DECEMBER 2013

Realizing Health Reform's Potential

What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces

Christine H. Monahan, Sarah J. Dash, Kevin W. Lucia, and Sabrina Corlette

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Sarah J. Dash, M.P.H.
Research Fellow
Center on Health Insurance Reforms
Georgetown University Health Policy Institute
sd850@georgetown.edu

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1720
Vol. 34

Abstract: The new health insurance marketplaces aim to improve consumers' purchasing experiences by setting uniform coverage levels for health plans and giving them tools to explore their options. Marketplace administrators may choose to limit the number and type of plans offered to further simplify consumer decision-making. This issue brief examines the policies set by some state-based marketplaces to simplify plan choices: adopting a meaningful difference standard, limiting the number of plans or benefit designs insurers may offer, or requiring standardized benefit designs. Eleven states and the District of Columbia took one or more of these actions for 2014, though their policies vary in terms of their prescriptiveness. Tracking the effects of these different approaches will enhance understanding of how best to enable consumers to make optimal health insurance purchasing decisions and set the stage for future refinements.

OVERVIEW

Purchasing health insurance is an extraordinarily complex process, with much at stake for consumers' financial protection and access to care.[1] To simplify the consumer shopping experience and set basic standards for plans, the Affordable Care Act introduces significant health insurance market reforms and establishes health insurance marketplaces (also referred to as exchanges), where consumers can compare and choose plans based on their overall cost and quality.[2] To help consumers understand the level of protection they are purchasing, health plans offered through the marketplaces must cover a largely similar set of essential health benefits and are categorized into levels—catastrophic, bronze, silver, gold, and platinum—based on the average percentage of health care expenses that will be paid for by the insurer.[3] The marketplaces will further enable consumers to compare and select plans through Web-based display, filter, and search functions—known as "choice architecture"—as well as through tools, such as a Summary of Benefits and Coverage, that provide standardized plan information.[4]

With these changes, consumers will have access to more comprehensive coverage and more information about their plan options than have traditionally been available.[5] However, significant variation in health plan design—for

instance, differing amounts of cost-sharing for specific services—may still occur. Experience with implementation of health insurance reform in Massachusetts, as well as with implementation of Medicare Part D and Medicare Advantage, provide some perspective: if insurers are given significant latitude to vary plan features or offer numerous plans with only minor differences between them, consumers might still have difficulty making comparisons and selecting a plan that offers them adequate financial protection and access to care at the best possible price.[6]

Whether state insurance marketplaces should seek to simplify plan choices to help consumers make optimal choices has been the subject of robust debate. Insurers have tended to support greater flexibility, emphasizing innovation and the diversity of consumer preferences. Consumer advocates, citing behavioral economics research demonstrating that having too many choices can impair decision-making, have encouraged measures to provide a manageable number of easily comparable options.[7] In determining their approach, marketplace administrators must contend with the twin challenges of "stocking the shelves" with enough plans to promote competition and consumer choice while ensuring that the number and variety of plans are not so overwhelming that consumers have difficulty identifying those that best fit their needs.

States running their own marketplaces have significant flexibility in how they balance these competing pressures.[8] This issue brief examines whether and how state-based marketplaces have taken any of three actions to simplify plan choices: 1) limiting the number of plans or benefit designs insurers may offer, 2) requiring standardized benefit designs, or 3) adopting a meaningful difference standard (Exhibit 1). These actions, while not required by the Affordable Care Act, may help consumers by creating a more transparent and competitive shopping experience.

