Wakely
Consulting Group

Benefit Standardization Study for the State of New York

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Introduction and Executive Summary

To inform decision-making about whether and (if so) how to standardize benefits designs in New York State's Small Business Health Options Program (SHOP) under the Patient Protection and Affordable Care Act (ACA), this analysis describes the existing range of benefits variation in the state's small group market. In developing its specifications for certifying QHPs in SHOP, the exchange will want to consider:

1. How diverse are small group offerings across the state?
2. Which are the most prevalent health insurance benefits designs among small employers?
3. How large are the regional variations in small group offerings?
4. What, if any, patterns are there to these regional variations?
5. Should the SHOP exchange try to accommodate existing variations in regional patterns when soliciting and certifying QHPs?
6. Should SHOP consolidate that range of offerings around a limited number of standardized benefits designs?
7. If so, to what extent should SHOP try to replicate and offer the most popular small group benefits designs?
8. Are there significant regional variations in the use of commercial distribution channels for small group health benefits?
9. How much change in benefits offered is likely to occur simply as a result of small health plans (in and out of SHOP) moving in 2014 to conformance with the four prescribed actuarial value tiers in the ACA (bronze, silver, gold and platinum)?
10. What other studies or experience may be relevant to better understanding the trade-offs between choice and standardization?

The Department of Financial Services (DFS) sent out a data call in December 2011 to those insurers covering 80% of the 2009 enrollment in the small group and individual markets in Downstate and Upstate New York: Oxford, Empire, GHI, Aetna, Excellus, HealthNow NY, MVP Health Plan, Independent Health Plan and Capital District Physicians' Health Plan (CDPHP). Due to multiple licenses for many of these insurers, sixteen entities were included in the data call to the nine insurers. (An insurer with multiple licenses due to different operating regions or product lines received separate data requests).

The data call asked insurers to provide detailed information on enrollment in their small-group offerings, by product, geographic market, benefit and plan design, provider network and service area, underwriting practices, and utilization (and compensation) of insurance producers and other intermediaries. Insurers were advised to return all responses to DFS so that they could be blinded before being shared with Wakely (DFS did identify Downstate and Upstate data separately for analytic purposes). The data call is appended to this report.

Although New York's standardized individual direct pay market is not the topic of this study, New York has 18,854[i] members enrolled in this market.
There are two standardized comprehensive managed care plan options available in New York - standard HMO plan and standard POS plan. The two plans have standard benefits that offer inpatient and outpatient hospital services, doctor services, preventive health care services, including well child care from birth, emergency services, prescription drugs obtained at participating pharmacies and other benefits. The standardized benefits are set forth in New York State Insurance Law, although the superintendent may establish additional standardized benefit plans if necessary to meet the needs of the public. With only two standardized plans, change will be necessary for the individual market in order to meet the existing actuarial value metal levels pursuant to the ACA. While standardization is supported for New York's market as a whole, New York will need to broaden choices for the individual direct pay market.

The responses from the largest nine licensed carriers in the state's small group market provide a basis for characterizing the health benefits designs prevailing among small employers in the first half of 2011. We use these data to describe some key elements of the small group market that should inform efforts by the NYS exchange to standardize benefits and certify qualified health plans (QHPs) that will be made available to small employers effective January 1, 2014. We also use some supplemental data gathered in the same data call for the first half of 2009 to add a little insight into the direction of recent trends leading up to 2011. In turn, the 2011 data can serve as a baseline for comparison with 2012 descriptive data, if the NYS exchange wishes to update its understanding of the small group market prior to releasing a solicitation for QHPs in 2013.

This analysis finds that:

- There is very broad dispersion of the types of health plans and level of cost-sharing prevailing across the small group market (HMO, PPO, POS &EPO), except that very little indemnity coverage remains;
- Distribution by product type differs between Upstate and Downstate, and there is some concentration in each region by type (EPO Downstate and PPO Upstate);
- The vast majority of small group plans are sold through a broker, especially Downstate;
- There are many different cost-sharing designs in small group, most of which serve very few enrollees—each of some 14,500 plan designs serve less than 500 employees;
- Downstate is more concentrated than Upstate around a relatively smaller number of plan designs, each serving 5,000 or more enrollees in the small group market;
- Enrollment (employee only) is concentrated in coverage with $501-$1,500 deductible, but there has been movement in recent years toward higher deductibles

- Enrollment (employee only) is concentrated in coverage with an out-of-pocket maximum of $2,000 or less, but there has been movement in recent years toward $6,000;
- There has been rapid movement from 2009 to 2011 into cost-sharing that exceeds ACA standards, especially Downstate;
- Coinsurance as a cost-sharing mechanism at the point of service applies to a relatively small percentage of enrollees, and is especially rare for office visits (5%);
- A majority of members have an Rx-specific deductible and/or out-of-pocket maximum, typically $50 or $100 (sometimes waived for generic prescriptions);
- 48% of enrollment falls within 2% +/- of the four prescribed actuarial values (AV) for small group insurance--bronze (60%), silver (70%), gold (80%) and platinum (90%). Seven percent falls below an AV value of 58%, and the remaining 45% of enrollment is in plans with an AV value above 58% but otherwise between the four ranges specified.

Dispersion of Small Group Enrollment by Plan Type and by Region

The state is interested in understanding how diverse the small group market is. One measure of that is the type and licensure category of health plans in which small employers and their employees enroll. Small group enrollment for the responding carriers is dispersed across four principal types of plans. In addition, the patterns of dispersion among the four types differ for Upstate versus Downstate New York.

There is very little indemnity coverage (i.e., reimbursement is available to all providers and there is no network of preferred or required providers), but significant penetration of the other four types listed below: Health Maintenance Organizations (16%), Preferred Provider Organizations (18%), Point of Service plans (22%), and Exclusive Provider Organizations (44%). While terminology is broadly applicable in the United States, these categories are often defined somewhat differently by each state for licensure and regulatory purposes. In New York State, they are generally understood to have the following meaning

HMO: In-network benefits only; some carriers require referrals and some do not (split is about 50/50)

PPO: In- and out-of-network benefit design; no referrals required

POS: In-and-out of network benefit design; some carriers require referrals, but many do not

EPO: In network benefits only; no referrals required

Table 1: Small Group Average Enrollment, Jan-Jun 2011

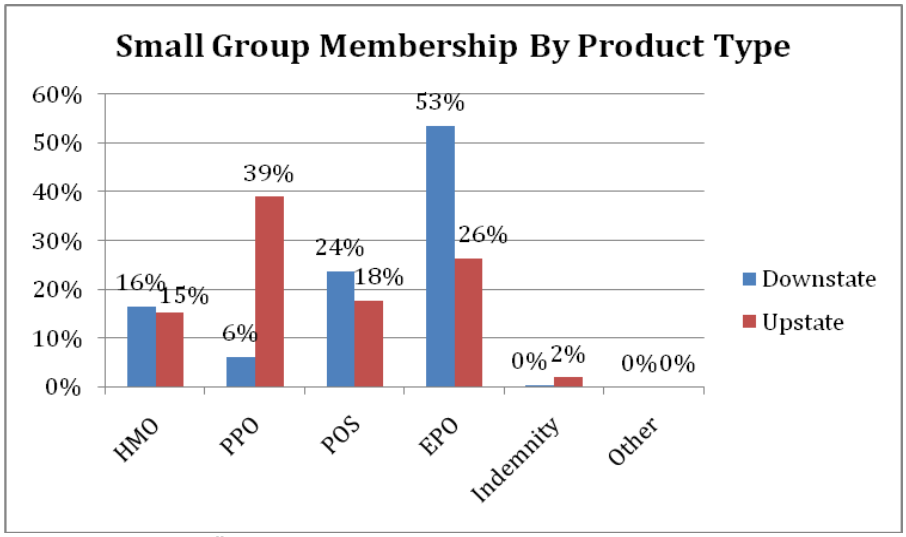
	Enrollment			% Enrollment		
	Downstate	Upstate	Total	Downstate	Upstate	Total
HMO	153,826	76,188	230,014	16%	15%	16%
PPO	57,444	194,272	251,716	6%	39%	18%
POS	221,672	88,125	309,797	24%	18%	22%
EPO	500,381	130,935	631,316	53%	26%	44%
Indemnity	3,342	9,098	12,440	0%	2%	1%
Total	936,665	498,618	1,435,283	100%	100%	100%

Source: Data call

Two-thirds of the state's small group market for which the nine carriers reported data is concentrated in the Downstate region, consisting of the five boroughs of NYC, plus the following counties: Nassau, Suffolk, Westchester, Ulster, Sullivan, Rockland, Putnam, Orange, and Dutchess (this region accounts for approximately 69% of the state's overall population[ii]). Despite considerable dispersion amongst licensure categories in both regions, there is a distinguishing pattern. By a slight majority (53%), small employers Downstate were purchasing EPOs, whereas Upstate employers were far more inclined (39%) to offer PPOs to their employees.

Qualitative information on the distribution channels in small group, in particular the use of general agencies Downstate, compared with their absence Upstate, and the prevalence of different carriers Downstate and Upstate, reinforces the picture of regional differentiation. This at least suggests the need to consider different QHP offerings to small employers for the Downstate and Upstate regions.

Table 2: Small Group Membership by Product Type



Source: Data call

Producer Participation in the Small Group Market

As these data points indicate, the small group market across New York State is heavily "producer-driven." Of course, this is well-known among producers and those in the insurance field, and it is typical of most small group markets in the United States. However, we note that over one-fifth of the small group enrollees Upstate are in plans that were not sold through a broker.

Table 3: Producer Participation in the Small Group Market

Producer Share	Downstate	Upstate	Total
Percent Sold Through Broker/Intermediary	94%	79%	89%

Source: Data call

Snapshot of Benefit Plan Diversity Across the Small Group Market

We first take a snapshot of the total number of plan designs offered to small employers by these nine carriers, including those differentiated by optional riders or non-standard benefits, such that any and all benefit design choices with actual enrollments are captured. To this end, carriers were asked to provide their enrollment for each different plan design on their books. (The specific benefits of these plan designs were not collected.) As the tables below indicate, there are a huge number of plan designs and cost-sharing combinations to be found in the small group market. Statewide, there were at least 14,999 cost-sharing combinations in the market in 2011, of which 97% (14,577) each enrolled less than 500 covered lives.

While each of these 14,577cost-sharing formulas served relatively few members, and many of them differ only slightly from one or more other plan designs, in aggregate, they do represent 23% of the total small group lives enrolled. This is a non-trivial part of the market. Conversely, if we focus on the 97 plan designs with relatively large enrollment (>2,500 each), they serve just over a majority (52%) of the market. So, there are many, many plans with very small enrollment each, and substantial variation among the nearly 100 largest plan designs that serve approximately half of New York's small group market.

Table 4: Statewide Plan Diversity (2011)

Members/Plan	Plans	Members	Average Members Per Plan	% Plans	% Members
Less Than 500	14,577	326,807	22	97%	23%
500 – 2,499	325	352,701	1,085	2%	25%
2,500 –4,999	47	164,709	3,504	0.3%	12%
5,000 –9,999	35	243,891	6,968	0.2%	18%
10,000 –19,999	13	172,487	13,268	0.1%	12%
20,000+	2	132,995	66,498	0.0%	10%
Total	14,999	1,393,590	93	100%	100%

Source: Data call

Table 5: Downstate Plan Diversity (2011)

Members/Plan	Plans	Members	Average Members Per Plan	% Plans	% Members
Less Than 500	3,259	127,484	39	93%	14%
500 – 2,499	183	204,449	1,117	5%	23%
2,500 –4,999	34	117,341	3,451	1%	13%
5,000 –9,999	28	196,343	7,012	1%	22%
10,000 –19,999	8	115,597	14,450	0%	13%
20,000+	2	132,995	66,498	0%	15%
Total	3,514	894,209	254	100%	100%

Source: Data call

Table 6: Upstate Plan Diversity (2011)

Members/Plan	Plans	Members	Average Members Per Plan	% Plans	% Members
Less Than 500	11,318	199,323	18	99%	40%
500 – 2,499	142	148,252	1,044	1%	30%
2,500 –4,999	13	47,368	3,644	0%	9%
5,000 –9,999	7	47,548	6,793	0%	10%
10,000 –19,999	5	56,890	11,378	0%	11%
20,000+	0	0	0	0%	0%
Total	11,485	499,381	43	100%	100%

Source: Data call

When we look for patterns separately, by the two major regions of New York State, the Downstate market with two-thirds of total small group enrollment among respondents shows far less dispersion by cost-sharing formula than Upstate. Compared with 11,485 separate cost-sharing designs Upstate, we see only 3,514 designs Downstate. Half of the small group lives reported for Downstate are in just 38 plans, each enrolling 5,000 or more members.

By contrast, only 21% of the Upstate enrollment is in plans with 5,000 or more members; and the even the 25 plan designs with 2,499 or more enrollees represent only 30% of Upstate small group enrollment. In total, the carriers reported 3.3 times as many discrete plan designs serving small employers Upstate as they reported for Downstate. Clearly, there is tremendous dispersion of plan designs Upstate, despite lower enrollment. Of course, Upstate represents five distinct geographic markets (Buffalo, Rochester, Syracuse, Utica/Watertown and Albany) served by five major carriers.

Dispersion of Enrollment by Extent and Type of Cost-sharing

In order to capture the breadth of variation among health plans, the state's data call asked carriers to "bucket" all enrollments into one of 28 plan designs, broadly defined by two member cost-sharing features - the annual deductible and out-of-pocket maximum[iii]. For each of these 28 broad plan designs, carriers provided enrollment by cost-sharing requirements at point of service for six sets of benefits. (For all eight variables [deductible, out-of-pocket maximum and the six sets of benefits identified below Table 9], ranges were used e.g., annual deductibles of $500 or less, or office visit copayments of $25 - $50.) This consolidation process was used to "lump" similar plan designs into one and provide an analytical framework for comparing the thousands of options available from all nine carriers.

Table 7: Basic Plan Design "Buckets" - Based on Member Cost-Sharing

28 Basic Plan Designs (Based on member cost-sharing)					
Plan Option	Deductible	Out of Pocket Max	Plan Option	Deductible	Out of Pocket Max
Plan Design 1	0 (none)	$2,000 or less	Plan Design 15	$1,501 - $3,000	$6,000 - $9,999
Plan Design 2	$ 1 – 500	$2,000 or less	Plan Design 16	$3,001 - $5,000	$6,000 - $9,999
Plan Design 3	$ 501 - $1,500	$2,000 or less	Plan Design 17	0 (none)	$10,000 +
Plan Design 4	0 (none)	$2,001 - $3,999	Plan Design 18	$ 1 - 500	$10,000 +
Plan Design 5	$ 1 - $ 500	$2,001 - $3,999	Plan Design 19	$ 501 - $1,500	$10,000 +
Plan Design 6	$ 501 - $1,500	$2,001 - $3,999	Plan Design 20	$1,501 - $3,000	$10,000 +
Plan Design 7	$1,501 - $3,000	$2,001 - $3,999	Plan Design 21	$3,001 - $5,000	$10,000 +
Plan Design 8	0 (none)	$4,001 - $5,999	Plan Design 22	$5,000 +	$10,000 +
Plan Design 9	$ 1 – 500	$4,001 - $5,999	Plan Design 23	0 (none)	No OOP Max
Plan Design 10	$ 501 - $1,500	$4,001 - $5,999	Plan Design 24	$ 1 - 500	No OOP Max
Plan Design 11	$1,501 - $3,000	$4,001 - $5,999	Plan Design 25	$ 501 - $1,500	No OOP Max
Plan Design 12	0 (none)	$6,000 - $9,999	Plan Design 26	$1,501 - $3,000	No OOP Max
Plan Design 13	$ 1 – 500	$6,000 - $9,999	Plan Design 27	$3,001 - $5,000	No OOP Max
Plan Design 14	$ 501 - $1,500	$6,000 - $9,999	Plan Design 28	$5,000 +	No OOP Max

Source: Data call

The six benefit sets are: Inpatient medical/surgical benefits; inpatient mental health/substance abuse (MH/SA) benefits; outpatient hospital/same day surgery; Emergency Room; routine (sick) office visit with PCP and routine (sick) office visit with a specialist.

Table 8: Cost-Sharing Ranges for Six Benefit Sets

Cost-Sharing Ranges for Six Benefit Categories
(1) For Inpatient Med/Surgical and (2) Mental Health/Substance Abuse benefits:
0 Coinsurance / 0 Co-pay
10% Coinsurance (+/- 5 points)
20% Coinsurance
Coinsurance greater than 20%
Co-pay of $499 or less
Co-pay of $500-999
Co-pay of $1,000-1,999
Co-pay of $2,000 +
(3) For Outpatient Hospital/Same Day Facility Surgery and (4) Emergency Room benefits:
0 Coinsurance / 0 Co-pay
10% Coinsurance (+/- 5 points)
20% Coinsurance
Coinsurance greater than 20%
Co-pay of $75 or less
Co-pay of $76-150
Co-pay of $151-249
Co-pay of $250 +
(5) For Routine (Sick) Office Visit, Primary Care Physician benefits:
0 Coinsurance / 0 Co-pay
10% Coinsurance (+/- 5 points)
20% Coinsurance
Coinsurance greater than 20%
Co-pay of $1-24
Co-pay of $25-39
Co-pay of $40+

(6) Routine (Sick) Office Visit, Specialist benefits:
0 Coinsurance / 0 Co-pay
10% Coinsurance (+/- 5 points)
20% Coinsurance
Coinsurance greater than 20%
Co-pay of $1-24
Co-pay of $25-49
Co-pay of $50+

The state's data call asked each carrier to fill out plan design information for at least 80% of its small group enrollment, as of the first six months of 2011. Some carriers provided data for 80% of their enrollment while others bucketed up to 100% of their enrollment into the 28 plan design options provided. As a result, the tables below reflect at least 80% but less than 100% of the small group enrollment among the dominant carriers, but only a subset of total small group enrollment in the state. Therefore, they probably understate the degree of variation in that market.

Again, these data capture ranges of cost-sharing, but this level of variation does not capture:

1. The different licensure/product types
2. Every difference in cost-sharing for each category of service, but ranges of cost-sharing
3. Cost-sharing for every service, such as durable medical equipment, chiropractic care, etc.
4. Every small group cost-sharing formula installed by each of the responding carriers
5. Every carrier in the small group market

Trends in Cost-sharing Over Time

Complicating this picture further are the changes over time to the cost-sharing designs for small group. Over the period of 2009 to 2011, the data reported indicate some shifts, and there is no reason to believe that similar (or more extensive) shifts will not continue between 2011 and 2014. Therefore, to the extent that the exchange wishes to anticipate where the small group market will be in 2014, as it develops specifications for QHPs in SHOP, updating these data will be critical.

