ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF
December 28, 2021

HP-2021-29

Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces

States use standardized plans to facilitate consumer choice by simplifying the shopping experience for Marketplace consumers. CMS proposes to require standardized plans on HealthCare.gov starting in 2023.

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KEY POINTS

- Standardized plans are a tool that can help consumers make plan choices and can also improve plan competition. These plans standardize actuarial value, maximum out-of-pocket, deductibles, and cost-sharing for a given metal level of coverage.
- Almost three quarters of HealthCare.gov consumers (72.9 percent) have more than 60 plan options to choose from, and the average number of plans is over 100 – far higher than in previous years. Research suggests too many choices can lead to "choice overload," making it hard for consumers to find plans that best fit their needs.
- Research evidence indicates that standardized plans make it easier for consumers to choose plans based on provider network, premiums, and quality, instead of cost-sharing differences within a metal level.
- For plan year 2022, nine states* require Marketplace issuers to offer plans with detailed standardized designs, and six of these states limit the number of non-standardized plans on their State-based Marketplaces. Two additional states require Marketplace issuers to offer plans with limits on deductibles.
- The introduction of standardized plans to HealthCare.gov starting in 2023, consistent with the President's 2021 Executive Order on competition,† may help consumers navigate their options, improve transparency, and increase plan competition.

BACKGROUND

Health insurance is a complicated product, and research shows that consumers often struggle selecting a health plan that they think meets both their medical and financial needs. Health Insurance Marketplaces were implemented under the Affordable Care Act (ACA) to allow consumers to shop for health plans that meet

* California, Connecticut, the District of Columbia, Maine, Massachusetts, New York, Oregon, Vermont, and the state of Washington.

† Executive Order (EO) 14036, "Promoting Competition in the American Economy." https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/

certain requirements such as defined actuarial values (AV) based on assigned metal levels (bronze, silver, gold, and platinum),[‡] limits on out-of-pocket costs, and coverage of 10 categories of essential health benefits (EHB).[§]

Standardized plans are a policy option that can simplify Marketplace consumer comparison shopping and bring more value to consumers by offering the same AV, maximum out-of-pocket (MOOP), deductibles, and cost-sharing for a given metal level of coverage. For some standardized plans with less detailed plan designs, only some of these features are the same for a given metal level. Standardization around health plan deductibles, cost-sharing, and MOOP allows consumers to better understand their plan options. This policy approach also pushes health plans to compete more directly on premiums, quality, provider networks, and other factors, which can sometimes be obscured through large differences in cost-sharing, as well as variation in the underlying AV, even within a designated metal level.

Currently, State-based Marketplaces (SBMs) operating their own eligibility and enrollment platforms and SBMs using the HealthCare.gov federal platform have the option to require standardized plans by metal level to make it easier for consumers to compare plans. A number of SBMs have required issuers to offer standardized plans since the first Marketplace plan year (PY) 2014. HealthCare.gov displayed optional "Simple Choice" standardized plans in PY 2017 and PY 2018 but stopped special display in PY 2019. For PY 2022, 10 of the 18 SBMs and one of the SBMs using the HealthCare.gov platform require Marketplace issuers to offer some version of standardized plans.

As CMS stated in recent rulemaking, it proposes to require issuers offering QHPs through Exchanges using the Federal platform to offer standardized plans beginning with PY 2023.[1] President Biden's July 2021 Executive Order on "Promoting Competition in the American Economy" directs the Secretary of Health and Human Services to implement standardized plans on the Marketplace beginning in PY 2023 to ensure that consumers can better compare plan offerings and choose health insurance plans that meet their needs.[2]

This issue brief reviews the research literature on how standardized plans affect consumers and insurance markets, examines standardized plan approaches taken by various states, and analyzes current data on plan choice in the Marketplaces.

METHODS

We used information from research studies, consumer studies, and state reports to describe consumer decision-making challenges and state standardized plans. We then obtained Summaries of Benefits and Coverage from SBM websites and SBM plan searches. We used Centers for Medicare & Medicaid Services (CMS) data on number of plans by county, issuer, and metal level to describe plan choices. HealthCare.gov landscape files and CMS plan selection data were used for enrollment in standardized plans by county and issuer. Standardized plan enrollment information was not available for four SBMs.[**]

[‡] Actuarial value for each metal level is described in more detail on page 6. Metal levels are categories of health plans with different cost-sharing levels, which determine how the consumer and the plan share the costs of care.

[§] The 10 categories of essential health benefits are emergency services, ambulatory patient services (outpatient services), hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

[**] We do not have enrollment data for the District of Columbia and Vermont, and we have limited data for Connecticut and New York.

FINDINGS

History of Standardized Plans Before the ACA

Standardized plans have been used in multiple insurance markets in the U.S., including Medicare supplement (Medigap) plans and the state individual and small group insurance markets, in order to facilitate consumer choice. Consumer understanding of health insurance concepts, including deductibles, cost-sharing, and coinsurance, is challenging.[3]

The Omnibus Budget Reconciliation Act of 1987 (OBRA) required Medigap plans to be standardized according to 10 plans identified as Plans A-J, which differ by deductibles, copayments, coinsurance, and covered services.[4] Medigap plans were standardized to simplify comparison of plans by consumers, stabilize the market, increase competition, and reduce duplicate coverage and adverse selection.[5] A study found that consumer choice was simplified and consumers and state regulators supported Medigap standardized plans.[6] The Medicare Prescription Drug Improvement and Modernization Act of 2003 added Plans K and L with MOOP and limits on cost-sharing.

In 1992, New Jersey health reform legislation required issuers to offer standardized plans for the individual and small group markets to make it easier for consumers to understand and choose among plans, and to make it easier for the state insurance department and issuers to administer the plans.[7] New Jersey started with five standardized plan designs with two different deductible levels and five different coinsurance/copayment designs; issuers were not allowed to offer non-standardized plans. Currently, the state has limits on deductible levels ($3,000 for bronze and $2,500 for all other metal levels), but cost-sharing can vary.[8] In all metal levels except for catastrophic plans, issuers can only offer standardized plans with these deductible limits.

