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Special Series: Health Reform Issues

May 21, 2009

DESIGNING BENEFIT STANDARDS FOR A HEALTH INSURANCE EXCHANGE

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To make a choice of affordable, comprehensive health plans available to individuals and small businesses under health reform, it is crucial to set benefit standards to ensure that all plans in a health insurance exchange cover a comprehensive array of services.

Well-designed benefit standards should help prevent adverse selection by barring benefit packages that will likely segment healthy and sick people into different plans, which would make coverage increasingly unaffordable for less-healthy people over time. Such benefit standards also would protect people with particular medical conditions from facing excessive cost burdens. If all plans meet certain basic coverage standards, that will advance another goal by better enabling consumers to compare plans based on price and quality.

An earlier Center on Budget and Policy Priorities analysis[1] outlined the four elements of a well-structured exchange. (See the text box on the next page.) This report examines the first of those elements: minimum standards for benefit design.[2]

Defining a Minimum or "Essential" Benefits Package

Although minimum coverage standards are critical, it is neither necessary nor desirable to try to write the particulars of those standards into legislation. The legislation need only establish the broad parameters of the benefit standards and charge the exchange or some other federal standard-setting entity with developing the specifics. This will simplify the passage of legislation and allow the benefit standards to be updated or modified over time in accordance with advances in medical research and practice. The broad parameters that the legislation should set are as follows:

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[1] Sarah Lueck, "Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees," Center on Budget and Policy Priorities, March 31, 2009.

[2] For a related discussion on the need for an annual cap on the combined premiums and out-of-pocket costs that low- and moderate-income beneficiaries must pay, see Judith Solomon, "Ensuring Affordable Health Coverage and Health Care Services Through an Exchange," Center on Budget and Policy Priorities, May 21, 2009.

Key Components of an Effective Insurance Exchange*

To ensure that an exchange provides affordable, comprehensive coverage to all enrollees, enables people to make informed choices among competing health plans, and fosters competition based on price and quality (rather than on which plans do best at deterring sicker, more costly enrollees and attracting healthier ones), the exchange will need four key components:

- *Minimum standards for benefit design* to ensure that individuals get the care they need at an affordable price. Without being overly prescriptive, the standards should assure that plans provide coverage for a comprehensive set of necessary services, such as physician visits, inpatient hospital care, and prescription drugs, and should define the scope of coverage. The standards should also include a limit on beneficiaries' total out-of-pocket costs. With these protections in place, individuals would not have to worry about having chosen the "wrong" insurance if they subsequently develop a medical condition or illness.
- *Limits on the degree of variation in different benefit designs* to prevent insurers in an exchange from creating benefit packages designed to deter less-healthy enrollees and attract only individuals in good health. Such limits — which are a basic feature of the Massachusetts health reforms as well as of the Medigap market, in which private insurers sell supplemental coverage to Medicare beneficiaries — also better enable consumers to compare the price and quality of different plans.
- *A limit on the number of different plan choices* in an exchange, which is crucial to helping individuals make intelligent decisions about coverage, rather than being overwhelmed by a bewildering number of choices.
- *A requirement that insurers in an exchange offer the full range of different benefit designs and that they base premiums for a geographic area on a single pool of all people in the area who are enrolled in any of the insurer's plans.* This requirement, which Massachusetts' Commonwealth Choice program includes, would allow premiums to be higher for plans that provide additional coverage. However, sicker individuals would not have to pay more than healthier people simply because they are enrolled in a plan that disproportionately enrolls sicker individuals.

*Adapted from "Fact Sheet: Using a Health-Insurance Exchange to Pool Risk and Protect Enrollees" Center on Budget and Policy Priorities, April 14, 2009.

- **Exchange plans should provide a comprehensive package of essential health benefits.** The legislation should require insurance plans offered through the exchange to provide "comprehensive coverage" — that is, coverage for medical services to prevent, treat, or cure a broad range of health conditions and restore function after an illness or injury. The legislation should direct the insurance exchange (or some other entity) to establish the specifics of the essential, or minimum, benefits package, including the health care services that participating plans must cover and the scope of coverage that must be available. The essential benefits package should ensure that individuals in the exchange do not encounter gaps in coverage if they face existing medical conditions or an unexpected illness. The essential benefits package would establish a minimum level of coverage; insurers would be free to design, and individuals could decide to purchase, insurance plans with benefit packages that are more comprehensive.

