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Gold, Silver, and Bronze

The Important Role of Product Standardization in Health Insurance Reform

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National health reform will rely on consumer choice and competition to control costs, whether or not a public option is available. Rational consumer choice in the health insurance market, however, is difficult without product standardization. Product standardization classifies different health insurance plans according to their value, for example, in categories labeled "gold," "bronze," and so on. States' experiences suggest that standardization can help consumers, though it may be challenging to sustain standardization in the long run — a challenge federal health insurance reforms may need to address.

What Is Product Standardization?

What is the difference between gold and bronze in health insurance? An intuitive answer is that gold is worth more. And according to health insurance reform legislation currently being considered by Congress, it is worth more. But how "worth" is determined can occur many different ways that might otherwise be confusing or difficult to distinguish from a consumer's point of view.

For instance, within one category of health insurance product, plans (e.g., gold) may differ in their cost-sharing options (e.g., higher or lower co-pays, deductibles) or differ in plan type (e.g.,

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health maintenance organizations, which require participants to use in-network providers; or preferred provider organizations, which allow more flexibility in the use of out-of-network physicians). Even if plans differ in these ways, as long as whatever the plan offers is valued similarly, it can be considered within the same category as another product. In general, lower valued plans, such as bronze, will likely have more cost sharing and fewer benefits than a gold plan.

Using more technical terminology, standardizing products means that they are actuarially equivalent (i.e., they have roughly the same value). The actuarial value is determined by the average amount of health care costs that a plan would pay in a given period of time.[1] Within proposed legislation in the US Senate, there are four potential value levels that plans could have: platinum, gold, silver, and bronze. In general, the name of the plan reflects its value. The value is determined by evaluating the plans against a set benchmark. For instance, the gold products in the proposed Senate legislation have an actuarial value of 80 percent, while the bronze plans have a value of 65 percent.

Product standardization is important, because if it is done in ways that are transparent, responsive to demand, and relatively understandable, consumers can purchase products they need and insurers are forced to compete on other plan features such as price of the products, customer service, or provider networks.

Why Product Standardization Is Important

The purpose of standardizing plans is to ensure a basic floor of benefits and to help consumers compare plans and thus make rational choices. Product standardization is important, because if it is done in ways that are transparent, responsive to demand, and relatively understandable, consumers can purchase products they need and insurers are forced to compete on other plan features such as price of the products, customer service, or provider networks. Competition, in turn, can make insurance affordable to more people, potentially lowering the number of uninsured. If consumers cannot make clear comparisons regarding the value of the plans — such as what medical conditions and services are covered under each plan — then they have a difficult task comparing plans and making rational choices.

However, too much standardization could limit the ability of insurers to offer certain products. Some states, such as New Jersey and Maryland, have tried to maintain standardized products while allowing flexibility by offering what are known as "riders," or exceptions to the policy. Riders may be created to offer benefits above what is required by standardized plans. For instance, a rider might be added to cover the cost of prescription eyeglasses. Alternatively, a rider might be added to change a cost-sharing arrangement so that a consumer or business would pay a lower premium but have a higher deductible when they use health services.

Overview

This paper examines the experiences of three states in order to suggest how standardization can work more effectively in a reformed health system. The paper concludes that the existence of standardization provides a starting point from which all insurers

must begin and from which consumers can more easily compare products. Without such standardization, comparison shopping would be difficult for consumers.

But in at least two of the states studied for this research, ensuring that products are understandable and comparable has been difficult because of a proliferation of insurance riders. To address the complexity posed by adding an array of riders to insurance product choices, these states had to develop ways to reduce complexity for consumers, such as listing all products in comparison to the standard plans, developing educational brochures, or revising information on their websites to make comparisons by consumers or insurance brokers easier.

The paper suggests that the approach Massachusetts is using, where products coming to market are closely monitored by a panel of varied experts and interests — known as the Connector Board — could be an approach that is more successful at simplifying the process consumers use to obtain health insurance.