The 2006 Massachusetts health reform legislation created the Massachusetts Health Insurance Exchange for individuals and required issuers to begin selling standardized plans in 2010 to shift consumer focus to plan network and quality rather than cost-sharing differences and benefit design.[9] Unsubsidized consumers purchased more generous standardized plans with lower deductibles compared to pre-standardized plans (29 percent with high deductible plans in 2010 compared to 54 percent in 2009, and 44 percent with bronze plans in 2010 compared to 63 percent in 2009).[10] Currently, Massachusetts ConnectorCare covers consumers with household income of 300 percent or less of the federal poverty level (FPL) with standardized plans without deductibles and with copayments that vary by income level.[11] Standardized plans for consumers with household income of more than 300 percent FPL have different levels of deductibles and cost-sharing according to metal level. All silver plans must be standardized, and issuers are limited to offering a total of three non-standardized plans at other metal levels.[12]

Impacts on Consumer Experience

Choice Overload vs. Simplified Plan Choice

Behavioral economics research shows that consumers make lower-quality decisions when presented with too many choices.[13] This phenomenon has been called "choice overload," which can be especially concerning when consumers face health insurance enrollment decisions, as individuals with low health literacy who face a choice of many plan offerings may enroll in suboptimal plans or even decide not to enroll at all.[14]

Consumer testing during the early years of the ACA showed that consumers struggle to understand the meaning of deductibles, coinsurance, and MOOP.[15] Many consumers do not understand what coinsurance is (a fixed percentage of expenditures that the patient is responsible for), and they have difficulty understanding which costs they are responsible for and which the health plan pays. Research shows that even individuals with high health literacy are often unable to figure out how much they would have to pay for coverage in various hypothetical scenarios.[16]

A particularly salient example of suboptimal plan choice is when consumers pick a "dominated" plan – that is, a plan with a premium equal to or higher than another plan but offering less generous coverage, or a plan offering identical coverage but at a higher premium. In one study of University of Michigan employees, 35 percent enrolled in a dominated plan.[17] The same problem occurred in California in 2018, due to the cessation of cost-sharing reduction (CSR) payments to issuers from the federal government, which led many issuers to raise their silver plan premiums, in some cases even above gold premiums. In California, two issuers offered silver plans with higher premiums than their gold plans, and about 20 percent of enrollees still chose to enroll in the silver plans (at higher cost with worse coverage), costing them on average $460 more in premiums per year for plans with a $2,500 higher individual deductible or $5,000 higher family deductible compared to the corresponding gold plans.[18]

Standardized plans offer one potential solution to the problems of choice overload and incomplete information through simplifying cost-sharing structures and increasing plan comparability, which allows consumers to focus on other factors such as premium, provider network, and plan quality.

A 2016 review of over 100 studies showed that too many health plan choices can lead to poor enrollment decisions due to the difficulty consumers face processing complex health insurance information.[19] This review also found that choice overload can reduce consumers' satisfaction with the choices they make. While having some choices can improve competition and let consumers find plans that best suit their needs and preferences, too much choice may worsen consumer well-being.

The optimal number of plan choices to facilitate enrollment may vary by age and other characteristics. Older adults tend to experience more challenges than younger adults when confronted with a large choice set,[20] and women, lower-income individuals, and individuals with chronic health conditions also tend to make enrollment decisions that result in higher expected costs.[21] Among older adults, a choice of 15 or fewer plans is associated with higher enrollment, while a choice of more than 30 plans decreased enrollment.[22] Among uninsured individuals, a choice of nine plans compared to three plans led to lower health insurance comprehension, which was associated with choosing a plan at least $500 more expensive in annual costs.[23] Thus, choice overload raises significant concerns in terms of health equity.

Issuer Competition

The ACA relies on a competitive private plan model to deliver value to consumers and to taxpayers. Such a model requires informed consumers to select among competing plans to realize that value. As the number of plan options increases, so does inertia, meaning consumers are less likely to switch plans. This results in reduced price competition, as issuers face reduced incentives to offer lower premiums, and taxpayer costs increase with increased premium tax credits.[24] Standardized plans can facilitate competition among issuers by improving transparency for consumers and distilling competition down to crucial factors like premium price, provider network, and plan quality, rather than allowing issuers to compete based on complicated and opaque cost-sharing structures. However, it also is possible that standardized plans may not fully meet the needs of, or be the best choice for, certain consumers, and these tradeoffs should be considered carefully in light of the evidence described in this report.

