

ACA Implementation – Monitoring and Tracking

Missed Opportunities: State-Based Marketplaces Fail to Meet Stated Policy Goals of Standardized Benefit Designs

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally.

ABSTRACT

The federally facilitated health insurance marketplace (FFM) is attempting to improve consumers' ability to make plan-to-plan comparisons during the 2017 open enrollment season by encouraging insurers to offer standardized benefit designs. In doing so, the FFM is following the path of several state-based marketplaces (SBMs) that require insurers to offer standardized health plans, although the FFM and most SBMs also allow insurers to offer nonstandardized options. Through an analysis of policy guidance, consumer-facing marketplace websites, and interviews with state officials and key stakeholders, this paper explores the experiences of SBMs in Connecticut, Massachusetts, New York, and Oregon that

have required participating insurers to offer standardized plans. The authors find that although broad consensus exists among state officials and stakeholders that the primary goal of health plan standardization is to facilitate "apples-to-apples" plan comparisons, these states' policy choices and website interfaces have curtailed their ability to achieve these stated goals. In particular, by allowing insurers to offer nonstandardized options in addition to standardized options and failing to use web-based decision support tools to differentiate between plan options, consumers in these SBMs have limited ability to conduct the plan-to-plan comparisons as originally envisioned by policymakers.

INTRODUCTION

Buying a health insurance plan that meets an individual's or family's health and financial needs is challenging. Consumers must weigh the plan price, benefits, cost-sharing (deductibles, co-payments and co-insurance) and annual cost-sharing limits, provider networks, and, in many cases, drug formularies. The Affordable Care Act (ACA) is designed to simplify this shopping experience through several insurance market reforms and the establishment of health insurance marketplaces that can facilitate the apples-to-apples comparison of health plans.

Under federal rules, health plans sold through the marketplaces must cover similar essential health benefits, and plans are categorized into levels of bronze, silver, gold and platinum based on their actuarial value.^{1,2} Until recently, however, federal regulators have not proposed standardizing the cost-sharing associated with benefits covered under

participating plans. Consequently, in many markets consumers must choose among hundreds of health plans at each actuarial value level, with different permutations of deductibles, co-payments, and co-insurance, for different services with varying provider networks covered by the plan.

This may soon change. In an effort to simplify the consumer shopping experience and facilitate plan-to-plan comparisons, the Centers for Medicare & Medicaid Services (CMS), which operates the federally facilitated marketplaces (FFM), has encouraged participating insurers in 2017 to begin offering standardized benefit designs in addition to other nonstandardized options. In making this shift, CMS is following the lead of several state-based marketplaces (SBMs) that have used their active purchasing authority to require insurers to offer standardized health plans.³ These states have done so primarily with the goal of supporting

apples-to-apples plan comparisons. The experience of these SBMs in developing and displaying standardized plans, as well as the experiences of consumers in shopping

for and enrolling in such plans, could provide valuable insights for federal officials and other states contemplating a similar policy.

ABOUT THIS STUDY

Seven SBMs currently require participating insurers to offer standardized options.⁴ For this report, we study Connecticut, Massachusetts, New York, and Oregon. These states have policies similar to the FFM's rule for 2017, which allows insurers to offer nonstandardized plans in addition to standardized options. The Massachusetts' marketplace has a unique bifurcated structure, described below. In that state, we focus on the portion of the marketplace that offers both standardized and nonstandardized plans. We

conducted a review of each state's legal authority related to standardized benefit design, policy guidance to insurers, and the plan shopping experience on each SBM's website. We supplemented this review with 18 interviews with SBM officials, insurance company executives, consumer advocates, and in-person assisters (marketplace navigators, insurance brokers, and certified application counselors). The interviews were conducted between March 2016 and April 2016.

BACKGROUND

The ACA requires that health insurance marketplaces, or exchanges, be established in every state. The goal of that requirement is to increase competition and transparency to expand health insurance coverage and reduce costs.⁵ States were given the option to create their own marketplaces with their own regulatory authority or defer to the FFM. As of 2016, 34 states have chosen to operate their marketplaces via the federal platform, Healthcare.gov.⁶ All marketplaces, whether state or federally run, must handle plan management, financial management, eligibility and enrollment, and consumer assistance and outreach.⁷ Additionally, under federal rules, all participating plans must meet actuarial value standards and offer minimum essential health benefits. SBMs may set higher standards or take a more active role in selecting and managing participating health plans.