FINDINGS

Eleven States and the District of Columbia Took Some Action to Simplify Plan Choice

Eleven states and the District of Columbia took action to simplify plan choices in their marketplaces. The level of intervention varied, with some states giving significant discretion to insurers and others being more prescriptive. Four states and the District of Columbia took just one action—either adopting a meaningful difference standard or limiting the number of plans or benefit designs an insurer may offer.[9] Seven states took at least two actions, with four states taking all three. Six states did not take any action to structure plan choices (Exhibit 2). The federal government—which has adopted similar approaches in the Medicare Advantage and Medicare Part D programs—will manage plan choices in states using the federally facilitated marketplace by deploying just one of the above tools: requiring insurers' plan offerings to meet a meaningful difference standard.[10]

Exhibit 1. Policy Options to Simplify Marketplace Plan Choice

Action	Description
Limit Number of Plans or Benefit Designs	Limit the number of plans that insurers may offer within a specified geographic area within an individual or Small Business Health Options Program (SHOP) exchange, or limit the number of benefit designs while allowing insurers to offer multiple plans for each benefit design within the same area using different product types (e.g., health maintenance organization or preferred provider organization) and/or networks.
Standardize Benefit Designs	Require insurers to offer plans that reflect, at minimum, predefined deductibles, out-of-pocket maximums, and in-network cost-sharing amounts for some or all essential health benefits. Insurers may vary plan features that are not included in the standardized design, such as product type and networks.
Adopt Meaningful Difference Standard	Require a plan's features, such as cost-sharing levels, scope of covered services, or networks, to be substantially distinct from those of other plans offered in the same area by the same insurer.

Market dynamics were paramount in some states' decisions to act. Officials in Rhode Island, which did not take any formal action, reported that they did not set explicit limits on the number of plans offered but instead encouraged insurers to offer a limited number. Given Rhode Island's small market, their priority for year one was to get all insurers on board to ensure consumers "had enough choice."[11] Washington State officials similarly noted that they were more concerned with getting all insurers to participate in the marketplace and offer plans throughout the state than with insurers "flooding the market" and overwhelming consumers.[12]

In states that took a proactive approach to managing plan choices, officials emphasized the importance of promoting informed consumer choice through benefit standardization and providing a reasonable number of plan options.[13] In New York, for example, officials expressed a concern that, without limits, the choices in the marketplace would be "endless."[14] In Nevada, officials have generally taken a "free market facilitator" approach but, out of concern that too many plans could discourage some consumers from making any choice at all, they adopted plan limits and a meaningful difference standard to "push" the market toward more manageable consumer choice.[15]

Exhibit 2. State and Federal Action to Simplify Marketplace Plan Choice

Number of Actions Taken	State	Limited Number of Plans or Benefit Designs	Standardized Benefit Designs	Adopted Meaningful Difference Standard
Three Actions	CA	X	X	X
	CT	X	X	X
	MA	X	X	X
	VT	X	X	X
Two Actions	NV	X	—	X
	NY	X	X	—
	OR	X	X	—
One Action[1]	CO	—	—	X[2]
	DC	—	—[3]	X
	KY	X	—	—
	MD	X	—	—
	UT	—	—	X
No Action	HI	—	—	—
	ID	—	—	—
	MN	—	—	—
	NM	—	—	—
	RI	—	—	—
	WA	—	—	—
Total States Taking Action		**9**	**6**	**8**

[1] The federally facilitated marketplace implemented a meaningful difference standard for 2014. Although not reviewed for the purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review. In states not conducting plan management for the federally facilitated marketplace, review for meaningful difference is the only action to manage plan choices in 2014.

[2] In Colorado, meaningful difference standards also apply to individual and small-group plans offered outside of the exchange.

[3] The District of Columbia intends to require insurers to offer standardized plans beginning in 2015.

Nine States Are Limiting the Number of Plans or Benefit Designs an Insurer Can Have

To prevent insurers from flooding the exchange with a large number of plans—potentially dominating "shelf space" on marketplace websites and, thus, reducing competition and impairing consumer decision-making—nine states limited the number of plans or benefit designs insurers may offer (Exhibit 3). Of these, two states—Kentucky and Maryland—did not take any other action to simplify plan choices. Nevada combined limits with a meaningful difference standard. Of the remaining six states, four (California, Connecticut, Massachusetts, and Vermont) also required insurers to standardize a subset of plans and set meaningful different standards, while two (New York and Oregon) also required insurers to standardize a subset of plans.

