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THE VOICE FOR HEALTH CARE CONSUMERS

Affordable Care Act

Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers

ISSUE BRIEF / MAY 2014

Millions of lower- and moderate-income consumers now have affordable health insurance. These consumers have bought marketplace plans and have received financial assistance—in the form of tax credits—to reduce their monthly premiums.

Of the four levels of marketplace coverage, platinum, gold, silver, and bronze,[1] the majority of these consumers have selected silver plans. Silver plans are an affordable option for lower- and moderate-income consumers because the tax credits they receive are designed to ensure that silver plans are affordable.

A recent analysis suggests that, in many marketplaces, the majority of silver plans have higher deductibles. This can create a barrier to obtaining care for many lower- and moderate-income consumers, because they have to pay their full deductible before their insurance starts covering their health care costs. Consumers with the lowest incomes can receive extra federal financial assistance that reduces their deductibles, but most consumers are not eligible for this type of assistance.

To ensure that access to coverage translates into access to care, it's important that marketplaces offer some silver plans that have more affordable upfront out-of-pocket costs (also called "cost-sharing"), at least for routine care and care of minor health issues.

Our research sought to identify ways to design silver plans with more affordable upfront cost-sharing. To do this, we analyzed the silver plans that are offered in the 34 federally facilitated marketplaces and the standardized silver plan designs that are required in six state-run marketplaces. Our analysis focused on silver plans that had either no deductibles or that exempted a number of services from the deductible (meaning that the plan helps pay for those services before consumers meet their deductible).

This brief discusses the findings of our analysis, and it provides detailed cost-sharing information for the plan designs that we identified. This research may be helpful for advocates, policymakers, and other stakeholders who are considering different silver plan designs that

Silver plans are popular with consumers who are buying coverage in the health insurance marketplaces, particularly those with lower and moderate incomes. This brief presents original research on silver plan designs that make upfront costs for care affordable.

insurers should be required or encouraged to offer in the marketplaces. The brief also outlines policy and advocacy strategies for promoting similar plan designs in marketplaces, and it discusses opportunities for measuring how well these plan designs work for consumers.

Many Silver Plans Have High Deductibles

Plans that are sold in the health insurance marketplaces are assigned to a "metal category" based on the portion of consumers' health care costs they pay, measured by the plan's actuarial value. Platinum plans pay the highest portion of health care costs and have the highest actuarial value, followed by gold, silver, and then bronze plans.

Silver plans have an actuarial value of 70 percent, meaning that they are required to cover 70 percent of people's health care costs (on average). Silver plans offer more generous coverage than the cheaper bronze plans, but they also have higher out-of-pocket costs than the more expensive gold and platinum plans. (For more information on actuarial value and metal categories, see "Actuarial Value and Silver Plans" on page 5.)

Insurers have some flexibility in how they design plans to meet the actuarial value requirements for silver plans. However, analyses of current marketplace plans suggests that the majority of silver plans have high deductibles. For example, a recent analysis by Avalere estimates that the average deductible for a silver plan is more than $2,500.[2]

Plans with such high deductibles may be a good fit for some consumers, such as those who are able to set aside savings to pay for the care they need before they meet their plan's deductible.[3] But high deductibles can create barriers to care: Research has consistently shown that even nominal cost-sharing can deter people—especially those with lower incomes—from getting necessary care.[4]

While the Affordable Care Act now requires health plans to cover certain preventive services before consumers have paid their deductible, there is no similar requirement for other services, like a doctor visit to treat a minor illness or manage a chronic condition. This is concerning, because many lower- and moderate-income consumers may be unable to afford the cost of even a routine doctor visit out of pocket.

Research has consistently shown that even nominal cost-sharing can deter people—especially those with lower incomes—from getting necessary care.

Why It Is Important to Offer Silver Plans without High Deductibles

It is important that marketplaces offer diverse plan options across all metal categories to meet the varied needs of consumers. But it is particularly important for marketplaces to offer silver plans with more affordable upfront cost-sharing, at least for routine and minor care, for the following reasons:

1. Silver Plans May Be the Most Generous Plans that Lower- and Moderate-Income Consumers Can Afford

Silver plans do not have the most comprehensive coverage, but they may be the most generous health plans that many lower- and moderate-income consumers can afford. This is because the tax credits that many of these consumers can receive to reduce their premiums are designed to ensure that the premiums for silver plans are affordable.

Enrollment data show that silver plans are popular with all consumers, but particularly among those with lower and moderate incomes. In the initial annual open enrollment period, across all federally facilitated marketplaces, 69 percent of consumers who had enrolled in a marketplace plan had chosen a silver plan. Among consumers with incomes between 100 and 400 percent of poverty who are receiving financial assistance with health care costs (through premium tax credits and, for those with low enough incomes, reduced cost-sharing), 76 percent had chosen a silver plan.[5]

2. Only Some Consumers Who Are Eligible for Cost-Sharing Reductions also Get Lower Deductibles

The Affordable Care Act reduces cost-sharing for care in silver plans, but only for the lowest-income consumers.

- People with incomes up to 200 percent of poverty (up to $22,980 for an individual or $47,100 for a family of four) qualify for significant cost-sharing reductions that lower their out-of-pocket costs, such as deductibles and copayments, and their out-of-pocket spending limit.
- People with incomes between 200 and 250 percent of poverty (between $22,981 and $28,725 for an individual or $47,101 and $58,875 for a family of four) are eligible for cost-sharing reductions that further limit their total out-of-pocket spending but not their deductibles.[6]
- Those with incomes above 250 percent of poverty do not qualify for any cost-sharing reductions.

3. Younger and Healthier Consumers May Not See High-Deductible Plans as a Worthwhile Investment

Younger, healthier consumers who do not expect to need a lot of care may not want (and may be unable to afford) the most expensive and generous health plans in the marketplace. However, these consumers still likely want a plan that offers good value for their premium dollars. Some younger consumers may decide not to buy any health insurance if the only affordable plans that are available have high deductibles, especially if these consumers don't expect to incur health care costs that rise above the amount of their deductible.

Actuarial Value and Silver Plans

Health plans in each metal category must cover a predetermined portion of consumers' health care costs, as measured by the plan's "actuarial value." Actuarial value estimates the percentage of a population's total health care costs that the plan will pay for in a year based on its cost-sharing design. Platinum plans must have a 90 percent actuarial value, gold plans must have 80 percent, silver plans must have 70 percent, and bronze plans must have 60 percent.*

When we say that silver plans must meet an actuarial value of 70 percent, we mean that a silver plan's cost-sharing must be designed so that the plan pays for, on average, 70 percent of people's medical expenses in a year. Consumers are expected to pay 30 percent of the cost of care out of pocket (on average) through deductibles, copayments, and co-insurance.

