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

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.⁵

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit Number of Plans or Benefit Designs</td>
<td>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.</td>
</tr>
<tr>
<td>Standardize Benefit Designs</td>
<td>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.</td>
</tr>
<tr>
<td>Adopt Meaningful Difference Standard</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.” 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. 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. In New York, for example, officials expressed a concern that, without limits, the choices in the marketplace would be “endless.” 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.

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

<table>
<thead>
<tr>
<th>Number of Actions Taken</th>
<th>State</th>
<th>Limited Number of Plans or Benefit Designs</th>
<th>Standardized Benefit Designs</th>
<th>Adopted Meaningful Difference Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three Actions</td>
<td>CA</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>CT</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>MA</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>VT</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Two Actions</td>
<td>NV</td>
<td>X</td>
<td>—</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>NY</td>
<td>X</td>
<td>X</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>X</td>
<td>X</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>CO</td>
<td>—</td>
<td>—</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>DC</td>
<td>—</td>
<td>—</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>KY</td>
<td>X</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>MD</td>
<td>X</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>UT</td>
<td>—</td>
<td>—</td>
<td>X</td>
</tr>
<tr>
<td>One Action¹</td>
<td>HI</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>ID</td>
<td>—</td>
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<td></td>
<td>MN</td>
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<td>NM</td>
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<tr>
<td></td>
<td>RI</td>
<td>—</td>
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<td>—</td>
</tr>
<tr>
<td></td>
<td>WA</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>No Action</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total States Taking Action</td>
<td>9</td>
<td>6</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>
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. 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.

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

<table>
<thead>
<tr>
<th>State</th>
<th>Maximum*</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFM States</td>
<td>No limit on number of plans or benefit designs</td>
<td>Not applicable¹</td>
</tr>
<tr>
<td>CA</td>
<td>One nonstandardized benefit design per coverage level²</td>
<td>Per service area</td>
</tr>
<tr>
<td>CT</td>
<td>3 plans per coverage level³</td>
<td>Per market</td>
</tr>
<tr>
<td>KY</td>
<td>4 plans per coverage level⁴</td>
<td>Per market</td>
</tr>
<tr>
<td>MD</td>
<td>4 plans per coverage level⁴</td>
<td>Per market</td>
</tr>
<tr>
<td>MA</td>
<td>7 non-standardized plans across bronze, silver, gold, and platinum coverage levels⁴⁵</td>
<td>Per exchange⁶</td>
</tr>
<tr>
<td>NV</td>
<td>5 plans per coverage level</td>
<td>Per exchange</td>
</tr>
<tr>
<td>NY</td>
<td>4 plans per coverage level⁴⁷</td>
<td>Per county</td>
</tr>
<tr>
<td>OR</td>
<td>5 plans per coverage level³</td>
<td>Per service area</td>
</tr>
<tr>
<td>VT</td>
<td>4 plans per bronze and silver levels; 3 plans per gold level; 1 plan per platinum and catastrophic levels⁷</td>
<td>Per exchange⁶</td>
</tr>
</tbody>
</table>

¹ 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.

² 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.

³ 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.

⁴ 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.

⁵ In Kentucky, Maryland, Massachusetts, and New York, plan limits do not apply to catastrophic plans.

⁶ 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.

⁷ 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.

⁸ 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

<table>
<thead>
<tr>
<th>State</th>
<th>Range of Standardized Benefit Designs</th>
<th>In-Network Cost-Sharing Standardized</th>
<th>Out-of-Network Cost-Sharing Standardized</th>
<th>Benefit Substitution Prohibited</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFM States</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>No&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>CA</td>
<td>All coverage levels</td>
<td>Yes</td>
<td>No</td>
<td>Yes&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>CT</td>
<td>All coverage levels except catastrophic</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>MA</td>
<td>All coverage levels except catastrophic</td>
<td>Yes</td>
<td>No&lt;sup&gt;3&lt;/sup&gt;</td>
<td>No</td>
</tr>
<tr>
<td>NY</td>
<td>All coverage levels</td>
<td>Yes</td>
<td>No</td>
<td>Yes&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>OR</td>
<td>Bronze, silver, and gold levels only&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Yes</td>
<td>No</td>
<td>Yes&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>VT</td>
<td>All coverage levels except catastrophic</td>
<td>Yes</td>
<td>No</td>
<td>No&lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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 hospi-
talization; outpatient surgery; and prescription drugs),
allowing insurers to vary cost-sharing for less-common services.\textsuperscript{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.\textsuperscript{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).\textsuperscript{22} For
example, under benefit substitution, if a state’s bench-
mark 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.\textsuperscript{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 ben-
efits in standardized plans, but allowed insurers to sub-
stitute benefits in nonstandardized plans.\textsuperscript{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-shar-
ing, 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 previ-
ously 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 con-
sidered 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 market-
places with a manageable number of easily comparable
plan choices.

In the first year of marketplace operations, con-
sumers’ 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 standard-
izing 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

<table>
<thead>
<tr>
<th>State</th>
<th>Example</th>
</tr>
</thead>
</table>
| **FFM States**<sup>1</sup> | • $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**<sup>2</sup> | • 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**<sup>3</sup> | • $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 medical homes) |
| **NV** | • Difference in product type  
  • Difference in premium and cost-sharing  
  • Difference in network  
  • Difference in formulary  
  • Difference in covered benefits |
| **UT**<sup>3</sup> | • $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.

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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. 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. 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.

Notes


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.


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).


13 Personal correspondence with exchange official, Vermont Health Benefit Exchange, May 14, 2013 (on file with authors).


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


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.


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.

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.


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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.

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Editorial support was provided by Martha Hostetter.