Notable among the changes evident from 2009 to 2011 are the marked increase in both deductibles and out-of-pocket maximums. In 2009, 87% of deductibles fell between $501 and $1500, but just two years later that percentage had slipped to 75%, whereas the percentage of enrollees in plans with a deductible of $1,501 to $3,000 had more than doubled from 5.4% to 12.5%. (Table 11) Interestingly, there was also a slight increase in the percentage of enrollees with deductibles under $500 or none at all.

In 2009, almost 4/5ths of enrollees were in plans with an annual out-of-pocket maximum at or below $2,000, but just two years later that portion had fallen below 63%. Every level of out-of-pocket maximums below $6,000 showed a decrease from 2009 to 2011. In 2009, only 11.1% of enrollees are reported in plans with an out-of-pocket maximum above $6,000, and by 2011 this figure had nearly tripled to 29.6%. These two sets of percentages apply to single policies; for family policies, the same carriers generally report that deductibles and out-of-pocket maxima are at least double the level for singles (and sometimes up to three times as great).

Given the limits on deductibles ($2,000/$4,000) and out-of-pocket maximum (approximately $6,000/$12,000) for minimum essential coverage under the ACA, it appears that a significant share of the small group market will not be in compliance with these limits. Whatever they decide about retaining their existing, grandfathered coverage that is outside these limitations on allowable cost-sharing, they would have to "buy-up" i.e., pay higher premiums for lower cost-sharing, were they to purchase group coverage on the SHOP exchange, or otherwise change plans and thereby forego grandfathered status.

Table 9: Trends in Cost-sharing Over Time: 2009 vs. 2011 (Statewide)

2009 - STATEWIDE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	3.1%	0.0%	76.3%	0.0%	0.0%	0.0%	79.4%
$ 2,001-3,999	0.1%	0.0%	1.0%	0.0%	0.0%	0.0%	1.1%
$ 4,001-5,999	0.0%	0.0%	5.4%	3.0%	0.0%	0.1%	8.5%
$ 6,000-9,999	0.0%	1.9%	2.5%	2.4%	0.0%	0.0%	6.7%
$10,000+	0.2%	1.9%	2.3%	0.0%	0.0%	0.0%	4.4%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	3.4%	3.8%	87.4%	5.4%	0.0%	0.1%	100.0%

2011 - STATEWIDE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	5.7%	0.0%	57.0%	0.0%	0.0%	0.0%	62.7%
$ 2,001-3,999	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	0.4%
$ 4,001-5,999	0.0%	0.0%	3.5%	3.3%	0.0%	0.4%	7.2%
$ 6,000-9,999	0.0%	2.1%	9.6%	9.3%	0.0%	0.0%	21.0%
$10,000+	0.0%	3.2%	4.9%	0.0%	0.0%	0.5%	8.6%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
Total	5.8%	5.3%	75.4%	12.5%	0.1%	0.9%	100.0%

Percentage Point Change - STATEWIDE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	2.6%	0.0%	-19.2%	0.0%	0.0%	0.0%	-16.6%
$ 2,001-3,999	0.0%	0.0%	-0.6%	0.0%	0.0%	0.0%	-0.7%
$ 4,001-5,999	0.0%	0.0%	-1.9%	0.3%	0.0%	0.3%	-1.3%
$ 6,000-9,999	0.0%	0.2%	7.1%	6.9%	0.0%	0.0%	14.3%
$10,000+	-0.2%	1.4%	2.5%	0.0%	0.0%	0.5%	4.2%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Total	2.4%	1.6%	-12.0%	7.2%	0.1%	0.8%	0.0%

Source: Data call

As of 2011, Downstate and Upstate differ considerably on enrollment and enrollment trends toward annual cost-sharing limits that may exceed the ACA's maximum deductible and out-of-pocket spending caps. (Tables 12 & 13) (For the deductible, the range of data captured does not break at $2,000, but includes $1,500-$3,000 deductibles, so only a portion of this enrollment is already beyond the limit that will apply in 2014; for out-of-pocket limits, the $6,000 cap approximates what will apply as of 2014.) Downstate, there has been more rapid movement recently toward higher deductibles, and 18.1% of 2011 enrollment is in coverage with deductibles that exceed $1,500; Upstate, only 5% exceed $1,500. Conversely, there is more enrollment as of 2011 in Upstate plans with out-of-pocket maximums that exceed $6,000 (41.7%) than Downstate (22.9%), but out-of-pocket maximums seem to be climbing rapidly Downstate.

Table 10: Trends in Cost-sharing Over Time: 2009 vs. 2011 (Downstate)

2009 –DOWNSTATE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	4.6%	0.0%	80.2%	0.0%	0.0%	0.0%	84.7%
$ 2,001-3,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$ 4,001-5,999	0.0%	0.0%	4.4%	3.4%	0.0%	0.1%	8.0%
$ 6,000-9,999	0.0%	0.6%	1.5%	3.2%	0.0%	0.0%	5.3%
$10,000+	0.0%	0.2%	1.8%	0.0%	0.0%	0.0%	2.0%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	4.6%	0.8%	87.9%	6.6%	0.0%	0.1%	100.0%

2011 –DOWNSTATE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	8.7%	0.0%	61.2%	0.0%	0.0%	0.0%	69.8%
$ 2,001-3,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$ 4,001-5,999	0.0%	0.0%	1.8%	4.8%	0.0%	0.6%	7.1%
$ 6,000-9,999	0.0%	0.9%	4.4%	12.4%	0.0%	0.0%	17.6%
$10,000+	0.0%	0.1%	4.8%	0.0%	0.0%	0.4%	5.3%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	8.7%	1.0%	72.2%	17.1%	0.0%	1.0%	100.0%

PERCENTAGE POINT CHANGE - DOWNSTATE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	4.1%	0.0%	-19.0%	0.0%	0.0%	0.0%	-14.9%
$ 2,001-3,999	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$ 4,001-5,999	0.0%	0.0%	-2.7%	1.4%	0.0%	0.5%	-0.8%
$ 6,000-9,999	0.0%	0.3%	2.9%	9.1%	0.0%	0.0%	12.3%
$10,000+	0.0%	0.0%	3.0%	0.0%	0.0%	0.4%	3.3%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	4.2%	0.3%	-15.8%	10.5%	0.0%	0.8%	0.0%

Source: Data call

Table 11: Trends in Cost-sharing Over Time (Upstate)

2009 – UPSTATE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	0.2%	0.0%	68.7%	0.0%	0.0%	0.0%	68.9%
$ 2,001-3,999	0.3%	0.1%	2.8%	0.0%	0.0%	0.0%	3.2%
$ 4,001-5,999	0.0%	0.0%	7.2%	2.2%	0.0%	0.0%	9.4%
$ 6,000-9,999	0.0%	4.3%	4.4%	0.7%	0.0%	0.0%	9.4%
$10,000+	0.5%	5.1%	3.3%	0.0%	0.0%	0.1%	9.0%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
Total	1.0%	9.5%	86.5%	2.9%	0.1%	0.1%	100.0%

2011 – UPSTATE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	0.2%	0.0%	49.4%	0.0%	0.0%	0.0%	49.6%
$ 2,001-3,999	0.2%	0.1%	1.0%	0.0%	0.0%	0.0%	1.2%
$ 4,001-5,999	0.0%	0.0%	6.8%	0.5%	0.0%	0.0%	7.3%
$ 6,000-9,999	0.0%	4.3%	19.2%	3.6%	0.0%	0.0%	27.1%
$10,000+	0.0%	8.9%	4.9%	0.0%	0.1%	0.7%	14.6%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%
Total	0.4%	13.3%	81.3%	4.0%	0.2%	0.8%	100.0%

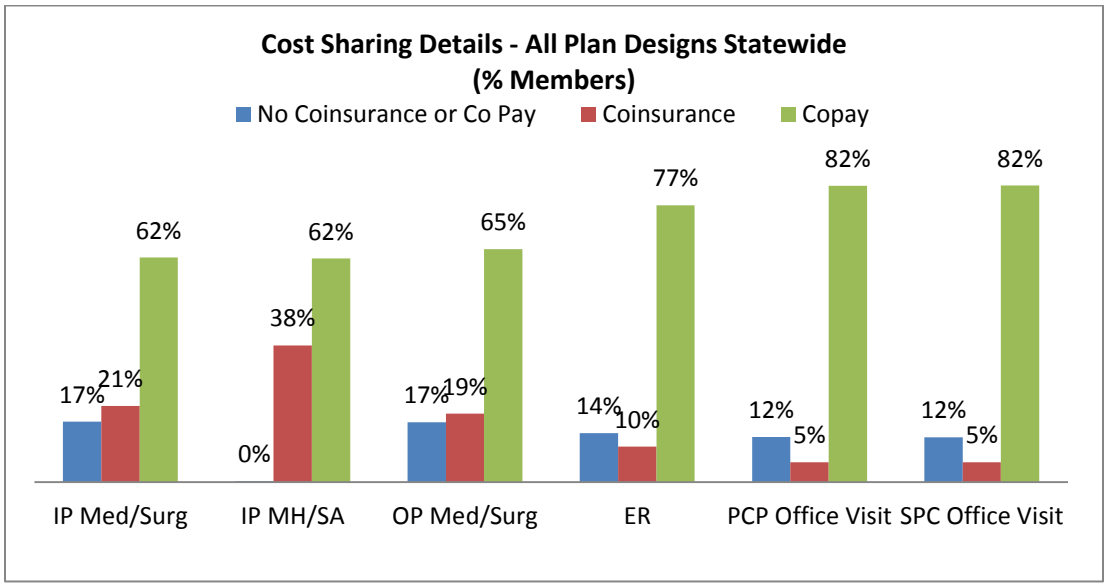
Percentage Point Change – UPSTATE							
	Deductible						
OOP	0 (none)	$ 1-500	$ 501-1,500	$ 1,501-3,000	$ 3,001-5,000	$ 5,001+	Total
$ 2,000 or less	0.0%	0.0%	-19.3%	0.0%	0.0%	0.0%	-19.3%
$ 2,001-3,999	-0.1%	0.0%	-1.9%	0.0%	0.0%	0.0%	-2.0%
$ 4,001-5,999	0.0%	0.0%	-0.4%	-1.7%	0.0%	0.0%	-2.2%
$ 6,000-9,999	0.0%	0.0%	14.8%	2.9%	0.0%	0.0%	17.7%
$10,000+	-0.5%	3.8%	1.6%	0.0%	0.1%	0.6%	5.6%
No OOP Max	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%
Total	-0.6%	3.7%	-5.2%	1.2%	0.1%	0.7%	0.0%

Source: Data call

Cost-sharing at Point of Service (coinsurance and copayments)

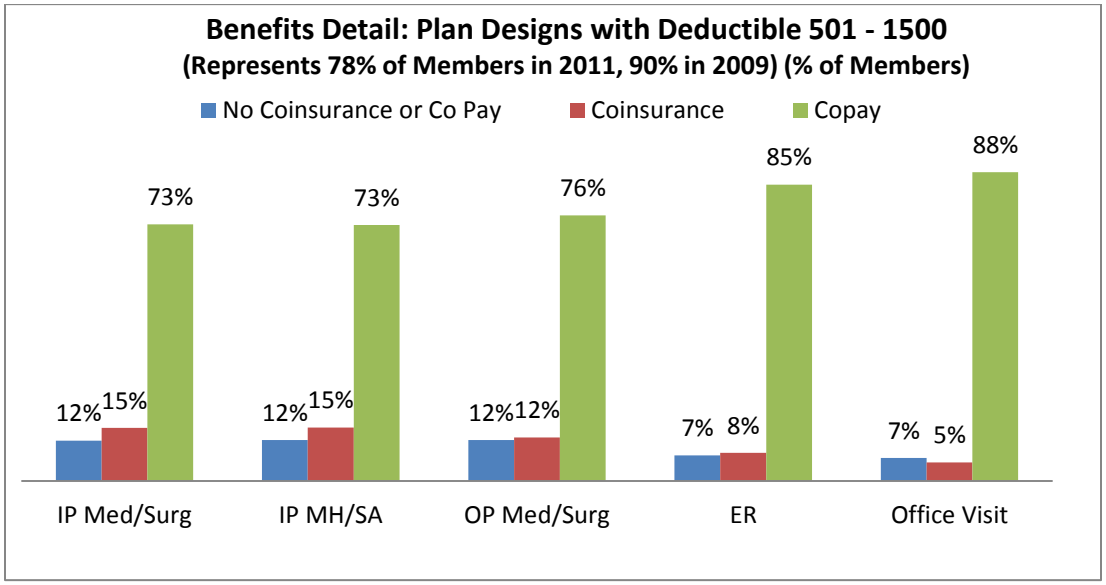
Amongst the wealth of detail on cost-sharing at the point of service (copayments and coinsurance), several patterns are notable. First, most plans use copayments or zero cost-sharing at the point of service, rather than a percentage coinsurance. With the exception of inpatient mental health and substance abuse (MH/SA), for which 38% of enrollees are required to pay coinsurance, enrollment in plans that apply coinsurance varies from a low of just 5% (for office visits) to a high of 21% for inpatient medical and surgical services. (Table 14)This pattern is even stronger for plans with the most popular level of annual deductible, $501-$1,500. (Table 15) For these plans, coinsurance only applies to a very small percentage of services--5% of enrollees pay coinsurance for office visits and 15% for inpatient stays.

Table 12: Cost Sharing Details - All Plan Designs Statewide



Source: Data call

Table 13: Benefit Detail: Plan Designs with Deductible $ 501- 1,500

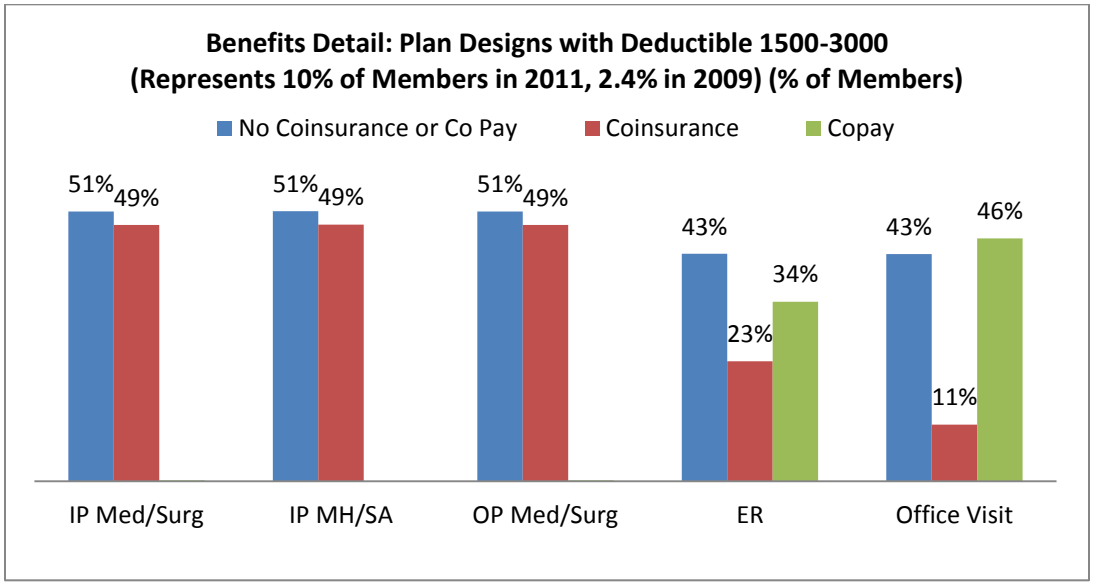


Source: Data call

Second, as is evident in the bar chart above, for those plans with modest annual deductible levels of $ 501-$1,500 – in the range that clearly fit within ACA limits -- approximately three-quarters of the enrollment is subject to copayments at the point of service. For emergency room and office visits, the percentage subject to copayments is even higher. However, as Table 17 indicates, the level of copayment for these plan designs (annual deductible of $501 - $1,500) varies considerably.

As discussed previously, a trend toward higher deductibles (over $1,500) is evident for recent years. Our third observation is that among plans with annual deductibles in the range of $1,500 to $3,000, copayments are relatively infrequent: responding plans report that half or so of the enrollment in such plans bears zero cost-sharing (other than the deductible) for hospital services (inpatient med/surgical and mental health/substance abuse, and outpatient hospital/same day surgery), while the remainder primarily pays coinsurance for these same services. For Emergency Room and office visits in these plans, there is far less use of coinsurance and more use of copayment.