States typically allowed insurers to offer between three and five plans per coverage level. California, in contrast, limited the number of different configurations of the covered benefits and cost-sharing (benefit designs) an insurer may offer. Participating insurers, however, may submit an unlimited number of plans using different networks or product types—such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs)—for each benefit design offered on the exchange.[16] For example, for a single benefit design, a California insurer may offer one plan with a broad provider network and another with a more restricted network. Massachusetts combined both approaches, restricting the total number of nonstandardized plans insurers may offer while allowing insurers to submit an unlimited number of standardized plans with different network configurations.[17]

Exhibit 3. Maximum Number of Plans or Benefit Designs Allowed per Insurer in Marketplaces

State	Maximum*	Applicability
FFM States	No limit on number of plans or benefit designs	Not applicable[1]
CA	One nonstandardized benefit design per coverage level[2]	Per service area
CT	3 plans per coverage level[3]	Per market
KY	4 plans per coverage level[4]	Per market
MD	4 plans per coverage level[4]	Per market
MA	7 non-standardized plans across bronze, silver, gold, and platinum coverage levels[4,5]	Per exchange[6]
NV	5 plans per coverage level	Per service area
NY	4 plans per coverage level[4,7]	Per county
OR	5 plans per coverage level[3]	Per service area
VT	4 plans per bronze and silver levels; 3 plans per gold level; 1 plan per platinum and catastrophic levels[7]	Per exchange[6]

* Numbers presented do not necessarily include variations of a single plan, such as certain plan variations that provide publicly subsidized cost-sharing protection to eligible low-income individuals, child-only variations, and variations of the same plan provided with and without embedded pediatric dental coverage. States typically did not include such plans for the purposes of calculating plan limits.

FFM = federally facilitated marketplace.

[1] Although not reviewed for purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review.

[2] In California, the exchange limited the number of nonstandardized benefit designs an insurer can offer per coverage level, but insurers may submit multiple plans for each standard and alternative benefit design within the same geographic service area using different product types and/or networks.

[3] In Connecticut and Oregon, insurers are limited to one catastrophic plan in the applicable area. For the bronze, silver, and gold coverage levels, Oregon specified that each qualified health plan issuer could offer one standardized plan, two nonstandardized plans per coverage level, and two "innovative" plans per coverage level. Like the nonstandardized plans, the "innovative plans" would not be required to comply with the standardized benefit design, but would be subject to an additional layer of review and approval by the exchange before they could be filed with the state insurance division. Oregon did not establish a standardized benefit design for the platinum level and allowed insurers to offer up to three nonstandardized platinum plans and two "innovative" platinum plans.

[4] In Kentucky, Maryland, Massachusetts, and New York, plan limits do not apply to catastrophic plans.

[5] In Massachusetts, plan limits do not apply to standardized plans—as in California, insurers may submit multiple plans for each standardized benefit design using multiple network configurations.

[6] "Per exchange" refers to the individual and small-group exchanges established in each state. In Massachusetts and Vermont, the individual and small-group markets are merged so plan limits apply to insurer participation in the exchange generally, rather than per market.

[7] In New York and Vermont, affiliated insurers will be considered one entity for purposes of calculating plan limits.

With either method, the number and variety of plans offered to consumers will depend, in part, on how limits are applied. In Kentucky, for example, insurers may offer only four plans at each coverage level statewide. In contrast, insurers participating in the marketplace in Oregon may offer up to five plans per coverage level in each service area in which they operate, giving them flexibility to design unique products within different service areas. States may also apply limits at the license or holding company level. For example, Maryland took the former approach while New York and Vermont took the latter, specifying that any insurers that are operating on different licenses but affiliated with the same holding company will be considered one entity for the purposes of calculating plan limits.[18]

Six States Established Standardized Benefit Designs to Support "Apples-to-Apples" Comparisons

Six states—California, Connecticut, Massachusetts, New York, Oregon, and Vermont—required insurers to offer a selection of plans with standardized benefit designs so consumers can more easily compare features such as benefits and cost-sharing among plans across different levels of coverage (Exhibit 4). In all six states, insurers are allowed to offer a limited number of nonstandardized plans or benefit designs. For such products, states often explicitly encouraged insurers to incorporate innovative features, such as value-based insurance design, tiered networks, and payment and delivery system reforms.[19] Four of the six states (California, Connecticut, Massachusetts, and Vermont) also adopted meaningful difference standards to differentiate nonstandardized plans.

