



REALIZING HEALTH REFORM'S POTENTIAL

DECEMBER 2015

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 author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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

Commonwealth Fund pub. 1853
Vol. 37

Increased Transparency and Consumer Protections for 2016 Marketplace Plans

Chiquita Brooks-LaSure

Abstract The open enrollment period that ends in December 2015 for coverage beginning January 2016 marks the third year of the health care exchanges or marketplaces and of coverage through new qualified health plans. This issue brief investigates several key changes to the qualified health plans, with a focus on increased transparency and consumer protections. A new out-of-pocket costs calculator, requirements regarding provider networks, and prescription drug cost-sharing requirements should serve to better inform and improve consumer selection. In addition, several policy changes will help individuals with more severe health needs. These include: improved prescription drug coverage for HIV/AIDS and other conditions, allowing prescription drugs that are obtained through the “exceptions” process to count toward the out-of-pocket spending cap, more comprehensive and consistent habilitative coverage, and an individual out-of-pocket spending cap within the family out-of-pocket maximum.

BACKGROUND

The Affordable Care Act significantly increased the regulation of the individual health insurance market. In the initial years after the law was passed, efforts were focused on the complexities of the rollout, including the new exchanges or marketplaces, issues surrounding the federal HealthCare.gov website, and the subsidies for eligible consumers. Now with many fundamental issues of functionality addressed, the U.S. Department of Health and Human Services (HHS) has had more time to address concerns in other areas, such as strengthening requirements on qualified health plans and providing consumer shopping tools.

The third open enrollment period runs from November 1 through the end of December 2015,¹ for coverage beginning January 1, 2016. For this open enrollment period, HHS issued its revised marketplace guidance much earlier than in previous years,² which allowed for a longer submission and review process and, in certain cases, strengthened requirements. This issue brief outlines the areas in which we should expect to see some key changes in plan coverage.

PRESCRIPTION DRUG COVERAGE AND DISCRIMINATORY DESIGN

The Affordable Care Act requires qualified health plans to offer 10 “essential health benefits” including prescription drugs and indicates that the benefit package cannot be discriminatory. That is, the benefit design cannot discriminate on the basis of age, life expectancy, disability, degree of medical dependency, quality of life, or other health condition.³ Consumer and disease advocacy groups have been concerned about the adequacy of the prescription drug benefit and the increases in cost-sharing for drugs in expensive, specialty tiers. In January 2015, two advocacy organizations⁴ asked the Obama Administration to strengthen the discrimination standard. These same organizations filed a complaint, arguing that several plans unlawfully discriminated against people with HIV/AIDS by placing all HIV drugs, including generics, on high-cost tiers.⁵ In addition, a recent study found increased cost-sharing in specialty tiers from 2014 to 2015.⁶

Changes in 2016 Coverage

HHS modified the prescription drug rules for 2016 qualified health plans in a number of ways.⁷ Consumers can more quickly obtain prescription drugs that are not on a plan’s formulary through a standard “exceptions process.” This means that a qualified health plan must have a process in place for a consumer, physician, or other designee acting on behalf of the consumer to request that a clinically appropriate drug be covered under the plan’s formulary. The plan must make a coverage decision within 72 hours. If the plan denies the request, the consumer or designee may request that an independent organization review the coverage decision and denial, which also must occur within 72 hours.⁸

All drugs covered through the exceptions process must be included as in-network in terms of cost-sharing, and refills must be covered. These costs will count toward the patient’s overall consumer spending cap, known as maximum out-of-pocket spending.

Plans must make more information available to determine cost-sharing amounts under the plan. Formulary drug lists must include any tiering structure adopted and any restrictions on the manner in which a drug can be obtained.

HHS did not specifically tighten the discrimination standard, but provided some important examples of what constitutes discrimination, singling out cost-sharing. Thus, the guidance signaled to state regulators and plans that a review of cost-sharing is part of the discrimination standard test. HHS issued guidance indicating that placing most or all drugs for a certain condition on a high cost tier may be discriminatory.

Anticipated Results

State and federal reviewers have the authority to disapprove certain types of formulary designs on the grounds of discriminatory benefit designs. The longer review process for 2016 coverage gave insurance commissioners, HHS, and marketplaces more time to look for problematic formularies. The overall value (i.e., actuarial value) of the prescription drug benefit is not likely to change much, but there should be less disparity in cost-sharing for particular conditions.



A qualified health plan must have a process in place for a consumer, physician, or other designee acting on behalf of the consumer to request that a clinically appropriate drug be covered under the plan’s formulary.

Consumers with drugs obtained through the exceptions process will benefit from having the process streamlined and having the costs applied to their maximum out-of-pocket cap.

Finally, increases in transparency for consumers regarding their drug coverage may improve their ability to choose a plan.