Summary of Sample States' Experiences

Three states, Massachusetts, Maryland, and New Jersey, were chosen for this research because they all have experience with standardizing insurance products in their small group markets (and, in the case of Massachusetts, a merged small group and individual market).[2] In addition, these three states have insurance markets that are more similar to New York than other states, and New York policymakers are a major audience for this research.

In 2006, Massachusetts implemented several health reforms, including establishing standardized insurance products in its merged small group and individual markets. The products are placed into tiers: gold, silver, bronze, and a young adult plan. Gold products are worth more than silver and silver are worth more than bronze — but there are several iterations of plans within each category. For instance, gold products are about equal in value but can offer slightly different benefits, cost sharing, or provider networks such as a health maintenance organization or preferred provider organization.

Using this tiered system, small businesses and individuals purchase products at the desired level through an insurance exchange, which is a marketplace. This exchange is overseen by a group known as the Massachusetts Connector. Among other responsibilities, the Connector has responsibility for overseeing the insurance products offered within the exchange, helping determine the value of the products and helping individuals find insurance. So far, this system of standardization in Massachusetts appears to be relatively successful in part because the "gold, silver, bronze" labeling may be easier for consumers to understand, as it is more intuitive, and because the Connector Board, which monitors the actuarial value of plans, has met frequently to consider modifications to what can be counted in each tier.

Maryland and New Jersey — neither of which currently has an insurance exchange or merged markets — created standardized products in their small group markets over a decade ago. Each plan is required to have a "floor" or minimum of benefits that could be offered. In Maryland, insurers in the small group market cannot offer anything less than the "Comprehensive Standard Health Benefit Plan (CSHBP)." Specifically, the benefits offered can be no less than the actuarial equivalent of a federally qualified health maintenance organization (HMO). In addition, the state also limited the premiums that insurers may charge to a percent of the average annual wage in Maryland. Currently the cap is 10 percent of average annual wage.[3] These measures created a minimum benefit floor and premium ceiling with the intent of helping to protect consumers from price spikes. But as the cost of health insurance premiums rose, it was difficult for insurers to offer products that met the cost cap requirements. As a result, insurers began to offer and policyholders began to purchase riders to "buy down" the cost-sharing amounts. In other words, consumers could decrease their monthly premiums by agreeing to pay more in co-pays when coverage was used. This made many people view standardization and the ways insurers got around the requirements as somewhat of a shell game.

A similar situation of a proliferation of health insurance riders occurred in New Jersey. Initially the state established five standardized plans and an HMO. Plan "A" was the most basic plan, covering hospitalization only. (This plan was thought to be more attractive to younger and healthier individuals.) Plans "B" through "E" were comprehensive medical plans covering the same medical and hospital services, but at different rates of coinsurance (the percentage of costs covered by the insurance plan). Plan "B" had a 60 percent coinsurance rate, "C" 70 percent, "D" 80 percent, and "E" 90 percent. Carriers were permitted flexibility in how they structured care delivery in these plans. For example, they could offer preferred provider organization (PPO) or point of services (POS) plans as long as either the in-network or out-of-network coinsurance rate conformed to one of the standard plans. A standard HMO plan was also available.

In 2008, the New Jersey Health Care Reform Act reduced the number of standard plans that a carrier was required to offer. Insurers were permitted to submit riders to the standardized plans that either increased or decreased the standard benefits. Any decreases to the benefits must be reviewed by the NJ Department of Banking & Insurance. Any increases to benefits are reviewed and approved by the Small Employer Health Benefits Program Board, the entity that was created through 1992 reform legislation and is charged with the oversight and administration of the program. The cumbersome legislative process involved with changing the standard plans and a market demand for different products resulted in the use of riders as a way to offer variations on the standard plans. Currently, those familiar with the market estimate

that there are up to 30,000 riders across all plans and carriers.[4]

As the use of riders spread in New Jersey, small businesses found it more difficult to distinguish between plan options. In an effort to respond to the confusion that can be caused by a proliferation of riders in the market, the state enacted several measures to assist small businesses with simplifying the process of choosing what standard plan could meet their needs. These measures included requiring that all plans disaggregate the cost of the rider from the standard plan. The state also reduced the number of standardized plans that carriers must offer from five to three and began a large public education campaign to help small businesses better understand their coverage options. Since the implementation of these changes is recent, it is premature to conclude if it is easier for small employers and their employees to navigate through the process of purchasing health insurance coverage. It is, however, a step in that direction.