Table 14: Benefits Detail: Plan Designs with Deductible $ 1,500- 3,000

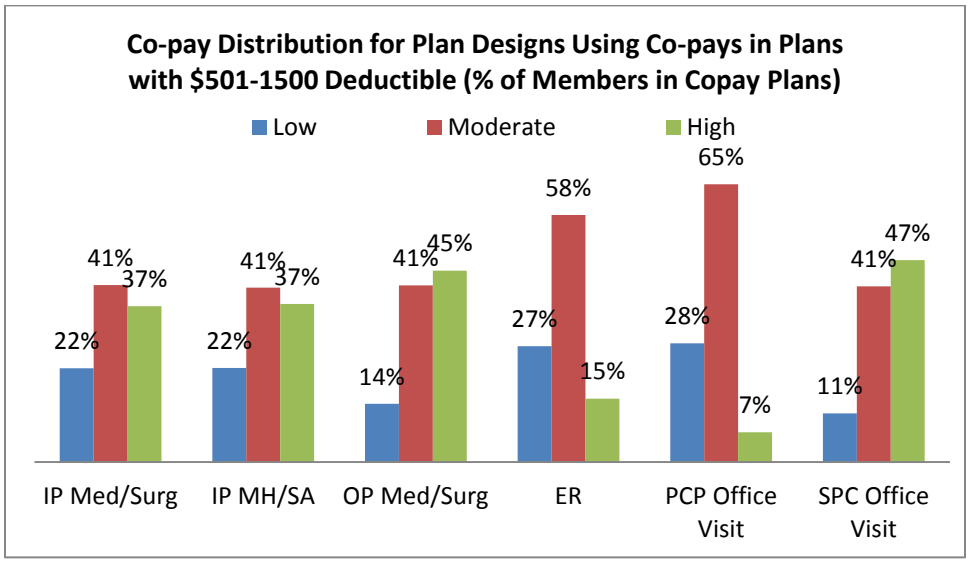


Source: Data call

Among plan designs that rely on copayments as the form of cost-sharing at point-of-service, the degree of reliance seems to depend on the level of upfront cost-sharing through an annual deductible. For the plans in the bar chart below, with relatively moderate annual deductibles (<$1,501 for single coverage), copayments for the major service copayments are "moderate" or "high," with the exception of ER services and office visits for primary care physicians. Here is the table of ranges that we used to distinguish high, medium and low copayments, by service:

	Inpatient	**OPD/ER**	**Office Visits**
Low	$ 499 or less	$ 75 or less	$ 1 - 24
Moderate	$ 500 – 999	$ 76 – 150	$ 25 – 39 PCP $ 25 – 49 Specialist
High	$1,000 +	$ 151 +	$ 40 + PCP $ 50 + Specialist

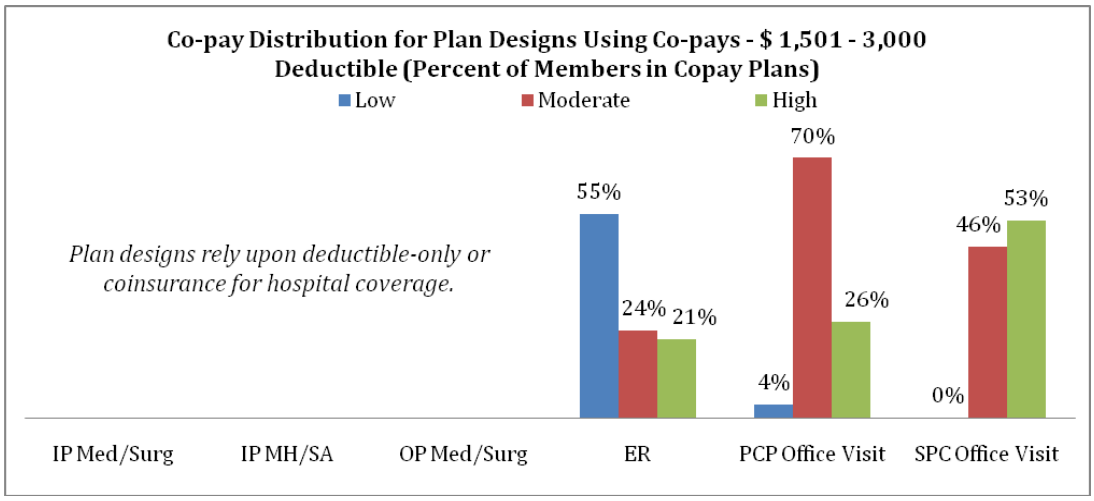
Table 15: Co-pay Distribution for Plan Designs Using Co-pays in Plans with $ 501- 1,500 Deductible



Source: Data call

For benefit designs with higher deductibles—in some cases, higher than the $2,000 for single coverage allowed for non-grandfathered plans in small group under the ACA—copayments are not being used for traditional hospital services, other than emergency room visits. Even for ER visits, over half of these copayments levels are "low" ($75 or less). As in the chart below, some plans differentiate office visits copayments for primary and specialty care, charging higher copayments for the latter.

Table 16: Co-pay Distribution for Plan Designs Using Co-pays - $1,501-3,000 Deductible



Source: Data call

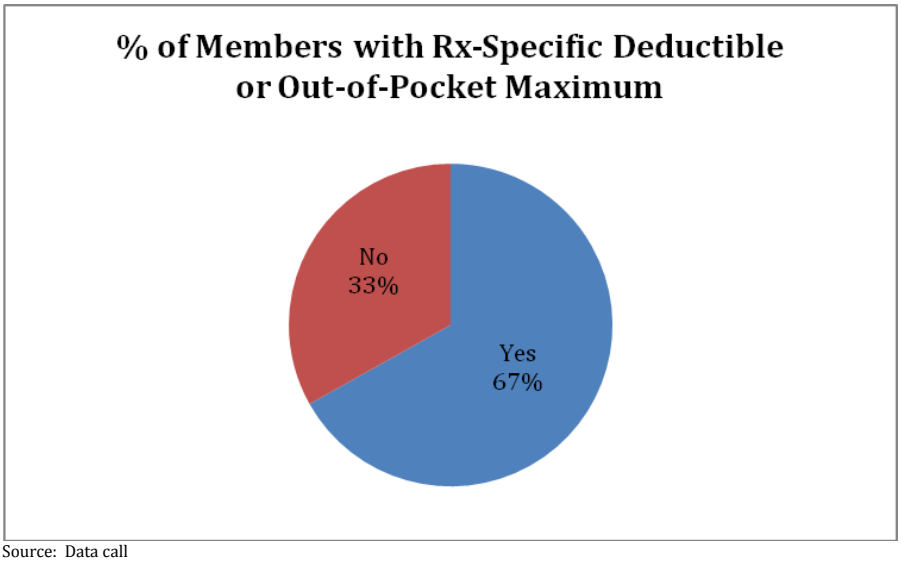
Deductible and Out-of-pocket Maximums for 2-Person or Family Coverage

Half of the carriers use a factor of 2 to calculate the deductible in 2-person or family coverage; meaning the deductible in one-person or employee-only coverage is doubled when any dependents are covered. Twenty-five percent of the carriers use a factor of 2.5 and nineteen percent use a factor of 3. One carrier uses a factor of 2 for High Deductible Health Plans (HDHPs) and 3 for non-HDHP plans. While the data call did not explicitly ask how the 2-person or family cost-sharing works, one carrier volunteered that any one member can satisfy the individual deductible and begin receiving benefits. This is not necessarily the case for all carriers. Some carriers require the full 2-person or family deductible to be met, even when only one member is incurring any claims. How carriers administer deductible and out-of-pocket maximum contract provisions clearly varies and is a good example of how ACA requirements for benefit standardization will help enrollees truly compare "apples to apples."

Cost-sharing for Prescription Drug Coverage

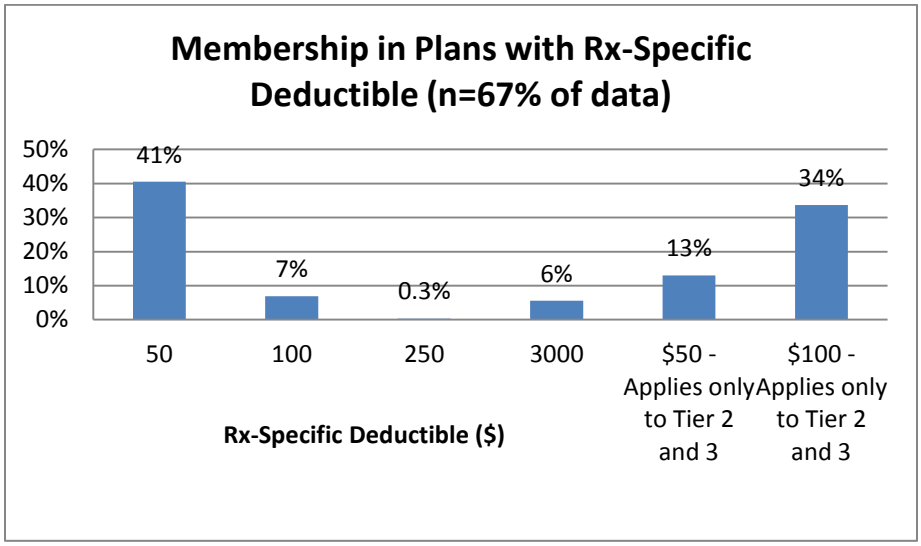
Two-thirds of small group enrollees are in plans that provide for a separate, Rx cost-sharing formula with its own deductible and/or out-of-pocket maximum (Tables 19 & 20). The vast majority of these members have an Rx-only deductible; only one reported plan design utilized an Rx-only maximum out of pocket. The most common separate deductible for prescription drugs is a modest $50 (54% of enrollees with a separate deductible), and some of these waive any deductible for generics. Most other coverage with an Rx deductible pegs it at $100, applied solely to brand-name drugs.

Table 17: Percentage of Members with Rx-Specific Deductible or Out-of-Pocket Maximum



Source: Data call

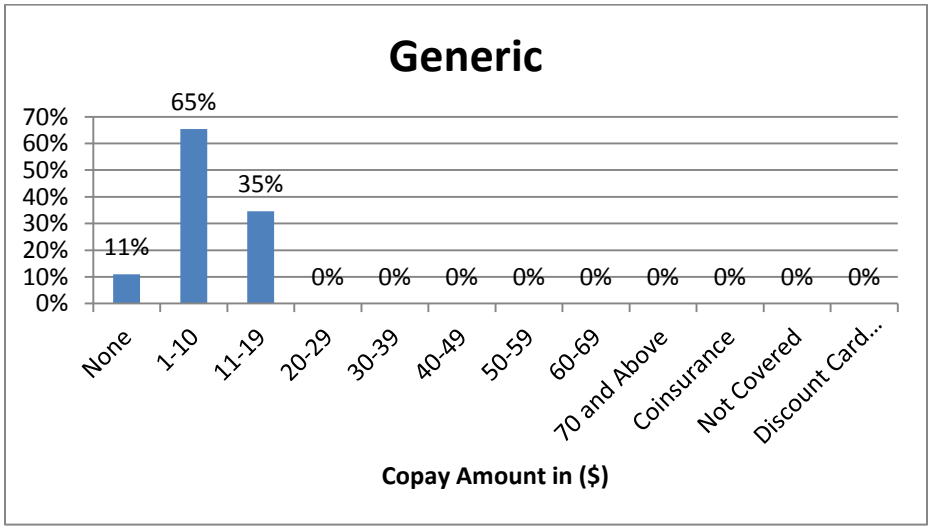
Table 18: Membership in Plans with Rx-Specific Deductible



Source: Data call

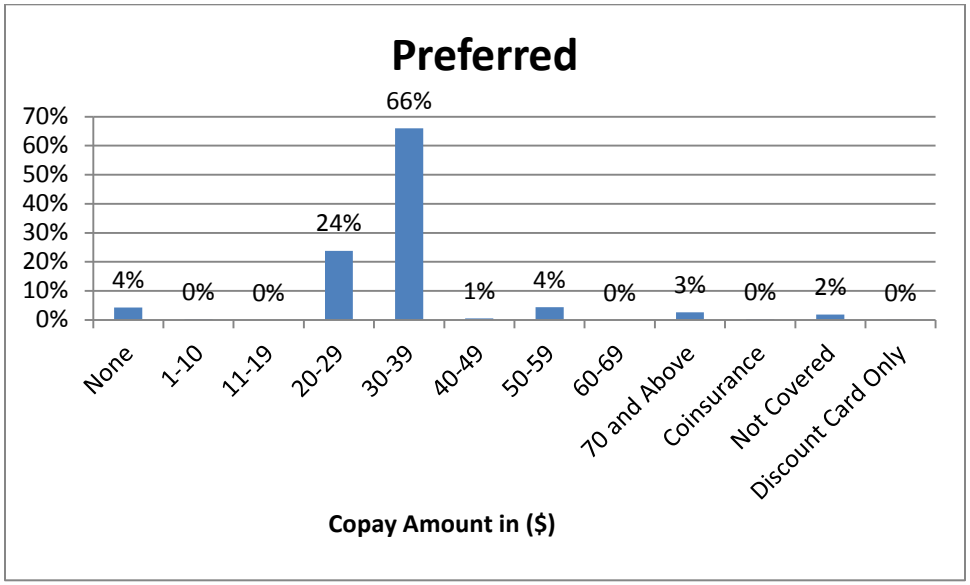
Prescription drug copayment levels are below $20 for generics; and typically range from $20 to $40 for preferred brand-name drugs i.e., those branded prescription drugs that are less expensive than the brand-name alternatives. The most expensive brands are typically placed on a non-preferred, brand-name tier with even higher patient copayments. For non-preferred brand-name drugs, cost-sharing typically starts at $50 copayments, ranging up from there, or in some cases is either a coinsurance obligation, or not covered at all (Tables 21-23).

Table 19: Generic Rx Cost-Sharing



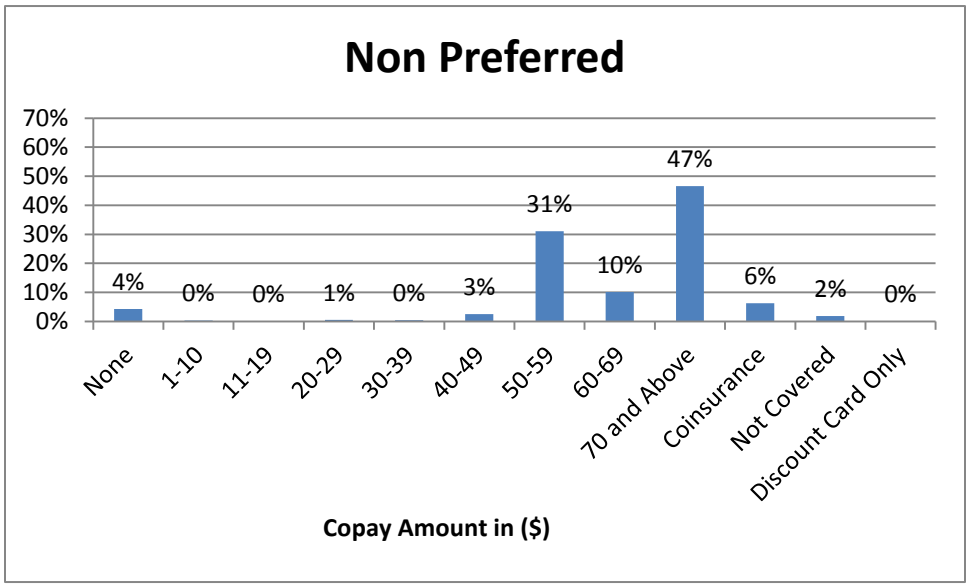
Source: Data call

Table 20: Preferred Brand Rx Cost-Sharing



Source: Data call (percentages add to more than 100% due to rounding)

Table 21: Non-Preferred Brand Rx Cost-Sharing



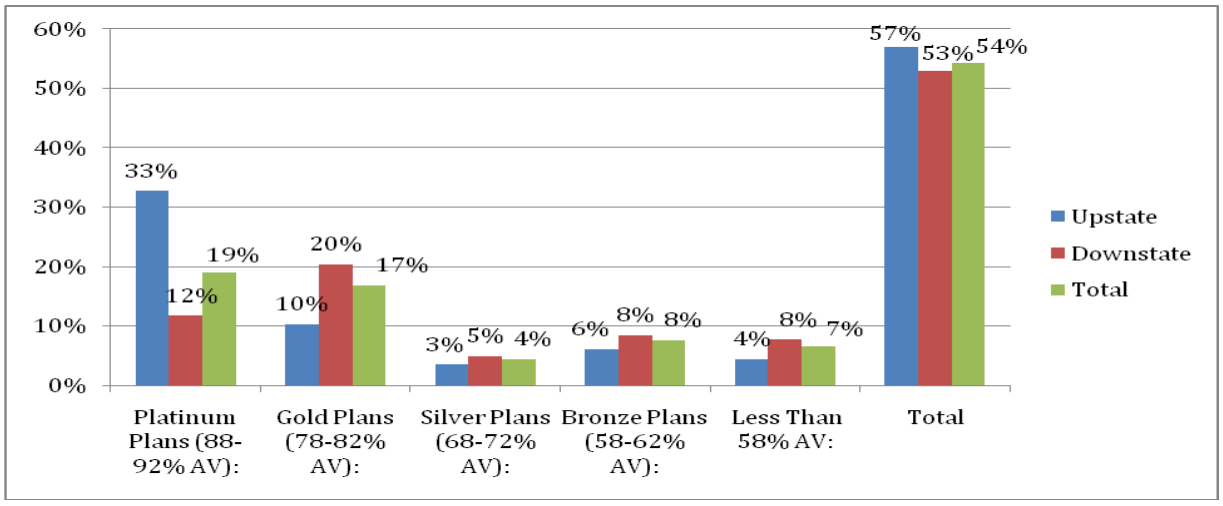
Source: Data call (percentages add to more than 100% due to rounding)

Actuarial Value (AV)

In addition to meeting the annual deductible and out-of-pocket limits, qualified health plans (QHPs) must also meet these other coverage standards under the ACA: (a) comply with the Essential Health Benefits standards set for New York State; and (b) fall within one of four actuarial value ranges. The state asked carriers in its data call to estimate what percent of their enrollees are in plans that fall within these actuarial ranges: 58%-to-62%, 68%-to-72%, 78%-to-82%, and 88%-to-92% (Table 24). The responding plans estimate that approximately 48% of their small group enrollment fall within one of these four ranges, as indicated in the table below. This average masks considerable variation across carriers, with a range between 6% and 100%, and a median and mean of 61%. Two-thirds of carriers have between 40% and 80% of their members in plans that meet this AV criteria. There is also considerable variation in the distribution of membership across the AV tiers, with a much higher portion of members in Upstate plans in Platinum products versus Downstate plans.

Importantly, only seven percent of enrollment is in plan designs estimated by the responding carriers to fall below an actuarial value of 58%, the minimum required for the SHOP exchange. This percentage is actually double for Downstate (8%) the percentage for Upstate (4%). However, important caveats should be noted: (a) these are only estimates by the carriers of actuarial value; (b) they are based on the covered services in these plans, which may differ from the medical services eventually required to be covered by the definition of Essential Health Benefits in NYS; and (c) market trends toward higher levels of employee cost-sharing could increase the enrollment in plans with actuarial value below 58% by 2013.

Table 22: Actuarial Values (AV) of Plan Designs in Small Group



Source: Data Call Note about Table 22: 46% Small Group enrollment is in plans with AV values above 58% but *between* the ranges specified for each metal level (i.e. more than 62% but less than 68%; more than 72% but less than 78%; more than 82% but less than 88%; and more than 92% but less than 100%).

Breadth and Depth of Network Options

All carriers responded that they offered provider networks that included most (85% or more) of the general, acute care hospitals in their service areas (data not shown). Carriers were also asked if they also offered either a narrow network (i.e., measurably fewer providers in the network) or tiered network (i.e., different cost-sharing for in-network providers) in their small group offerings. Statewide, four of the nine carriers report the availability of a more selective network product (i.e., a selective network includes fewer providers than the carrier offers in their full network product); two of these carriers predominantly serve the Downstate market and two primarily serve Upstate. The Upstate selective network enrollment is less than 2% while Downstate the enrollment is much more significant at 22%.

Other Plan Design Characteristics

Among carriers offering an HMO product, half require members to obtain a referral from their primary care physician (PCP) before receiving specialty care (data not shown). For other product designs (PPO, POS, EPO), only one carrier (Downstate) requires PCP referrals for specialty care (for its POS plans).

The data call also asked carriers to report any "value-added" programs or benefit features. "Value-added" programs or benefit features generally include coverage for services (not conventionally covered as medical care) and/or financial incentives which aim to improve enrollees' health and/or help them prevent, minimize or cope with conditions which can generate illness. Virtually all carriers reported some type of program or benefit but the specific features largely varied from one carrier to another, and sometimes were specific to a given carrier product offering. Reported "value-added" programs include: Health risk assessments (and incentives for completing); employee assistance program (EAP); disease management; programs to instill health habits in enrollees in all age categories; waiver of pharmacy deductibles for certain Rx purchases; gym reimbursement benefits and cash rewards for healthy behaviors. Producers interviewed for this research report that small employers are less likely to purchase "value-added" benefit features with discrete pricing. Producers generally explain that community rating does not reward small employers to pay an additional short-term cost to reduce mid- or long-term claim expenses.