Because silver plans must stay within the bounds of a 70 percent actuarial value, they can never completely protect consumers from having to pay higher out-of-pocket costs if they need expensive care. However, the Affordable Care Act does cap the maximum amount a health plan in any metal category can require a consumer to pay for care in a year—this is called the plan's out-of-pocket limit. For 2014, the highest out-of-pocket limit a health plan can have is $6,350 for individual coverage and $12,700 for family coverage.

Insurers must make trade-offs when deciding how to distribute the cost-sharing in their silver plans to meet the required 70 percent actuarial value. Silver plans that set higher deductibles are able to charge relatively lower copayments for care received after a consumer meets the deductible. On the other hand, silver plans that set low deductibles, or that exempt coverage for certain services from the deductible and instead charge copayments for those exempted services, may have to charge relatively higher copayments or co-insurance for other health care services.

It is important to note that actuarial value does not estimate how individual consumers might fare in a plan given their particular health needs. Also, actuarial value considers only the costs of covered services that are delivered by in-network health care providers. A plan's actuarial value does not consider out-of-pocket costs that consumers must pay if they need services that are not included in the plan's covered benefits or if they receive care out of network.

*The Department of Health and Human Services (HHS) allows plans to have an actuarial value that varies by up to 2 percentage points from the required actuarial value for their metal category. For example, to be considered a silver plan, the plan can have an actuarial value that is between 68 and 72 percent.

Identifying Silver Health Plan Designs with More Affordable Upfront Cost-Sharing

In this analysis, we identify existing silver plans that charge more affordable upfront cost-sharing than high-deductible plans do for care of routine and minor health issues. The plans we identified serve as models that officials, advocates, and other stakeholders can promote in their marketplaces.

Our analysis focuses on two types of silver plans that may make cost-sharing for some care more affordable: 1) plans with no medical deductible and relatively affordable cost-sharing for certain types of routine care, and 2) plans that do have a deductible but that exempt care for many routine and minor health issues from the deductible and that charge lower copayments for these exempted services (referred to as plans with deductible-exempt services).

Plan Criteria and Abridged Methodology

The first stage of our analysis aimed to identify silver plan designs with no medical deductible and relatively affordable cost-sharing for certain types of routine care. To do this, we used the healthcare.gov data set QHP Landscape Individual Market Medical to analyze the silver-level qualified health plans (QHPs) that are offered in the 34 federally facilitated marketplaces (including partnership marketplaces). We searched for plans with all of the following five elements:

- No medical deductible
- Primary care office visit copayments of no more than $50
- Specialist office visit copayments of no more than $100
- Generic drug copayments of no more than $30
- If co-insurance is charged for multiple services, the majority of co-insurance charges are no greater than 40 percent

We selected these elements because of their importance to lower- and moderate-income consumers, and based on available plan design information in the healthcare.gov data set. (Due to limitations in the data set, we were unable to analyze the silver plan offerings in all federally facilitated marketplaces to identify plans that had a deductible but that exempted coverage of certain services from that deductible.)

Next, we identified silver plans that have a deductible but that exempt care for many routine and minor health issues from the deductible, and that charge lower copayments for these exempted services. To do

this, we reviewed the standardized silver plan designs in the six state-based marketplaces that required insurers to follow standardized design in 2014. The states with these plans are **California, Connecticut, Massachusetts, New York, Oregon,** and **Vermont**. We reviewed a total of eight standardized silver plan designs in these states. Four states—Connecticut, Massachusetts, New York, and Oregon—each have one standardized silver plan design. California and Vermont each have two standardized silver plan designs.

None of these states has standardized silver plans with no medical deductible, but seven of the eight standardized silver plan designs have a deductible but exempt some services or drugs from the deductible. Of these seven designs, we selected those that we believe do a good job of exempting a number of services from the deductible while keeping copayments relatively low for these exempted services. The standardized plan designs we feature generally have standardized cost-sharing for a high proportion of covered services, which allows for a more comprehensive understanding of how plans meet the 70 percent actuarial value requirements.

For additional information on our methodology, see the Appendix on page 24.

Findings

Across the 34 federally facilitated and partnership marketplaces, we identified seven unique silver plan designs with no medical deductible that also have all of the other lower cost-sharing elements listed on page 6. These designs were used in plans sold in four states: Arizona, Florida, Pennsylvania, and Texas.[7]

Table 1, starting on page 8, shows an apples-to-apples comparison of the in-network cost-sharing for a range of health care services and tiers of prescription drugs in each of the seven **no-deductible silver plan designs** we identified.

Of the eight state standardized plan designs, we identified four silver plan designs that met our criteria. These plans are from California, Connecticut, Oregon, and Vermont.

Table 2, starting on page 12, shows an apples-to-apples comparison of the in-network cost-sharing for a broad range of health care services and tiers of prescription drugs for the **standardized silver plans with deductible-exempt services** and charge relatively lower copayments for these exempted services.

Table 1. No-Deductible Silver Health Plan Designs

This table shows in-network cost-sharing for a broad range of covered health care services for each of the seven no-deductible plan designs in the federally facilitated marketplaces that met our criteria for affordable cost-sharing. The cost-sharing listed is based on information from each plan's Summary of Benefits and Coverage (SBC) document. This table does not provide cost-sharing information for every covered benefit or information on benefit limits. The amounts listed are for people who are not eligible for cost-sharing reductions. For more detailed information about these plans, refer to the plan's SBC, contact the plan directly, or refer to the documents cited on page 27.

	BCBS COPAY COMPLETE 40	COMMUNITY HEALTH CHOICE	INDEPENDENCE HMO PROACTIVE[A]	KEYSTONE HEALTH PLAN HMO 0.0	MOLINA SILVER 250 PLAN	MYCIGNA COPAY 25/45	MYCIGNA COPAY 30/60
							