Discussion and General Recommendations

Understandability

The fact that insurance reform legislation emerging from Congress closely mirrors Massachusetts' use of the "gold, silver, bronze, and young adult plan" is no accident. Using such labels for standardized products is more intuitive and presumably easier for consumers to understand. Most consumers don't have the time to know details such as whether one plan allows up to three office visits per year before they must pay for the office visit or whether it allows four and whether the visits will count toward the annual deductible or not. Rather, consumers are likely to make a decision based on whether they might use more or fewer benefits — making a gold, silver, bronze system easier to navigate.

In Maryland and New Jersey, where there are so many riders, it may be difficult for small businesses and individuals to understand all the possible ways a plan could deviate from the standard plans. Yet, at the same time, the proliferation of riders suggests that businesses in New Jersey and Maryland embraced the opportunity to deviate from the standard plan. Every time a business has deviated from a plan, even if it is a slight change in cost sharing to accommodate one employee, the plan must have a rider. From the insurers' perspective, adding a rider is a relatively simple administrative process.

The major drawback of the rider system is that it is not necessarily as transparent or easily navigable from a consumer's point of view. Although many of the thousands of riders in New Jersey simply modify a current rider, the sheer number of these can be overwhelming for a consumer to understand. If one were to assess the various rider policies' actuarial values, it is possible that most policies would still be within a few percentage points of the standard plans in terms their value — but this information is hard to decipher when there are so many options.

In Massachusetts, the complexity of weighing through all the cost-sharing or benefit iterations of a health insurance plan is somewhat mitigated by the Connector. The Connector undertakes the difficult task of determining how the differences in plans result in meaningful differences between plans' values. In New Jersey, such differences in value are not always as apparent.

A system, such as that used in Massachusetts, where plans are easily distinguished (i.e., gold, silver, bronze) by an actuarial value that allows some variance from the standard without always requiring the filing of riders, seems to be a more manageable system for consumers because it allows them to more easily distinguish what they are purchasing. The job of distinguishing between plans' actuarial values, and ensuring that they offer something of value has been the subject of much debate by the Connector Board in Massachusetts. Minutes from the Connector Board meetings show that a considerable amount of time has been spent debating what could be considered "minimum creditable coverage" and what levels of maximum annual deductibles were acceptable to include in the bronze plan, for instance. The Board also has debated such issues as how many preventive office visits must be covered per year, whether prescription drugs should be a covered service, or whether the cost of generic drugs should or should not be counted toward an individual's maximum annual allowable deductible.[5] Were it not for the Connector Board, it might be up to consumers to navigate these differences.

By providing more standardized information about health insurance products, employers, individuals, or insurance brokers can more easily compare the cost of different policies within and across carriers and better understand how the price was derived. This allows consumers to make rational choices about what products will best meet their needs.

Transparency

The complexity of the proliferation of riders in New Jersey and Maryland was mitigated by the fact that these states, after realizing how complex the system had become, made it easier for consumers to comparison shop, for instance, by listing the price for a standard plan separately from the price adjustment(s) for riders to the standard plan. Maryland also created a rate guide that gives standardized comparisons, although not actual premium costs.[6] Transparency also was improved by requiring that agents and brokers disclose their fees and commissions to consumers. These measures did not completely eliminate the complexity of the excessive number of riders, but they did make the system somewhat more transparent and therefore slightly easier to understand.

Massachusetts developed a web-based tool that helps consumers compare product descriptions and pricing across carriers in "actuarially defined categories of insurance products established by the Massachusetts Connector."[7] By providing more standardized information about health insurance products, employers, individuals, or insurance brokers can more easily compare the cost of different policies within and across carriers and better understand how the price was derived. This allows consumers to make rational choices about what products will best meet their needs.

The Case of New York State

For the past few years, New York has been examining options to increase coverage in the state. One of the options the state is considering is an incremental approach to reform, largely modeled after Massachusetts. Whether or not national reforms are enacted, New York has been considering the tradeoffs of merging the small group and individual insurance markets (as well as the Healthy NY market), instituting a mandate for coverage, and establishing a statewide insurance exchange.