Choice or Confusion?

In this paper we have described the breadth of variation in plan cost-sharing and other benefit design features which characterize NYS' small group market. Across all carriers and regions of the state, the amount of choice is overwhelming.

Our findings echo observations from a 2008/2009 study of one Upstate market -- New York's Finger Lakes region. This study sought to understand why small business

enrollment in rural, poor areas was lower than it should be, particularly based on the availability of the state-subsidized Healthy New York program for small employers. Initially, the study set out to determine whether re-designing benefits and/or lowering costs in Healthy New York could make the program more attractive to small business owners and thereby increase enrollment. To the researcher's surprise, small business owners reported that misunderstanding the various plans was more of a barrier than affordability.[iv] Once confusion about plan options was identified as a bigger barrier to enrollment than cost or benefits, the study focused on what rural employees did not understand about health insurance programs and how to overcome this barrier. Additional focus groups and interviews confirmed that the difficulty and complexity of accessing health insurance and navigating the different available options were bigger obstacles than cost alone.

Nationally, consumer engagement in complex decision-making around health care use and financing is on the increase. In a 2004 General Population Survey conducted by the Kaiser Family Foundation, the number of respondents who reported actively seeking information on health plans increased from 27% in 2000 to 35% in 2004. Of those that found comparative information on health plans, nearly half reported using that information.[v] More recently, in New York and across the country, so-called "consumer-directed health plans" are growing; these plans typically provide pre-tax dollars to consumers, but require them to be more active and involved in deciding how to use services and pay for them before insurance coverage starts i.e., after a high deductible is satisfied, and how to manage their own health and health care.

Consumer research suggests that the average consumer is balancing two goals: (1) to reach a quality decision and, (2) to limit the cognitive effort required to reach that decision.[vi] This creates a particular problem for decisions about health care and health insurance because of the complexity and inadequacy (or lack) of some data, and the risk and uncertainty of any decision. To take just one example, choices about accessing medical care, picking a plan and associated provider network, or picking a physician would seem to require the consumer to have access to considerable comparative quality information on physicians, while the reduction of cognitive effort requires a simplification of this information into a manageable number of health care choices, such as star-rating systems provide. Research from the California HealthCare Foundation has shown that, "too many choices can lead to an inability to make decisions; people experience a kind of decision overload where they become incapable of acting upon any information."[vii]

Recent consumer testing by Consumers Union (the advocacy and policy arm of *Consumer Reports*) confirms the widely held perception that people struggle to understand their health insurance choices.[viii] Consumers Union conducted three studies between September 2010 and May 2011 to explore consumer understanding of health insurance. One study included participants from New York State. Key findings from these studies are summarized below:

- Consumers dread shopping for health insurance and will take short-cuts to get it done;
- Some consumers doubt the value of health insurance and don't necessarily consider the value of protecting against *unexpected* medical costs;
- Consumers want the best value they can afford (and while consumer perceptions of value were fairly refined, their focus was mostly on how much coverage they would get, while whether their doctor was in the plan was mentioned somewhat less often, a perhaps surprising finding);
- Even though consumers' concept of value in health plans was fairly sophisticated, they had little ability to assess the overall coverage offered by a plan;
- Cost-sharing terms, are an important starting point for making any benefit choices or comparisons, are the greatest source of confusion; ; and
- Consumers need a manageable number of choices;

Participants were typically asked to compare just two health plans at a time and most struggled with this exercise because of the large number of variables on which the two plans differed. Comparing a large number of choices, with multiple differences amongst them, the author concluded, is beyond the cognitive abilities of most people.

Based on these findings, Consumers Union makes four recommendations to reduce confusion. The first, to increase the standardization of health plan designs which consumers are comparing and choosing among, is partially addressed by the ACA's requirement that QHPs be standardized into four distinct actuarial values (plus catastrophic coverage). However, there is room for considerable variation in type of product and cost-sharing on each actuarial tier. Consumers Union's findings suggest that 6-9 distinct plan designs may be optimal but recommends that further consumer testing in every state be conducted to find the right answer for local needs.

Second, how health plan information is presented (including the format, design, order and source) determines how and whether consumers will use the information. Again, the ACA prescribes certain requirements that will help, such as standardized coverage comparisons, but exchanges will still have latitude in presentation features, the ease with which users can navigate their websites, look up and understand definitions for key terms ("deductible," copayment," coinsurance," "tiered cost-sharing," "out-of-pocket maximum," "pre-authorization," "out of network," etc.).

Third, consumer education that is both timely and well executed will help. In this respect, the notion of a teachable moment is important i.e., that consumers receive education and outreach when, where and in a format that they are ready to use. This is generally at the point where they recognize a need to make a decision or otherwise act, but may also require information to motivate them to act.

Last, personal assistance by well-trained representatives to help both consumers and employers will be needed, regardless of how well-designed the exchange website and marketing materials may be. This last recommendation applies to the exchange's own customer call center as well as to navigators and producers assisting individuals, small businesses and employees enrolling through the exchange.

Many of the Consumers Union findings reflect the lessons learned by the Massachusetts Health Connector over its first several years of operation.

Comparison Shopping Experience in Commonwealth Choice (MA HealthConnector)

As a model for exchanges under the ACA, the evolution of the shopping experience and visual layout for Commonwealth Choice in the Massachusetts Health Connector may be instructive. With some 1.1 million hits in 2009, including 443,000 unique Massachusetts users, and very heavy use of the website by most buyers, the Massachusetts experience is worth examining. First, to simplify the comparison shopping experience, Commonwealth Choice shoppers typically begin their web-based purchasing process by entering just four pieces of information –their own age, zip code, number of dependents to be covered, and coverage start date. With these readily accessible identifiers, the Connector can price the plans available to them.

Second, they are given a simple "intuitive" choice of Bronze, Silver or Gold actuarial levels of benefit plans from which to select. Alternately, if they want more specificity to select a "metal" level, they can view a summary description of all six benefit plan options—three Bronze, two Silver and one Gold – as shown on page 34.

From inception (2007), the plans offered on each tier were all comparable on several important elements:

1. all are HMOs, the dominant form of coverage in the Massachusetts market
2. all cover the same basic set of services commonly covered in the commercial market,
3. all include state mandates and the Connector's definition of Minimum Creditable Coverage

However, consumer research subsequently unearthed considerable confusion, so the Connector took additional steps to standardize plan designs in order to simplify consumer shopping.

This easy selection of an actuarial tier originally (2007 - 2009) took shoppers to pages comparing different benefit packages from each issuer, all of whom designed their own Bronze, Silver and Gold plans. Notably, consumers in user focus groups conducted by the Connector in early 2009 reported considerable confusion among the plan options presented. They had trouble translating and giving full credence to the concept of "actuarial equivalence" – meaning that different designs on "Bronze" all provide comparable levels of coverage. Ironically, many thought the most expensive premiums indicated the richest coverage. As a result, price was being interpreted as a proxy for coverage, even quality of health plans, instead of simply a measure to the consumer of his/her monthly cost. The confusion seems to have generated perverse buying behavior.

In these focus groups, consumers stated that they wanted "apples-to-apples" comparisons. Why, they asked, couldn't the issuers offer similar benefits, so that consumers could more readily compare coverage for such other important features as price and network? In response to consumer preferences, expressed through both the focus groups and follow-up surveys of enrollees and non-enrollees, the Health Connector made two important improvements to simplify and enhance the shopping experience in Commonwealth Choice.

First, the Health Connector selected from among the plan designs that were already being offered in Commonwealth Choice the most popular, distinct cost-sharing and coverage designs. Based on enrollment, it selected three Bronze designs, three Silver and one Gold. (With most services covered under Gold at or near 100% of cost, there is little room for variation.) Then, the Health Connector solicited benefit offerings for all seven designs from the issuers, so that every carrier offered the same seven benefit designs. As a result, consumers can select the cost-sharing design of their choice, and then focus on a comparison of price, brand and network. (The Connector subsequently narrowed the choice of standard Silver benefit designs from three to two, because of relatively low enrollment and its judgment that the difference between two of the three standard designs was not meaningful.)

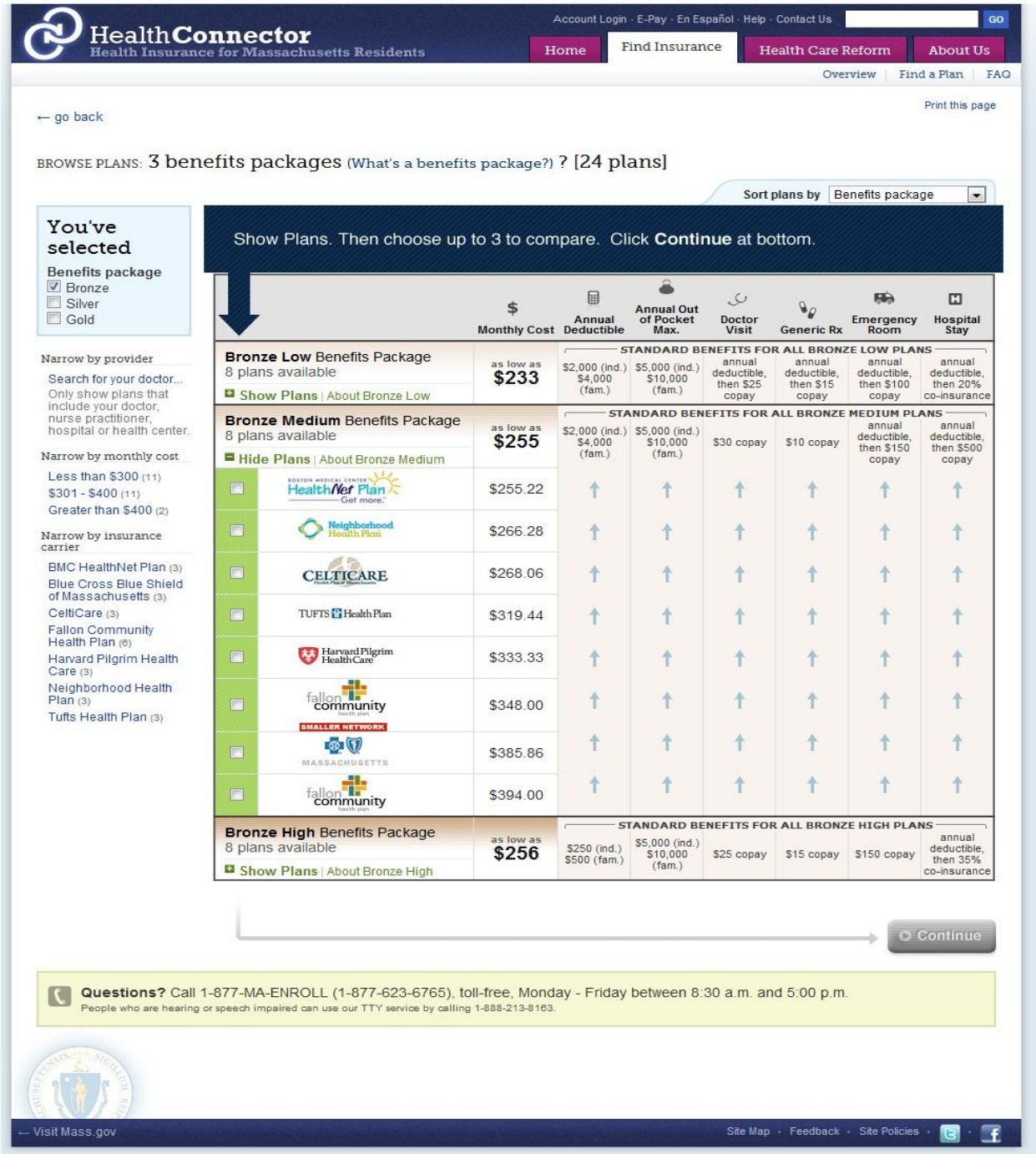
Second, to make it easier to compare provider networks and quality, the Health Connector added a physician and hospital finder, whereby the consumer can look up which plans include specific providers in their networks, and also view how the plans are rated by NCQA.

Consumers responded favorably to this further standardization and simplification of choice dynamics. One of the most notable trends has been a steady increase since 2009 in the enrollment in lower-priced, less recognized brands, displacing enrollment in the most expensive plans. At one end of the price spectrum, Neighborhood Health Plan has more than doubled its enrollment share in Commonwealth Choice to over 40%, while the share for the most expensive plans, offered by Blue Cross Blue Shield of Massachusetts, have fallen by half, to less than 20%. This trend seems to be a consequence of making it easier for consumers to isolate price from coverage variations in comparing plans.

In 2007, there were only six issuers statewide, with 3-5 of them covering any zip code of Massachusetts, but since then total issuers participating in Commonwealth Choice has increased from six to eight across the state. The two new issuers also serve the subsidized Commonwealth Care, making it easier for consumers to stay with the same carrier if they switch between (unsubsidized) Commonwealth Choice and (subsidized) Commonwealth Care. (However, premiums and point-of-service cost-sharing are not the same across the two programs.) Not only have the number of issuers expanded from six to eight, but one of them offers a choice of two different provider networks (Fallon Community Health Plan offers both a broad and a narrow network HMO product), and they cover larger swaths of the state. In Boston, there are now seven issuers offering eight networks options.

In summary, the Connector has expanded the number of participating issuers, while standardizing and reducing the variation in plan designs to be compared. Overall, it is fair to say that consumers now enjoy a broader choice of plans and networks, yet a simpler set of choices to make before enrollment than they had when the program began.

After viewing the cost-sharing summary for the three Bronze designs, consumers can view the plans offered under a specific Bronze design – in this case, "Medium," on the screen below.



To go into further depth, the shopper is then able to compare up to three carrier plans on a side-by-side basis as shown below (in part):**

**This level of detail continues on for two more pages, but was shortened here for ease.

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NCQA Rating	4 out of 4 stars → View insurer's report card	4 out of 4 stars → View insurer's report card	4 out of 4 stars → View insurer's report card
Benefits Package	Bronze Medium	Bronze Medium	Bronze Medium
About Benefits Package	About Bronze Medium • Higher annual deductibles compared to Bronze High. • No deductible for visits to your doctor. • Separate deductible for prescription drugs. • Prescription copays are lower for most generics, higher for most brand-name drugs. • Always check the details of a plan before you buy it.	About Bronze Medium • Higher annual deductibles compared to Bronze High. • No deductible for visits to your doctor. • Separate deductible for prescription drugs. • Prescription copays are lower for most generics, higher for most brand-name drugs. • Always check the details of a plan before you buy it.	About Bronze Medium • Higher annual deductibles compared to Bronze High. • No deductible for visits to your doctor. • Separate deductible for prescription drugs. • Prescription copays are lower for most generics, higher for most brand-name drugs. • Always check the details of a plan before you buy it.
Plan Name	NHP Choice Optimum 2000/4000	Harvard Pilgrim Bronze HMO 2000	Select Care Rx Saver 2000
Provider Network	Neighborhood Health Plan Comprehensive	Harvard Pilgrim Full Network	FCHP Select Care HMO

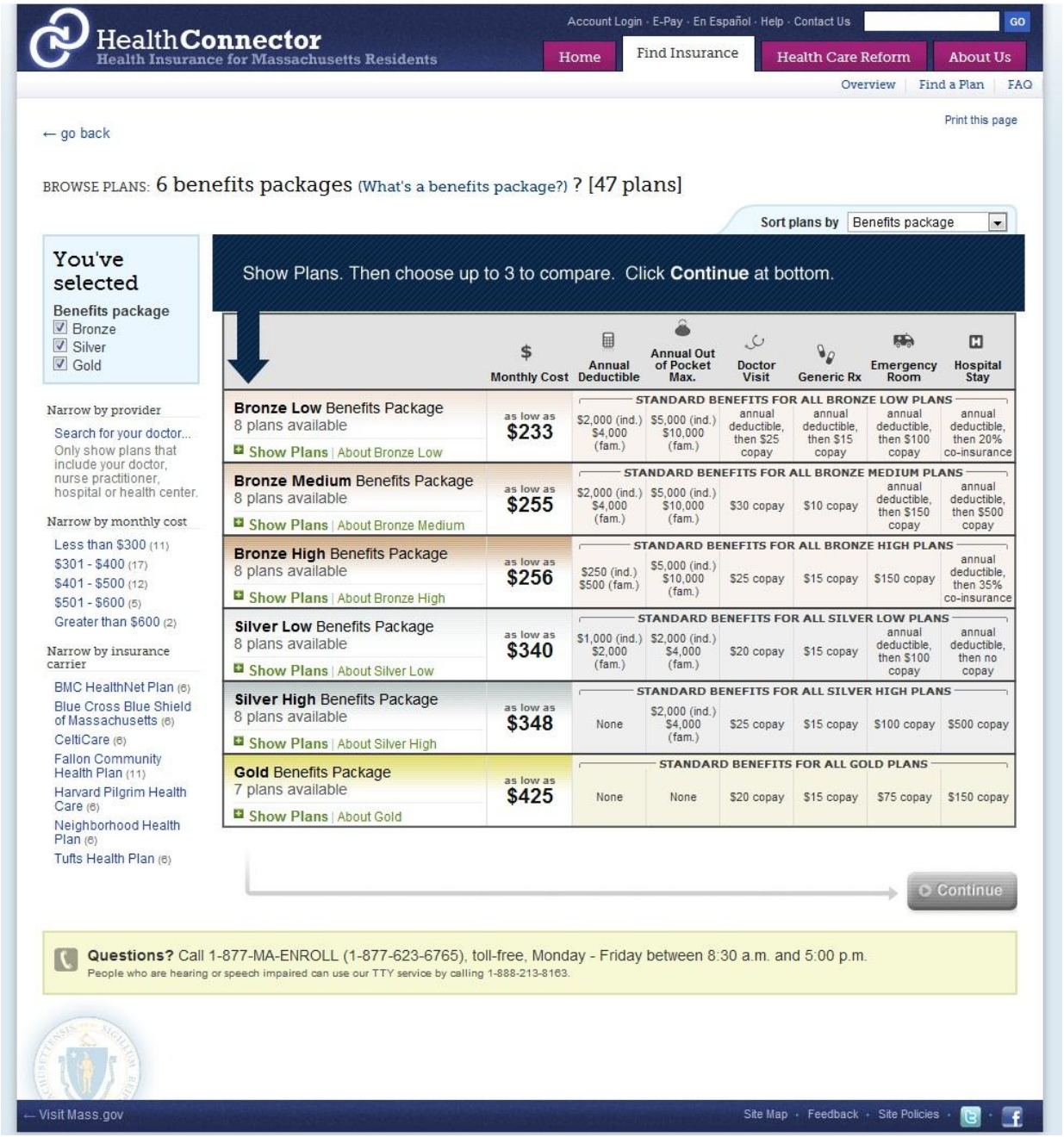
Doctor / provider acceptance

Find out whether your doctor, nurse practitioner or health clinic accepts the plan(s) you're viewing.