	DEDUCTIBLES FOR AN INDIVIDUAL (DOUBLE FOR FAMILY COVERAGE)						
Medical Care	$0	$0	$0 / $3,000 (Tier 1/Tier 2 or Tier 3)	$0	$0	$0	$0
Drugs	$0	$0	$0	$500	$0	$0	$0
	OUT-OF-POCKET LIMITS FOR AN INDIVIDUAL (DOUBLE FOR FAMILY COVERAGE)						
Medical	$6,350	$6,350	$6,350	$6,350	$6,350	$6,350	$6,350
Drug	combined wtih medical	combined wtih medical	combined wtih medical	combined wtih medical	combined wtih medical	combined wtih medical	combined wtih medical
	COST-SHARING FOR MEDICAL SERVICES						
▼ OFFICE VISITS							
Primary Care	$40	$40	$20/$35/$50 (Tier 1/Tier 2/Tier 3)	$50	$30	$25/$55 (ACO/PCP)[B]	$30
Specialist	$80	$75	$45/$70/$100 (Tier 1/Tier 2/Tier 3)	$70	$75	$45/$75 (ACO/PCP)[B]	$60

continued ▼

Table 1. No-Deductible Silver Health Plan Designs *(continued)*

	BCBS COPAY COMPLETE 40	COMMUNITY HEALTH CHOICE	INDEPENDENCE HMO PROACTIVE[A]	KEYSTONE HEALTH PLAN HMO 0.0	MOLINA SILVER 250 PLAN	MYCIGNA COPAY 25/45	MYCIGNA COPAY 30/60
▼ TESTING							
Diagnostic Tests (X-Rays)	$40/day	$40/visit	$60	$200/service	$75	40%	40%
Laboratory Services (Blood work)	$40/day	$40/visit	$0	$0/$75 (stand-alone lab/ hospital lab)	$50	40%	40%
Advanced Imaging (CT, MRI)	$500/scan type	$250/visit	$250	$200/service	40%	$750/scan	$750/scan
▼ OUTPATIENT CARE							
Outpatient Surgery Facility Fee	$500/day (+ $1,000 for bariatric surgery)	$175/visit	$200/$700*/ $1,250* (Tier 1/Tier 2/Tier 3)	$500/service	40%	$2,000/visit	$2,000/visit
Outpatient Surgery Physician Fee	$0	$175/procedure	$0/5%*/10%* (Tier 1/Tier 2/Tier 3)	$0	40%	30%	30%
▼ EMERGENCY CARE							
Emergency Room Services	$500/day	$250/visit	$450	$400/service	$500/visit	$500/visit	$500
Emergency Transport	$250/day	$75/trip	$200	$0	$500/visit	$500/trip	$500/trip
Urgent Care	$80/day	$75/visit	$100	$100/service	$75/visit	$75/visit	$75

** deductible applies*

continued ▼

Table 1. No-Deductible Silver Health Plan Designs *(continued)*

	BCBS COPAY COMPLETE 40	COMMUNITY HEALTH CHOICE	INDEPENDENCE HMO PROACTIVE[A]	KEYSTONE HEALTH PLAN HMO 0.0	MOLINA SILVER 250 PLAN	MYCIGNA COPAY 25/45	MYCIGNA COPAY 30/60
▼ INPATIENT CARE							
Inpatient Facility Fee	$1,000/day (max 4 copays/ admission)	$400/day (max 5 copays/ admission)	$400/day; $800/day*; $1,250/day* (max 5 copays/ admission) (Tier 1/Tier 2/Tier 3)	$750/day (max 5 copays/ admission)	40%	$2,000/day	$2,000/day
Inpatient Physician Fee	$0	$75/procedure	$0/5%*/ 10%* (Tier 1/Tier 2/Tier 3)	$0	40%	30%	30%
▼ MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE							
Outpatient Mental/Behavioral Health/Substance Use Disorder	$40/$80/$500 (applicable office visit or outpatient facility fee)	$75/visit	$45	$70	$75/visit	$60/visit	$60
Inpatient Mental/Behavioral Health/Substance Use Disorder	$1,000/day (max 4 copays/ admission)	$400/day (max 5 copays/ admission)	$400/day (max 5 copays/ admission)	$0	40%	$2,000/day	$2,000/day
▼ MATERNITY CARE							
Prenatal/Postnatal	$40/$80 (applicable office visit copay)	$40	$45/$70/$100 (Tier 1/Tier 2/Tier 3)	$0	$0	30%	30%
Delivery and Inpatient Services	$1,000/day (max 4 copays/ admission)	$400/day (max 5 copays/ admission)	$400/day; $800/day*; $1,250/day* (max 5 copays/ admission) (Tier 1/Tier 2/Tier 3)	$0	40%	$2,000/day	30%

** deductible applies*

continued ▼

Table 1. No-Deductible Silver Health Plan Designs *(continued)*

	BCBS COPAY COMPLETE 40	COMMUNITY HEALTH CHOICE	INDEPENDENCE HMO PROACTIVE[A]	KEYSTONE HEALTH PLAN HMO 0.0	MOLINA SILVER 250 PLAN	MYCIGNA COPAY 25/45	MYCIGNA COPAY 30/60
▼ REHABILITATIVE AND HABILITATIVE CARE							
Outpatient Rehabilitative/ Habilitative	$80/visit	$40/visit	$60	$70/visit	40%	$60/visit	$60/visit
	PRESCRIPTION DRUG COST-SHARING (RETAIL PHARMACY)						
Preferred Generic/Tier 1	$25	$25	$4	$20*	$30	$4	$4
Non-Preferred Generic/Tier 1	$25	$25	$10	$20*	$30	$25	$25
Preferred Brand/Tier 2	$70	$75	50% up to $250/Rx	$65*	$65	$60	$60
Non-Preferred Brand/Tier 3	$160	$100	50% up to $250/Rx	$110*	40%	50%	50%
Specialty/Tier 4	50%	35%	50%	$150*/$300*/ $450* (generic/preferred/ non-preferred)	40%	40%	40%

** deductible applies*

[A] This plan has a three-tiered provider network and charges higher cost-sharing for certain types of health services when care is received from a Tier 2 or Tier 3 provider. For these services, cost-sharing information is provided for care received at each provider tier, delineated as Tier 1/Tier 2/Tier 3. The plan also has a combined deductible for care received from a Tier 2 or Tier 3 provider. This deductible applies only to certain types of services, which are marked with an asterisk.

[B] ACO stands for accountable care organization. MyCigna Copay 25/45 charges lower copayments for primary care office visits and specialist office visits if care is received from a provider that is part of a local independent physician association, called Renaissance Physician Organization, which is part of Cigna's Collaborative Care Initiative.

Note: Information regarding whether a copayment applies per visit, service, trip, or procedure is based solely on information in a plan's Summary of Benefits and Coverage. Individual insurers may define what these terms mean differently. For more information, contact the plan directly.

Table 2. Silver Health Plans with Deductible-Exempt Services

This table shows in-network cost-sharing for a broad range of covered health care services for the four state standardized silver plan designs that have deductible-exempt services, more affordable cost-sharing for these exempted services, and standardized cost-sharing for a high proportion of services in general. The cost-sharing listed is based on information from official state documents and, in certain situations, communications with state officials or state marketplace advisory committee members. This table does not provide cost-sharing information for every covered benefit or information on benefit limits. For more information on these standardized plans, refer to the documents cited on page 27.