In defining their standardized benefit designs, all six states fixed deductibles and out-of-pocket maximums for in-network benefits, and many set in-network cost-sharing for most or all essential health benefits, including specific services such as ambulance or other forms of emergency transport. These steps provide consumers with a stable basis for comparing out-of-pocket costs for a broad array of health care services across coverage levels. Other states, such as Massachusetts, standardized only a subset of essential

Exhibit 4. Approaches to Standardizing Plan Benefit Designs in Insurance Marketplaces

State	Range of Standardized Benefit Designs	In-Network Cost-Sharing Standardized	Out-of-Network Cost-Sharing Standardized	Benefit Substitution Prohibited
FFM States	N/A	N/A	N/A	No[1]
CA	All coverage levels	Yes	No	Yes[2]
CT	All coverage levels except catastrophic	Yes	Yes	Yes[2]
MA	All coverage levels except catastrophic	Yes	No[3]	No
NY	All coverage levels	Yes	No	Yes[4]
OR	Bronze, silver, and gold levels only[5]	Yes	No	Yes[4]
VT	All coverage levels except catastrophic	Yes	No	No[6]

FFM = federally facilitated marketplace.

[1] The federally facilitated marketplace generally allows benefit substitution. However, states with a federally facilitated marketplace may prohibit benefit substitution for insurers in their state and without otherwise establishing standardized plans.

[2] In California and Connecticut, benefit substitution is prohibited with respect to both standardized and nonstandardized plans.

[3] In Massachusetts, out-of-network cost-sharing is standardized for pediatric dental coverage only.

[4] In New York and Oregon, insurers are generally allowed to substitute one benefit for another within the essential health benefits. However, this practice is prohibited with respect to standardized plans.

[5] In Oregon, insurers offering plans in the individual and small-group markets both on and off the exchange are required to offer a standardized bronze plan and a standardized silver plan. The requirement to offer a standardized gold plan only applies within the exchange.

[6] In Vermont, benefit substitution is allowed. However, insurers must justify any substitution, including explaining how it supports insurer initiatives to promote wellness and innovation and providing a survey of supporting clinical literature.

health benefits (primary care, specialist, and emergency department visits; high-cost imaging; inpatient hospitalization; outpatient surgery; and prescription drugs), allowing insurers to vary cost-sharing for less-common services.[20] Connecticut is the only state to standardize cost-sharing for out-of-network benefits, potentially offering consumers a gauge of their total anticipated financial risk, given that it can be difficult to predict out-of-network costs.[21]

To further limit variability in benefit design and help consumers more easily compare health plans, states may prohibit insurers from substituting one benefit for another within an essential health benefit category, such as outpatient services or prescription drugs (a practice known as benefit substitution).[22] For example, under benefit substitution, if a state's benchmark plan covers blood screens for ovarian cancer, an insurer would be allowed to substitute coverage of that service for coverage of an actuarially equivalent service within the laboratory services category.[23] Prohibitions on benefit substitution, therefore, allow consumers to more easily compare plans based on features such as cost-sharing and premiums, while minimizing the need to factor in differences in benefit design. California and Connecticut prohibited benefit substitution in all plans offered in the marketplace, standardized or not. New York and Oregon prohibited changes to covered benefits in standardized plans, but allowed insurers to substitute benefits in nonstandardized plans.[24] Although they standardized cost-sharing, Massachusetts and Vermont allowed insurers to substitute benefits within standardized plans as well as nonstandardized plans.

Seven States and the District of Columbia Required Insurers to Offer "Meaningfully Different" Plans

To help consumers distinguish among plans, seven states—California, Colorado, Connecticut, Massachusetts, Nevada, Utah, and Vermont—and the District of Columbia instituted meaningful difference standards, which commonly call for state regulators to review differences in plan features such as cost-sharing, networks, and formularies (Exhibit 5). Plans are rejected or must be modified if they are too similar to others that the insurer proposes to sell within a given service area and coverage level. In some cases, states also encourage insurers to differentiate their plans through the use of innovative plan features, as previously discussed. Initially, at least, many states provided significant discretion to state or marketplace officials to determine if plans were meaningfully different, without quantifying what degree of difference in such features as networks, formularies, or cost-sharing would be considered meaningful.