NETWORK ADEQUACY

Network adequacy—that is, the number of providers available to consumers at in-network cost-sharing rates—has been an area of concern.⁹ One report found that the average provider networks for plans offered on the health insurance marketplaces include 34 percent fewer providers than the average commercial plan offered outside the marketplace.¹⁰ As there are trade-offs between premiums and network size, it is not clear how concerned consumers are with “narrow networks.” A recent Kaiser Family Foundation survey found that current enrollees appear to value cost over any other factor: 82 percent of people in the individual market ranked monthly premiums as an extremely or very important factor in choosing a plan, compared with 60 percent who said network size was an extremely or very important factor.¹¹ Further, a recent Commonwealth Fund survey found that 66 percent of 2015 new marketplace enrollees or enrollees who switched plans indicated that cost was most important in their decision compared with 22 percent who ranked having a preferred provider in their network as most important. The survey also found that more than half of enrollees who were offered a limited network in exchange for a lower premium chose the limited network.¹²

Changes in 2016 Coverage

Although HHS specifically deferred establishing new network adequacy rules for 2016 coverage, several policy changes will help address these issues. HHS strengthened the transparency of plan networks by requiring monthly updates, more detail, and easier accessibility (such as being accessible online without the need to create an account or a policy number) of in-network provider directories. For 2016, qualified health plans¹³ must include more specific standards on the inclusion of providers who work in underserved areas or care for underserved populations. Also, in August 2015, the National Committee for Quality Assurance announced that it would add network adequacy to its accreditation process.¹⁴ Additionally, some states appear to be increasing their scrutiny of provider networks under state law.¹⁵

Anticipated Results

Given the continued emphasis on low premiums, plan networks in 2016 likely will closely resemble those offered in 2015. Nevertheless, the changes should prevent plans with extremely narrow networks from being approved. Additionally, the increased scrutiny on provider directories should improve accuracy of and consumer satisfaction with chosen plans.



HHS strengthened the transparency of plan networks by requiring monthly updates, more detail, and easier accessibility (such as being accessible online without the need to create an account or a policy number) of in-network provider directories.

HABILITATIVE SERVICES

When HHS issued its initial guidance on essential health benefits, it noted that the commercial market had limited experience offering habilitative services—that is, services to help an individual attain or maintain a skill or function or prevent deterioration of one because of a disabling condition. This initial guidance allowed states to define the benefit. In the absence of a state definition, qualified health plans could define the benefit themselves by offering a habilitative benefit equivalent to its rehabilitative benefit.¹⁶ As a result, there was great variation across and within states.

Changes in 2016 Coverage

In 2016, HHS will require plans to meet a new federal definition. Qualified health plans must offer health care services that help a person keep, learn, or improve skills and functioning for daily living.¹⁷ Also, plans cannot impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. States can continue to set standards as long as they do not interfere with the federal standard. Additionally, if the state standard is higher than the federal standard, the cost of the additional benefits will not accrue to the state.¹⁸

Anticipated Results

There should be less variation among plans across the country and within states, as now all state and federal regulators will be using a standard definition to evaluate the adequacy of the habilitative benefit offered by qualified health plans. There should be more consistency and a higher standard of care, particularly in states where plans were previously defining the benefit. The decision to not hold states financially responsible also may encourage states to raise the habilitative standard. Requiring states to pay for additional costs can be a deterrent to mandated benefits. While only a small segment of enrollees are likely using the habilitative services, the strengthened standard will mean better coverage for the families affected.

REQUIRING AN INDIVIDUAL CAP WITHIN THE MAXIMUM OUT-OF-POCKET FAMILY LIMIT

The Affordable Care Act included a cap on cost-sharing for benefits provided within a plan's network for individual and family coverage. Above that amount, known as the maximum out-of-pocket cap, the consumer's share of costs is eliminated. For 2016, those amounts are \$6,850 for individual coverage and \$13,700 for family coverage.

Changes in 2016 Coverage

HHS indicated in its rules for 2016¹⁹ that qualified health plans must include the individual out-of-pocket maximum within the family maximum amount. Meaning, once a family member has spent \$6,850 on health care costs, his or her spending is eliminated. Prior to this change, an individual family member would have to wait until total costs borne by the family reach \$13,700.

Anticipated Results

By including a per-person cap within the family cap, the threshold for reduced cost-sharing is much lower. A person in a family with high costs will reach the out-of-pocket cap and have additional services covered, regardless of the other family members' spending. This policy change will have a major effect on families where multiple members are covered under one plan but one or two individuals

have high health care needs. For example, a family of four is enrolled in a single qualified health plan. One person pays \$6,850 in out-of-pocket costs by April. During the same time, the other three family members have paid a total \$500 in out-of-pocket costs. Previously, either the high-spending family member—or another member of the family—would have to spend another \$6,350 before reaching the total out-of-pocket threshold. Under the new rule, the high-spending (and presumably high-need) family member no longer pays cost-sharing after meeting his or her threshold, although the other members still do when they need care.

OUT-OF-POCKET DECISION TOOL

The HealthCare.gov website provides a tool for consumers to compare qualified health plans.