Several SBMs have chosen to be active purchasers, with some taking action to selectively contract with insurers, organize their markets, and promote the reporting and display of a plan's performance on quality metrics. For example, the FFM and many SBMs require all participating plans to have "meaningful differences" from one another to help consumers differentiate among plan options.⁸ Further, seven of the SBMs have required that standardized plans be offered within their marketplaces.^{9,10} Of these, six also allow insurers to offer nonstandardized plans. Only California's SBM requires all plans sold via the marketplace to be standardized. Massachusetts' SBM has a unique bifurcated structure. One of Massachusetts' SBMs (ConnectorCare) serves people with incomes under 300 percent of the federal poverty level (FPL) and requires all participating plans to be standardized. For

those with incomes above 300 percent of FPL, the other Massachusetts SBM (the Health Connector) offers both standardized and nonstandardized plans.¹¹

Standardized plans typically share defined cost-sharing parameters (deductibles, co-payments, and co-insurance) within each metal level, allowing consumers to more easily compare plans based on network, brand, and price. For example, a standardized benefit design might require all gold plans in the marketplace to include an annual deductible of \$1,000, a \$500 co-payment for inpatient hospital services, a \$30 co-payment for primary care visits, a \$45 co-payment for specialty visits, and so on. In addition, states can pursue a range of policy options related to benefit design standardization. For example, a state could require all nongroup insurers, both inside and outside the marketplace, to offer standardized benefit designs, or they could be required only of marketplace insurers. States can also require standardization at only selected tiers, such as only for silver and gold plans. States can also choose the specific types of benefits or services for which cost-sharing will be standardized. For example, Massachusetts now standardizes cost-sharing for 14 benefits but will be expanding to 21 benefits in 2017.¹²

Massachusetts, whose marketplace was the first to implement plan standardization in 2010, found that standardizing plan designs made consumers more likely to accurately differentiate among plans, leading them to choose more generous benefit designs.¹³ Behavioral economics research has also shown that giving consumers too many choices can harm their ability to

make good decisions.^{14,15} Perhaps for these reasons, plan standardization is not unique to SBMs. Several private health insurance exchanges, such as those operated by Aon, Mercer, and Towers Watson, require some standardization across their plans.¹⁶

In addition to facilitating improved consumer decision-making through “apples-to-apples” comparisons, some states have also embraced standardized designs to help deliver more up-front value to consumers, such as reducing or eliminating cost-sharing for primary care services and lowering co-payments for generic drugs. Requiring standardized plans can also curb the ability of an insurer to set discriminatory cost-sharing structures that discourage enrollment by sicker people. For example, one

study found the average annual cost of a generic HIV drug to be three times more expensive in nonstandardized plans than in standardized plans.¹⁷

Starting in 2017, insurers participating in the FFM will also be encouraged, though not required, to offer standardized plans.¹⁸ Called “simple choice” plans, the FFM will display them prominently via Healthcare.gov. “Simple Choice plans will help consumers make apples-to-apples cost-sharing comparisons as they shop,” according to federal officials.¹⁹ After seeking public input on how to best to display these plans, federal officials indicated they would test different options and plan descriptions, so that consumers can “best understand what they offer, a clear, easy-to-understand choice.”²⁰

FINDINGS

Study States Share Common Policy Goals for Plan Standardization

Marketplace officials across our four study states identified three policy goals associated with standardizing benefit designs. First, these SBM officials universally conveyed that the primary goal of plan standardization is to streamline consumers’ shopping experiences and make comparing plans easier. Massachusetts’s SBM, often cited as the model for the health insurance marketplaces in the ACA, was the first to standardize its health plan benefits. In doing so, officials told us, “The ultimate goal was to give consumers ‘apples-to-apples’ comparison capabilities...and take as much mystery out of the game as possible.” Officials and stakeholders alike in the state analogize the Massachusetts SBM to a store, with health plan products on its shelves. “When [consumers] look across that shelf,” one official said, “we want them to see the same thing over and over—with the goal of facilitating comparison on the most important variables,” such as network design and price.