DISCUSSION

As the health insurance marketplaces under the Affordable Care Act launch and initial technical hurdles are overcome, consumers around the nation will gain more information and tools to shop for health plans in the individual and small-group markets. In an attempt to further facilitate consumer decision-making, many state-based marketplaces—and to a lesser extent, the federally facilitated marketplace—are going beyond the minimum requirements of the Affordable Care Act to set rules to "stock the shelves" of the new marketplaces with a manageable number of easily comparable plan choices.

In the first year of marketplace operations, consumers' ability to make "apples-to-apples" comparisons and select a plan that offers them the optimal level of protection is likely to vary according to the different approaches taken by state and federal marketplaces. For example, limiting the number of plans each insurer may offer may provide a more manageable number of plans for consumers to consider, while standardizing benefit designs will further enhance consumer choice by enabling them to better distinguish between the plans offered on the marketplace. In addition, the effectiveness of "meaningful difference" rules may depend on the degree of difference demanded by such standards and the regulators implementing them. If state regulators or marketplace officials require insurers to demonstrate their plans are meaningfully different on only one criterion, such as a $50 dollar difference in deductibles, plans may not be substantially different in

Exhibit 5. Examples of Meaningful Plan Differences Provided in State and Federal Guidance

State	Example
FFM States[1]	• $50 or more difference in both individual and family in-network deductibles • $100 or more difference in both individual and family in-network annual out-of-pocket maximum • Difference in network • Difference in formulary • Difference in covered essential health benefits
CA[2]	• Difference in network design • Difference in level of provider integration • Innovative delivery system features
CO	• $50 difference in deductible • $100 difference in annual out-of-pocket maximum • Difference in formularies • Difference in networks and service areas • Difference in benefit design (essential health benefits, other benefits offered between plans)
CT	• $50 difference in medical deductible • $50 difference in drug deductible • $100 difference in annual out-of-pocket maximum • Difference in payment structure (e.g., copayment versus coinsurance) • Difference in product type (e.g., HMO, PPO, etc.) • Difference in care management (e.g., gatekeeper model; patient-centered medical home; community health teams; wellness programs)
DC[3]	• $50 or more difference in both individual and family in-network deductibles • $100 or more difference in both individual and family in-network annual out-of-pocket maximum • Difference in network • Difference in formulary • Difference in covered essential health benefits
MA	• Innovative plan designs that can help achieve premium cost savings for enrollees • Difference in network design (e.g., tiered or narrower networks) • Plan features intended to reduce costs through increasing transparency or efficiency (e.g., value-based insurance designs; patient-centered medial homes)
NV	• Difference in product type • Difference in premium and cost-sharing • Difference in network • Difference in formulary • Difference in covered benefits
UT[3]	• $50 or more difference in both individual and family in-network deductibles • $100 or more difference in both individual and family in-network annual out-of-pocket maximum • Difference in network • Difference in formulary • Difference in covered essential health benefits
VT	• Difference in medical deductible • $50 difference in drug deductible • Greater than $1,000 difference in annual out-of-pocket maximum • 10 percent difference in cost-sharing for inpatient or outpatient care • $10 or 10 percent difference in cost-sharing for primary care provider or specialist office visit • $5 average difference in generic drugs • $10 or 10 percent average difference in brand-name drugs • Different payment structure (e.g., copayment versus coinsurance) • Additional rating tier offerings

FFM = federally facilitated marketplace.

[1] Although not reviewed for purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review. In states not conducting plan management for the federally facilitated marketplace, review for meaningful difference is the only action to manage plan choices in 2014.

[2] In California, within a given product design, the exchange may choose not to contract with two plans with broad overlapping networks within a rating region unless they offer different innovative delivery system or payment reform features.