	CALIFORNIA		CONNECTICUT		OREGON		VERMONT	
								
	DEDUCTIBLES FOR AN INDIVIDUAL (DOUBLE FOR FAMILY COVERAGE)							
Medical Care	$2,000		$3,000		$2,500		$1,900	
Drug	$250		$400		$0		$100	
	OUT-OF-POCKET LIMITS FOR AN INDIVIDUAL (DOUBLE FOR FAMILY COVERAGE)							
Medical Care	$6,350		$6,250		$6,350		$5,100	
Drugs	Combined with medical		Combined with medical		Combined with medical		$1,250	
	COST-SHARING FOR MEDICAL SERVICES							
	EXEMPT FROM DEDUCTIBLE	**COST-SHARING**	**EXEMPT FROM DEDUCTIBLE**	**COST-SHARING**	**EXEMPT FROM DEDUCTIBLE**	**COST-SHARING**	**EXEMPT FROM DEDUCTIBLE**	**COST-SHARING**
▼ **OFFICE VISITS**								
Primary Care	✓	$45	✓	$30	✓	$35	✓	$20
Specialist	✓	$65	✓	$45	✓	$70	✓	$40

continued ▼

Table 2. Silver Health Plans with Deductible-Exempt Services *(continued)*

	CALIFORNIA		CONNECTICUT		OREGON		VERMONT	
▼ TESTING								
Diagnostic Tests (X-Rays)	✓	$65	✓	$45		30%	Not Specified[c]	Not Specified[c]
Laboratory Services (Blood work)	✓	$45	✓	$30		30%	Not Specified[c]	Not Specified[c]
Advanced Imaging (CT, MRI)	✓	$250	✓	$75/service (annual max: $375 for MRI/ CT; $400 for PET)		30%		40%
▼ OUTPATIENT CARE								
Outpatient Surgery Facility Fee	✓	20%		$500		30%		40%
Outpatient Surgery Physician Fee	✓	20%		0		30%		40%
▼ EMERGENCY CARE								
Emergency Room Services		$250	✓	$150		30%		$250
Emergency Transport		$250	✓	$0		30%	✓	$100
Urgent Care	✓	$90	✓	$75	✓	$90	✓	$60
▼ INPATIENT CARE								
Inpatient Facility Fee		20%		$500/day (max $2,000/ admission)		30%		40%
Inpatient Physician Fee		20%		$0		30%		40%

[c] Where cost-sharing is "not specified," cost-sharing can vary by insurer.

continued ▼

Table 2. Silver Health Plans with Deductible-Exempt Services *(continued)*

	CALIFORNIA		CONNECTICUT		OREGON		VERMONT	
▼ MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE								
Mental/Behavioral Health/ Substance Use Disorder Office Visit	✓	$45	✓	$30	✓	$35/$70 (PCP/Specialist)	✓	$20
Inpatient Mental/Behavioral Health/Substance Use Disorder		20%		$500 (max $2,000/ admission)		30%		40%
▼ MATERNITY CARE								
Delivery and Inpatient Services		20%		$500 (max $2,000/ admission)		30%		40%
▼ REHABILITATIVE AND HABILITATIVE CARE								
Outpatient Rehabilitative/ Habilitative	✓	$45	✓	$30	✓ (office visit)	$35/30% (office visit/ emergency care setting)	✓ (office visit)	$40 (office visit)
	PRESCRIPTION DRUG COST-SHARING							
Preferred Generic	✓	$19	✓	$10	N/A	$15	✓	$12
Non-Preferred Generic	✓	$19	✓	$10	N/A	$15	✓	$12
Preferred Brand		$50		$25	N/A	$50		$50
Non-Preferred Brand		$70		$40	N/A	50%		50%
Specialty		20%		40%	N/A	50%	Not Specified[c]	Not Specified[c]

Notes: The services included in Table 2 vary from those in Table 1 in two primary ways: 1) For the state standardized plans, Mental Health/Substance Use Disorder Outpatient Services is replaced with Mental Health/Substance Use Disorder Office Visits. This is because, while all four states clearly defined standardized cost-sharing for mental health and substance use disorder office visits, they did not all provide comparable information about cost-sharing for other mental health or substance use disorder outpatient services. 2) For the state standardized plans, we excluded prenatal care because different states interpreted the scope of services under that category differently. Information regarding whether a copayment applies per visit, service, trip, or procedure is based solely on information in state documents. Individual insurers may define what these terms mean differently. For more information, contact the plan directly.

[c] Where cost-sharing is "not specified," cost-sharing can vary by insurer.

Lessons Learned

Making Routine Care and Care for Minor Health Issues More Affordable

The cost-sharing designs we feature use different strategies to meet the actuarial value requirements for a silver plan, but they all make routine and minor care much more affordable compared to plans with high deductibles or plans that do not exempt any services from the deductible. Many of the featured plan designs keep consumers' out-of-pocket costs lowest for office-based services, minor outpatient care, and generic drugs.

Among the seven **no-deductible silver plan designs** in the federally facilitated marketplaces (see Table 1):

- Four of the designs keep copayments for primary care office visits at or below $30, and three designs keep copayments for specialist office visits between $45 and $60.
- Six designs keep copayments for outpatient rehabilitative and habilitative services (such as physical therapy) between $40 and $80.
- Six plan designs keep copayments for generic drugs at or below $25, and three plans charge only $4 copayments for preferred generic drugs.

Among the four state **standardized silver plans with deductible-exempt services** (see Table 2):

- All four plans exempt primary care, specialty care, mental health office visits, urgent care services, and outpatient rehabilitative and habilitative services from the deductible.
- Every plan keeps copayments for these services (with the exception of urgent care) between $20 and $70.
- Oregon's plan does not have a deductible for prescription drugs–the plan begins paying for these drugs immediately. The plan charges $15 copayments for generic drugs and $50 copayments for preferred brand drugs.
- The other three states set a separate, smaller deductible for prescription drugs, exempt generic drugs from that deductible, and charge copayments of between $10 and $19 for generic drugs.

While these costs may still be a financial burden for some families, they are much more affordable than having to pay the full cost of care out of pocket (as would happen in plans with higher deductibles until the deductible is met). They also help consumers get timely, necessary care. Therefore, marketplaces that have mostly silver plans with high deductibles should consider replicating these models so that consumers have plan choices with more affordable upfront cost-sharing.

Distributing Cost-Sharing between Routine Care and More Expensive Care

Some plan designs struck a balance when assigning levels of cost-sharing to routine, minor care and more expensive care. For example:

- Among the **no-deductible plans** in the federally facilitated marketplaces, the silver plan offered by Community Health Choice of Texas (see Table 1) charged the least for outpatient surgery ($175) and emergency care ($250). It also set some of the lowest cost-sharing for inpatient care ($400 a day for inpatient facility fees, and a $75 copayment per procedure for inpatient physician fees) and specialty drugs (35 percent co-insurance). As a trade-off, this plan had somewhat higher copayments for generic drugs ($25), primary care office visits ($40), and specialty care office visits ($75), compared with some of the other no-deductible plans.