Access to Care

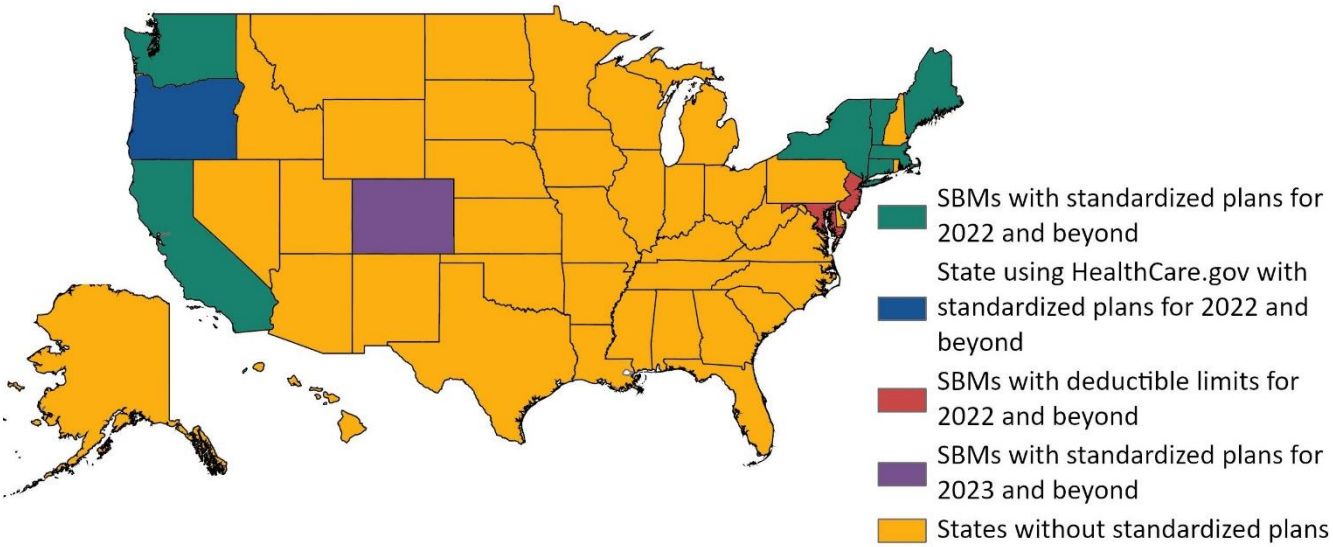
Standardized plans may benefit consumers by improving access to care and reducing discrimination. A 2016 study found that standardized silver plans with coverage of primary and specialty care visits, all drugs, mental health visits, and urgent care *before the deductible* – meaning plans are required to cover these services with consumers only paying a copayment or coinsurance even before the deductible limit is reached – would have comparable premiums to non-standardized silver plans premiums.[25] Therefore, offering standardized plans could improve access to outpatient care without driving up premiums. This is important because consumers are highly sensitive to net premiums (i.e., after subsidies): consumers are 24 percent less likely to enroll in a silver plan with a 10 percent higher premium than other plans in the same rating area.[26]

In addition, standardized plans have the potential to reduce discrimination and market segmentation by standardizing cost-sharing structures for certain services such as prescription drugs and provider services. For example, some issuers engage in "adverse tiering," which is the practice of placing all drugs for a certain chronic condition (e.g., HIV, multiple sclerosis, rheumatoid arthritis) in the highest cost-sharing tier to discourage individuals with these conditions from enrolling in their plan(s).[27] A 2016 study of 45 plans offered through SBMs with varying standardized plan policies showed that plan standardization appeared to eliminate adverse tiering and led to significant financial savings for those taking HIV drugs, with no significant difference in premiums.[28] Another practice that issuers may use to discourage enrollment by high-cost individuals involves excluding certain categories of specialists from their networks, such as those who treat individuals with the aforementioned chronic conditions.[29] New network adequacy proposals from CMS accompanying the standardized plans proposal in the HHS Notice of Benefit and Payment Parameters for 2023 proposed rule could help prevent this practice.

States Requiring Standardized Plans in the Marketplaces

Ten SBMs (California, Connecticut, the District of Columbia, Maine, Maryland, Massachusetts, New Jersey, New York, Vermont, and state of Washington) and one SBM using HealthCare.gov (Oregon) have implemented some version of standardized plans (Figure 1). Maine began requiring standardized plans in PY 2022. Colorado will implement its standardized plan policy for PY 2023.

Figure 1. State Standardized Plan Initiatives, Plan Year 2022



These states' policies vary widely with respect to permitting or limiting the number of non-standardized offerings and how cost-sharing structures are designed. Maryland's "value plans" and New Jersey's "standard plans" have limited deductibles but do not require identical dollar or percentage amounts for each cost-sharing value. Maryland allows non-standardized plans.[30] New Jersey only allows non-standardized plans for catastrophic coverage.[31] The other nine states require issuers to offer plans with detailed standardized plan designs by metal level for AV, MOOP, deductibles, and cost-sharing. Six of these nine states (California, Connecticut, Maine, Massachusetts, New York, and Oregon) have restrictions on the number of non-standardized plans.[32]

California was an early adopter of standardized plans, as it has required issuers to offer standardized plans since the launch of its SBM, Covered California, in PY 2014.[33] It is the only state without non-standardized

plans[††] and requires issuers to offer standardized plans for every metal level and CSR variant, including high-deductible health plan options.[34] Covered California also uses the active purchaser model, negotiating premium prices and requiring issuers to meet quality standards to participate in their SBM.[35] In addition, California limits the number of plans issuers can sell at each metal level to only one plan with a given network per metal level, which makes plan comparison easier for consumers by reducing the number of plans without meaningful differences.[36]

The state of Washington first implemented standardized options in PY 2021, and new legislation builds on its original requirements for 2023 and beyond. The Cascade Care legislation created two new types of standardized plans for plan year 2021: Cascade plans and Cascade Select plans (which are public option plans).[37] The state requires Marketplace issuers to (1) offer standardized silver and gold plans in every county in which they participate on the Marketplace, and (2) offer a standardized bronze plan if they offer any Marketplace bronze plans. It also caps the number of non-standardized plans starting in 2023 at two non-standardized bronze plans, one non-standardized silver plan, two non-standardized gold plans, one non-standardized platinum plan, and one non-standardized catastrophic plan.[38] For PY 2021, Cascade plans were available in all 36 counties in the state, while Cascade Select public option plans were available in 19 of 36 counties.[39] Cascade Care plan deductibles were $1,000 lower on average than non-standardized plans in the same tier, and Cascade Care silver plans were the lowest-cost silver plan in 25 percent of the state's counties. Cascade Care enrollees were twice as likely to enroll in a more comprehensive gold plan than non-standardized plan enrollees.

Oregon – currently the only state using the HealthCare.gov platform that has implemented standardized plans – has required issuers to offer standardized plans since PY 2014, the only year it was an SBM operating its own platform. Oregon has been an SBM using HealthCare.gov since PY 2015. HealthCare.gov does not differentially display Oregon's standardized plans, but their plans' marketing names include the term "Standard."

