjected to higher cost-sharing.

## POLICY DEVELOPMENT AND IMPLEMENTATION:

### AN OPEN PROCESS WITH STAKEHOLDER INPUT

The study states developed standardized plan designs for their Marketplaces with significant input from insurers and consumer advocates. One Marketplace official noted, “Everything we do here, by and large, with respect to policy decisions [is] driven by stakeholder input.” In California, Connecticut, and DC, an advisory group develops the standardized plan designs. Advisory groups meet in public before making their recommendations to the Marketplace board of directors. In all three states, consumer or health care advocates are members of these advisory groups. Consumer advocates generally agreed that the benefit design development process has been open, although one consumer advocate in Connecticut observed that the Marketplace is not as “vigorous about consumer and community input as [Marketplace officials] were.” The Massachusetts Marketplace does not have a benefit design advisory committee, but designs are developed by staff who receive input from insurers and consumer advocates. Their recommendations are submitted to and voted on by the board of directors. Massachusetts consumer advocates applauded the process, noting that it is “mostly driven by a lot of research and conversations of staff with insurers and the community.”

Insurers we interviewed also agreed that the process of developing standardized plan designs is open. One insurer said, “There’s always an open door policy.” However, some insurer respondents raised concerns that some advocacy groups pushing for coverage of certain items and services in the standardized benefit designs were funded to engage in that advocacy by special interests, such as pharmaceutical companies. One insurer noted that there is little transparency around the funding of patient advocacy groups, noting that financial disclosure “by and large does not happen.” But another insurer shrugged off these concerns, noting that in the relatively small world of state policy advocacy, “we generally know where [a policy] is coming from and which group is advocating for it.”

Insurers also use the process to voice concerns about the costs of implementing standardized benefit plans that incorporate VBID, particularly because costs for services and drugs differ in markets around the state. “They [costs] can be big; this is a tight Marketplace with very thin margins.” Insurers

also expressed reservations about these benefit designs leading to higher use among enrollees; this could increase their costs and, ultimately, their premiums.

#### IMPLEMENTATION CHALLENGES:

##### DEVELOPING APPROPRIATE BENEFIT DESIGNS WITHIN FEDERAL LIMITS

Under the ACA, the cost-sharing associated with specific covered services must apply within the context of the federally set AV levels. As a result, many respondents described the process of deciding what to provide predeductible as a series of trade-offs. One official said, “We do a bit of push and pull, raise the deductible here and lower the copay there, and then look at the impact... It’s definitely a trade-off.” For some respondents, keeping deductibles as low as possible was important to help consumers feel they were getting value out of their monthly premium payments, but doing so often meant that cost-sharing was higher in other parts of the benefit package.

Some respondents described predeductible coverage as cost-shifting, noting that “it’s a zero-sum game” and “somebody else is going to pay more” when some services are made available predeductible. One insurer pointed out that because most consumers don’t incur large costs, the burden shifts to those who use services the most—usually people in the worst health: “I’m not sure we are helping the right people.” One insurer respondent asserted that costs had gone up as a result of their state’s requirement to provide standardized plans, citing the operational cost of implementing the new plans as well as higher use. However, the insurer conceded that it is difficult to isolate the effect of plan standardization because there were “a lot of interactions between benefits and changes every year.”

Providing coverage predeductible in the bronze level was particularly challenging, largely because enrollees must cover such a high percentage (40 percent) of the cost of covered services. One DC consumer advocate respondent said, “There’s no good decision within the bronze level.” Advocates in New York noted that Marketplace officials cited the constraints of the federal AV levels as a reason not to make this predeductible coverage mandatory.

#### EVALUATION CHALLENGES:

##### OBTAINING TIMELY DATA TO ASSESS IMPACT OF PREDEDUCTIBLE COVERAGE

Although one insurer asserted that their state’s requirement of predeductible coverage had prompted higher use of health care services, most insurer respondents and state officials did not have data on enrollees’ use of services covered predeductible. Most think it is too early to determine whether patient access to these services has improved, or whether there has been any effect on health outcomes or overall spending. In general, state officials noted that they must rely on participating insurers to report the data. One Marketplace official said, “Utilization data tends to trail behind.” Some said that even if insurers regularly provided state regulators with data on service use, they would have difficulty analyzing it because reports are not uniform and staff resources are insufficient. In addition, many consumers in the individual market switch health plans and insurers year to year, making data on utilization trends less useful. One insurer said that for smaller populations, it’s difficult to substantiate “any positive population health [trend] down the road.”