- In addition to exempting more routine care, the standardized **plans with deductible-exempt services** in California and Connecticut (see Table 2) exempt some of the more expensive services from their deductibles, charging relatively more affordable copayments for these exempted services instead. These services include diagnostic tests such as X-rays, and advanced imaging such as MRIs.

In addition to silver plans that keep costs lowest for routine and minor care, balanced plan designs that are similar to those mentioned here could be good models for marketplaces to consider promoting. While some of these plan designs come with slightly higher cost-sharing for minor care, they may do a better job at shielding lower-income consumers from financially burdensome out-of-pocket costs if they need more expensive care.

Trade-Offs in Plan Design

The featured plan designs also show that, because silver plans must meet specific actuarial value requirements, the plans are limited in how low they can keep cost-sharing overall. This is evident in the trade-offs that these plan designs make: Since the plans keep cost-sharing for some services more affordable, the plans must charge relatively higher cost-sharing for other services.

Many of the plan designs with affordable cost-sharing for routine and minor care charge higher cost-sharing for more expensive services, such as inpatient and emergency care, outpatient surgeries, imaging, and specialty drugs.

Among the seven **no-deductible plan designs** in the federally facilitated marketplaces (see Table 1):

- Six of the plans had copayments for inpatient hospital stays (referred to in Table 1 as an Inpatient Facility Fee) that ranged from $400 a day to $2,000 a day. The other plan charged 40 percent co-insurance for this service, which is quite high.

Some plan designs struck a balance when assigning levels of cost-sharing to routine, minor care and more expensive care.

- Six plans charged copayments for advanced imaging services (such as MRIs or CT scans) that ranged from $200 to $750. Again, one plan charged 40 percent co-insurance for this service.

Among the four state **standardized silver plan designs with deductible-exempt services** (see Table 2):

- All four plans had an annual medical deductible that ranged from $1,900 to $3,000 for an individual plan (deductibles were double this for family plans).
- In each plan, the deductible applied to inpatient services, meaning consumers would have to pay the full amount of the deductible before the plan would help pay for a hospital stay.
- Once the deductible is met, all four plans had additional co-insurance or high copayments for inpatient care.
- The standardized plans in Connecticut and Oregon had co-insurance for specialty drugs at 40 percent to 50 percent, respectively.

As these plans show, even when silver plans have relatively affordable cost-sharing, consumers with greater health care needs will likely still face high out-of-pocket costs. For example, consumers who need expensive medications or more complex care (such as surgery) will still have to pay high out-of-pocket costs in many of these plans until they reach their out-of-pocket spending limit.

The Affordable Care Act's caps on out-of-pocket spending (described in "Actuarial Value and Silver Plans" on page 5) provide critical financial protection to these consumers and ensure that they do not face extreme medical debt. But as policymakers and stakeholders consider how to promote silver plans with more affordable cost-sharing, they should also consider ways to provide additional financial assistance (such as state or charity assistance) to lessen the burden that some consumers face (see "States Can Provide Additional Assistance with Costs"). Over the long term, policymakers should also consider federal solutions to further strengthen cost-sharing assistance protections for consumers.

States Can Provide Additional Assistance with Costs

Two states, Massachusetts and Vermont, offer additional financial assistance with cost-sharing to consumers whose incomes are too high to qualify for federal cost-sharing subsidies. Both states' programs provide additional financial assistance to consumers with incomes up to 300 percent of poverty ($34,470 for an individual, $70,650 for a family four). This is a strategy other states could pursue to ensure that lower- and moderate-income consumers can afford care.

- To learn more about the Massachusetts program, see the program's website at https://www.mahealthconnector.org/HomePortal/content/conn/UCM/path/Contribution%20Folders/Content%20Folders%20for%20Connector/Learn/Plan_Info/ConnectorCare/documents/ConnectorCare_Overview.pdf.
- To learn more about Vermont's program, see its website at http://info.healthconnect.vermont.gov/healthplans#COMPANION.

Potentially Problematic Cost-Sharing Designs

Among the no-deductible plans, we identified some cost-sharing designs that could be problematic for certain groups. These designs include tiered cost-sharing that requires consumers to pay more for certain drugs or for care from certain providers, as well as a plan design that increases cost-sharing for care of certain conditions.

Some of these cost-sharing arrangements can be designed in ways that protect consumers. However, if these cost-sharing arrangements are designed poorly, they can create barriers to care for certain groups—or even run afoul of important nondiscrimination requirements of the Affordable Care Act.

Examples of potentially problematic cost-sharing designs among the no-deductible plans include:

- **Three-Tiered Provider Networks:** One plan in Pennsylvania has a three-tiered provider network, and it charges higher copayments for care from providers in higher tiers.

  If done well, tiered provider networks can steer patients to providers that offer higher-value care. But if plans do not have sufficient numbers of first-tier providers in all specialties, consumers could be forced to see providers in higher tiers and pay higher cost-sharing.

- **Four-Tiered Drug Formularies:** All seven no-deductible plans in the federally facilitated and partnership marketplaces have drug formularies with at least four tiers, which charge significantly higher cost-sharing for specialty drugs.

  Some specialty drugs have no generic alternative and are essential to the treatment of certain chronic conditions, such as HIV/AIDS. Charging extremely high co-insurance for these medications could make critical treatment unaffordable for patients with these conditions.

- **Potentially Discriminatory Cost-Sharing for Select Treatments:** One plan raises its outpatient surgery facility fee from $500 to $1,500 specifically for bariatric surgery.

  Plans that increase cost-sharing for a service the insurer generally covers when that service is used to treat a specific health condition—in this instance, morbid obesity—could violate the nondiscrimination requirements of the Affordable Care Act.[8]

Marketplaces need to be mindful of the potential negative consequences of these types of cost-sharing designs. Officials, insurers, and stakeholders should ensure that plan designs in the marketplaces do not create greater barriers to care for particular populations or violate the nondiscrimination requirements of the Affordable Care Act.

Officials, insurers, and stakeholders should ensure that plan designs in the marketplaces do not create greater barriers to care.

Advocating for Plans that Don't Have High Deductibles

While the plans we identified have some shortcomings, they are still valuable models of silver plan designs that can make routine and minor care much more affordable for lower- and moderate-income consumers compared to plans with high deductibles.

Here, we discuss policy strategies that marketplaces and state and federal officials can use to require or encourage insurers to offer plans with more affordable cost-sharing. We then provide tips for advocates and other stakeholders who are interested in getting these policies in place to promote the offering of these plans in their marketplaces.