Officials in the other study states—Connecticut, New York, and Oregon—similarly identify the goal of apples-to-apples shopping as the “fundamental” goal of standardizing benefit designs. In Oregon, by equalizing cost-sharing across benefits, SBM officials wanted to narrow consumers’ focus to a plan’s price and quality. A Connecticut official observed, “We found that consumers tend to focus on price, but we want people to worry about network, the formulary, and then plan coverage.” This shared goal, however, was ultimately undermined in all four of our study states by other policy and operational choices, discussed below.

In Connecticut, SBM officials identify a second important goal for standardizing plan benefits: “We wanted a more patient-centered plan design,” said one official. State officials thus approached the design of standard plans with the goal of improving access to valued services, such as primary care.

Third, although perhaps not explicitly articulated as a goal of standardization, several SBM officials cited its ancillary benefit of easing the regulatory oversight of health plans. By prescribing the deductibles and cost-sharing for specific services at each plan level, the policy narrows insurers’ ability to use benefit design to select favorable risk and deter enrollment by those who are sick. An insurance executive in New York further suggested that the policy has taken away “some of the gaming” in product design. Further, as one state official observed, the policy makes it easier for regulators to “monitor the market and find outliers more quickly.”

Insurer and consumer stakeholders alike generally agree on value of standardization

Insurance company executives and consumer advocates in all the study states consistently noted the value in the availability of standardized plan offerings for consumers. “From my perspective, it’s all about the consumer understanding their choices,” noted an insurance executive. “The prospective member can compare easily; it’s essentially the same thing across the plans.”

In addition, most insurers with whom we spoke believe their state marketplace had found an appropriate balance between standardization and innovation of plan design. “We thought [plan standardization] was fine—we didn’t have any

objections to it,” noted one insurance company executive in Connecticut. However, in all of our study states, insurers pushed hard to ensure they could market nonstandardized plans alongside the standardized options. And some state officials conceded that insurers are generally in the best position to design plan benefits and cost-sharing. “The carriers can innovate and react to changes in the market and medicine much quicker than we can,” one official said.

Insurers stress that the ability to offer nonstandardized options is important to maintaining their competitive edge, and they successfully argued before marketplace officials that if all plans were standardized there would be little to differentiate them from other insurers. However, other stakeholders noted that health plans have several key facets other than benefit design upon which insurers can compete, such as provider network, pricing, quality ratings, and customer service.

Generally, insurers with whom we spoke indicated that, several years in, the policy was working reasonably well. These comments of a New York insurer reflect similar comments from representatives in other states: “I think New York got the balance [between standardization and innovation] pretty well.... Maybe even got it just right.”

Consumer advocates and assisters, including insurance brokers, also expressed support for the SBMs’ standardization policy; in all four states consumer advocates were among those that initially lobbied for the policy and continue to push for maintaining and expanding it. Assisters told us that the standardized designs have made comparisons easier when they help consumers select a plan. As noted, Massachusetts’ marketplace is unique because consumers with incomes under 300 percent of FPL are eligible for plans via ConnectorCare, which offers only standardized plans. Consumer assisters report that shopping for a plan in ConnectorCare is much easier than shopping for

one in the Health Connector, where nonstandardized options are available. They note that in ConnectorCare, “all we have to explain is network and premium differences. It really is that apples-to-apples comparison.”

At the same time, some assisters and state officials acknowledge the value of maintaining nonstandardized options. For example, an Oregon broker has found that some nonstandardized plans have lower cost-sharing for lab services than the standardized options, leading clients with certain health conditions, such as diabetes, to prefer these plans. Similarly, in New York some of the nonstandardized options cover adult dental services, which has been appealing to many consumers helped by one assister we interviewed.

Evolving SBM approaches to standardization in support of policy goals

To meet their stated goals of facilitating apples-to-apples plan comparisons, all four of our study states will require participating insurers in 2017 to offer gold, silver, and bronze health plans with predefined cost-sharing amounts (table 1). This approach is similar to the states’ 2016 policies except for Massachusetts, which does not currently require a bronze standardized plan. In Massachusetts and New York, insurers must also continue to offer a platinum plan with predefined cost-sharing amounts. Consistent with the marketplaces’ 2016 standards, insurers in all four states will be permitted (but not required) to offer nonstandardized plans at each plan level.^{21,22}

Our study states also limit the total number of plans, either standard or nonstandard, to provide a more manageable number of plans for consumers to consider. Only Massachusetts limits the number of standard plans offered by an insurer on alternative or additional provider networks; all study states limit the number of nonstandard plans.