[3] The District of Columbia and Utah referred to the federal guidance on meaningful difference standards, which includes the examples highlighted.

practice. Even with these policies in place, insurers in most states will still have significant freedom to shape a portfolio of plan offerings.

The approaches we have discussed do not exist in a vacuum; their effectiveness will be significantly affected by the level of insurer participation in a marketplace, which in turn depends on factors such as the state's existing market dynamics and other marketplace design decisions affecting insurer participation.[25] For example, marketplaces adopting limits on plan offerings may still offer dozens of plans per coverage level if a large number of insurers participate, while marketplaces without limits may offer a smaller number of plans if few insurers participate or voluntarily limit plan offerings. Moreover, consumers' experience will depend not just on the plan choices available to them, but also on the user-friendliness and choice architecture of marketplace websites and their access to in-person assistance with selecting a plan and understanding the health insurance product they are buying.

Even with these external factors at play, differences in state and federal policymakers' initial approaches to facilitating consumer choice provide an important learning opportunity for policymakers. Since establishing its marketplace in 2006, Massachusetts has periodically updated its approach to managing plan choices based on feedback from consumers solicited through focus groups and surveys as well as analysis of consumers' plan selections.[26] Similarly, actions taken, or not taken, by state-based marketplaces for 2014 will serve as a starting point to analyze how different policies affect consumers' ability to enroll in the plan most suitable for their financial and health situations. In the longer term, tracking consumers' plan choices, their satisfaction with those plans, and whether they switch plans during future open enrollment periods could yield additional insights into how marketplace design decisions affect purchasing experiences.

As they evaluate how well their marketplaces are working for consumers, state and federal officials should compare the effectiveness of different approaches to facilitating consumer choice, including the examination of metrics such as the number and choice of plans available, differences and similarities in plan design, and consumers' reviews of the shopping experience and actual choice of plans. Over time, these findings could help states narrow in on the optimal number and variety of plan choices for consumers, given their local needs and circumstances.

About the Study

This issue brief examines policy decisions made by the 17 states (California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington) and the District of Columbia that chose to establish state-based marketplaces.

For the purposes of this brief, we refer to Idaho, New Mexico, and Utah as state-based marketplaces. However, Idaho and New Mexico operate as "supported state-based exchanges" in 2014, leveraging the federal information technology infrastructure as they build their own systems. Utah has a "bifurcated" marketplace in which it operates the small-business marketplace while the federal government operates the individual marketplace. In all three cases, the states can set health plan certification requirements and review plans for compliance, although the federal government will have final authority over certification decisions for the individual marketplace in Utah. Although not reviewed for purposes of this paper, states conducting plan management on behalf of the federally facilitated marketplace also may take actions to manage plan choices in addition to conducting a meaningful difference review.

Our findings are based on public information—such as state laws, regulations, subregulatory guidance, marketplace solicitations, and other materials related to marketplace development—and interviews with state regulators. The resulting assessments of state action were confirmed by state officials.

Source: S. Dash, C. Monahan, and K. Lucia, "Health Policy Brief: Health Insurance Exchanges and State Decisions," *Health Affairs*, July 18, 2013.

Notes

[1] K. Pollitz, E. Bangit, J. Libster et al., *Coverage When It Counts: What Does Health Insurance in California Cover and How Do Consumers Know?* (Washington, D.C.: Georgetown University Health Policy Institute, May 2009), http://hpi.georgetown.edu/papers.html.

[2] Pub. L. 111–148, 124 Stat. 782 (2010) §§ 1311, 1312, 1321 (codified at 42 U.S.C. §§ 13031, 18032, 18041 (2012)).

[3] Pub. L. 111–148, 124 Stat. 782 (2010) § 1302 (codified at 42 U.S.C. § 18022 (2012)). We present catastrophic coverage as a coverage level alongside the precious metal tiers—bronze, silver, gold, and platinum—although different rules apply. Instead of meeting a specified actuarial value level, catastrophic plans must provide no benefits other than three primary care visits and certain recommended preventive services until the enrollee has incurred the maximum out-of-pocket costs allowed under the law. Catastrophic plans can only be sold in the individual market, and eligibility is limited to individuals under the age of 30 or who have received an exemption from the individual mandate based on plan affordability or hardship.