Cost-Sharing

The nine[‡‡] SBMs that have detailed standardized plans have varying levels of AV by metal level. The AV of a health plan is the average percentage of total costs of in-network EHB covered by the health plan. The AV available to all qualified health plan (QHP)-eligible individuals ranges from 60 percent for bronze plans, 70 percent for silver, 80 percent for gold, and 90 percent for platinum. For certain QHP-eligible individuals (generally with household incomes 100-250 percent of the FPL), silver CSR plans are available that enhance AV from 70 percent to 73, 87, or 94 percent, depending on income. AV is allowed to vary within a *de minimis* range by -4/+2 percentage points, and expanded bronze plans that pay for at least one major service other than preventive services before the deductible or meet the requirements of high deductible health plans can vary by -4/+5 percentage points for 2022 (45 CFR 156.140(c)). CMS's proposed 2023 changes would reduce the *de minimis* range to -2/+2 percentage points for platinum, gold, and non-expanded bronze, +2/0 for silver non-CSR, and +1/0 for silver CSR plans.[40]

SBMs can set MOOP and deductible amounts, which vary across the SBMs, by metal levels. For example, silver non-CSR deductibles range from $1,300 to $5,500, and MOOP ranges from $6,300 to $6,950 for PY 2022. Four states have separate drug deductibles for at least some of their metal levels. These states allow consumers to pay just the cost-sharing after meeting the separate drug deductibles, which are significantly lower than the medical deductibles, but create additional complexity in the plans.

[††] Issuers can apply to offer non-standardized plans; see Covered California DRAFT Qualified Health Plan Certification Application Plan Year 2023 Individual Marketplace, page 78, available at: https://hbex.coveredca.com/stakeholders/plan-management/qhp-certification/downloads/DRAFT%20Certification%20Application_Qualified%20Health%20Plan_Individual%20Market_Plan%20Year%202023.pdf.

[‡‡] Maryland and New Jersey not included because these states only have an upper limit on deductibles and no set cost-sharing.

All nine states require copayments or coinsurance after the deductible for inpatient hospital services, and all nine states have copayments for primary care, mental health/substance use disorder (SUD), and specialist visits. Eight of the nine states require copayments for generic drugs before the deductible. Primary care visits, visits for mental health/SUD, generic drugs, and other services are often moved in front of the deductible, thus encouraging utilization of these high-value services.[41]

Cost-sharing varies by state for preferred brand drugs, non-preferred brand drugs, and specialty drugs with copayments or coinsurance before or after the deductible. States have different types of cost-sharing for diagnostic imaging and ambulatory surgery center facility fees, with copayments or coinsurance required before or after the deductible. Appendix Table 1 shows the range of PY 2022 standardized plan design features across these states.

Special Display of Standardized Plans on SBM websites

Another tool SBMs have leveraged in standardized plan implementation is special display of standardized plans on their websites. Standardized plans in Connecticut, the District of Columbia, Massachusetts, and Oregon are labeled "standard," while New York uses an "ST" label, Maine uses a "Clear Choice" label, Maryland uses a "Value" label, and state of Washington uses a "Cascade" label.[42] Vermont standardized plans are not labeled as such.[§§] In the District of Columbia and state of Washington, standardized plans are further identified with graphics like award ribbons and other icons. The District of Columbia and Maine allow consumers to filter plans by standardization status, so consumers can view a subset of plans that are all standardized. HealthCare.gov could implement some or all these display strategies to encourage consumers to enroll in standardized plans.

Enrollment

Enrollment in standardized plans as of 2021 is shown in Table 1. All Covered California Marketplace plans are standardized. Almost all of New Jersey and Massachusetts Marketplace enrollment (99.6 percent and 98.9 percent, respectively) was in standardized plans. Almost half (47.3 percent) of Maryland's Marketplace enrollment was in standardized plans. State of Washington only started requiring standardized plans in PY 2021 and had 21.7 percent enrolled in Cascade standardized plans, but a higher percentage (43.1 percent) of new consumers enrolled in Cascade plans. Other states had standardized plan enrollment between 36 and 60 percent.

[§§] California and New Jersey plans don't have a standardized label. All of Covered California plans are standardized plans. All of New Jersey's plans are standardized except catastrophic plans.

Table 1. Plan Enrollment in SBM States with Standardized Plans

State	Total Marketplace Plan Enrollment	Total Marketplace Standardized Enrollment	% Standardized Enrollment
California (June 2021)	1,580,130	1,580,130	100.0%
Connecticut* (October 2021)	106,343	49,981+	47%+
Maryland (June 2021)	165,610	78,741	47.5%
Massachusetts (July 2020)	297,558	294,295	98.9%
New Jersey (2020 Q4)	269,560	268,385	99.6%
New York** (February 2020)	272,948	163,769+	60%+
Oregon on HealthCare.gov (February 2021)	141,089	50,838	36.0%
State of Washington (Fall 2021) New customers	214,429 68,928	46,564 29,679	21.7% 43.1%

* All silver plans with 47 percent of the enrollment are standardized in Connecticut. Some of the other metal level plans are standardized but enrollment was not available. See endnote 43.
** A New York report stated that more than 60 percent of enrollment was in standardized plans. See endnote 43.
Sources: SBM reports.[43] Note differential timing of state enrollment figures, ranging from early 2020 through fall 2021.

Evidence on Effects of State Standardized Plans

Prior to implementing standardized plans in 2010, Massachusetts conducted consumer testing to determine the optimal number of plans, and the state reduced proposed offerings from 36 to nine plans as a result. Consumers reported being highly satisfied with the standardization of benefits on the Marketplace, which they stated enabled easier plan comparisons.[44] Researchers found that consumers chose more comprehensive plans and benefited financially after the Massachusetts SBM shifted to standardized plans.[45] Enrollment assisters in Massachusetts report that shopping for a plan on ConnectorCare (which only offers standardized plans) is much easier than shopping for a plan on the Health Connector (offering both standardized and non-standardized products), since consumers only have to understand network and premium differences for ConnectorCare plans.[46] This evidence suggests benefits of limiting the number of non-standardized plans.