Table 1. Study-State Approaches to Standardization for 2017

State	Availability of standardized plan	Limits total number of standard plans? ^a	Limits total number of nonstandard plans? ^a
Connecticut	Gold, silver, bronze ^b	No	Yes, up to 11
Massachusetts	Platinum, gold, silver, bronze ^c	Yes, up to 8	Yes, up to 3
New York	Platinum, gold, silver, bronze ^d	No	Yes, up to 11
Oregon	Gold, silver, bronze	No	Yes, up to 9

a Does not include catastrophic plans.

b Connecticut allows, but does not require, individual market insurers to offer a standard platinum plan.

c Massachusetts requires insurers to offer standardized plans on their broadest commercial network and allows for the same standard plan to be offered on a different type of network (i.e., tiered or narrow).

d New York will allow, but not require, insurers to offer standardized products with three primary care visits not subject to the deductible; if insurers opt to offer this type of standard product, they must do so in the gold and silver plan levels.

Massachusetts adds an additional layer of standardization by defining three types of provider networks (“broadest commercial,” “narrow,” and “tiered”); the state requires insurers to offer standardized plans with the broadest commercial network, with the option to also offer standardized plans with narrow or tiered networks. Connecticut also differs from the other states because it requires that the standard silver plan offered by insurers be the lowest-cost silver plan offered by that insurer.²³ Consequently, the standardized plans in Connecticut have attracted 72 percent of enrollment compared with nonstandardized plans.²⁴

In addition to simplifying the consumer shopping experience, some states are trying to provide consumers with a better value through their standardized benefit designs. For example, Connecticut limits cost-sharing in most plans for certain high-value services, such as primary care, and limits the number of services subject to co-insurance. The latter is a form of cost-sharing that makes it difficult for consumers to calculate their out-of-pocket costs.²⁵ In Massachusetts, the marketplace is seeking public feedback on proposed insurance designs for 2018 that would lower cost-sharing for high-value services.²⁶ For 2017, New York allows (but does not require) insurers to offer standard plans that offer three visits to a primary care provider not subject to the deductible.²⁷ Whether insurers there will choose to do so is unknown; unlike the FFM, New York will not provide insurers with standardized plans “preferential” display on the marketplace website. In Oregon, the standard benefits were modeled off of an existing popular plan design.

All the states with standardized benefit designs must adjust them annually to ensure that they meet the actuarial value targets for each plan level. Officials in all four states further acknowledge that their benefit designs should change over time to keep pace with customer

demands and medical evidence (table 2). For example, Connecticut and Massachusetts report that they have made substantive policy and benefit design changes in the face of feedback from consumer advocates and other stakeholders. Connecticut’s marketplace has also changed the benefit design over time in an attempt to bring more up-front value to consumers (i.e., by lowering cost-sharing for primary care services).

Another standard that states continue to adjust is the number of nonstandardized plans allowed on a state’s marketplace. Massachusetts’ approach has evolved the most. Initially, that state’s marketplace required all plans to be standardized, but it soon shifted to allow insurers to offer nonstandardized options. The marketplace did so in response to concerns from insurers and small-business stakeholders who argued that employers were demanding more innovative plan designs than individual consumers (Massachusetts has a merged small-group and nongroup market).

In addition, in 2016, Massachusetts reduced the total number of nonstandardized plans that an insurer can offer. “Having less is more” with health insurance, said one assister, remarking that with less choice, consumers are more likely to “dig deeper into the plans.” Going forward, officials suggest that returning to all-standardized offerings could further improve the consumer shopping experience. “We’re on a path to move away from having any nonstandard plans, but we’re not there yet,” officials said.

Similarly, Oregon officials have reduced the limit on the number of plans insurers can offer each year, dropping from a limit of five per plan level in 2014 to three in 2017. According to one Oregon insurer, the goal of limiting plans is to “make things less confusing” and potentially “limit the ‘analysis paralysis’” that consumers face when confronted with too many plans.

Table 2. Study SBMs’ Changes to Standardization Policy, 2014–2016

SBM	Changed benefit design?	Changed maximum number of standardized or nonstandardized plans?	Changed website display of standardized vs. nonstandardized plans?
Connecticut	Yes	No	Yes
Massachusetts	Yes	Yes	Yes
New York	No ^a	No	Yes
Oregon	No	Yes	No

a In 2017, insurers in New York have the option to provide standardized plans with three primary care visits not subject to the deductible. If insurers opt to offer this type of standardized plan, they must offer them at the gold and silver levels.