Policy Strategies to Promote Plans with More Affordable Upfront Cost-Sharing

Establishing Standardized Plan Designs or Standardized Cost-Sharing for Certain Services

Like the state-based marketplaces featured in this brief, other marketplaces could develop standardized plan designs and require marketplace insurers to offer them. Requiring standardized plans that have no deductibles or that have deductibles but exempt certain services from these deductibles would ensure that all consumers in the marketplace have a choice of plans with relatively affordable cost-sharing for at least some routine and minor care.

If implementing standardized plans is not feasible, marketplaces can establish similar protections on a smaller scale. For example, a marketplace could require qualified health plans to exempt a certain number of primary care visits and/or generic drugs from their deductible.

Taking it a step further, a state could apply these requirements more broadly to all plans sold in the individual and small group insurance markets, both inside and outside the marketplace.

Active Purchasing

Some marketplaces have the authority to actively negotiate with insurers about the way they design their plans and set costs for consumers, and others may want to seek this authority. Marketplaces with this "active purchasing" authority could notify insurers interested in participating in the marketplace that they are expected to offer plan designs with more affordable cost-sharing like those we featured.

Informal Negotiations with Insurers

Even states where the marketplaces don't have active purchasing authority or set few requirements for qualified health plans, more informal conversations can take place between the marketplace or state insurance department and insurance companies to encourage plan designs with more affordable cost-sharing. During the period when insurers are proposing plans and marketplaces and insurance departments are reviewing them, the marketplace or insurance department could engage in informal negotiations to encourage insurers to offer plan options like those featured in this brief.

Advocacy Strategies to Promote Plans with More Affordable Upfront Cost-Sharing

Advocating at the State Level

Regardless of what type of marketplace a state has, there are strategies that can be used at the state level to promote plans with more affordable upfront cost-sharing. However, the type of marketplace will affect which stakeholders and officials can make an impact.

State-Based Marketplaces

In most states with state-based marketplaces, marketplace board members, the marketplace's director and staff, the state's insurance department, and state legislators will all have some authority over the marketplace's ability to implement policies like those described on page 19. Therefore, they can all be key partners for advocates and other stakeholders who are interested in promoting marketplace plans with affordable cost-sharing.

In addition, many state-based marketplaces convene stakeholder advisory groups to discuss and make recommendations on policy issues. These can be important forums where advocates and other stakeholders can push for policies that promote affordable upfront cost-sharing.

Federally Facilitated Marketplaces with State Participation in Plan Management

States with federally facilitated marketplaces are allowed to take on some plan management functions for the marketplace if they choose to do so.[9] In these states, officials can be key partners in advancing policies that promote marketplace plan designs with affordable upfront cost-sharing. These officials include insurance regulators and state legislators.

These states may also have marketplace oversight or advisory committees where advocates and other stakeholders can push for policies that require or encourage more affordable plans.

Fully Federally Facilitated Marketplaces

Although the Department of Health and Human Services (HHS) maintains authority for certifying qualified health plans in states with fully federally facilitated marketplaces, all plans in those states (including marketplace plans) still must follow applicable state insurance laws and regulations. Therefore, advocates and other stakeholders in these states can discuss with their insurance departments and state legislators options for promoting plans with more affordable upfront cost-sharing across their state's insurance market.

All Marketplaces

In every state, advocates and other stakeholders can reach out to insurers directly to discuss options for making marketplace plans with more affordable upfront cost-sharing available to consumers and to suggest plan designs that insurers could use as models for designing their own offerings.

Advocating at the Federal Level

Advocates and other stakeholders in states with all types of marketplaces can benefit from working at the federal level to push for marketplace plans with more affordable upfront cost-sharing.

HHS establishes the requirements for plans that wish to sell coverage through **federally facilitated marketplaces**. Advocates and other stakeholders in states with such marketplaces can urge HHS to require, or, at minimum, encourage, insurers in these marketplaces to offer plans with more affordable upfront cost-sharing. For example, HHS could establish standardized plan designs and require all insurers in federally facilitated marketplaces to offer them.

Because HHS also has the authority to establish certain federal requirements that qualified health plans in **all marketplaces** (including state-based marketplaces) must follow, advocates and other stakeholders in any state could encourage HHS to establish universal requirements to improve the affordability of cost-sharing in marketplace plans. For example, in its *Draft 2015 Letter to Issuers in Federally Facilitated Marketplaces*, HHS proposed requiring plans to cover three primary care visits outside of any deductibles.[10] This proposal was not adopted in HHS's final letter to issuers, but stakeholders should continue to urge HHS to implement this policy and other similar policies to help ensure that all marketplaces offer plans with more affordable upfront cost-sharing.

Advocates and other stakeholders can work with their HHS regional office, or they can contact HHS directly regarding any of these issues.[11] In addition, advocates and other stakeholders should look for opportunities to comment on federal regulations and guidance related to the affordability of cost-sharing.

Sharing Consumer Stories

Another tactic to build the case for affordable cost-sharing is to share with HHS and state officials any instances in which consumers have had problems due to the lack of availability of plans with affordable cost-sharing. This could include stories from consumers who have:

- struggled to afford the cost-sharing in their marketplace plan and therefore ended up delaying or forgoing care or suffering financially
- struggled to find an affordable plan in their marketplace that also had affordable cost-sharing
- decided not to buy health insurance because they could not find an affordable marketplace plan that also had affordable cost-sharing

Such stories can provide critical information to officials about the need to take action to ensure that plans with more affordable cost-sharing are available.

Stories can provide critical information to officials about the need to take action to ensure that plans with more affordable cost-sharing are available.

Monitoring How Well Plan Designs Work for Consumers

Since 2014 is the first year that insurers are selling plans in the four metal categories, there is little available evidence to suggest which plan designs within a specific metal category will work best for consumers.

Therefore, states and the federal government should start gathering data on how consumers are faring in different plan designs in order to a) monitor whether plans with higher deductibles are preventing some consumers from obtaining necessary care, and b) provide feedback to insurers on how they should structure plans to better meet consumer needs.

The Affordable Care Act created two opportunities for gathering information that could help this effort. The law established the Qualified Health Plan Enrollee Satisfaction Survey, which will assess the consumer experience in all marketplace plans and will include questions about whether cost-sharing has created barriers to necessary care. The law also established a Qualified Health Plan Quality Rating System (QRS), which requires marketplace plans to report on certain quality measures and which rates these plans on their performance.

As of the date this brief was published, HHS was still deciding how to implement these two programs.

To make the enrollee survey and QRS useful tools for monitoring the effects of cost-sharing in different plans, advocates should urge HHS to add more detailed measurements of consumers' experience with cost-sharing and to make the complete results of these data collection efforts publicly available. It is also critical that the data that are made publicly available be specific to every health plan in a particular metal category. This is the only way to tell which insurers are designing silver plans that make care affordable for consumers versus which insurers have silver plans that make it more difficult for consumers to obtain affordable care.