  The law also could set a minimum value of coverage, known as an actuarial value. This may be a useful way to ensure, in legislation, that benefit packages in the exchange at least meet a certain basic level of generosity But an actuarial-value standard on its own would be

inadequate. It would not assure that plans provide adequate coverage. Under such a standard, plans still could be designed to attract primarily healthier beneficiaries and deter enrollment by those in poorer health. For example, insurers could offer a benefits design that omits or severely limits services needed by people with serious medical conditions, while offering richer benefits in other areas such as vision care or health-club memberships. In that way, an insurer could meet an actuarial standard while designing a package calculated to deter sicker people (by failing to cover basic services they need) and attract healthy ones. In short, while the legislation could require plans in the exchange to have the same actuarial value as a benchmark plan (such as the Blue Cross Blue Shield Standard Option under the Federal Employees Health Benefits Program), many enrollees still are likely to end up underinsured for key health services unless an actuarial-value standard is *combined* with the above requirement that all plans offer basic comprehensive coverage and with the additional requirements described below.

- **Insurers must not place harmful limits on coverage.** Legislation should require the exchange or some other entity to prevent benefit designs from being offered if they are likely to provoke adverse selection (including among plans in the same coverage tier, if there are tiers) or would place an excessive cost burden on people with particular medical conditions or high-cost medical needs. In addition, benefit designs should not include annual or lifetime caps on the amount that will be paid out in claims.

  It would be up to the exchange or other entity to translate these broad principles into more detailed rules. These requirements, together with the essential benefits package, would assure that plans in the exchange could not selectively provide less-generous coverage for certain services or conditions, such as maternity care or chemotherapy for cancer, in order to attract primarily low-cost enrollees or deter people who are likely to have higher medical costs. These requirements could accomplish this goal without the need for a list of specific conditions or benefits in legislation.

- **Exchange plans must include adequate protections against high out-of-pocket costs.** The law should direct the exchange to set an annual out-of-pocket spending limit and a maximum annual deductible amount for plans in the exchange. With a ceiling on out-of-pocket spending, enrollees could be confident they would have protection from very high medical costs no matter what plan they select. The out-of-pocket limit should be global — that is, it should encompass deductibles and cost-sharing amounts for all benefits the plan covers. Creating a maximum deductible amount would prevent plans from setting deductibles so high that they contribute to adverse selection by attracting primarily very low-cost beneficiaries and deterring sicker ones.

- **Insurers should cover preventive care at little or no cost to the beneficiary.** The benefit standards should reflect the importance of cost-effective preventive care by requiring, in legislation, that plans provide high-value services to enrollees with low or no cost-sharing. This might mean that adults could get an annual physician visit without having to first pay the plan deductible; certain disease screenings and well-child care would also be potential candidates. The exchange or other standard-setting entity, possibly in collaboration with panels of experts, would determine what high-value preventive care should be provided to people for little or no cost.

Conclusion

A new health insurance exchange is envisioned in the context of national health reform as a way to offer new and improved coverage options to individuals and businesses. Yet a major goal of health reform — providing affordable health insurance of decent quality to millions more Americans — will not be realized if the plan options in an exchange have significant gaps, require enrollees to pay prohibitive out-of-pocket costs for the health care they need, or limit the ability of people with serious illnesses or injuries to obtain affordable coverage.

Requiring exchange plans to cover a set of essential health care benefits, to place limits on out-of-pocket costs and to promote the use of high-value preventive services — in addition to prohibiting benefit designs likely to provoke adverse selection — would help to ensure that the coverage available through an exchange provides financial protection and access to health services for people with a wide variety of medical needs. Combined with other recommendations for a well-functioning exchange outlined in our earlier analyses, these elements related to setting minimum benefit standards would help ensure that coverage options available in an exchange are comprehensive and affordable and that an exchange does not unravel over time as a result of the corrosive effects of adverse selection.