Websites of the SBMs we studied are not being leveraged to achieve stated policy goals

Although a general agreement appears to exist among SBM officials and stakeholders about the value of plan standardization, and SBM officials and board members indicate that they have devoted “many, many hours” to their approach to standardizing benefits, the SBMs we studied have generally not taken steps to achieve the desired policy goal.

The marketplace websites are the route through which most consumers shop for and select a plan. And although these sites deploy several decision-support tools to simplify and streamline consumers’ shopping experiences, none of our four study state websites have leveraged the benefits of standardization to ease plan-to-plan comparisons, thus limiting their ability to meet their stated policy goals (table 3).

None of the four states provide educational information about standardized plans on the web pages most consumers see (Massachusetts provides a fact sheet, but it’s on a separate page). Standardized plans are not prioritized or highlighted on these websites, and consumers are unable to filter or sort for them. One consumer advocate noted that after all the effort spent in his state to design the standard plans, no commensurate effort has been made to “advertise them as standard or tell people how great they are.” Stakeholders in the other study states reported the same phenomenon.

Three of the four states differentiate standardized plans from nonstandard plans by including the word “standard”

in the plan name (or, in New York, the abbreviation “ST”). The fourth state, Massachusetts, currently does not mark its standardized plans but will for the 2017 open enrollment period. Several stakeholders agree that consumers on their own are unlikely to pay much attention to the plan name and, even if they do pay attention to it, are unlikely to know what “standard” refers to. “The public doesn’t understand the terminology,” noted one insurer.

Some of our study states do, however, educate assisters about terminology so that those assisters can help consumers compare and select plans. For example, Connecticut and Oregon officials, conceding that the website alone does not help consumers differentiate among plans, pointed out that the state has a very strong broker community that understands the differences among plans and helps educate consumers. “We believe brokers are the key parties equipped to assist a consumer in selecting a suitable plan,” said a Connecticut official.

Assisters in New York also indicated that they had received good training from the state on the differences between standard and nonstandard plans. “We’re trained and know the difference,” one New York assister said, “but a consumer on [his or her] own isn’t going to understand.” Similarly, an Oregon broker observed, “When you take the professional out of the equation, standardized plans are probably not serving a purpose.” Assisters in all of our study states are a significant source of enrollment. For example, New York officials have found that more than 50 percent of enrollees receiving marketplace subsidies use an in-person assister.

Table 3. Display of 2016 Standardized Plans on Study States’ Websites

	Connecticut	Massachusetts ^a	New York	Oregon ^b
Is “standard” in name of plan?	Yes	No ^c	Yes, denoted by “ST”	Yes
Are they given any special designation (i.e., pop up box or flag)?	No	No	No	No
Are they prioritized on default landing page?	No	No	No	No
Can you sort for them? ^d	No	No	No	No
Can you filter for them? ^e	No	No	No	No
Any educational or marketing information about them?	None found	Fact sheet on standardized plans available on a separate “Resources” page	None found	None found

a Analysis reflects the website of Massachusetts’s Health Connector, which offers both standardized and nonstandardized options. Researchers did not assess the website for ConnectorCare, where all plans are standardized.

b Oregon’s website is www.healthcare.gov, the platform for the federally facilitated marketplace.

c Massachusetts will require “standard” to be in plan name for 2017.

d Site may have an initial screen to allow consumer to “sort” plans (e.g., by “High to Low Premiums” or “Low to High Deductibles”).

e Site may allow you to “filter” plans (e.g., by plan level, name of carrier, or quality rating).

However, this training may not be adequate or universal across assister types. One assister in Massachusetts asked several of her “most experienced and knowledgeable” colleagues if they knew what a standardized plan was—none did. Similarly, an assister in Connecticut doubted any of her colleagues were using standardized plans to help consumers compare options, noting a lack of training.

To some degree, the lack of website tools that might steer consumers to standardized plans reflects the tension shared across our study states. On one hand, officials in the four states strongly supported simplifying and streamlining the plan shopping experience for consumers. On the other hand, they expressed a real hesitancy to be perceived as limiting consumer choices or steering consumers to a particular kind of plan. Some officials noted that depending on some consumers’ finances and health, standardized plans might not always be the best option. For example, Connecticut officials rejected the idea of prioritizing standardized plans on their site, saying: “We want the opportunity for the consumer to look at everything. We don’t want to necessarily steer them to the standard plans.” Insurers too were concerned that filtering out nonstandard plans or making standard plans the default option would be inappropriate. “For someone with specific needs,” one insurer said, “the standardized plans might not be the best option.”