Search For Your Doctor

Plan details	Download Plan Details	Download Plan Details	Download Plan Details
Premium	**$266.28**	**$333.33**	**$394.00**
Provider Network Disclosure			
Provider network disclosure	This is a **General Provider Network** plan. If you purchase this plan, you will receive services through the broadest network of health care providers offered by this insurer.	This is a **General Provider Network** plan. If you purchase this plan, you will receive services through the broadest network of health care providers offered by this insurer.	This is a **General Provider Network** plan. If you purchase this plan, you will receive services through the broadest network of health care providers offered by this insurer.
Annual Deductible [1]			
Per person	$2,000	$2,000	$2,000
Family total	$4,000	$4,000	$4,000
Annual Out-Of-Pocket (OOP) Maximum [2]			
Per person	$5,000	$5,000	$5,000
Family total	$10,000	$10,000	$10,000
Costs that count towards OOP maximum			
Office visit: Adult routine physical	Not applicable	Not applicable	Not applicable
Office visit: Routine gynecological (GYN) exam	Not applicable	Not applicable	Not applicable
Office visit: Well-child care	Not applicable	Not applicable	Not applicable
Office visit: All other visits to Primary Care Provider (PCP)	No	Yes	Yes
Office visit: Specialist	No	Yes	Yes (excluding mental and behavioral health, dental and chiropractic services)
Prescription Drugs (Rx)	No	No	No
Emergency Room	Yes	Yes	Yes
Hospital care: Inpatient	Yes	Yes	Yes (excluding mental and behavioral health)
Outpatient surgery	Yes	Yes	Yes
Annual Benefit Maximum [3]	**Unlimited**	**Unlimited**	**Unlimited**
Routine Medical Office Visits			
Subject to annual deductible	No	No	No
Adult routine physical	$0	$0	$0
Routine gynecological (GYN) exam	$0	$0	$0
Well-child care	$0	$0	$0
Routine Vision			
Subject to annual deductible	No	No	No
Routine vision exam	$30	$30	$0
One vision exam per	per calendar year	per 24 months	per 12 months

Alternate (and More Detailed) View of Three Actuarial Levels, Instead of the Three Medallions shown on page 29:



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BROWSE PLANS: 6 benefits packages (What's a benefits package?) ? [47 plans]

Sort plans by: Benefits package

You've selected
Benefits package
☑ Bronze
☑ Silver
☑ Gold

Narrow by provider
Search for your doctor...
Only show plans that include your doctor, nurse practitioner, hospital or health center.

Narrow by monthly cost
Less than $300 (11)
$301 - $400 (17)
$401 - $500 (12)
$501 - $600 (5)
Greater than $600 (2)

Narrow by insurance carrier
BMC HealthNet Plan (6)
Blue Cross Blue Shield of Massachusetts (6)
CeltiCare (6)
Fallon Community Health Plan (11)
Harvard Pilgrim Health Care (6)
Neighborhood Health Plan (6)
Tufts Health Plan (6)

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

	$ Monthly Cost	Annual Deductible	Annual Out of Pocket Max.	Doctor Visit	Generic Rx	Emergency Room	Hospital Stay
Bronze Low Benefits Package 8 plans available Show Plans | About Bronze Low	as low as **$233**	STANDARD BENEFITS FOR ALL BRONZE LOW PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	annual deductible, then $25 copay	annual deductible, then $15 copay	annual deductible, then $100 copay	annual deductible, then 20% co-insurance
Bronze Medium Benefits Package 8 plans available Show Plans | About Bronze Medium	as low as **$255**	STANDARD BENEFITS FOR ALL BRONZE MEDIUM PLANS					
		$2,000 (ind.) $4,000 (fam.)	$5,000 (ind.) $10,000 (fam.)	$30 copay	$10 copay	annual deductible, then $150 copay	annual deductible, then $500 copay
Bronze High Benefits Package 8 plans available Show Plans | About Bronze High	as low as **$256**	STANDARD BENEFITS FOR ALL BRONZE HIGH PLANS					
		$250 (ind.) $500 (fam.)	$5,000 (ind.) $10,000 (fam.)	$25 copay	$15 copay	$150 copay	annual deductible, then 35% co-insurance
Silver Low Benefits Package 8 plans available Show Plans | About Silver Low	as low as **$340**	STANDARD BENEFITS FOR ALL SILVER LOW PLANS					
		$1,000 (ind.) $2,000 (fam.)	$2,000 (ind.) $4,000 (fam.)	$20 copay	$15 copay	annual deductible, then $100 copay	annual deductible, then no copay
Silver High Benefits Package 8 plans available Show Plans | About Silver High	as low as **$348**	STANDARD BENEFITS FOR ALL SILVER HIGH PLANS					
		None	$2,000 (ind.) $4,000 (fam.)	$25 copay	$15 copay	$100 copay	$500 copay
Gold Benefits Package 7 plans available Show Plans | About Gold	as low as **$425**	STANDARD BENEFITS FOR ALL GOLD PLANS					
		None	None	$20 copay	$15 copay	$75 copay	$150 copay

Continue

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People who are hearing or speech impaired can use our TTY service by calling 1-888-213-8163.

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Medicare Part D: Benefit Standardization and Consumer Choice

The Medicare Prescription Drug, Improvement, and Modernization act (MMA) of 2003 created a new prescription drug benefit program for Medicare beneficiaries known as Medicare Part D. This new drug benefit is provided through stand-alone prescription drug plans (PDPs) or Medicare Advantage plans that include prescription drug coverage (MA-PD) and administered exclusively through private health insurers. [ix] The goal of Part D is to "encourage private sector organizations who meet the law's requirements to offer a range of Part D plan options… by providing flexibility in plan design and management".[x]

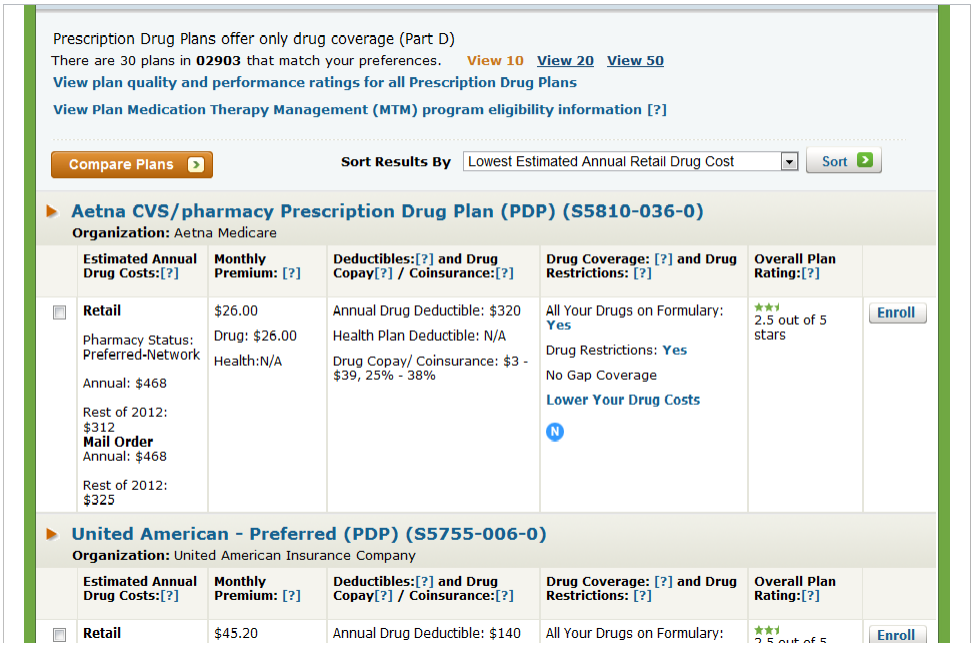
Consumers' experiences with the Medicare Part D marketplace provide further insights into choice dynamics. Research from 2005 to 2009 suggests that beneficiaries' knowledge of Part D's benefit structure and design was poor.

In the initial planning phase for Part D, there was a high level of uncertainty as to whether insurance companies would participate in the new market. However, in 2006, the market was immediately flooded. There were a total of 1,429 stand-alone Part D plans, forcing seniors in each geographic region to compare and choose among 40 - 70 different plans. Beneficiaries often did not pick the lowest cost Part D plan and were reluctant to switch plans to improve their benefits. Knowledge gaps, enrollment issues, and plan choice difficulties were most apparent when Part D was first implemented (2006), but these issues persisted. Many Part D-eligible beneficiaries reported feeling overwhelmed by the number of plan choices. Less than half of survey respondents reported actually making a comparison of the costs and benefits of different plans; and of those who did so, most compared four or fewer plans.[xi] Plan choices seem to be based on name recognition or low premiums, and beneficiaries often chose plans with which they had a prior relationship or from which they had received information through a representative or advertisement.[xii]

Medicare.gov Part D Plan Finder Tool

The Medicare Prescription Drug Plan Finder, created by CMS, is the only source of continually updated, comprehensive plan information. This tool underwent changes in 2010 in order to increase the interface usability.[xiii]The Plan Finder allows consumers to search for Part D plans by zip code or through entering their Medicare information. Consumers can then enter drug information, select a pharmacy**,** and refine coverage options by choosing plan rating, drug coverage, or deductible criteria.

Example Plan Listing



Prescription Drug Plans offer only drug coverage (Part D)
There are 30 plans in **02903** that match your preferences. View 10 View 20 View 50
View plan quality and performance ratings for all Prescription Drug Plans
View Plan Medication Therapy Management (MTM) program eligibility information [?]

Compare Plans | Sort Results By: Lowest Estimated Annual Retail Drug Cost | Sort

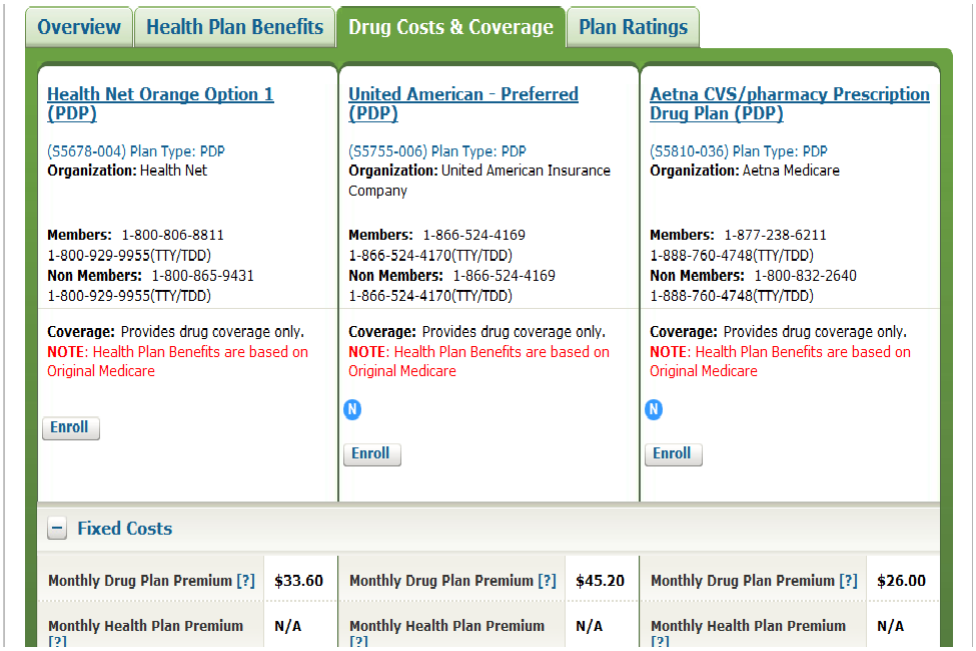
Aetna CVS/pharmacy Prescription Drug Plan (PDP) (S5810-036-0)
Organization: Aetna Medicare

Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles:[?] and Drug Copay[?] / Coinsurance:[?]	Drug Coverage: [?] and Drug Restrictions: [?]	Overall Plan Rating:[?]	
Retail Pharmacy Status: Preferred-Network Annual: $468 Rest of 2012: $312 **Mail Order** Annual: $468 Rest of 2012: $325	$26.00 Drug: $26.00 Health:N/A	Annual Drug Deductible: $320 Health Plan Deductible: N/A Drug Copay/ Coinsurance: $3 - $39, 25% - 38%	All Your Drugs on Formulary: Yes Drug Restrictions: Yes No Gap Coverage Lower Your Drug Costs N	2.5 out of 5 stars	Enroll

United American - Preferred (PDP) (S5755-006-0)
Organization: United American Insurance Company

Estimated Annual Drug Costs:[?]	Monthly Premium: [?]	Deductibles:[?] and Drug Copay[?] / Coinsurance:[?]	Drug Coverage: [?] and Drug Restrictions: [?]	Overall Plan Rating:[?]	
Retail	$45.20	Annual Drug Deductible: $140	All Your Drugs on Formulary:		Enroll

Example Plan Comparison



Overview | Health Plan Benefits | Drug Costs & Coverage | Plan Ratings

Health Net Orange Option 1 (PDP)	United American - Preferred (PDP)	Aetna CVS/pharmacy Prescription Drug Plan (PDP)
(S5678-004) Plan Type: PDP **Organization:** Health Net	(S5755-006) Plan Type: PDP **Organization:** United American Insurance Company	(S5810-036) Plan Type: PDP **Organization:** Aetna Medicare
Members: 1-800-806-8811 1-800-929-9955(TTY/TDD) **Non Members:** 1-800-865-9431 1-800-929-9955(TTY/TDD)	**Members:** 1-866-524-4169 1-866-524-4170(TTY/TDD) **Non Members:** 1-866-524-4169 1-866-524-4170(TTY/TDD)	**Members:** 1-877-238-6211 1-888-760-4748(TTY/TDD) **Non Members:** 1-800-832-2640 1-888-760-4748(TTY/TDD)
Coverage: Provides drug coverage only. **NOTE:** Health Plan Benefits are based on Original Medicare	**Coverage:** Provides drug coverage only. **NOTE:** Health Plan Benefits are based on Original Medicare	**Coverage:** Provides drug coverage only. **NOTE:** Health Plan Benefits are based on Original Medicare
Enroll	N Enroll	N Enroll

Fixed Costs

Monthly Drug Plan Premium [?]	$33.60	Monthly Drug Plan Premium [?]	$45.20	Monthly Drug Plan Premium [?]	$26.00
Monthly Health Plan Premium [?]	N/A	Monthly Health Plan Premium [?]	N/A	Monthly Health Plan Premium [?]	N/A

Evidence indicates that the large number of Medicare drug plan options is problematic for beneficiaries because of both the complexity of the benefit designs and the barriers that the elderly may face when trying to enroll in a plan. Previous research has suggested that decision quality deteriorates as the number of plans increases.[xiv] Although CMS has started to encourage consolidation of the Part D market in order to reduce confusion for seniors, some healthcare policy makers have recommended plan standardization measures to help seniors make informed decisions about Part D plans. These plan standardization measures could include requiring sponsors to clearly label and define plans with enhanced benefits, encouraging the use of standard forms and procures, and providing standard descriptions and precise definitions of benefits.[xv1]

Conclusion

New York State's nine major health insurers offer a tremendous range of benefits and plan designs to small employers. At least 15,000 different plan designs were available in 2011, and there is no reason to believe that this number decreased substantially in 2012. Most of these plan designs serve a relatively low number of enrollees: each of 14,577 (or 97% of total) plan designs serve 500 or fewer enrollees. On average they serve only 22 apiece and the majority of these 14,577 plans enrolled less than that. In total, they serve 23% of the small group market. At the other end of the spectrum, less than one hundred plan designs serve 52% of enrollees.

Clearly, accommodating the breadth of diversity found in the State's existing small group market on the SHOP exchange would be challenging; and such breadth of choice is unnecessary to provide either continuity of coverage for the majority of covered employees, or to provide meaningful choice among clearly distinct plan designs.

The state's current small group market can also be subdivided by product type (which often equates to licensure category) and by geography: significant portions of small group enrollment are represented by four different types of products: HMO, PPO, POS and EPO. Adding to this complexity is considerable variation by region. Even at the grossest level of geographic distinction—Upstate versus Downstate—we observe considerable variation. For example, PPO is most prevalent among small groups Upstate (representing 39% of enrollment) and EPO dominates the Downstate market, with 53% of enrollment.

The Downstate and Upstate markets differ from each other in several major ways. First, Downstate is almost entirely producer-driven, but 21% of the Upstate market did not use a producer. Second, Downstate carriers typically use general agents, but not Upstate. Third, despite its much larger population and total small-group enrollment, Downstate New York evidences half the variation in plan design as Upstate. Just 72 larger plans accommodate 63% of small-group enrollment Downstate – or almost half the statewide total—whereas

the largest 167 plans Upstate accommodate only 60% of Upstate enrollment. More granular benefit-pattern differences are evident in the tables presented in this report.

As noted above, the ACA will introduce considerable standardization among non-grandfathered, small-group plans—in or out of the exchange. As a result, much of the small-group market will experience considerable discontinuity of coverage. For example, plans with annual deductibles exceeding $2,000/$4,000 (single/family), caps on total out-of-pocket cost-sharing exceeding approximately $6,000/$12,000 (single/family), plans which do not cover NYS' definition of essential health benefits, and/or do not fall within two percentage points, up or down, from the four prescribed actuarial values (60%, 70%, 80%, and 90%) will all be closed or adjusted, except for grandfathered enrollment. (Note: exceptions to the ACA-set deductibles and out-of-pocket limits apparently will be allowed to the extent that an employer's contribution to an HSA or HRA plan impacts the actuarial value of the plan. Final guidance is pending.)

Within the remaining set of plans, they will be standardized based on the variables described above, both in and out of the exchange. On the exchange, small employers will be able to shop amongst plans which cover a standard set of what New York defines as its essential health benefits, with deductibles and maximum cost-sharing per year that cannot exceed for single coverage $2,000/$6,000 and for family coverage $4,000/$12,000, and which will cover on average approximately 90%, 80%, 70% or 60% of the expected cost of care for a typical commercial population. Responses to the 2011 data call suggest that thousands of existing plan designs are likely to meet these requirements, or will need relatively minor 'tweaking" to do so, such as adding coverage of "habilitative" services.

An important design question for the SHOP exchange in developing its specifications for soliciting and offering qualified health plans (QHPs) is whether to mimic the existing market by developing a way to offer all such plan designs--and perhaps some new ones as well; or to offer a much smaller set of plan designs on the exchange. This is a "gating" decision in QHP certification. We address the pros and cons of these two approaches below.

