

Plan Levels/Standardization of Coverage

Beginning in 2014, consumers and employers can expect more standardization in the scope and value of private health insurance coverage available. This standardization will help individuals and businesses make better informed comparisons among insurance plan options. It should also help guard against insurance company efforts to use benefit design to cherry pick healthier people at the expense of those with high cost health conditions.

Background

Under the Patient Protection and Affordable Care Act of 2009 (PPACA) health plans¹ will be required to provide four levels of coverage: bronze, silver, gold and platinum.² In the exchanges, participating plans must offer at least one silver and one gold plan.³

Each plan in each level must cover the same set of minimum essential benefits that will be detailed in future regulations.⁴ And some states may require plans to cover additional benefits, if the state defrays any additional costs of those benefits.⁵ But while the scope of benefits will be the same among the plans, the value of those benefits will vary across the bronze, silver, gold and platinum levels, based on the kind of cost-sharing required. Bronze plans will be the least generous, with more cost-sharing for covered benefits, and platinum plans will be the most generous, with less cost-sharing.

However, no plan will be allowed to impose deductibles, copayments or other forms of cost sharing greater than those imposed by high deductible plans (for 2010, the limit would be \$5,950 for an individual and \$11,900 for a family).⁶ And plans for small businesses are barred from charging deductibles greater than \$2000 per year for individual coverage or \$4000 per year for family coverage (this amount will be annually adjusted to account for inflation).⁷ And no plan can apply a deductible or charge any cost sharing for certain evidence-based preventive health services.⁸

¹ This requirement applies to qualified health plans both inside and outside the exchanges, but “grandfathered” plans and large, self-insured employer plans are exempted (Patient Protection and Affordable Care Act (PPACA) of 2009, §§ 1251, 1301).

² PPACA § 1302(d).

³ § 1301(a)(1)(C)(ii).

⁴ The statute sets out categories of benefits that must be covered, as follows: 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. § 1302(b)(1).

⁵ § 1311(d).

⁶ § 1302 (c).

⁷ Ibid.

⁸ Ibid.

Levels of Coverage Based on “Actuarial Value”

The four levels of coverage are based on “actuarial value.”⁹ Actuarial value is a measure of the level of protection a health insurance policy offers and indicates the percentage of health costs that, for an average population, would be covered by the health plan. The four levels provided in PPACA are:

Bronze: 60%
Silver: 70%
Gold: 80%
Platinum: 90%

In other words, for a bronze plan, the health plan would cover 60% of the cost for an average population and enrollees (on average) would cover 40%. For a platinum plan, an average individual would pay 10% out of pocket for their covered benefits and the plan would pay 90%. However, individuals with cancer and other high cost health conditions could end up paying significantly more than the average.

Some individuals will also be able to purchase “catastrophic” plans that cover essential benefits but have high deductibles.¹⁰ The only people who can purchase catastrophic coverage are young adults (under 30) and individuals who’ve been exempted from the individual mandate because there’s no available affordable coverage.¹¹

Premium Subsidies and Cost Sharing Credits

Starting in 2014, PPACA provides financial assistance to low- and moderate-income people (up to about \$88,000 per year for a family of four) who need help paying insurance premiums and cost-sharing expenses.¹² The amount of premium help each individual or family receives is based on the price of the second lowest-cost silver plan available.¹³ This means that the plan will cover 70% of the average costs, with the enrollee paying, on average, 30%. If the individual purchases a gold or platinum plan, he or she will need to pay the difference between the premium credit amount and the cost of the more expensive plan. However, he or she will get a more robust level of coverage, with the plan covering, on average, 80% or 90% of costs.¹⁴

Individuals under 250% of the federal poverty line (about \$55,000 for a family of four) are also eligible for cost-sharing credits, provided on a sliding scale basis. Thus, in addition to premium credits, the federal government will help defray any co-payments, coinsurance, and deductibles. In order to access the cost-sharing credits, the individual has to enroll in a silver plan. But eligibility for cost-sharing help means that the enrollee would not have to pay the full 30% average cost sharing for a silver plan. In effect, they will be enrolled in a plan with a higher actuarial value. For

⁹ § 1302(d).