The SBMs have commissioned little or no consumer testing to assess how best to display standardized plan options on their websites

Of our four study states, none are conducting the kind of one-on-one observational consumer testing that experts recognize is critical to designing a website that allows consumers to make the best decisions about health plans.²⁸ SBM officials report that they have fielded consumer surveys, but none have asked about how consumers use standardized plans to shop for coverage or about their experience accessing services in standard versus nonstandard plans.

Further, the SBMs do not report consistent data on whether and why consumers choose standardized vs. nonstandardized plans. Of our four study states, only Connecticut and Massachusetts had data from the 2016 enrollment season. As noted above, Connecticut’s enrollees clearly favored the standardized options, with 72 percent choosing those plans. This is most likely because the state requires insurers to make the standardized plan at the silver level their lowest cost option. In Massachusetts, approximately 55 percent chose standardized plans.²⁹ New York does not yet have data on 2016 enrollment, but for 2015, 61 percent of consumers enrolled in a standardized

plan option.³⁰ Oregon does not publicly report this data. Officials in these states were uncertain why consumers might be selecting standardized over nonstandardized plans.³¹

Some SBMs report conducting consumer focus groups, but such groups appear primarily designed to help the SBMs develop effective outreach and enrollment messages. Connecticut reports conducting usability testing, in which marketplace officials convened groups of consumers to see how they interacted with the website. Officials report that the usability study was very helpful in generating a prioritized list of improvements. However, it was conducted during the initial development of the website and has not been repeated. Massachusetts officials have conducted consumer testing of their display of standardized plan offerings before the ACA, but they have not done so since shifting to a new plan comparison platform in 2014.

Simultaneously, state officials in Connecticut, Massachusetts, and New York highlight the importance of their relationships with local consumer advocacy groups and assister organizations, which regularly inform them of trouble areas and issues that make the enrollment process more challenging. Officials indicate that many changes both to plan and website designs were made in response to their feedback. For example, New York changed, and Massachusetts will change, the health plans’ names to reflect their standardized status, in part because of assisters’ concerns about the lack of differentiation between standardized and nonstandardized plans.

Limited flexibility of information technology (IT) platforms hinders efforts to improve the shopping experience

SBM officials generally acknowledge that most consumers would have difficulty differentiating standard and nonstandard plans on their websites. Officials point to the lack of flexibility of their IT systems as one reason, and they note that adding filtering or sorting options or pop-up windows to flag standardized plans can be expensive add-on features. “Our website limits our ability to achieve the goal [of highlighting standardized plans],” said a Massachusetts official. New York and Connecticut officials claim that any changes to the external-facing website are a difficult operational and resource challenge. “There’s been some frustration around this,” said one. In particular, the SBMs’ limited financial resources have required them to prioritize system improvements that had more urgency than the development of decision-support tools and display options for standardized plans.

In Oregon, where the marketplace uses the federal IT platform, officials observe that the state's goals for plan standardization "never materialized" for consumers because of the platform's limits. Oregon residents can currently only

differentiate standardized plans from nonstandardized via the plan name. State officials are also uncertain how their state's policy for plan standardization would be integrated into the emerging federal one.

LOOKING AHEAD: MANAGING THE TENSION BETWEEN SIMPLICITY AND CHOICE

A difficult balancing act

SBMs pursuing plan standardization have attempted to balance improving consumers' ability to make plan choices with insurers' interest in greater flexibility to develop "innovative" plan designs. For our study states, this has meant allowing insurers to market nonstandardized plans alongside standardized ones. Some SBM officials acknowledge that in doing so they are to some extent undermining the goals of plan standardization. "There is value in having nonstandard options," said one Oregon executive, "but it takes away from the benefit of having standardized plans in the first place. I can't say which approach is better."