[4] L. Quincy, "Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices," *Health Affairs Blog,* July 13, 2012; Pub. L. 111–148, 124 Stat. 782 (2010) § 1001 (codified at 42 U.S.C. §§ 300gg-15 (2012)).

[5] J. R. Gabel, R. Lore, R. D. McDevitt et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs* Web First, May 23, 2012; K. Pollitz and L. Levitt, *Health Insurance Transparency Under the Affordable Care Act* (Washington, D.C.: Kaiser Family Foundation, March 8, 2012).

[6] See, for example, L. Quincy and J. Silas, *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making* (Washington, D.C.: Consumers Union, Nov. 2012); R. Day and P. Nadash, "Simplifying Choices Among Health Plans: New State Insurance Exchanges Should Follow the Example of Massachusetts," *Health* Affairs, May 2012 31(5):982–89; L. Quincy, *What's Behind the Door: Consumers' Difficulties Selecting Health Plans* (Washington, D.C.: Consumers Union, Jan. 2012); Blue Cross Blue Shield of Massachusetts Foundation, *Health Reform Toolkit Series: Determining Health Benefit Designs to Be Offered on a State Health Insurance Exchange* (Boston: BCBSMA, Nov. 2011); J. M. McWilliams, C. C. Afendulis, T. G. McGuire et al., "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decision Making," *Health Affairs,* Sept. 2011 30(9):1786–94; E. O'Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice* (New York: The Commonwealth Fund, April 2008); G. Dallek and C. Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, Oct. 2001); and J. Hoadley, *Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries* (New York: The Commonwealth Fund, May 2008).

[7] See, for example, S. Iyengar and M. Lepper, "When Choice Is Demotivating: Can One Desire Too Much of a Good Thing?" *Journal of Personality and Social Psychology,* Dec. 2000 79(6):995–1006.

[8] S. Dash, K. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).

[9] The District of Columbia Health Benefits Authority expects to require insurers to offer standardized plans beginning in 2015. D.C. Health Benefit Exchange Authority, *Carrier Reference Manual v.5* (Washington, D.C.: Health Benefit Exchange Authority, June 2013).

[10] U.S. Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, *Letter to Issuers on Federally Facilitated and State Partnership Exchanges* (Washington, D.C.: Department of Health and Human Services, April 5, 2013); and The Center for Medicare Advocacy, *The Obama Administration's 2010 Call Letter for Medicare Advantage and Prescription Drug Plans: Implications for Beneficiaries* (Washington, D.C.: The Henry J. Kaiser Family Foundation, May 2009). In 2010, the Centers for Medicare and Medicaid Services adopted new policies to facilitate beneficiary decision-making between plans, such as encouraging Medicare Advantage and Part D plan sponsors to eliminate plan options that are duplicative of other plan offerings or that have low enrollment.

[11] Personal correspondence with exchange official, Rhode Island Health Benefit Exchange, May 14, 2013 (on file with authors).

[12] Personal correspondence with exchange official, Washington Health Benefit Exchange, May 17, 2013 (on file with authors).

[13] Personal correspondence with exchange official, Vermont Health Benefit Exchange, May 14, 2013 (on file with authors); and personal correspondence with exchange official, Oregon Health Insurance Exchange, May 13, 2013 (on file with authors).

[14] Personal correspondence with exchange official, New York Health Benefit Exchange, May 15, 2013 (on file with authors).

[15] Personal correspondence with exchange official, Silver State Health Insurance Exchange, May 15, 2013 (on file with authors).

[16] California Health Benefit Exchange, *2012–2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond* (Sacramento, Calif.: California Health Benefit Exchange, revised Jan. 16, 2013).

[17] Commonwealth Health Insurance Connector Authority, *Request for Responses: Health Benefit Plans—Seal of Approval* (Boston: Health Connector, Feb. 15, 2013); and Commonwealth Health Insurance Connector Authority, *Final Bidders Conference Questions* (Boston: Health Connector, March 8, 2013).