As part of these reform discussions, at least three different organizations have provided analyses of what would happen if the small group and individual markets were merged in New York State.[8] The assumptions about standardized benefits in each modeling projection differ. The Empire Blue Cross and Blue Shield model presupposes a merger of only standardized or direct pay products or something different.[9] Estimates by the United Hospital Fund (UHF) include lower priced products (with fewer benefits) like what is currently available under Healthy NY. Regardless of what is included in the models, a market merger is projected to lower the cost of purchasing insurance for individuals by pooling risk.

If New York moves forward, or if federal legislation requires such reforms, some degree of product standardization will be important to ensure the marketplace is understandable to consumers so they may make rational choices.

If New York moves forward, or if federal legislation requires such reforms, some degree of product standardization will be important to ensure the marketplace is understandable to consumers so they may make rational choices. Without product standardization, comparison shopping will be even more difficult for consumers. As health insurance experts Paul Fronstin and Murray Ross point out, "The more benefit design is allowed to vary to meet consumer preferences — the more difficult it is to avoid and detect gaming and favorable selection.... Without a standardized means of comparison, it may be difficult to judge the value of one complicated insurance policy against 20 others."[10]

New York and the federal government can learn from the experience of Massachusetts and make the labeling of the plans understandable. The state or federal government could also consider developing a specialized entity, similar to the Massachusetts Connector, to oversee the standardization of products so that a large proliferation of riders is unnecessary and consumers can be assisted with finding a product that meets their needs. Finally, as is done by the three other states studied for this research, New York can further assist consumers by listing products in actuarially defined categories and clearly illustrate on all educational and consumers materials and websites how products differ from one another.

Endnotes

1 For a detailed explanation of actuarial value see Sarah Lueck, "What Level of Coverage Will Health Reform Likely Provide?: The Basics of Actuarial Value" (Washington, DC: Center on Budget and Policy Priorities, October 13, 2009).

2 The New Jersey Small Employer Health Benefits program case study was written by Dina Belloff and Margaret Koller. Enrique Martinez-Vidal reviewed the case study of Maryland, and Courtney Burke was the author and an anonymous reviewer provided comments about Massachusetts. These case studies were instrumental to this policy brief's analysis. For more information, please visit http://www.rockinst.org/pdf/health_care/2009-11-10-Case_Studies.pdf.

3 Thomas R. Oliver, "Holding Back the Tide: Policies to Preserve and Reconstruct Health Insurance Coverage in Maryland," *Journal of Health Politics, Policy and Law* 29, 2 (April 2004): 203-36.

4 "State Case Studies: Product Standardization in Small Group and Individual Insurance Markets" (Albany, NY: The Nelson A. Rockefeller Institute of Government, November 9, 2009).

5 For meeting minutes from the Connector Board see https://www.mahealthconnector.org/portal/site/connector/menuitem.be34eb79b090a7635734db47e6468a0c/?fiShown=default, accessed on 10/26/09. In particular, for discussions about "actuarial value" and plan benefits, see meeting minutes from 1/22/07, 10/16/08, 6/11/09, and 10/2/09.

6 For Maryland's plan comparisons, see http://mhcc.maryland.gov/smallgroup/mia_rateguide.pdf.

7 Deb Faulkner, Amy Lischko, and Deborah Chollett, "Considering a Health Insurance Exchange: Lessons from the Rhode Island Experience" (Washington, DC: Robert Wood Johnson Foundation, State Coverage Initiatives, June 2009).

8 The three organizations modeling the effects of a merged small group and individual market were the United Hospital Fund, Empire Blue Cross and Blue Shield, and the Urban Institute.

9 Peter Newell, "Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools" (presentation by the United Hospital Fund for the NYS Health Foundation Conference, New York, NY, November 17, 2008).

10 Paul Fronstin and Murray Ross, "Addressing Health Market Reform Through an Insurance Exchange" (Washington, DC: Employee Benefits Research Institute, June 9, 2009).

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