Others believe that standard and nonstandard plans can comfortably coexist, but the website shopping experience must clearly allow consumers to differentiate among them and provide tools to facilitate the "apples-to-apples" comparisons that the marketplaces are supposed to provide. In any event, requiring all plans to be standardized does not, by itself, guarantee a smooth and easy plan selection process. In California's marketplace, where all plans are standardized, a minority of visitors to the website report being satisfied with their shopping experience.³²

Support for limiting the number of plans

All four study states require insurers to offer standardized plan designs and to limit the total number of nonstandard plans they can offer. Limiting the number of plan choices in the study-state SBMs is an idea with broad support, including among insurers. For example, an Oregon insurer told us: "The most helpful thing for Oregon consumers was placing plan limits on each carrier.... Most people are only going to look at the first couple of pages [of the website] anyway for plan options." Insurers in the three other states shared similar sentiments.

Assisters reported that reducing the number of plans offered at each plan level made the shopping experience easier, although a common refrain was that the number and variety of plan choices remains "overwhelming" for most consumers. A consumer survey in Massachusetts

found that the optimal number of plans consumers wanted to choose among is three to five (although whether respondents were referring to insurers or their plan offerings was unclear).

At the same time, our study states generally have many insurers participating on their marketplaces. There were 15 in New York, 11 in Massachusetts, 10 in Oregon, and 4 in Connecticut, although not all of these companies offer plans statewide.³³ Some SBM officials acknowledge that in parts of the country with fewer insurers competing, there might be less of a need to limit the number of plans being offered.

Get data on the consumer experience and use it

SBM officials highlight the value of collecting data and feedback from their customers about their experiences shopping for and using standardized health plan designs. "Listening to the people using your system is always a good idea—both users and stakeholders are really important," said a New York official. At the same time, officials acknowledge that other, more urgent priorities have limited their ability to collect and act on such data.

However, SBM officials and stakeholders broadly agree that the development and offering of standardized plan options will be iterative. "It's going to be a year-over-year learning experience," said one insurer. "We have to see how these products work." Marketplace officials also stated their commitment to keeping up with a rapidly evolving market. Doing so, however, will require SBMs to commit to consumer testing, surveys, and data analysis efforts that are more robust than currently underway.

Marketplace websites can deploy more tools to support plan comparisons

Officials and stakeholders generally agree that the current structure and tools available on the study-state websites do little to help consumers differentiate between standard and nonstandard options. Assisters, consumer advocates, and some marketplace officials propose that standardized plans should be the first ones that consumers see when they visit the marketplace website. Others suggest that the

sites allow consumers to filter for standard plans at each plan level. Consumer advocates further argue that the websites should clearly denote those standard plans that may deliver a particular value, such as covering primary care services or certain drugs before the deductible. However, insurer stakeholders tend to disagree, arguing that nothing is inherently better about standardized plans.

Assisters also point out that, even after cost sharing for plan benefits has been standardized, many important

facets of coverage exist that consumers must research and understand, including provider networks and drug formularies. Those working with consumers emphasize the lack of health insurance literacy and question whether adding more educational information or tools to SBM websites would sufficiently support consumer decision-making. “There is such a huge health insurance literacy challenge, no matter how easy you make it, people are still going to be confused,” a Connecticut assister noted.

CONCLUSION

SBM officials and stakeholders in our study states universally agree that health plan standardization helps consumers understand their choices and compare plans. The four SBMs in this study established their marketplaces with standardized health plans to simplify the shopping experience for consumers.

Between adopting the policy and operationalizing it, however, these SBMs may have missed an opportunity to fully realize the policy’s purpose. Competing policy goals and IT capacity challenges have limited the SBMs’ ability to help shoppers make an “apples-to-apples” comparison among plans. Currently, the states’ SBM websites do not allow for filtering or a meaningful differentiation between standardized or nonstandardized plans. Limited or no data on the consumer

shopping experience and website usability have also stalled progress toward making marketplace websites a place for consumers to more easily assess plan features.

In comparison, the FFM, which is just now establishing a standardization policy for 2017 (via the “simple choice” plan), will use a “prominent display” and “visual support cues,” designed with input from consumer testing, to facilitate apples-to-apples plan comparisons. Although FFM officials can likely benefit from the SBMs’ experiences working with stakeholders such as insurers and marketplace assisters to effectively implement a standardized plan policy, both the FFM and the SBMs should consider ways for states to leverage the greater resources of the FFM to conduct consumer testing, website design, and data analysis.

ENDNOTES

1. "Actuarial value" represents the average percentage of covered health care expenses that will be paid by the insurer.
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