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Private Insurance Benefits and Cost-Sharing Under the ACA

The Department of Health and Human Services (HHS) recently released guidance on the two key components that determine the level of protection that private insurance plans will provide to consumers under health reform. The first involves the services that insurance plans must cover, and the second involves how much patients must pay out-of-pocket for those services.

The Affordable Care Act (ACA) establishes new rules for what insurers must provide for both components starting in 2014. This requires balancing sometimes competing goals of standardizing plan design -- which provides certain guarantees to consumers no matter where they live or what plan they choose and facilitates comparisons across insurers – and permitting more diversity of choices in the marketplace. With recent guidance issued by the federal government on **benefits** and patient **cost-sharing**, how insurance options could vary by plan and by state has become quite a bit clearer.

Covered Services: The ACA requires HHS to identify essential health benefits for insurance plans offered in the individual and small group markets. The covered benefits must include at least 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

While quite comprehensive, these 10 categories also leave some room for variation, including specifically what services within a category are covered and whether there are limits on those services (e.g., caps on the number of visits for physical therapy or home health care, both of which are quite common today). Rather than specify a complete standard benefit package, the federal guidance would let each state determine those specifics by choosing a benchmark plan. This is similar to the approach used for the Child Health Insurance Program. Options available to states for the benchmark include: one of the three largest small group products in the state, one of the three largest plans offered to state employees, one of the three largest national plans offered to federal employees, or the largest Health Maintenance Organization (HMO) in the state. States would need to augment the chosen benchmark if it does not provide coverage for one of the required categories (e.g., habilitative services). Benchmarks will certainly vary from state to state, but the covered benefits will likely look relatively similar.

The guidance also allows insurers within a state to vary what services they cover. The federal guidance uses the concept of “actuarial equivalence,” meaning that plans can trade one benefit for another so long as the coverage overall provides the same value on average for consumers. The guidance offers two options for plans to make these benefit trades. One would allow equivalent substitutions only within each of the 10 overall categories. The other would allow substitutions across categories as well, providing plans with greater flexibility. The HHS bulletin indicates that further guidelines will be issued so that insurer substitutions will not result in discrimination against enrollees or applicants with health conditions.

Insurers will also have flexibility in how they actually cover certain benefits. For example, all plans will have to include prescription drug coverage, but the formularies that specify which drugs are covered will vary. The federal guidance requires only that plans cover at least one drug in each class (e.g., antidepressants, drugs to lower cholesterol, protease inhibitors for HIV, etc.). This is somewhat different from federal standards for Medicare prescription drug plans. Medicare plans must cover at least two drugs in each class, and for six protected categories – antidepressants, antipsychotic drugs, anticonvulsant drugs, cancer drugs, immunosuppressant drugs used by transplant patients, and antiretroviral drugs used by patients with HIV – all or substantially all licensed drugs must be covered. Plans also will have different networks of providers and different ways of managing access to providers and covered services.

Cost-Sharing: How much patients must pay out-of-pocket for covered services is determined by a measure called “actuarial value” (AV), which is the percentage of health care expenses a plan would cover on average for a standard population. For example, a plan with an actuarial value of 70% would be expected to cover on average 70% of health care expenses, with enrollees paying the remaining 30% through some combination of deductibles, copays, and coinsurance.

Some amount of diversity in cost-sharing is built into the statute itself, with plans required to offer coverage in any of four standardized “metal tiers:” bronze (AV of 60%), silver (AV of 70%), gold (AV of 80%), and platinum (AV of 90%). (To put this in perspective, **current employer-based plans** have an average actuarial value between gold and platinum, and current individually-purchased plans have an actuarial value between bronze and silver.)

Within each tier, insurers could design a wide range of options with varying deductibles, copays, and coinsurance to meet the specific actuarial value. The only cost-sharing element specified for all plans is a cap on total annual out-of-pocket costs, equal to the out-of-pocket limit in Health Savings Account qualified plans (currently $6,050 for an individual and $12,100 for a family).

Lower-income enrollees who buy coverage through a health insurance exchange would have lower out-of-pocket caps and be eligible to enroll in plans with lower cost-sharing levels. For example, enrollees with incomes between 150% and 200% of the poverty level ($34,575 to $46,100 for a family of four) would have an out-of-pocket maximum equal to one-third of the standard level (e.g., a little over $2,000 per person) and receive coverage with an actuarial value of 87%.

The recent federal guidance indicates that actuarial values will be determined using a standard calculator developed by the federal government, rather than allowing insurers to use their own data and assumptions. This means that two plans from different insurers with the same plan design will have the same actuarial value. This approach could mitigate one potentially large source of variation across insurers in the cost-sharing they require of patients within a given tier. Last year, for example, Kaiser commissioned three consulting firms to estimate the cost-sharing that would be required in 2014 to meet the actuarial value thresholds in the ACA using their own data and some common assumptions. The **results** varied tremendously. For a silver plan with 20% coinsurance, the estimated deductible for a single person ranged from $1,850 to $4,200.

The guidance notes, however, that the calculator may not be able to provide results for some complicated plan configurations, such as tiered networks or donut hole designs. Insurers may be able to adjust the way they use the calculator in these situations, introducing more subjective actuarial judgment into the calculation. States would also be given flexibility to customize the actuarial value calculator using local data, which could result in some variation across states in what cost-sharing is required.

There are still a number of outstanding questions about how the rules governing benefits and cost-sharing will work. For example, will plans be prevented from discriminating against very high-cost patients by imposing substantial cost-sharing or limiting coverage for specialty drugs and other services affecting a small number of people? Will consumers be able to readily recognize and understand variations in plan benefit and cost-sharing designs, and evaluate the differences in protection they offer?

But, the basic approach for how this will all work is now coming into view. Individual consumers and small businesses will be able to choose from a very wide range of options, from bronze plans offering essentially catastrophic coverage to platinum plans with much lower cost-sharing (and higher premiums). Deductibles and other cost-sharing features will vary somewhat from plan to plan and state to state, but a bronze, silver, gold, or platinum plan should provide approximately the same degree of protection everywhere. Benefits may vary somewhat across the country, depending on the benchmarks that states choose, and across insurers as well. That variation is likely to be more around limits on the number of days or visits that are covered rather than outright exclusions for entire categories of services, and coverage will certainly vary less than it does today.

Different people, of course, will come to different judgments about how this approach balances the goals of ensuring minimum protection for consumers, comparability, and diversity of choice.

—Larry Levitt, Gary Claxton, Karen Pollitz

http://healthreform.kff.org/notes-on-health-insurance-and-reform/2012/february/private-insurance-benefits-and-cost-sharing-under-the-aca.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+NotesOnHL+%28Notes+on+Health+Insurance+and+Reform+%28Headlines%29+-+Kaiser%27s+Health+Reform+Source%29