## Discussion

The uninsured rate is at a historic low, but consumers' out-of-pocket costs for accessing services have been climbing, largely because of higher deductibles, coinsurance, and copayments. Opponents of the ACA have pointed to high cost-sharing in the individual market as one reason to repeal the ACA. However, proposals to repeal and replace the ACA would encourage enrollment in plans with even higher deductibles and potentially less comprehensive coverage, thereby increasing the amount consumers must pay to access high-value services such as primary care or specialist visits and prescription drugs.

At the same time, federal policymakers have called for states to have increased authority and flexibility to regulate their insurance markets. Some states may choose to use that authority to help reduce the financial barriers that could prevent consumers from obtaining needed, high-value health care services or prescription drugs. In doing so, states may be able to learn from the experiences of the six states and DC which have enacted standardized benefit designs that include coverage of key services predeductible.

Our review of the policies in these states and interviews with insurers, consumer advocates, and Marketplace officials finds that although data on consumer use of services or health outcomes of plans with predeductible coverage are not yet available, most stakeholders believe that these plans offer consumers a better value than plans that do not cover any services predeductible. The study states have also generated stakeholder buy-in and, in some cases, the support of participating insurers, thanks to design and implementation processes that incorporated public input and stakeholder views.

State officials and advocates also noted that providing predeductible coverage involves a series of trade-offs, resulting in winners and losers among enrollees. The actuarial value targets prescribed by the ACA mean that lowering cost-sharing for one set of goods or services necessarily means increasing cost-sharing for another set of goods or services. Choosing among these, and thinking through the impact on different patient populations as well as the enrollee population as a whole, is a significant challenge for state officials and the stakeholder advisory committees. This challenge is compounded by the lack of timely access to data about how these benefit designs are affecting service use over time. Nor do state officials yet have a quantifiable method to demonstrate whether they are meeting their policy goal of delivering greater plan value and improving enrollee retention.

How health insurance will be regulated after an ACA repeal is uncertain, but lowering financial barriers to needed care remains an important policy goal. As policymakers call for greater state autonomy to establish standards for health insurance coverage, states may wish to consider requiring coverage of services predeductible or establishing cost-sharing limits for specific services in order to improve consumers' access to necessary care.

## About the Authors

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## Notes

<sup>1</sup> See, for example, American Health Care Act of 2017, H.R. 1628, 115<sup>th</sup> Cong, (1<sup>st</sup> Sess., 2017).

<sup>2</sup> Analysis of High Deductible Health Plans. RAND Corp. [http://www.rand.org/pubs/technical\\_reports/TR562z4/analysis-of-high-deductible-health-plans.html](http://www.rand.org/pubs/technical_reports/TR562z4/analysis-of-high-deductible-health-plans.html). Accessed February 2017.

<sup>3</sup> See Value-Based Insurance Design: An Innovative Approach to Improve Medicare Advantage, Health Savings Accounts, and TRICARE. Bipartisan Staff Briefing, House of Representatives, 115<sup>th</sup> Congress, Feb. 7, 2017, <http://vbidcenter.org/wp-content/uploads/2017/02/V-BID-Briefing-Dear-Colleague.pdf>. VBID for Better Care Act of 2014, S. 2783, 113<sup>th</sup> Cong. (2013-2013). Retrieved from Congress.gov. Directs a pilot program for Medicare Advantage organizations to use VBID.

<sup>4</sup> Cost-sharing does not include the amount for covered services provided by an out-of-network provider referred to as "balance bills." See Hoadley, J. et al. *Balance Billing: How Are States Protecting Consumers from Unexpected Charges?* Princeton: Robert Wood Johnson Foundation, June 2015.