Researchers have also found that issuers, assisters, and consumer advocates perceive the value of standardized plans in making it easier for consumers to compare plans on provider network and premiums, rather than specific cost-sharing amounts.[47] State officials from California, Connecticut, the District of Columbia, and Massachusetts reported that standardized plans improve the value of coverage while simplifying benefit design, although some states' evaluations of the policy have been delayed due to data lags.[48]

Standardized Plans on HealthCare.gov

History of Standardized Plans on HealthCare.gov

For PY 2017, HealthCare.gov issuers had the option of offering standardized plans with a special display on HealthCare.gov to simplify the shopping experience for consumers.[49] There were six national standardized plan designs called "Simple Choice" (one silver non-CSR, three silver CSR variations, one bronze, and one gold) that were similar to the most popular 2015 plans on HealthCare.gov. Twenty states had issuers that offered these plans. In those states, 57 out of 112 HealthCare.gov issuers offered Simple Choice plans, which had enrollment of 390,208 enrollees, reflecting 5.4 percent of HealthCare.gov enrollment in those states.[50] The market share of enrollees in Simple Choice plans ranged from 0.5 percent in North Carolina to 15.4 percent in Kentucky. Some issuers had substantially more enrollment in Simple Choice plans. At least one issuer in eight

states had more than a third of its enrollment in Simple Choice plans in counties where the issuers offered those plans. Optional Simple Choice plans continued for PY 2018.[51] A total of 37 issuers in 14 states offered these Simple Choice plans. Table 2 shows details for Simple Choice Plans.

Table 2. Simple Choice Plans in PY 2017 and PY 2018

	PY 2017	PY 2018
Number of States with Simple Choice Plans	20	14
Number of Issuers offering Simple Choice Plans	57	37
% Issuers offering Simple Choice Plans in States with Simple Choice Plans	50.9%	49.3%
Simple Choice Enrollment	390,208	373,396
% Simple Choice Enrollment in States with Simple Choice Plans	5.4%	6.8%

Source: PY 2017 and PY 2018 HealthCare.gov Landscape Files and CMS Enrollees

For PY 2019, CMS did not specify standardized plan designs or provide for special display on HealthCare.gov, essentially discontinuing the policy. This decision was later successfully challenged in court as discussed later in this report on page 11.[52]

Number of Plans Available to Consumers in HealthCare.gov States

The average number of issuers and plans available to enrollees increased significantly from PY 2019 (when the display of Simple Choice plans was discontinued to avoid disincentives to issuers to offer other plans[53]) to PY 2022. From PY 2019 to PY 2022 the average number of issuers available to enrollees increased from 2.8 to 6.4, the average number of total plans available to enrollees increased from 25.9 to 107.7, and the average number of silver plans available to enrollees increased from 12.3 to 45.8.[54] Some rating areas now experience what some analysts have called "silver spamming," in which one issuer offers multiple very similar silver plans as the lowest-cost and second lowest-cost silver plans, priced significantly below other issuers in the same rating area.[55] With only very slight differences with respect to cost-sharing structures and provider networks, this strategy can make it especially hard for consumers to choose the best and most affordable plan for them.

Table 3 shows the average number of issuers and plans available to enrollees for PY 2019, PY 2020, PY 2021, and PY 2022.

Table 3. Average Number of Issuers and Plans Available to Enrollees (by County)

	PY 2019	PY 2020	PY 2021	PY 2022
Average Number of Issuers	2.8	3.5	4.5	6.4
Average Number of Plans (All Metal Tiers)	25.9	38.5	61.4	107.7
Average Number of Silver Plans	12.3	17.4	28.1	45.8

Source: CMS Plan Year 2022 Qualified Health Plan Choice and Premiums in HealthCare.gov States

Table 4 shows the range of plan offerings by county for PY 2021 and PY 2022. The upper end of the range of issuers by county, number of total plans by county, and number of total plans per issuer by county all increased over time.

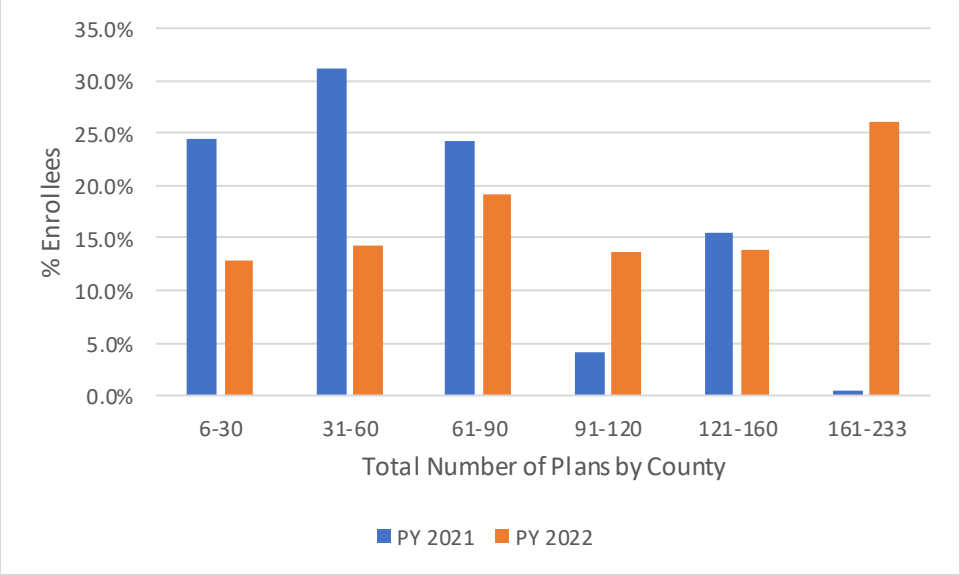
Table 4. Range of Number of Issuers, Total and Silver Plans, and Total and Silver Plans Per Issuer (by County)