[18] Personal correspondence with exchange official, Maryland Health Benefit Exchange, May 15, 2013 (on file with authors); Office of the New York Health Benefit Exchange, *Invitation to Participate in the New York Health Benefit Exchange* (Albany, N.Y.: New York Health Benefit Exchange, Jan. 31, 2013); and Vermont Health Connect, *Request for Proposals: Selection of Qualified Health Plans* (Williston, Vt.: Vermont Health Connect, Nov. 1, 2012).

[19] Value-based insurance design is an approach to health insurance that reduces consumer cost-sharing for items and services that are deemed high value because the clinical benefits outweigh the costs or risks and increases cost-sharing or items and services of low or uncertain value. With tiered provider networks, providers are grouped by tier based on their average cost and/or quality of care and health insurers vary consumer cost-sharing for certain services depending on their providers' tier. S. Corlette, D. Downs, C. Monahan et al., "State Insurance Exchanges Face Challenges in Offering Standardized Choices Alongside Innovative Value-Based Insurance," *Health Affairs*, Feb. 2013 32(2): 418–26.

[20] Commonwealth Health Insurance Connector Authority, *Request for Responses: Health Benefit Plans—Seal of Approval*, 2013.

[21] K. Kyanko, L. Curry, and S. Busch, "Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?" *Health Services Research*, June 2013 48(3):1154–72.

[22] In all states allowing benefit substitution, insurers must comply with the federal government's minimum rules for substituting benefits, including that the substitute benefit is actuarially equivalent to the benefit that is being replaced, as certified by a member of the American Academy of Actuaries, and that it is within the same benefit category. 45 C.F.R. § 156.115. States may adopt additional rules as well. In Vermont, for example, insurers must also explain how any substitutions support insurer initiatives, such as innovation and wellness, and, if they elect to not provide a service and related quantitative limits, they must submit a survey of clinical literature supporting the substitution of the service. Vermont Health Connect, *Request for Proposals: Selection of Qualified Health Plans*, 2012.

[23] S. Corlette, K. W. Lucia, and M. Levin, *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan* (New York: The Commonwealth Fund, March 2013).

[24] While substitution is prohibited outright in standardized plans in New York, insurers may only substitute benefits within the preventive, wellness, and chronic disease management and rehabilitative and habilitative services categories in nonstandardized plans. New York Health Benefit Exchange, *Invitation to Participate in the New York Health Benefit Exchange*, 2013.

[25] S. Dash, K. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).

[26] Blue Cross Blue Shield of Massachusetts Foundation, *Health Reform Toolkit Series: Determining Health Benefit Designs to Be Offered on a State Health Insurance Exchange*, 2011.

About the Authors

Christine H. Monahan is a student at Yale Law School. Prior to attending Yale, she worked as a senior health policy analyst at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms, focusing on state and federal implementation of health insurance marketplaces and the regulation of private health insurance. Previously, she worked as a health policy advisor at the National Partnership for Women & Families.

Sarah J. Dash, M.P.H., is a research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms, where her principal research focus is comprehensive monitoring of state health insurance marketplace implementation. She also focuses on the intersection of public and private health insurance with delivery system reforms. Previously, she was a senior health policy aide on Capitol Hill. Dash earned her master's degree in public health from Yale University.

Kevin W. Lucia, J.D., M.H.P., is a senior research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. He focuses on the regulation of private health insurance, with an emphasis on analyzing the market reforms implemented by federal and state governments in response to the Affordable Care Act. Lucia received his law degree from the George Washington University School of Law and his master's degree in health policy from Northeastern University.

Sabrina Corlette, J.D., is a senior research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. Her areas of focus include state and federal regulation of private health insurance plans and markets, and implementation of new rules for insurance markets under the Affordable Care Act. She serves as a consumer representative to the National Association of Insurance Commissioners, and was appointed to its Consumer Information Workgroup. She received her law degree from the University of Texas at Austin.

Acknowledgments

The authors thank the state marketplace and insurance department officials who shared their time to review our findings and offer valuable comments. We further thank Jack Hoadley and Lynn Quincy for their thorough review and feedback.

Editorial support was provided by Martha Hostetter.

www.commonwealthfund.org