Presenting producers, employers, and employees with a meaningful choice of QHPs is clearly consonant with the intent of federal reform. Whether meaningful choice suggests thousands of options is a different question. There are three possible reasons to offer a very broad choice of plan designs.

Reasons to Offer Broad Choice

First, innovations in plan design are hard to anticipate, and specifying just a few acceptable QHP plan designs, arguably, stifles innovation. However, this argument would be far more credible if the restriction of plan designs were applied across the entire market, or were NYS to exclude the market outside the exchange, as Vermont is doing. In fact, the SHOP exchange is likely to represent, at best, a modest percentage of NYS's robust small-group market. Therefore, anxiety about stifling innovation is unjustified. To the contrary, by

limiting the number of plans on the exchange, it may be able to differentiate itself from the outside market by simplifying comparison shopping, and use its market leverage to encourage certain specified innovations. Conversely, if innovative plan designs occur outside the exchange, the exchange always has the opportunity to build such innovation into its own QHP certification criteria or to relax its criteria in order to accommodate new concepts.

Second, there are "transition" issues for existing plan designs. To the extent that New York State's SHOP exchange limits the diversity of QHPs, compared with the outside market, it cannot satisfy demand which is tied to existing designs. For example, an employer may be perfectly satisfied with, and his employees accustomed to, a particular plan design and carrier which would not be available as one of the standard plan designs on the exchange; that employer may decide not to use the exchange simply because the plan that s/he prefers is unavailable there. Alternately, an employer qualified for the special small business tax credit that will be available only through the SHOP exchange after 2013 would have to switch to a new plan design in order to use the exchange, thereby disrupting his employees' coverage. Because of the very small enrollment and standardization of designs in the non-group market, this issue is unique to SHOP.

Third, even modest differences in benefits and price can be meaningful to employers who are using multiple strategies to pursue a goal, such as cushioning an increase in premiums at annual renewal. Because of demographic changes, such as more dependent coverage among employees, underlying premium trend, and/or changes in the employer's other expenses or revenues, small employers often explore a series of options to meet their financial objectives. For example, an employer considering multiple strategies to restrain his/her increase next year to 5%, against an 8% premium increase at renewal, may want to combine a slight increase in employee contributions for dependent coverage with a switch from HSA to HRA funding, plus a modest increase in office visits and brand name drug copayments. While the modest increase in copayments may not look like a meaningful difference outside the context of the employer's overall strategy for addressing the 8% premium increase, in this example that modest change is one important piece of this employer's broader strategy.

[Footnote: Of course, some of these arguments assume that the employer is selecting one plan or a benchmark plan for calculating the contribution level. Under a true defined contribution, employee-choice model, where the employer defines a percentage or flat dollar contribution and encourages employees to pick their own plan, it is really an individual choice, not an employer-choice.]

The argument in favor of plentiful choice is weaker for households buying directly –with or without a defined employer contribution -- because they face a simpler set of choices, such that a $5 difference in office visit copayments, generating a 1% difference in premiums, may be relatively meaningless. (After all, the subscriber will likely pay this miniscule difference one way or another—either at the doctor's office or in her monthly premiums.

Moreover, buyers on New York's direct market will be coming into exchanges having had very little choice in the outside market.)]

Reasons to Manage Choice

Balanced against the reasons for "letting a hundred flowers bloom" are some strong arguments against "meaningless choice" among hundreds or thousands of design options. The strongest argument against a proliferation of options is articulated in the previous section on the ease with which consumers can be confused and the value in simplifying choice. While it is technically possible to offer hundreds or even thousands of different plan designs, using decision-support tools to help employers and employees narrow their search before comparing a few options, it is hard to see how such tools can screen for minor differences among plans. Such differences present "meaningless" choice in so far as they do not represent distinct value propositions. For example, difference between two plan designs with the same deductible, OOP Maximum, and coinsurance, but differing by $5 on copayments for office visits and brand-name drugs would not seem to represent meaningful choice. No decision-support tool could discriminate between them for a given employer, let alone a group of employees. Avoiding a proliferation of meaningless choice is the overwhelming reason to limit plan design variations.

A second reason to limit the number of plan options is the practical need for administrative simplicity, both for the exchange and for carriers. Each QHP must be reviewed, found compliant with the minimum certification requirements set by federal regulation, re-priced quarterly or even monthly for SHOP, tracked for premiums in and outside the exchange, consumer complaints, analyzed and reported, reconciled for enrollment and premium changes month-to-month, and so forth. Complicated as this might be for a dozen designs across five, ten or more issuers, the challenge will be far greater for hundreds of designs resulting in thousands of QHPs.

Third, it easier to add new plans than to terminate existing ones, so starting off with a plethora of QHP designs will prove burdensome if the exchange decides to narrow the selection. "Terminating" existing QHPs generally means freezing new enrollment, but allowing current enrollees to renew. Unless it is part of the carrier's elimination of plans altogether, SHOP will need to "grandfather" and maintain existing accounts or send them to the outside market and forfeit any revenues associated with that customer. This is especially complex in an employee choice situation, where some employees may be in "continuing" QHPs and others in "terminating" QHPs. Over time, maintaining hundreds of "frozen" designs or eliminating them will prove burdensome and costly to the SHOP exchange.

Finally, if the exchange intends to use price as one of its screening criteria—it cannot screen exclusively based on price—this suggests some exclusion of issuers, if not plans. To the extent that the exchange offers enough variety to attract customers, it will be able to

reward cooperative, price-competitive QHPs with more volume by not offering every option in the outside market.

On balance, mimicking the breadth of choice in the outside market and proliferation of options on the exchange seems unjustified. Therefore, we suggest that specifying benefits and cost-sharing for QHPs, beyond the statutory requirements under ACA related to maximum deductibles, out-of-pocket spending, coverage for essential health benefits, and actuarial value, should be considered. In doing so, we also caution that care taken not to unduly constrain choice, particularly in the SHOP exchange. For small employers, transition issues from the current market to a few standardized QHPs are substantial and their annual renewal strategies require more choice of plans than individual direct buyers may want.

Establishing Reasonable Choice

Short of unlimited choice, how might the SHOP exchange define a "reasonable" range of options? We suggest three approaches for consideration.

One, the exchange might invite each issuer to propose one or several plan designs of its own choosing for each of the four actuarial values in the SHOP exchange. (Of course, these options must meet the minimum, federally-mandated criteria for certification.) Depending on what each carrier submits, the result might actually result in less than a full breadth of options on any actuarial tier, thereby constraining choice, or it might generate a broad range of different, non-standardized plan designs on each actuarial tier, which could make it hard for employers and employees to compare premiums for similar benefits.

A variant on this first approach would be to ask each issuer to propose its most popular 2-3 existing plan designs at each of the four actuarial values, adjusted for compliance with essential health benefits, from which the exchange would select one or more. This approach would at least ensure that some small employer groups could keep their current coverage while moving from the outside market to the SHOP exchange, and it should create an appealing set of options for the SHOP exchange, by comparison with the existing small-group market. It would also accommodate the different licenses that competing carriers currently hold and write small group business under.

The exchange would have the option of eventually (after 2014) selecting a limited number of designs among all the options offered, and "standardizing" around those designs. For example, the exchange might select the two or three highest enrollment designs at each actuarial value, and require all issuers to offer those three standard plan designs. This is what the Health Connector in Massachusetts did. And/or the NYS exchange might require all issuers to develop certain standard features for one or more QHPs at each actuarial level, such as a gatekeeper HMO, pay-for-performance incentives to improve quality, or narrow-network plans that lower premiums for a given set of benefits.

Two, at the other extreme, the exchange might specify 2-3 standard plan designs for each actuarial value and require issuers to submit these exact designs. (At the Platinum level, there is relatively little room for meaningful variation in cost-sharing, because so much is covered by the plan, so fewer options at this level than at Gold, Silver or Bronze might be appropriate.) This would allow employers and employees to shop for value across truly comparable plans. .

Given the wide dispersion even among relatively popular plans—some 97 plan designs represent only half the market—this approach would probably not accommodate existing coverage for most groups. It would also require most issuers to develop new plan designs just for the exchange, thereby actually adding to the total number of plan designs in the market.
Moreover, if the exchange were to develop standardized designs without regard to the relative popularity of existing plans, it would likely "miss" most of the market. There is very little subsidy available exclusively through SHOP, so the exchange must prove itself a better insurance "store" for small employers than the outside market in order to attract small employers. To ensure that the standard designs have market appeal, the SHOP exchange might pattern its benefit requirements on the most popular plan designs in the small-group market. Even if patterned on popular designs, there is so much diversity in the small-group market now that this approach would certainly miss some popular designs. And the more popular designs are likely to evolve, year-to-year.

Therefore, the SHOP exchange might want to consider a third approach, which is a hybrid of the two described above. Under a third approach, the SHOP exchange would specify some standard plan designs at each actuarial level and also allow or require issuers to propose a limited number of additional designs. The standard designs might represent clear trade-off between deductible and out-of-pocket maximum, on the one hand, and point-of-service cost-sharing on the other hand, such that customers can select from a design on each actuarial level with:

1. maximum deductibles and OOP maximum (and modest point-of-service cost-sharing); or

2. minimum deductible and OOP maximum (and higher point-of-service cost-sharing)

The standard plan designs prescribed the exchange might incorporate features that the exchange wishes to promote, such as lower-cost, narrow provider networks.

In addition, the exchange would allow each issuer complete discretion (within federal certification requirements) to propose its non-standard designs; or the exchange might require issuers to propose their most popular small-group plans at each actuarial level, adjusted for the state's definition of EHBs and minimum federal certification requirements, which are not substantially duplicative of the standardized designs prescribe by the exchange. By offering on the SHOP exchange two clearly differentiated standard designs, plus one or two more designs from each carrier that represent high-enrollment offerings in the current small-group market, the SHOP exchange can limit options to a reasonable

number, offer clearly differentiated standard designs across all issuers for ease of comparison shopping, and offer unique designs that are already selling well in the market.

At the bronze level, where there is the most "room" for variation in cost-sharing, because these lower actuarial levels require more cost-sharing, the exchange would "stake-out" the extremes in its standardized plan designs, as described above, and issuers would be asked to submit their most popular two plan designs at each actuarial tier, that are "in-between" the standard benefits prescribed by the exchange. At the silver and gold levels, where there is still "room" for different cost-sharing formulas to reach the prescribed actuarial values, the SHOP exchange might offer two prescribed designs plus one unique design from each carrier, representing its most popular option at that actuarial value. At the Platinum level, where there is relatively little "room" for variation in cost-sharing at a 90% actuarial value, the exchange might prescribe one standard design and allow (not require) issuers to propose one unique design.

Next Steps

Whatever approach the exchange adopts, it should be developed in the context of a comprehensive QHP management strategy. For example, does the exchange expect all issuers to serve both the non-group and small-group markets on the exchange, and will it allow more variation in QHP designs on SHOP, to meet demand from a large and diverse market, than on the non-group exchange? If the exchange wants to leverage access by participating issuers to both the individual and SHOP exchange markets in order to apply pressure on premiums, it might limit certification to the two, three or four lowest-priced issuers in each geography. In this context, the exchange may want to allow more benefits variation among fewer QHPs. Or if the exchange wants to encourage Medicaid MCOs to develop QHPs, so that enrollees can retain the same plan when they switch coverage because of a change in income, it may need to pay particular attention to the capabilities of such issuers to support various plan designs.

As an interim next step, NYS should capture current enrollment data on prescribed, standardized designs and the major carriers' most popular plan designs. The data call would be used to gather information from the major issuers in small group as to how their current offerings would fit into options described above for SHOP. They would submit the enrollment and specific designs for their 2-3 highest-enrollment plans that cover all or most EHBs at each of the four actuarial levels. In addition, they would be asked to submit their current small-group enrollment and specific plan designs at each of the four AV levels in designs that fit the following parameters:

1. For all four AV levels, zero deductible, allowable MOOP, and coinsurance and/or copayments that achieve the relevant actuarial value

2. For Bronze and Silver, $2,000/$4,000 deductibles, maximum allowed MOOP, and the minimum levels of coinsurance and/or copayments that achieve the relevant actuarial values (60% and 70%)

3. For Gold and Platinum, maximum deductible and MOOP that would, in combination with modest copayments, achieve the relevant actuarial values (80% and 90%)

From this information, the exchange would be in a position to develop its own "standardized" specifications on the basis of empirical market information, and to anticipate the "unique" designs that issuers would likely propose if required to submit their most popular small-group offerings that fit minimum federal certification criteria.

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[i] Data confirmed by NY Department of Financial Services in 5/21/12 email to Wakely.
[ii] 2010 Census; http://quickfacts.census.gov/qfd/states/36/36085.html
[iii] A 29th Plan Design was possible but was inadvertently left out of the data call template. The carrier that identified the missing plan design volunteered that less than 2% of their total small group enrollment would have qualified for this plan design, which would have included a deductible of $3,001-5,000 and an out of pocket maximum of $4,001-5,999. No other carriers identified the missing plan design as an issue.
[iv] "*Making it Easy: A Rural Plan to Increase Health Insurance Enrollment*." Prepared by the S2AY Rural Health Network and Funded by the NYS Health Foundation. 2009.
[v] Jonathan Gruber. *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?* Henry J. Kaiser Foundation, March 2009.
[vi] Payne, J.W.; Bettman, J.R.; Johnson, E.J; *The Adaptive Decision Maker.* Cambridge University Press, May 1993
[vii] Shaller, Dale. Consumers in Health Care: The Burden of Choice. California HealthCare Foundation. October, 2005
[viii] "*What's Behind the Door: Consumers' Difficulties Selecting Health Plans."* Health Policy Brief. January 2012. WWW.CONSUMERSUNION.ORG.
[ix] Juliette Cubanski and Patricia Neuman, "Status Report On Medicare Part D Enrollment In 2006: Analysis Of Plan-Specific Market Share And Coverage," *Health Affairs* 26, no. 1 (January 1, 2007): w1–w12.
[x] Toby S. Edelman, "Oversight and Enforcement of Medicare Part D Plan Requirements: Federal Role and Responsibilities" (Kaiser Family Foundation, September 2006), http://www.kff.org/medicare/upload/7558.pdf.
[xi] Jennifer M Polinski et al., "Medicare Beneficiaries' Knowledge of and Choices Regarding Part D, 2005 to the Present," *Journal of the American Geriatrics Society* 58, no. 5 (May 2010): 950–966.
[xii] Cubanski and Neuman, "Status Report On Medicare Part D Enrollment In 2006"; Polinski et al., "Medicare Beneficiaries' Knowledge of and Choices Regarding Part D, 2005 to the Present."
[xiii] Polinski et al., "Medicare Beneficiaries' Knowledge of and Choices Regarding Part D, 2005 to the Present"; Jack Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries" (The Commonwealth Fund, May 2008), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2008/May/Medicare%20Part%20D%20%20Simplifying%20the%20Program%20and%20Improving%20the%20Value%20of%20Information%20for%20Beneficiaries/Hoadley_MedicarePartD_1118_ib%20pdf.pdf.
[xiv] YanivHanoch et al., "How Much Choice is Too Much? The Case of the Medicare Prescription Drug Benefit." Health Services Research 44, no. 4 (August 1, 2009): 1157-1168.
[xv] Hoadley, Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries."

Appendix A

NY Data Call Template to Carriers

Small Group Template Tab

1	Data Call Template
2	**SMALL GROUP MARKET** (Assumes group size 2-50 - enter "No Sole Props"; if sole proprietors qualify for group coverage, enter "Groups of 1 Permitted in All Small Group products" or "Groups of 1 Permitted in Select Small Group products only")….See separate workbook tab for **INDIVIDUAL MARKET**
3	Enter Carrier Name:
4	Enter NYS licensing authority(s) for all carrier products in the Small Group Market (For example, if carrier offers Article 42 and 43 products in the Small Group Market, enter 42, 43). If carrier underwriting staff is not shared for all licensed products and questions below cannot be answered as asked by product, carrier should submit separate responses for each carrier licensing authority)
5	Enter name, title, telephone and email address of contact for questions on response
6	For Jan-June 2011, enter total member months for all carrier **HMO** lives in Small Group Market
7	For Jan-June 2011, enter total member months for all carrier **PPO** lives in Small Group Market
8	For Jan-June 2011, enter total member months for all carrier **POS** lives in Small Group Market
9	For Jan-June 2011, enter total member months for all carrier **EPO** lives in Small Group Market
10	For Jan-June 2011, enter total member months for all carrier **Indemnity** lives in Small Group Market
11	For Jan-June 2011, enter total member months for any carrier products not otherwise included above in HMO, PPO, POS, EPO or Indemnity lives in Small Group Market. If member months for Row 11 exceed 25% of the total entered in Row 12 immediately below, please provide description(s) of products.
12	Enter total member months for Rows 6-11 above; total should represent all Carrier Small Group Business
13	Do your HMO plan designs require a referral for specialty care? (Yes/No)
14	Other than HMO plan designs, do any other product offerings (e.g., POS or EPO) require a referral for specialty care, and if yes, specify which ones do. (Yes/No)
15	Enter estimated percentage of Carrier's Small Group Market total enrollment sold through brokers or other intermediaries, such as Chambers, GAs, associations, etc. - reciprocal should identify the percentage of Small Group enrollment sold direct by carrier (i.e., through carrier's own website or by in-house sales force)
16	Describe Plan Service Area in New York State - enter **Statewide NY**; **Regional NYS** [and define regional by using counties, MSAs or other geographical descriptor)
17	Do you offer a provider network that includes most acute care general hospitals (i.e., 85% or more) in your New York State Service Area?
18	Do you also offer either a more select provider network or tiered network products to the Small Group Market (Yes/No)?
19	If you do offer a more select network and/or tiered network products to the Small Group Market, approximately what percent of your Small Group enrollment are in those products?
20	Do you offer any plan designs that include any "value-based" benefits, and if yes, pls briefly describe. Value-based benefit might include (but are not limited to): Health Risk Assessment tools and rewards/incentives for completing; member rewards programs for incenting desired behavior [i.e., managing risk, seeing primary care doc, staying on maintenance Rxs, active pt management of certain diseases like diabetes]; Rx deductible for non-pref brands only; transportation and translator services, etc.)
21	Provide your **best estimate** for the percentage of your Small Group enrollment in plans that are generally equivalent in value to each of the four actuarial values (AV) outlined in the ACA (for example: Platinum = 90% AV; Gold = 80% AV; Silver = 70% and Bronze = 60%). Use a factor of +/- 2 points for each range (i.e., Platinum = 88-92%; Gold = 78-82%; Silver = 68-72%; and Bronze = 58-62%). Plan design should include Rx benefits and all other "essential benefits."
22	Platinum Plans (88-92% AV):
23	Gold Plans (78-82% AV):
24	Silver Plans (68-72% AV):
25	Bronze Plans (58-62% AV):
26	Less Than 58% AV:

27	**Provide your standard Deductible factor for family coverage (i.e., deductible is 2X Indiv for 2 person contracts and no more than 3X Indiv for all Family contracts; or, deductible is no more than 2X Indiv for any family contract regardless of the number of covered members).**
28	**Provide your standard Out of Pocket Maximum factor for family coverage (i.e., OOP Max is 2X Indiv for 2 person contracts and no more than 3X Indiv for all Family contracts; or, OOP Max is no more than 2X Indiv for any family contract regardless of the number of covered members).**
29	**Intent of survey is to capture 80% of carrier's Small Group Market enrollment for the Jan-June 2011 timeframe by the 28 Plan Designs defined to the right (defined by deductible and out-of-pocket maxima). Enrollment in "substantially like"plan designs should be combined as shown to comply with the 28-plan matrix. See instructions below on lines 37 and 38 for further direction.**
30	**INDIVIDUAL Deductible:**
31	**For each Plan Design indicate if the deductible typically does not apply to Rx Benefit (Enter "Generally Does/Does Not apply to Rx")**
32	**Indicate what services (beyond Rx) are generally exempt from the deductible; or, is there no pattern?**
33	**INDIVIDUAL Out of Pocket Maximum (includes deductible and coinsurance in all cases; and may include co-pays if defined as included in plan design):**
34	**For each Plan Design indicate if the Out of Pocket Max typically includes the Rx benefit (Enter "Generally Does/Does Not Include" Rx)**
35	**Indicate what services (beyond Rx) are generally exempt from the Out of Pocket Max calculation; or, is there no pattern?**
36	**For each of the Plan Designs provided, enter total member months for Jan-Jun 2011 period.**
37	**To assist us in comparing enrollment trends by Plan Design over time, provide the total member months for each of the Plan Designs for the Jan-Jun 2009 period.**
38	Divide Row 34 by number in cell D12 to provide percentage of Carrier's Small Group Business total enrollment in each given Plan Design
39	Fill in the following information for each of the largest Plan Designs, which account in aggregate for 80% of your Small Group enrollment. We seek detailed benefit cost-sharing information for each of these larger Plan Designs, in two different ways. First: which combination of cost-sharing ranges across the six BENEFITS (below) defines the single combination of benefits with the highest enrollment for each Plan Design? Mark X next to the cost-sharing range in each of the six BENEFITS (below) that represents the single most popular combination of cost-sharing, and provide on this line the total Small Group enrollment (member months) for that benefits combination. (Example: for a given Plan Design: a benefit consisting of 20% coinsurance across all 6 BENEFITS might have more enrollment than any other combination of cost-sharing across all 6 BENEFITS, even though more enrollees have an inpatient copayment of $500 than an inpatient coinsurance of 20%; in this example, mark "X" next to 20% coinsurance for each of the 6 BENEFITS (below) and give on this line the total enrollment (MMs) in Plan Design 1 that has 20% coinsurance across the board.)
40	Fill in the following information for each of the largest Plan Designs, which account in aggregate for 80% of your small group enrollment. We seek detailed benefit cost-sharing information for each of these larger Plan Designs, in a second way: how many enrollees (MMs) fall into each of the cost-sharing ranges in each of the 6 BENEFITS below? For each of the 6 BENEFITS (below), indicate the actual enrollment (MMs) next to each cost-sharing range, which should total 100% of the enrollment in that Plan Design for each BENEFIT. (Example: for Plan Design 1, under BENEFIT #1 (Inpatient Med/Surg), indicate the MMs with 0 coinsurance/0 Co-pay, coinsurance of 10%, 20%, 21+%, or copayments of <$500, $500-$999, $1,000-$1,999, or $2,000+. The total MMs for these 8 cost-sharing ranges should add to the total MMs for Plan Design 1.) Complete the enrollment for the cost-sharing ranges for each of the 6 BENEFITS below, across the Plan Designs accounting for 80% of Small Group enrollment.

41	BENEFIT # 1: Inpatient Med/Surg. Describe per admission **cost sharing**; unlimited admissions and days will be assumed, unless indicated otherwise. If a per-day copayment applies, assume an ALOS of 3 days, and triple the per-day copayment to create a per-admission copay.
42	0 Coinsurance / 0 Co-pay
43	10% Coinsurance (+/- 5 points)
44	20% Coinsurance
45	Coinsurance greater than 20%
46	Co-pay of $499 or less
47	Co-pay of $500-999
48	Co-pay of $1,000-1,999
49	Co-pay of $2,000 +
50	BENEFIT # 2: Inpatient Mental Health/Drug/Alcohol in Speciality Facility [i.e., excluding acute care, general hospital benefit] Describe per admission cost sharing; 30 day (or less) annual limit for MH and separate 30 day (or less) annual limit for Drug/Alcohol will be assumed, unless indicated otherwise. Triple per-day copays, as instructed for BENEFIT #1
51	0 Coinsurance / 0 Co-pay
52	10% Coinsurance (+/- 5 points)
53	20% Coinsurance
54	Coinsurance greater than 20%
55	Co-pay of $499 or less
56	Co-pay of $500-999
57	Co-pay of $1,000-1,999
58	Co-pay of $2,000 +
59	BENEFIT # 3: Outpatient Hospital/Same Day Facility Surgery
60	0 Coinsurance / 0 Co-pay
61	10% Coinsurance (+/- 5 points)
62	20% Coinsurance
63	Coinsurance greater than 20%
64	Co-pay of $75 or less
65	Co-pay of $76-150
66	Co-pay of $151-249
67	Co-pay of $250 +
68	BENEFIT # 4: Emergency Room
69	0 Coinsurance / 0 Co-pay
70	10% Coinsurance (+/- 5 points)
71	20% Coinsurance
72	Coinsurance greater than 20%
73	Co-pay of $75 or less
74	Co-pay of $76-150
75	Co-pay of $151-249
76	Co-pay of $250 +
77	BENEFIT # 5: Routine (Sick) Office Visit, Primary Care Physician
78	0 Coinsurance / 0 Co-pay
79	10% Coinsurance (+/- 5 points)
80	20% Coinsurance
81	Coinsurance greater than 20%
82	Co-pay of $1-24
83	Co-pay of $25-39
84	Co-pay of $40+
85	BENEFIT # 6: Routine (Sick) Office Visit, Specialist
86	0 Coinsurance / 0 Co-pay
87	10% Coinsurance (+/- 5 points)
88	20% Coinsurance
89	Coinsurance greater than 20%
90	Co-pay of $1-24
91	Co-pay of $25-49
92	Co-pay of $50+
93	Does Plan Design typically qualify as a Health Savings Account plan? Enter yes or no

94	Provide benefit design for the 5 most popular (by enrollment) Prescription Drug Plans
95	Does this plan have an Rx specific deductible and out of pocket maximum ? (Yes/No)
96	If so, please provide deductible for Individual:
97	….and out of pocket maximum for Individual:
98	Rx - Generic…Enter co-pay or coinsurance
99	Rx - Preferred Brand…Enter co-pay or coinsurance
100	Rx- Non Preferred Brand…Enter co-pay or coinsurance
101	Rx - Provide Small Group enrollment in each of the 5 most popular RX plans
102	**Survey Question**: As a carrier in the Small Group Market, how many different benefit plan options do you offer and what is the approximate enrollment in each (as measured by the total member months for the Jan-June 2011 period)? Any different combination of optional riders and different cost sharing considerations will constitute a different benefit plan option. For example, two PPO products that cover the same benefits, with the same set of copayments for all services except one, i.e. differ by cost-sharing for just one benenfit, will count as two different benefit options. We expect the number of benefit plan options to be large, and are looking for the enrollment in each different option. We do not need to know how many benefit plan options are theoretically available if they do not currently have enrollment. Provide data by using a separate Excel workbook page and two columns of data. We do not need to know what the benefit plan option looks like as long as you label it in such a way that your staff can identify the benefits at a future date if there are questions about it. Please see Survey 1 SGM tab for an example of how to present the data.

Information to be Blinded by Dept of Financial Services

Line:	29	30	31	32	33	34	...
Survey Questions/ Plan Designs	**Individual Deductable**	**For each Plan Design indicate if the deductible typically does not apply to Rx Benefit (Enter "Generally Does/Does Not apply to Rx")**	**Indicate what services (beyond Rx) are generally exempt from the deductible; or, is there no pattern?**	**Individual OOP Max**	**For each Plan Design indicate if the Out of Pocket Max typically includes the Rx benefit (Enter "Generally Does/Does Not Include" Rx)**	**Indicate what services (beyond Rx) are generally exempt from the Out of Pocket Max calculation; or, is there no pattern?**	
Plan Design 1	0 (none)			$ 2,000 or less			
Plan Design 2	$ 1-500			$ 2,000 or less			
Plan Design 3	$ 501-1,500			$ 2,000 or less			
Plan Design 4	0 (none)			$ 2,001-3,999			
Plan Design 5	$ 1-500			$ 2,001-3,999			
Plan Design 6	$ 501-1,500			$ 2,001-3,999			
Plan Design 7	$ 1,501-3,000			$ 2,001-3,999			
Plan Design 8	0 (none)			$ 4,001-5,999			
Plan Design 9	$ 1-500			$ 4,001-5,999			
Plan Design 10	$ 501-1,500			$ 4,001-5,999			
Plan Design 11	$ 1-501-3,000			$ 4,001-5,999			
Plan Design 12	0 (none)			$ 6,000-9,999			
Plan Design 13	$ 1-500			$ 6,000-9,999			
Plan Design 14	$ 501-1,500			$ 6,000-9,999			
Plan Design 15	$ 1,501-3,000			$ 6,000-9,999			
Plan Design 16	$ 3,001-5,000			$ 6,000-9,999			
Plan Design 17	0 (none)			$10,000+			
Plan Design 18	$ 1-500			$10,000+			
Plan Design 19	$ 501-1,500			$10,000+			
Plan Design 20	$ 1,501-3,000			$10,000+			
Plan Design 21	$ 3,001-5,000			$10,000+			
Plan Design 22	$ 5,001+			$10,000+			
Plan Design 23	0 (none)			No OOP Max			
Plan Design 24	$ 1-500			No OOP Max			
Plan Design 25	$ 501-1,500			No OOP Max			
Plan Design 26	$ 1,501-3,000			No OOP Max			
Plan Design 27	$ 3,001-5,000			No OOP Max			
Plan Design 28	$ 5,001+			No OOP Max			

Survey 1SGM Tab

Name of Carrier:

Plan ID:	# Total Member Months (Jan-Jun 2011)
Plan A	505,432
Plan B	501,200
Plan C	499,455
Plan D	350,000
etc…	

Individual Market Template Tab

	DRAFT: Data Call Template					
2	**Individual Market**….See separate workbook tab for **SMALL GROUP MARKET**					
3	Enter Carrier Name:					
4	Enter name, title, telephone and email address of contact for questions on response	Name:	Title:	Tele:	Email:	
5	For Jan-June 2011, enter total member months for all carrier **Standard HMO (Section 4321)** lives in Individual Market					
6	For Jan-June 2011, enter total member months for all carrier **Standard HMO lives with POS option (Section 4322)** in					
7	For Jan-June 2011, enter total member months for all carrier **Grandfathered Product(s)** lives in Individual Market (i.e., provide combined enrollment for all pre- 1996 medical/surgical products still in force)					
8	For Jan-June 2011, enter total member months for all carrier **HOSPITAL BENEFIT ONLY** lives in Individual Market					
9	For Jan-June 2011, enter total member months for all carrier **MEDICAL BENEFIT ONLY** lives in Individual Market					
10	For Jan-June 2011, enter total member months for all carrier **Healthy New York (Section 4326) - With Rx Benefit** lives in Individual Market					
11	For Jan-June 2011, enter total member months for all carrier **Healthy New York (Section 4326) - Without Rx Benefit** lives in Individual Market					
12	For Jan-June 2011, enter total member months for all carrier **Healthy New York (Section 4326) - With Rx Benefit and With High Deductible Option** lives in Individual Market					
13	For Jan-June 2011, enter total member months for all carrier **Healthy New York (Section 4326) - Without Rx Benefit and With High Deductible Option** lives in Individual Market					
14	Enter total member months for Rows 5-13 above; total should represent **all** Carrier lives in the Individual Market (if total does not represent full Individual Market, provide an explanation below)					
15	Explanation for why total member months entered on Row 14 does not represent carrier's entire Individual market (if applicable):					
16	Enter estimated percentage of Carrier's Individual total enrollment sold through brokers or other intermediaries (reciprocal should identify the percentage of Individual business sold direct by carrier (i.e., through carrier's own website or by in house sales force)					
17	Enter number of in-state acute care general hospitals in network					
18	Enter number of in-state unique physicians/Ods covered as in-network (count physicians once; do not include multiple offices/locations or specialties). If unique count is not available, define count provided.					
19	Describe Plan Service Area - enter **Statewide NY**; **Multi-state** [and define by listing other states covered] or **Regional NYS** [and define regional by using counties, MSAs or other geographical descriptor)					
	Highlighted rows indicate information to be blinded by Dept of Financial Services					

Broker Underwriting Info Tab

	Name of carrier:
	For Small Group Market (50 or less employer eligibles):
1	What percent of your total Small Group Market is sold through a General Agency agreement ? Discuss your use of General Agents (Is it recommended? Mandatory? Rquired for certain size groups?)
1a	How many GA agreements do you have in force?
2	What percent of your total Small Group Market is sold through brokers, whether affiliated or not with any GA agreement that may or may not be in place ?
2a	How many brokers are included in your response to question 2?
2b	How many brokers included in your response to question 2 are responsible for selling 70% of the percentage of business represented in question 2?
3	What percent of your total Small Group Market is sold through either Chambers or Associations ?
4	What percent of your total Small Group Market is sold through a direct sales force (i.e., sales staff employed by the carrier, with or without broker licenses)?
5	Do you utilize any distribution channels not shown above (i.e., Brokers, GA, Chambers, Associations, Direct Sales)? If yes, please describe and provide the corresponding percent of your Small Group market sold by each additional channel.
6	Please provide an outline of your broker commission program for 2010 (i.e., a sales slick or PDF of material provided to brokers is acceptable). Program should include both new sales and renewals, bonuses and any/all other award opportunities)
7	Please provide an outline of your broker commission program for 2011 (i.e., a sales slick or PDF of material provided to brokers is acceptable). Program should include both new sales and renewals, bonuses and any/all other award opportunities).
8	material provided to brokers is acceptable). Program should include both new sales and renewals, bonuses and any/all other award opportunities).
10	Please describe your minimum enrollment requirements for Small Employers (i.e., what percent of eligible enrollees must enroll)
11	Do you allow Small Employers to offer more than one of your plans to eligible employees (i.e., dual or triple choice plans; high/low options, etc). If yes, please describe. If any group size restrictions apply, please describe.
12	Do you allow your health plan products to be offered along side of those of other carriers (i.e., allow eligibile employees to choose between a plan from your company and a plan from another health plan)? If yes, please describe. If any group size restrictions apply, please describe.
13	Do you allow Sole Proprietor groups (self employed/one contract) to enroll in your Small Group Market products? If yes, please describe and include any restrictions or limitations.

Appendix B

Medicare Part D: Benefit Standardization and Consumer Choices

- Background
  - The Medicare Prescription Drug, Improvement, and Modernization act (MMA) of 2003 created a new prescription drug benefit program for Medicare beneficiaries known as Medicare Part D.[1]
  - This new drug benefit is provided through stand-alone prescription drug plans (PDPs) or Medicare Advantage plans that include prescription drug coverage (MA-PD). This benefit is provided exclusively through private health insurers.[2]
  - Part D was implemented in 2006 after CMS contracted with hundreds of different organizations, offering thousands of different prescription drug plans.[3]
  - Enrollment is voluntary but beneficiaries need to either enroll in a Part D plan or keep existing coverage if it is comparable to the Part D benefit or face a penalty.[4]
  - Goal of Part D is to "encourage private sector organizations who meet law's requirements to offer a range of part D plan options… by providing flexibility in plan design and management".[5]
- Objective
  - How has plan standardization (or a lack thereof) in the Medicare Part D marketplace affected consumer choices?
- Plan Standardization in 2006
  - 266 firms (3,873 plans offered) participated in 2006 but enrollment was concentrated among 10 firms that accounted for 72% of enrollment. Two organizations, UHC-Pacific Care and Humana accounted for 25% and 19% of enrollment in 2006 respectively. Two PDPs, United's AARP MedicareRx and Humana's Standard plan, accounted for 23% of enrollment.[6]

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[1] Juliette Cubanski and Patricia Neuman, "Status Report On Medicare Part D Enrollment In 2006: Analysis Of Plan-Specific Market Share And Coverage," *Health Affairs* 26, no. 1 (January 1, 2007): w1–w12.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Toby S. Edelman, "Oversight and Enforcement of Medicare Part D Plan Requirements: Federal Role and Responsibilities" (Kaiser Family Foundation, September 2006), http://www.kff.org/medicare/upload/7558.pdf.
Toby S. Edelman, "Oversight and Enforcement of Medicare Part D Plan Requirements: Federal Role and Responsibilities" (Kaiser Family Foundation, September 2006), http://www.kff.org/medicare/upload/7558.pdf.
[6] Cubanski and Neuman, "Status Report On Medicare Part D Enrollment In 2006."