¹⁰ § 1302(e)

¹¹ § 1302(e).

¹² §§ 1401, 1402.

¹³ § 1402(b)(3).

¹⁴ For a good explanation of the premium assistance and cost-sharing credits in PPACA, see Center on Budget and Policy Priorities, *Making Health Care More Affordable: The New Premium and Cost-Sharing Credits*, May 19, 2010, available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3190>.

example, a very low-income family (below 150% of poverty line) would be eligible for cost-sharing credits that would provide them coverage with an actuarial value of 94 percent. For a family between 150-200 percent of poverty, the actuarial value of their plan would be about 87%.¹⁵

Example:

Juan is a 23 year old waiter with diabetes who makes \$21,000 per year. He enrolls in the lowest-cost silver plan he can find. His annual premium is \$3500, but because of his income, the government pays \$2635 of that (he pays \$865). Unfortunately, shortly after he signs up for his new plan, he needs emergency surgery for a burst appendix. However, because he's eligible for cost-sharing assistance, his out-of-pocket liability (premiums plus cost-sharing) is capped at \$3840, or 18% of his income.

Issues to Consider

Financial impact of plan choices

For cancer patients and their families, there are significant implications connected to the level of health plan they choose. Higher level plans (i.e., gold and platinum) will impose lower deductibles, co-payments and co-insurance on people who use health care services, but will likely have higher monthly premiums. Conversely, bronze and silver plans will be cheaper to buy but could expose consumers to significant cost sharing over time.

Examples:

The Peters family of four earns \$100,000 a year. They're all pretty healthy, so they purchase a bronze plan because the premiums are relatively low, \$700 per month. However, in April their son Carl is diagnosed with a rare form of leukemia that requires aggressive treatment and hospitalization. The bronze plan requires a deductible of \$7500, as well as co-insurance on cancer drugs of 20%. During the course of the year the Peters exhaust their deductible and reach the out-of-pocket limit (\$11,900) imposed by the law. Over the course of the year, the Peters spend \$20,300 on premiums, deductibles and other out-of-pocket costs — over 20% of their income. [Note: each plan is required to offer an annual “open enrollment” period, so the Peters can, later in the year, move to a more comprehensive plan].

Sarah is a 35 year-old engineer who makes \$75,000 as an independent contractor. She's a breast cancer survivor and signs up for a platinum plan in the exchange. Her annual premiums are \$8000, but there is no deductible and co-payments are low. During the course of the year her breast cancer returns, requiring immediate treatment. She has numerous doctor visits, surgery, and must start chemotherapy. Her cumulative copayments reach \$500. In total she spends \$8500 on premiums and other cost-sharing combined, or 11% of her income.

¹⁵ *Ibid.*

Adverse Selection Between Plan Levels

Just as adverse selection can arise between plans inside and outside the exchanges, so too can adverse risk selection occur among the plans inside the exchanges. If high cost patients gravitate to plans at the platinum level because they face less cost sharing, and healthy people gravitate to bronze level plans because the premiums are lower, over time the premiums in the platinum plans will increase.¹⁶ The new law provides some tools to mitigate this problem, such as through the use of risk adjustment, reinsurance and risk pooling across all product lines. But these tools are imperfect and will not completely protect from adverse selection.

Conclusion

PPACA's requirements for greater standardization and information about benefit design and plan pricing empowers consumers to compare and choose the health plan that is right for them. But allowing them to make these choices comes with some risk — those who are healthy may choose plans that aren't adequate if and when they get sick. People will need comprehensive, easy-to-understand information about their options and the estimated cost-sharing they will face. And because individuals who are sick will likely gravitate to the gold and platinum levels, it could cause premiums to rise for people enrolled in plans in those levels. The exchanges will need the tools, skills and resources to effectively tackle any adverse selection.

¹⁶This is called the insurance rate “death spiral.” This happens when an insurance risk pool attracts sicker and more costly enrollees because of the benefits offered, low cost sharing, and/or an attractive provider network. Because premiums reflect the cost of providing care to a particular population, when the risk pool attracts sicker people, it drives premium prices higher, causing healthier individuals to seek coverage elsewhere, compounding the problem of increasing premium costs.