	PY 2021	PY 2022
Number of Issuers	1 to 10	1 to 11
Number of Total Plans	5 to 174	6 to 233
Number of Silver Plans	2 to 70	2 to 100
Maximum Number of Total Plans Per Issuer	5 to 44	5 to 66
Maximum Number of Silver Plans Per Issuer	1 to 19	1 to 26

Source: PY 2021 and PY 2022 HealthCare.gov Landscape Files

PY 2022 has seen a substantial increase in the number of consumers with large numbers of plan choices. Almost three quarters of enrollees (72.9 percent) have more than 60 plan options, and more than a quarter (26.0 percent) have to pick from more than 160 different plans, as shown in Figure 2. Even consumers who focus on a particular metal tier face the risk of choice overload (Appendix Figure 1). About half of consumers (48.3 percent) have more than 40 plan options within the silver tier alone, and about one third (32.2 percent) have more than 60 silver plan options. Finally, even among those consumers who choose to focus on a particular metal tier and a specific issuer, more than two thirds of consumers (71.0 percent) would still have more than 10 silver plans available from at least one issuer in their county (Appendix Figure 2).

Figure 2. Percentage of Enrollees with Access to Total Number of Plans (by County)



Source: PY 2021 and PY 2022 HealthCare.gov Landscape Files and CMS PY 2021 enrollees

The ACA requires plans to cover 10 categories of EHB, limits MOOP costs, and limits AV by metal level. However, within these requirements, deductibles and cost-sharing for specific services vary widely. Table 5 shows the range of cost-sharing for selected types of services in HealthCare.gov silver non-CSR plans. In PY 2022, 10.1 percent of plans had no deductibles, and in plans with deductibles, the amounts ranged from $1,250 to $8,700. The silver non-CSR plans had 46 different combinations of cost-sharing for primary care visits, ranging from $0 to $100 per visit or 10 to 50 percent coinsurance.

Table 5. Range of PY 2022 Cost-Sharing for HealthCare.Gov Silver Non-CSR Plans

	Before Deductible	After Deductible	Before and After Deductible
Deductible Range: $0 - $8,700			
Inpatient Hospital Facility	$500 - $2,500 per day OR $2,500 per stay OR 20% - 50%	$250 - $1,500 per day OR $0 - $2,000 per stay AND/OR 10% - 50%	
Primary Care Visits: Copay ($) or Coinsurance (%)	$0 - $100	$0 - $70 OR 10% - 50%	$25 - $45 before AND 10% - 40% after
Specialist Visits: Copay ($) or Coinsurance (%)	$0 - $175	$0 - $95 OR 10% - 50%	$30 - $90 before AND 20% - 30% after
Generic Drugs: Copay ($) or Coinsurance (%)	$0 - $40 OR 20% - 40%	$0 - $35 OR 10% - 50%	
Preferred Drugs: Copay ($) or Coinsurance (%)	$30 - $200 OR 30% - 50%	$0 - $150 OR 10% - 50%	

Source: PY 2022 HealthCare.gov Landscape file

Future of Standardized Plans on HealthCare.gov

In March 2021, a federal district court ruled in favor of the plaintiffs (a group of cities and individuals) in *City of Columbus v. Cochran*, in which the plaintiffs argued that CMS's PY 2019 discontinuation of the prior standardized options policy was arbitrary and capricious.[56] The court agreed with the plaintiffs' arguments, vacated the withdrawal of the standardized option policy, and required HHS to take further action on the policy.[57] After this ruling, CMS indicated that it intended to resume the designation of standardized options starting in PY 2023 and propose specific plan designs in more complete detail in the 2023 Payment Notice.[58] CMS stated that the number of issuers and plan options on HealthCare.gov had increased and cited the Executive Order on Competition in reinstating standardized plans.[59]

The proposed 2023 Notice of Benefit and Payment Parameters has eight standardized plan designs for Bronze, Expanded Bronze, Standard Silver, Silver 73 CSR, Silver 87 CSR, Silver 94 CSR, Gold, and Platinum, as shown in Appendix Tables 2 and 3.

In most HealthCare.gov states, some key proposed standardized plan features include:

- Standardized *non-expanded* bronze plans will have a simple design – a $9,100 deductible after which all covered services will be available without any additional cost-sharing.
- Standardized *expanded* bronze plans will have a $7,500 deductible and will cover provider visits ($50 for primary care and behavioral health visits, $100 for specialty visits) and generic drugs ($25 copay) before the deductible.
- Standardized silver plans (without CSRs) will have a $5,800 deductible; plans will cover primary care and behavioral health visits ($40 copay) and specialty visits ($80 copay) before the deductible; and many prescription drugs will also be covered before the deductible ($20 generic drug copay and $40 preferred brand drug copay).
- The most generous CSR plans (94 percent AV) for lower-income consumers will have a standardized design with a $0 deductible, no cost-sharing for primary care and behavioral health visits, a $10 copay for specialty visits, $0 copay for generic drugs, and a $15 copay for preferred brand drugs.

Many of the covered services are not subject to the deductible for all metal levels except non-expanded bronze, including visits for primary care, urgent care, specialists, mental health/SUD outpatient care, generic drugs, and speech, occupational, and physical therapy. These services, as well as all covered drugs including brand and specialty medications, feature fixed-dollar copayments rather than coinsurance percentages, since the former are more transparent and easier for consumers to understand.[60] These changes are designed to improve competition and assist consumer decision-making, in keeping with the evidence on standardized plans reviewed in this report.

CONCLUSION

The average Marketplace consumer has more than 100 plans from which to choose. Research indicates that an excess number of options can lead to "choice overload," dampening enrollment and leading consumers to plans that may not best meet their needs. There is a long history of using standardized plans in health insurance markets, including Medicare's Medigap program, as a mechanism to facilitate consumer choice. Nine states currently require their Marketplace issuers to offer detailed standardized plans, and six of these states have restrictions on the number of non-standardized plans. Enrollment in the eight states with standardized plan enrollment data shows that a significant portion of consumers purchase standardized plans, and research evidence indicates that these plans can improve consumer satisfaction and improve financial protection for enrollees.