Changes in 2016 Coverage

HHS launched an out-of-pocket calculator for 2016 open enrollment that allows consumers to approximate out-of-pocket costs under different plans.²⁰ Consumers choose whether they are high, medium, or low consumers of health care services, and total estimated premiums, deductibles, copayments, and any other costs are displayed.

Anticipated Results

While the calculator may not influence plan designs, it provides a way for consumers to have a better idea of the costs associated with each plan and will assist them in plan selection. Research previously noted²¹ in this brief suggests that consumers are very focused on costs when choosing plans. The availability of this tool may encourage consumers to factor cost-sharing, and not just premiums, in their decisions.

CONCLUSION

Most of the changes discussed in this brief will improve transparency, helping consumers to better understand their options and, once they purchase a plan, their health care coverage. With marketplaces trying to attract millions of additional consumers this year, these changes are particularly important. New 2016 enrollees are likely to be harder to reach—people who are either unaware of coverage or skeptical of its value.²² Simplicity will be important to attract these populations and ensure that enrollment in the marketplaces continues to grow. If the guidance and review process work effectively, the 2016 qualified health plan offerings also will include improvements to help people with high health care costs and specific conditions, like AIDS or HIV.



A person in a family with high costs will reach the out-of-pocket cap and have additional services covered, regardless of the other family members' spending. This policy change will have a major effect on families where multiple members are covered under one plan but one or two individuals have high health care needs.

NOTES

- ¹ As of this writing, the HHS has extended open enrollment until December 17, and several state based exchanges have enrollment dates through the end of December.
- ² HHS has issued final guidance for 2016 qualified health plans well in advance of plan review timelines compared with previous years. For example, the Letter to Issuers for 2015 plan year was issued in draft on February 4, 2014, and in final form on March 14, 2014; the 2016 plan year Issuer Letter was released in draft on December 19, 2015, and in final form on February 20, 2016.
- ³ U.S. Department of Health and Human Services, [HHS Notice of Benefit and Payment Parameters for 2016, Final Rule](#), *Federal Register*; Feb. 27, 2015.
- ⁴ Letter to HHS from the AIDS Institute and the National Health Law Program.
- ⁵ A. Lotven, “[Advocates Seek Meeting with CMS Following Avalere Study on Drug Tiers](#),” *Inside CMS*, Feb. 17, 2015.
- ⁶ C. F. Pearson, *Avalere Analysis: Exchange Benefit Designs Increasingly Place All Medications for Some Conditions on Specialty Drug Tier* (Washington, D.C.: Avalere Health, Feb. 11, 2015). In 2015, Avalere found in silver plans in eight states, more plans had specialty tiers where consumers paid more than 30 percent coinsurance.
- ⁷ U.S. Department of Health and Human Services, [HHS Notice of Benefit and Payment Parameters for 2016, Final Rule](#), *Federal Register*; Feb. 27, 2015.
- ⁸ A consumer can also request an expedited review process if enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug. The review time for each process is 24 hours.
- ⁹ The cost-sharing paid by enrollees for in-network providers counts toward the enrollee’s maximum out-of-pocket limit.
- ¹⁰ C. Sloan and E. Carpenter, *Avalere Analysis: Exchange Plans Include 34 Percent Fewer Providers than the Average for Commercial Plans* (Washington, D.C.: Avalere Health, July 15, 2015).
- ¹¹ L. Hamel, M. Norton, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, May 2015).
- ¹² S. R. Collins, M. Gunja, M. M. Doty et al., *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not* (New York: The Commonwealth Fund, September 2015).
- ¹³ U.S. Department of Health and Human Services, [HHS Notice of Benefit and Payment Parameters for 2016, Final Rule](#), *Federal Register*; Feb. 27, 2015.
- ¹⁴ T. Ready, “[NCQA Adds Narrow Networks to 2016 Accreditation Standards](#),” *Health Leaders Media*, Aug. 12, 2015.
- ¹⁵ Health Plan Week, “Plans See Sharper Regulatory Attention to Networks, Fine-Tune Strategies for 2015–16,” *Health Plan Week*, Aug. 24, 2015.
- ¹⁶ Plans had to offer the equivalent to the rehabilitative services benefits offered under the state’s benchmark plan.
- ¹⁷ Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

- ¹⁸ U.S. Department of Health and Human Services, [HHS Notice of Benefit and Payment Parameters for 2016, Final Rule](#), *Federal Register*, Feb. 27, 2015.
- ¹⁹ U.S. Departments of Labor, Treasury, and Health and Human Services, [FAQs About Affordable Care Act Implementation \(Part XXVII\)](#).
- ²⁰ Centers for Medicare and Medicaid Services, [Out-of-Pocket Calculator Bulletin](#), June 4, 2015.
- ²¹ L. Hamel, M. Norton, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, May 2015); and S. R. Collins, M. Gunja, M. M. Doty et al., *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not* (New York: The Commonwealth Fund, September 2015).
- ²² S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Americans' Experiences with Marketplace and Medicaid Coverage: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015* (New York: The Commonwealth Fund, June 2015).



The
COMMONWEALTH
FUND

www.commonwealthfund.org