States and the federal government should consider how to supplement these data collection efforts so that sufficient data are available to inform how to design affordable cost-sharing. Researchers, advocates, and other stakeholders can also play a role in gathering information through focus groups, surveys, and studies on what types of plan design elements are hindering or facilitating consumers' access to care.

Conclusion

Recent analyses of the deductibles in silver plans raises concerns that many marketplaces may have few silver plans with affordable upfront out-of-pocket costs. This could be problematic for many of the lower- and moderate-income consumers who are likely to enroll in silver plans.

The findings of our analysis prove that it is possible to design silver plans that *don't have* high deductibles and that *do have* more affordable copayments, at least for routine care and care for minor health problems. Putting policies in place that require or encourage insurers to offer these types of plans in the marketplace will help make sure that lower- and moderate-income consumers can afford routine care.

By design, silver plans cannot necessarily shield consumers who need expensive care from high out-of-pocket costs. That is why, over the longer term, efforts to get marketplaces to offer more diverse silver plans must be part of a larger initiative to identify and implement state and federal solutions that will prevent lower- and moderate-income consumers from being underinsured. Examples of such solutions include policies to ensure that this population receiving greater financial assistance to help them afford more comprehensive coverage, or policies to expand cost-sharing assistance to more moderate-income consumers.

The findings of our analysis prove that it is possible to design silver plans that *don't have* high deductibles and that *do have* more affordable upfront out-of-pocket costs. Putting policies in place that require or encourage insurers to offer these types of plans in the marketplaces will help make sure that lower- and moderate-income consumers can afford routine care.

Appendix: Full Methodology

In order to identify no-deductible silver plans that met our five criteria for affordable cost-sharing, we analyzed the silver plans offered in all federally facilitated marketplaces using the healthcare.gov data set "QHP Landscape Individual Market Medical" (available online at data.healthcare.gov). This data set consists of the plan offerings in all federally facilitated and marketplaces (including partnership marketplaces), which is a total of 34 states' marketplaces. It includes limited information on these plans' cost-sharing, including the size of deductibles and the amount of cost-sharing required for primary care and specialty care office visits, as well as links to every plan's Summary of Benefits and Coverage. We searched for plans with all of the following five elements:

- No medical deductible
- Primary care office visit copayments of no more than $50
- Specialist office visit copayments of no more than $100
- Generic drug copayments of no more than $30
- If co-insurance is charged for multiple services, the majority of co-insurance charges are no greater than 40 percent

We selected these elements because of their importance to lower- and moderate-income consumers, and based on available plan design information in the healthcare.gov data set.

We conducted an initial screen of the data set using the filter and sort tools available through data.healthcare.gov to identify silver level plans with no medical deductible and copayments for primary and specialist office visits that were within our analysis' specified limits (see page X). We then conducted a second screen of the Summary of Benefits and Coverage documents for all plans that met these first three criteria to identify plans that met all five cost-sharing criteria. In situations where a single insurer appeared to market multiple silver plans with identical cost-sharing designs, based on information in their Summary of Benefits and Coverage documents, we treated those identical plans as one unique plan design.

All cost-sharing information for the no-deductible plans that is included in this brief is based on information in the Summary of Benefits and Coverage document for these plans.

The data set "QHP Landscape Individual Market Medical" did not systematically collect information regarding whether plans exempted coverage of certain services from deductibles. We were therefore unable to analyze the silver plan offerings in all federally facilitated marketplaces to identify plans that had deductibles but that exempted coverage of certain services from those deductibles.

To identify silver plans that exempted coverage of certain care from their deductibles, we analyzed state standardized silver plans in every state that established standardized plan designs for 2014. These states are California, Connecticut, Massachusetts, New York, Oregon, and Vermont. We reviewed a total of eight standardized silver plan designs in these states. Four states—Connecticut, Massachusetts, New York, and Oregon—each have one standardized silver plan design. California and Vermont each have two standardized silver plan designs. We obtained cost-sharing information for each state standardized plan from state documents, supplemented in some circumstances by communications with state and marketplace officials and members of state marketplace advisory committees who were involved in designing a state's standardized plans.

None of the standardized plans had no medical deductibles, but every state had designed at least one standardized silver plan that exempted certain services or drugs from its deductible. We selected the standardized plan designs to include based on their exempting a number of services from their deductible while keeping copayments relatively low for these exempted services, and based on their generally having standardized cost-sharing for a high proportion of covered services (which allows for more rigorous comparisons of cost-sharing across plan designs).

Endnotes

1 Catastrophic plans are also available to young adults under age 30, as well as to people who cannot otherwise find an affordable plan and who have a certified "hardship exemption" from the requirement to purchase more comprehensive coverage. Catastrophic plans offer coverage that is slightly less generous than the coverage in a bronze plan.

2 Matthew Eyles, *Analysis: Consumer Deductibles Vary Significantly across Exchange Plans* (Washington: Avalere, December 11, 2013), available online at http://avalerehealth.net/news/analysis-consumer-deductibles-vary-significantly-across-exchange-plans.

3 Consumers in high-deductible plans have the option of using a Health Savings Account (HSA) to save for health care expenses without having to pay taxes on those savings. In order to use an HSA in 2014, a consumer must be enrolled in a health plan that has a deductible of at least $1,250 for individual coverage or $2,500 for family coverage. In addition, the plan cannot cover any care, other than preventive services, prior to the individual paying this deductible. However, studies have found that HSAs mostly benefit higher-income consumers. Low- and moderate-income consumers are significantly less likely to contribute to HSAs. Paul Fronstin and Sara Collins, *Findings from the 2007 EBRI/ Commonwealth Fund Consumerism in Health Survey* (Washington: Commonwealth Fund and Employee Benefits Research Institute, March 2008).

4 Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes* (Princeton, NJ: The Robert Wood Johnson Foundation, December 2010), available online at http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html; Michel Chernew et al., "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care," *Journal of General Internal Medicine* 23, no. 8 (April 29, 2008).

5 These are consumers with incomes between $11,490 and $45,960 for an individual, or $23,550 and $94,200 for a family of four. Data on the plans selected by consumers who receive financial assistance is currently available only for the federally facilitated marketplace. Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (Washington: HHS, May 1, 2014), available online at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

6 The Affordable Care Act specifies that consumers with household incomes between 200 and 250 percent of poverty are eligible for cost-sharing reduction subsidies to reduce their maximum out-of-pocket limit by 50 percent and to reduce other cost-sharing as needed in order to raise the actuarial value of their silver plan to 73 percent. Because HHS found that reducing the maximum out-of-pocket limit for a silver plan by 50 percent would result in a silver plan actually exceeding an actuarial value of 73 percent, HHS decreased the magnitude of cost-sharing subsidies available to consumers in this income range, such that they are now eligible only for subsidies that reduce their out-of-pocket limit by one-third. Plans are required to reduce other cost-sharing if the silver plan still has an actuarial value below 73 percent after reducing the out-of-pocket limit , but these reductions are likely to be very minimal. To learn more, see "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules," *Federal Register* 78, no. 47 (March 11, 2013); 45 CFR Parts 153, 155, 156, 157, and 158.