The policy rationale for implementing standardized plans in the Marketplaces includes enhancing the value of Marketplace coverage, simplifying consumer choice, reducing administrative expenses for issuers and state regulators, and encouraging utilization of key health care services such as primary care and behavioral health services by covering them before the deductible.

Standardized plans also have the potential to improve health equity, as studies suggest low-income individuals, women, older adults, and individuals with chronic health conditions may be particularly harmed by choice overload when facing large choice sets. In addition, standardizing prescription drug tiers could assist in combatting issuer practices like adverse tiering and could help ensure that individuals with chronic health conditions are not as overburdened by prescription drug costs. Finally, standardized plans can promote meaningful competition between issuers on the key domains of premiums, quality, and provider networks, without the potential complexity and opaqueness of a plethora of cost-sharing designs. Resuming the designation of standardized plans on HealthCare.gov and requiring issuers to offer standardized options, as proposed in the 2023 HHS Notice of Benefit and Payment Parameters, would extend the advantages of standardized plans to millions of consumers nationally who enroll in Marketplace plans.

APPENDIX

Appendix Table 1. Range of Selected PY 2022 Standardized Plan Design Features Across Participating States

	Bronze	Silver Non-CSR	Silver 73% CSR	Silver 87% CSR	Silver 94% CSR
Permissible Actuarial Value	60.0%-64.97%	70%-72%	72%-74%	86%-88%	93%-95%
Deductible	$4,700-$8,700	$1,300-$5,500	$1,100-$3,700	$250-$1,200	$0-$200
Prescription Drug Deductible (4 states)	$500-$1,100	$250-$400	$10-$300	$10-$200	none
Maximum OOP	$8,200-$8,700	$6,750-$8,200	$6,300-$6,950	$2,200-$2,850	$800-$1,000
Inpatient Hospital Services	$1,000-$1,500 or 0%-50%, both after deductible	$750-$1,500 or 20%-50%, both after deductible	$750-$1,500 or 20%-50%, both after deductible	$100-$425 or 10%-30%, both after deductible	$75-$100 or 10%-15%, both after deductible
Primary Care and Mental Health/SUD Visit	First visit free, $40-$65 or 3 visits at $50 or $65 before deductible, or $35-$65 after deductible	First visit free, $25-$40 before deductible, or $30 after deductible	First visit free, $20-$40 before deductible, or $30 after deductible	First visit free, $10-$20 before deductible, or $15 after deductible	First visit free, $3-$10 before deductible, or $10 after deductible
Specialist Visit	$100-$125 or 3 visits at $75 or $95 before deductible, or $70-$100 after deductible	$50-$80 before deductible, or $50 after deductible	$50-$70 before deductible, or $50 after deductible	$25-$45 before deductible or $35 after deductible	$8-$30 before deductible or $20 after deductible
Outpatient Facility Fee (Ambulatory Surgery Center)	$150-$500 or 0%-50%, both after deductible	20% before deductible or $150-$600 or 30%-50%, both after deductible	20% before deductible or $50-$600 or 30%-50%, both after deductible	15% before deductible or $35-$325 or 10%-40%, both after deductible	10% before deductible or $20-$100 or 10%-15%, both after deductible
Generic Drugs (Tier 1)	$15-$32 before deductible or $10 after deductible	$10-$25 before deductible or $10 after deductible	$10-$20 before deductible or $10 after deductible	$5-$15 before deductible or $9 after deductible	$3-$7 before deductible or $6 after deductible
Preferred Brand Drugs (Tier 2)	$35-$85 or 0%-50%, both after deductible	$50-$70 before deductible or $35-$60 after deductible	$40-$70 before deductible or $35-$60 after deductible	$10-$40 before deductible or $20 after deductible	$10-$20 before deductible or $15 after deductible
Non-Preferred Brand Drugs (Tier 3)	$70-$150 or 0%-60%, both after deductible	$85 or 50% before deductible or $75-$250 or 30%-50%, both after deductible	$85 or 50% before deductible or $70-$200 or 30%-50%, both after deductible	$25-$160 before deductible or $40 or 20%-50%, both after deductible	$10-$35 or 30% before deductible or $15-$50 or 30%, both after deductible
Specialty Drugs (Tier 4)	$70-$250 or 0%-50% after deductible	20% or 50% before deductible or $70-$250 or 20%-50%, both after deductible	20% or 50% before deductible or $70-$250 or 20%-50%, both after deductible	$160, 15% or 50% before deductible or $40-$160 or 20%-50%, both after deductible	$35 or 10%-25% before deductible or $150 or 20% after deductible

Sources: SBM websites and some Issuer Summaries of Benefits and Coverage[61]

Appendix Table 2. PY 2023 Proposed Standardized Plan Designs for HealthCare.gov States Except Delaware, Louisiana, and Oregon***

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	59.86%	64.06%	70.04%	73.10%	87.04%	94.02%	78.00%	88.00%
Deductible	$9,100	$7,500	$5,800	$5,700	$800	$0	$2,000	$0
Annual Limitation on Cost Sharing	$9,100	$9,000	$8,900	$7,200	$3,000	$1,700	$8,700	$3,000
Emergency Room Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Urgent Care	No charge after deductible	$75*	$60*	$45*	$30*	$5*	$45*	$15*
Specialist Visit	No charge after deductible	$100*	$80*	$60*	$40*	$10*	$60*	$20*
Mental Health/Substance Use Disorder Outpatient Office Visit	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Laboratory Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
X-rays and Diagnostic Imaging	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician and Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	No charge after deductible	$25*	$20*	$20*	$10*	$0*	$15*	$5*

*** Delaware and Louisiana have their own cost-sharing requirements and Oregon has its own standardized plans.

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Preferred Brand Drugs	No charge after deductible	$50	$40*	$40*	$20*	$15*	$30*	$10*
Non-Preferred Brand Drugs	No charge after deductible	$100	$80	$80	$60	$50*	$60*	$50*
Specialty Drugs	No charge after deductible	$500	$350	$350	$250	$150*	$250*	$150*