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<sup>21</sup> 80 Fed. Reg. 75488. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, Proposed Rule*. Dec. 2, 2015, 75543. Note the median individual deductible for health plans in the federally facilitated Marketplaces, weighted for financial assistance was \$850. See *Data Brief: 2016 Median Marketplace Deductible \$850, with Seven Health Services Covered Before the Deductible on Average*. Washington: Centers for Medicare and Medicaid Services (CMS), July 2, 2016. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html>. Accessed Jan. 2017.

<sup>22</sup> See, for example, Utah Code Ann. § 31A-22-641 requires that if a health plan covers both types of chemotherapy, cost-sharing for oral chemotherapy is no more restrictive than for intravenous therapy or if the cost-sharing is more restrictive, cannot apply cost-sharing that exceeds \$300 per prescription; Vernon's Texas Code Ann. § 1301.0046 limits coinsurance to 50 percent of the total covered amount for non-preferred providers with preferred provider organizations.

<sup>23</sup> Massachusetts, which passed its states' health reform law in 2006, established minimum credible coverage standards that limit deductibles. 956 Code of Mass. Reg. 5.03, Massachusetts Health Connector, Admin. Bulletin 01-03, May 6, 2013 and Admin. Bulletin 02-13, Oct. 2, 2013. In general, in order to meet minimum creditable coverage (MCC) standards, individual health plans must limit deductibles to \$2,000 for individuals and \$4,000 for families. However, the Massachusetts Health Connector has the authority to grant MCC status to health plans that deviate from MCC standards as long as they meet certain guidelines including an actuarial value equal or greater to the bronze plan offered through the Massachusetts Health Connector.

<sup>24</sup> In 2014 and 2015, Vermont required all individual and small group plans to be sold on its Marketplace. In DC, all individual and small group plans must be sold on its Marketplace.

<sup>25</sup> N.J. Admin. Code § 11:22-5.3 (limiting deductibles to \$2,500 for individual coverage and \$5,000 for family coverage in the individual and small group markets); N.J. Admin. Code § 11:22-5.3 (limiting coinsurance percentages to 50 percent); N.J. Admin. Code § 11:22-5:4 (prescribing copayment limits for specific services) and N.J. Ins. Bul. No. 2015-4, May 4, 2015 (increasing the individual deductible to \$3,000 in bronze level plans). Under New Jersey's standardized plans, the copayments for emergency room visits cannot be more than \$100, which is payable in addition to the deductible and any coinsurance, but is waived if the consumer is admitted within 24 hours of the visit. There are also coinsurance limits to covered services for each type of standardized plan. In addition, pre-natal visits and second surgical opinions must be provided pre-deductible. See New Jersey IHC Program Forms. [http://www.state.nj.us/dobi/division\\_insurance/ihcseh/ihcforms.html](http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html). Accessed February 2017. N.J. Rev. Stat. §§ 17:48-6c, 17:48A-7c, 17B:26-2.1k, 17B:27-46.1k; N.J. Rev. Stat. §§ 17:48E-33, 17B:27-46.2.

<sup>26</sup> 81 Fed. Reg. 12204. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017*. March 8, 2016.

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<sup>28</sup> Some selected medication(s) and services are not required to be zero-cost-sharing on the base Silver plan. Massachusetts Health Connector. All Assister Conference Call: Health Connector 2017 Seal of Approval Process and Results, Sept. 21, 2016. [http://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review\\_FINAL.pdf](http://www.masshealthmtf.org/sites/masshealthmtf.org/files/2017%20Seal%20of%20Approval%20Review_FINAL.pdf). Accessed Jan. 2017.

<sup>29</sup> See *Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability Discussion DRAFT – Options and Recommendations*. California Health Benefit Exchange. July 16, 2012. [http://board.coveredca.com/meetings/2012/06%20Jun-19%20Bay%20Area%20Meeting%20Materials/PDFs/CHBE-QHP\\_Discussion\\_Draft\\_7162012.pdf](http://board.coveredca.com/meetings/2012/06%20Jun-19%20Bay%20Area%20Meeting%20Materials/PDFs/CHBE-QHP_Discussion_Draft_7162012.pdf). Accessed April 2017.



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