7 These plan designs were used in a total of 10 marketed silver health plans. For two of the plan designs identified, insurers sold multiple plans that had different marketing names but identical cost-sharing designs.

8 Section 1302(b)(4)(B) of the Affordable Care Act requires that the Essential Health Benefits not include "coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability or expected length of life." Enforcing final regulations 45 CFR § 156.125(a) clarified that "an issuer does not provide the Essential Health Benefits if its benefit design, or the implementation of its benefit design, discriminates" based on any of the above factors.

9 In 2014, states with federally facilitated marketplaces could take on plan management functions through an agreement to operate a plan management partnership marketplace, or more informally, as a federally facilitated marketplace that performs some plan management functions. In 2015, there will no longer be an option for plan management partnership marketplaces. Federally facilitated marketplaces will simply be permitted to take on certain plan management functions on an ad hoc basis. For more information, see Centers for Medicare and Medicaid Services, *Blueprint for Approval of Affordable Health Insurance Marketplaces* (Baltimore: CMS, March 7, 2014), available online at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1254283.html.

10 Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM)* (Baltimore: Center for Consumer Information and Insurance Oversight, February 4, 2014).

11 To find information for a particular state's regional HHS office, go to http://www.hhs.gov/about/regions/.

Table Notes

No-Deductible Plan Design Table

Alphabetical by Plan Name

Blue Cross Blue Shield of Arizona Copay Complete 40 (Plan ID 53901AZ580002): Arizona Health Insurance Marketplace 2014 Plan Offerings. *Summary of Benefits and Coverage: Coverage Period 01/01/14-12/31/14*, available online at http://www.azblue.com/plans/CopayComplete40. The same plan design is used in **Blue Cross Blue Shield of Arizona Copay Complete Alliance 40 (Plan ID 53901AZ0750002) and Copay Complete Select 40 (Plan ID 53901AZ0760002):** Arizona Health Insurance Marketplace 2014 Plan Offerings.

Community Health Choice Inc. Silver (Plan ID 27248TX0010002): Texas Health Insurance Marketplace 2014 Plan Offering. *Summary of Benefits and Coverage: Coverage Period 01/01/14-12/31/14*, available online at https://www.chchealth.org/AffordableHealth/BenefitsandCoverage/Silver.aspx.

Independence HMO Silver Proactive (Plan ID 33871PA0040006): Pennsylvania Health Insurance Marketplace 2014 Plan Offering. *Summary of Benefits and Coverage: Coverage Period on or after 01/01/2014*, available online at http://www.ibx4you.com/ffm/hmosilverproactive.

Keystone Health Plan Healthy Benefits 0.0 HMO (Plan ID 53789PA0100002): Pennsylvania Health Insurance Marketplace 2014 Plan Offering. *Summary of Benefits and Coverage: Coverage Period on or after 1/1/204*, available online at http://www.capbluecross.com/pdf/benefits_summary/ia/53789PA010000201_2014.pdf. The same plan design is used in **Keystone Health Plan Healthy Benefits Value 0.0 HMO (Plan ID 53789PA0110002):** Pennsylvania Health Insurance Marketplace 2014 Plan Offering.

Molina Silver 250 (Plan ID 45786TX0010002): Texas Health Insurance Marketplace 2014 Plan Offering. *Summary of Benefits and Coverage: Coverage Period 01/01/2014-12/31/2014*, available online at http://www.molinahealthcare.com/members/tx/en-us/hp/marketplace/plans/silver.

myCigna Copay Assure Silver 24/45 (Plan ID 55409TX0020015): Texas Health Insurance Marketplace, 2014 Plan Offering. *Summary of Benefits and Coverage: Coverage Period 01/01/2014-12/31/2014*, available online at http://www.cigna.com/individuals-families/plans/texas-copay-assure-silver.

myCigna Copay Assure Silver 30/60 (Plan ID 48121FL0020008): Florida Health Insurance Marketplace, 2014 Plan Offering. *Summary of Benefits and Coverage: Coverage Period 01/01/2014-12/31/2014*, available online at http://www.cigna.com/individuals-families/plans/florida-copay-assure-silver.

State Standardized Silver Plans Table

Alphabetical by State

Covered California, *Standard Benefit Plan Designs-Final: Summary of Benefits and Coverage* (Sacramento: California Health Benefit Exchange, July 18, 2013), available online at http://www.healthexchange.ca.gov/BoardMeetings/Documents/February%2020,%202014/2014%20Standard%20Benefit%20Designs.pdf.

Connecticut Health Insurance Marketplace, *Standard Silver Plan -70%* (Hartford, CT: Connecticut Health Insurance Marketplace, August 30, 2013), available online at http://www.ct.gov/hix/lib/hix/Silver_70__Grid_8.30.13.pdf; email communications with Arlene Murphy, Access Health CT Consumer Advisory Committee, March 27, 2014.

Oregon Insurance Division, *SB 91: Oregon Standard Plans* (Salem: Oregon Insurance Division, March 2013), available online at http://www.oregon.gov/DCBS/insurance/legal/bulletins/Documents/2013-02-attachments/StandardPlan-RxCharts-full.pdf; email communication with Rhonda Saunders Rick, Oregon Insurance Division, February 28, 2014.

Vermont Health Connect, *Standard & Non-Standard Plan Designs & Monthly Premiums* (Williston, VT: Vermont Health Connect, October 2, 2013), available online at http://info.healthconnect.vermont.gov/sites/hcexchange/files/CostSharingReductions_2page_updated%2010%204%2013.pdf.

A selected list of relevant publications to date:

Principles for Consumer-Friendly Value-Based Insurance Design (December 2013)

Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States (January 2013)

The Basic Health Option: Will It Work for Low-Income Consumers? (July 2011)

For a more current list, visit:
www.familiesusa.org/publications

Publication ID: ACT051214

This publication was written by:
Lydia Mitts, Senior Policy Analyst, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Cheryl Fish-Parcham, Private Insurance Program Director

Claire McAndrew, Private Insurance Program Director

Evan Potler, Art Director

Carla Uriona, Director of Content Strategy

Ingrid VanTuinen, Director of Editorial

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

1201 New York Avenue NW, Suite 1100
Washington, DC 20005
202-628-3030
info@familiesusa.org
www.FamiliesUSA.org
facebook / FamiliesUSA
twitter / @FamiliesUSA