* Benefit category not subject to the deductible

Source: Proposed 2023 HHS Notice of Benefit and Payment Parameters

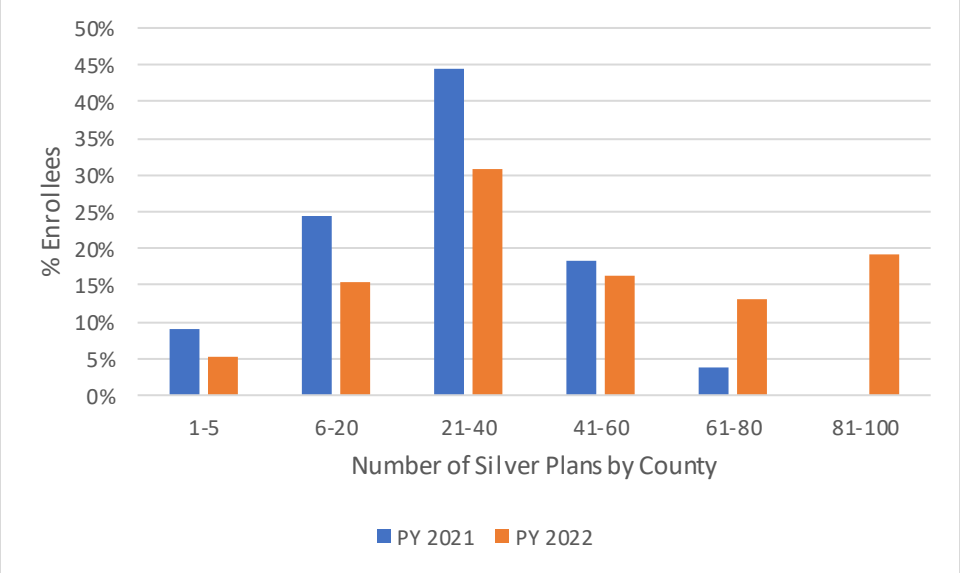
Appendix Table 3. PY 2023 Proposed Standardized Plan Designs for Delaware and Louisiana

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	59.86%	64.07%	70.05%	73.01%	87.05%	94.02%	78.02%	88.01%
Deductible	$9,100	$7,500	$5,800	$4,100	$800	$0	$2,000	$0
Annual Limitation on Cost Sharing	$9,100	$9,000	$8,900	$7,200	$3,000	$1,800	$8,700	$3,000
Emergency Room Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Urgent Care	No charge after deductible	$75*	$60*	$60*	$30*	$5*	$45*	$15*
Specialist Visit	No charge after deductible	$100*	$80*	$80*	$40*	$10*	$60*	$20*
Mental Health/ Substance Use Disorder Outpatient Office Visit	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	No charge after deductible	$50*	$40*	$40*	$20*	$0*	$30*	$10*
Laboratory Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
X-rays and Diagnostic Imaging	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician and Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	No charge after deductible	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	No charge after deductible	$50	$40*	$40*	$20*	$5*	$30*	$10*

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Non-Preferred Brand Drugs	No charge after deductible	$100	$80	$80	$60	$10*	$60*	$50*
Specialty Drugs	No charge after deductible	$150	$125	$125	$100	$20*	$100	$75*

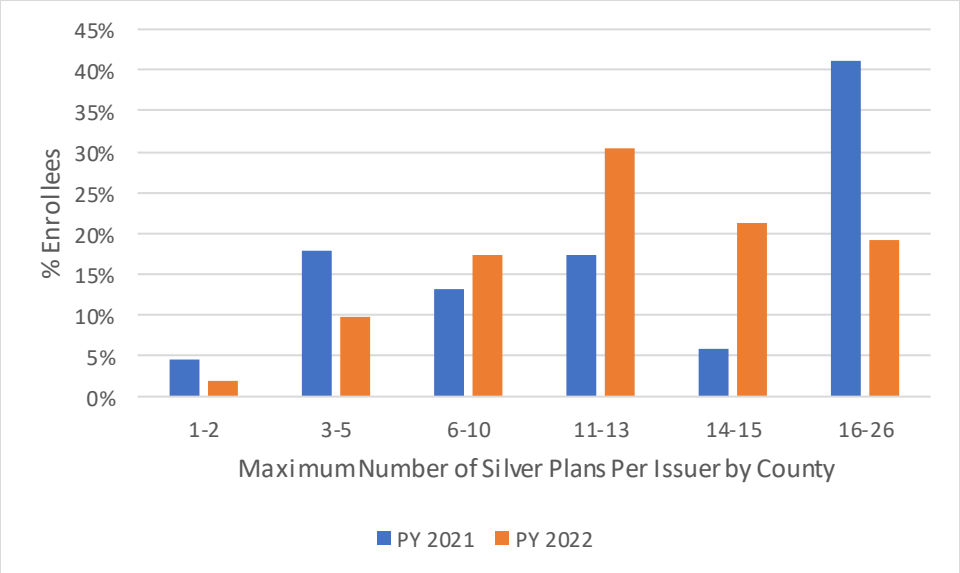
Delaware and Louisiana have state cost-sharing requirements.
* Benefit category not subject to the deductible
Source: Proposed 2023 HHS Notice of Benefit and Payment Parameters

Appendix Figure 1. Percentage of Enrollees with Access to Number of Silver Plans by County



Source: PY 2021 and PY 2022 HealthCare.gov Landscape Files and CMS PY 2021 enrollees

Appendix Figure 2. Percentage of Enrollees with Access to Number of Silver Plans Per Issuer by County



Source: PY 2021 and PY 2022 HealthCare.gov Landscape Files and CMS PY 2021 enrollees

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SUGGESTED CITATION

Chu, R.C., Rudich, J., Lee, A., Peters, C., De Lew, N., and Sommers, B.D. Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces (Issue Brief No. HP-2021-29). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. December 2021.

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