    - In 2006, CMS indicated that starting in 2008, they may not renew contracts with sponsors with less than 5,000 enrollees since these sponsors have few options to spread risk and may not be able to negotiate lower drug prices.[7]
    - Standard benefit in 2006: $250 deductible, 25% coinsurance up to initial benefit limit, $2,850 coverage gap, and catastrophic coverage after beneficiaries spend $3,600 out of pocket.
        - Most plans did not offer this standard benefit and only 17% of enrollees are enrolled in standard benefit part D plans. The majority (52%) are enrolled in plans that have actuarially equivalent coverage to the standard benefit. These plans typically have no deductible and tiered copayments in place of the 25% coinsurance. 30% of enrollees are enrolled in plans with enhanced benefits which may offer lower deductibles, cover some excluded drugs, or offer gap coverage. More MA-PD enrollees had enhanced coverage than PDP enrollees.[8]
        - Enhancements can include coverage for the deductible ($250), coverage for the doughnut hole, broader formularies than what Medicare regulations dictate, variations in coinsurance or copayment policies, and convenience factors, such as pharmacy participation and mail-order services.[9]
- Plan Standardization in 2007
    - Part D market expanded, with 31% more stand-alone PDPs offered nationwide.[10]
    - Mixed results were reported after 2007: there was high enrollment but a majority of beneficiaries reported that the selection process was too complicated. Researchers have suggested the complexity of the benefit design and variations among plans did not allow beneficiaries to find the plan that was best for them or may have prevented them from enrolling in Part D altogether.[11]
- Plan Standardization in 2008
    - Deductible was $275, 25% up to coverage limit of $2,510, and modest cost-sharing after $4,050 out of pocket drug costs have been reached. Most plans

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[7] Ibid.
[8] Ibid.; Joachim Winter et al., "Medicare Prescription Drug Coverage: Consumer Information and Preferences," *Proceedings of the National Academy of Sciences* 103, no. 20 (May 16, 2006): 7929–7934.
[9] Winter et al., "Medicare Prescription Drug Coverage."
[10] Ibid.
[11] Jack Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries" (The Commonwealth Fund, May 2008), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2008/May/Medicare%20Part%20D%20%20Simplifying%20the%20Program%20and%20Improving%20the%20Value%20of%20Information%20for%20Beneficiaries/Hoadley_MedicarePartD_1118_ib%20pdf.pdf.

offered 3-4 tiers for generic drugs, preferred name brand, non-preferred brand name, and specialty.[12]

- Plan Standardization 2011-2012
    - For changes in the deductible, coverage limit, and cost-sharing for the standard benefit from 2006-2012, see: http://www.q1medicare.com/PartD-The-2012-Medicare-Part-D-Outlook.php
    - Insurers can change drug formulary and cost sharing mechanisms at any time.[13]
    - The biggest change with implementation of the ACA is the phase out of the doughnut hole. Most plans offer little or no coverage for the gap beyond what's required in ACA in 2011 but compared to past years, more plans are offering some additional coverage.[14]
    - CMS is implementing other statutory and regulatory changes that have resulted in consolidation of some Part D plan offerings in 2011. Regulations issued in 2010 indicate that CMS wants to eliminate duplicative plan offerings and plans with low enrollment.[15]
    - The number of PDPs increased between 2006 and 2007 but then has decreased every year. The number of PDPs in 2011 is nearly 1/3 lower than in 2010 but at least 28 PDPs are offered in every region in 2011. There is a decline because of mergers between sponsoring organizations and consolidation of plan offerings by individual sponsors.[16]
    - In the past, plans have offered 3 options but now they offer two (basic and enhanced).[17]
    - Marketplace is moderately concentrated with 10 largest firms accounting for almost 75% of all enrollees in 2011.
    - In 2012, beneficiaries have the choice of 31 stand-alone PDPs on average (lowest number since 2006).[18]
- Consumer Choices
    - In general, consumers have had a hard time navigating the benefit.[19]

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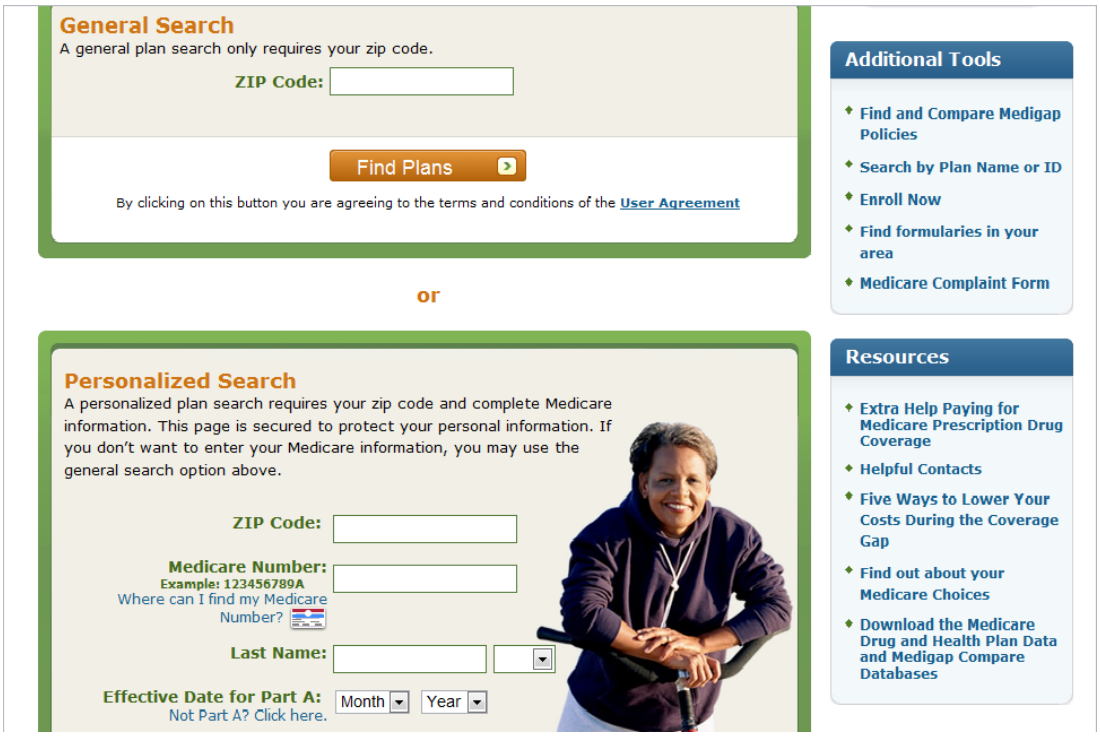
[12] Ibid.
[13] Jennifer M Polinski et al., "Medicare Beneficiaries' Knowledge of and Choices Regarding Part D, 2005 to the Present," *Journal of the American Geriatrics Society* 58, no. 5 (May 2010): 950–966.
[14] Jack Hoadley, Laura Summer, et al., "Medicare 2011 Part D Data Spotlight: Analysis of Medicare Prescription Drug Plans in 2011 and Key Trends Since 2006" (Kaiser Family Foundation, September 2011), http://www.kff.org/medicare/upload/8237.pdf.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Jack Hoadley, Juliette Cubanski, et al., "Medicare 2011 Part D Data Spotlight: A First Look at Part D Plan Offerings in 2012" (Kaiser Family Foundation, October 2011), http://www.kff.org/medicare/upload/8245.pdf.
[19] William H Shrank and Jennifer M Polinski, "Medicare Part D--lessons Learned and Guidance for Health-care Reform," *Journal of General Internal Medicine* 25, no. 1 (January 2010): 3–4.

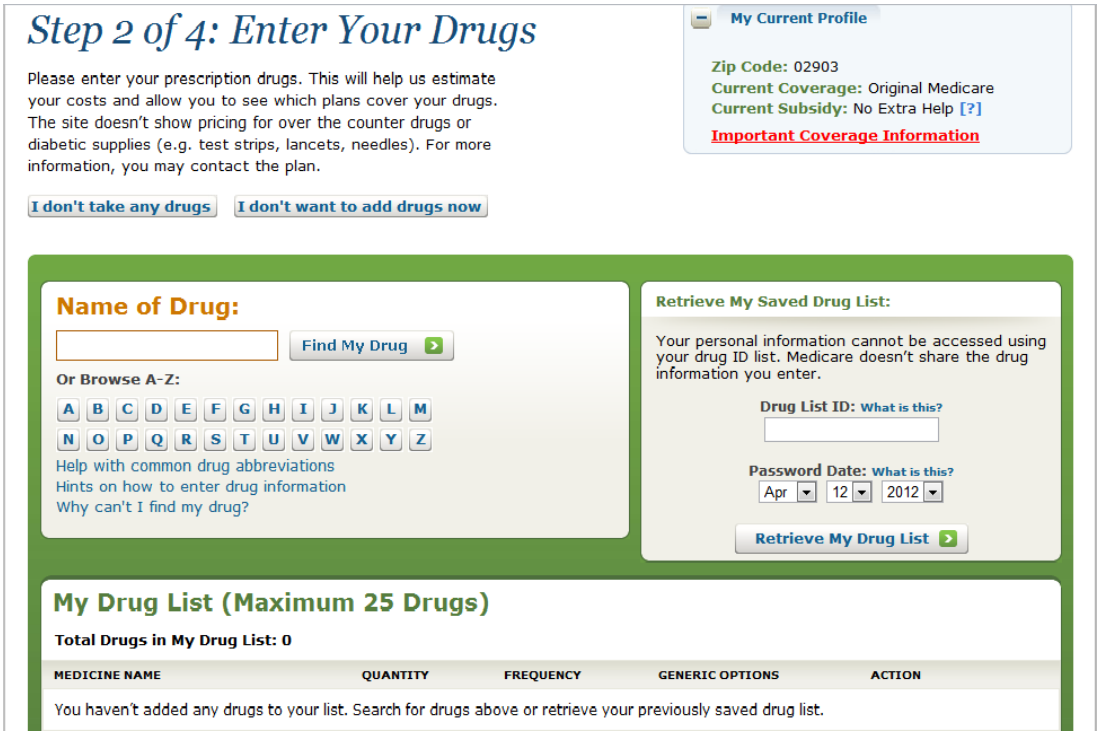
    - Plan choices seem to be affected by name recognition or low premiums or both.[20]
    - From 2005-2009, beneficiaries' knowledge of Part D and benefit structure/design was poor. Beneficiaries often did not pick the lowest cost Part D plan and were disinclined to switch plans to improve their benefits. Knowledge gaps, enrollment issues, and plan choice difficulties were most notable when Part D was implemented in 2006 but these problems also continued into subsequent years.[21]
    - Many part D eligible beneficiaries felt that there were too many choices when they were trying to select a plan and felt overwhelmed.[22]
    - Beneficiaries indicated that they felt that specific drugs covered, premium amounts a plan offered, and copayment amounts were important when selecting a plan when in practice, they did not compare plans by looking for these characteristics. Less than half of respondents in a survey reported comparing costs and benefits of plans and most only compared 4 plans.[23]
    - Beneficiaries chose plans with which they had a prior relationship or from which they had received information through a representative or advertisement.[24]
    - Many beneficiaries did not choose plan that would save them the most money and many expressed little desire to switch plans to improve benefits. Additionally, despite limited knowledge, the beneficiaries expressed confidence in their decisions. Problems with gaps in knowledge and difficulty with plan selection persisted through 2008.[25]
- Medicare.gov Part D Plan Finder Tool
    - Medicare Prescription Drug Plan Finder created by CMS is the only source of continually updated, comprehensive plan information.[26] The plan finder underwent changes in 2010 to make the interface more user-friendly.[27]
    - Link to a tutorial on using the Plan Finder: http://www.q1medicare.com/PartD-Medicare_PartDPlanFinderTutorial.php
        - An online video is also available on the Medicare.gov website: http://www.youtube-nocookie.com/embed/iQQJ7ry_H6k
    - First page of the plan finder website: search for Part D plans by zip code or with a more personalized search using Medicare information

[20] Cubanski and Neuman, "Status Report On Medicare Part D Enrollment In 2006."
[21] Polinski et al., "Medicare Beneficiaries' Knowledge of and Choices Regarding Part D, 2005 to the Present."
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries."

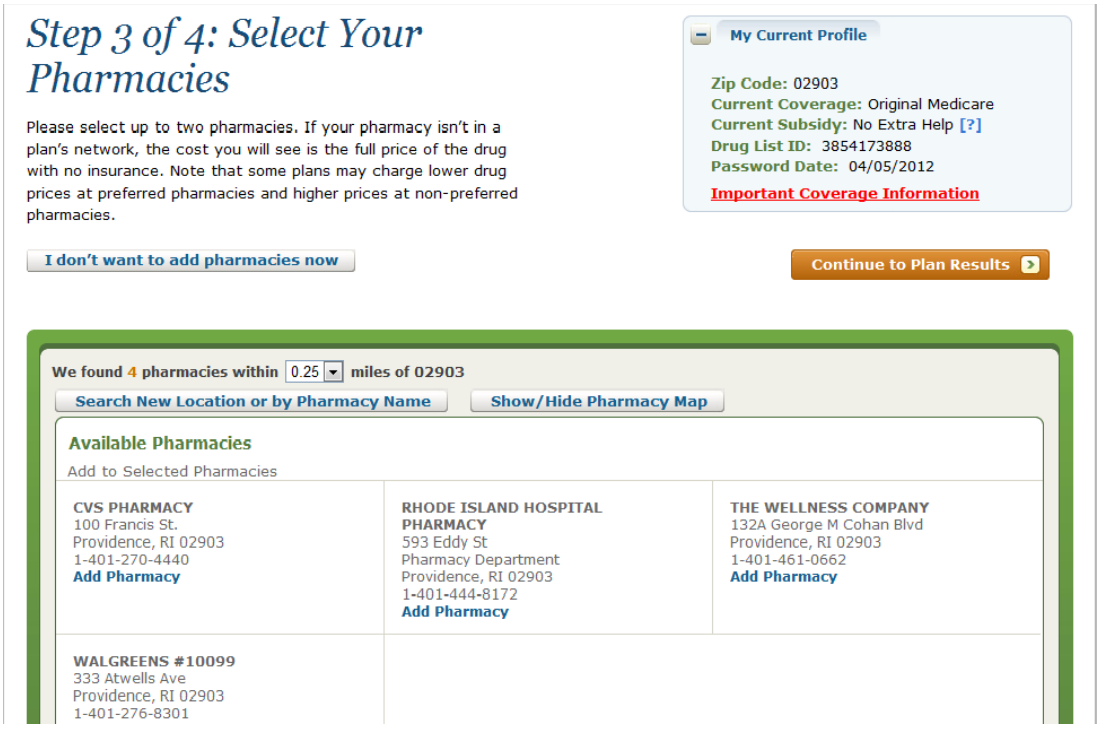


- Enter information about Medicare coverage

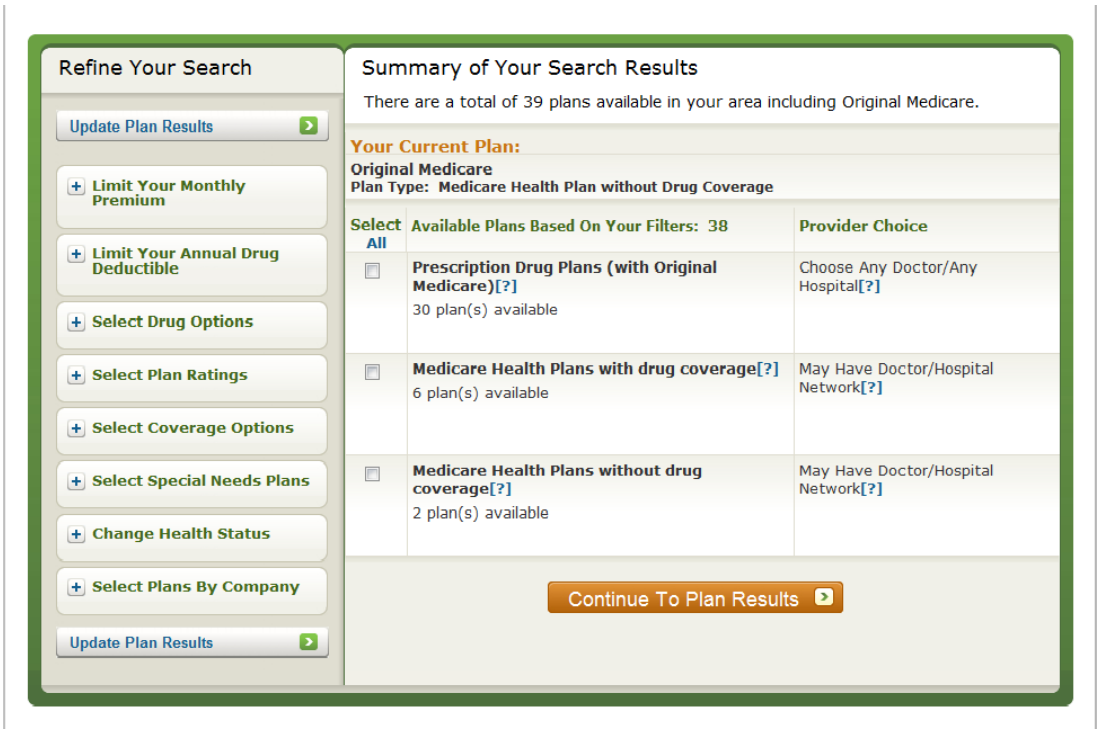
- Enter drug information – this includes dosing information and frequency of taking the drug



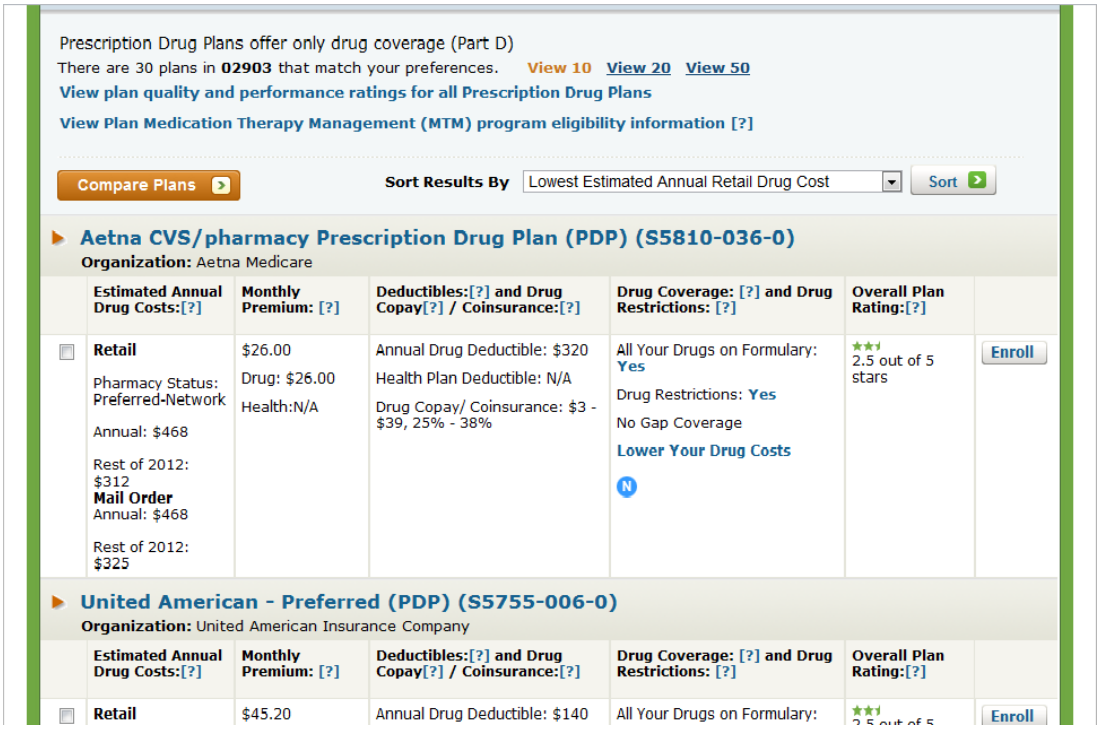
- Select a pharmacy



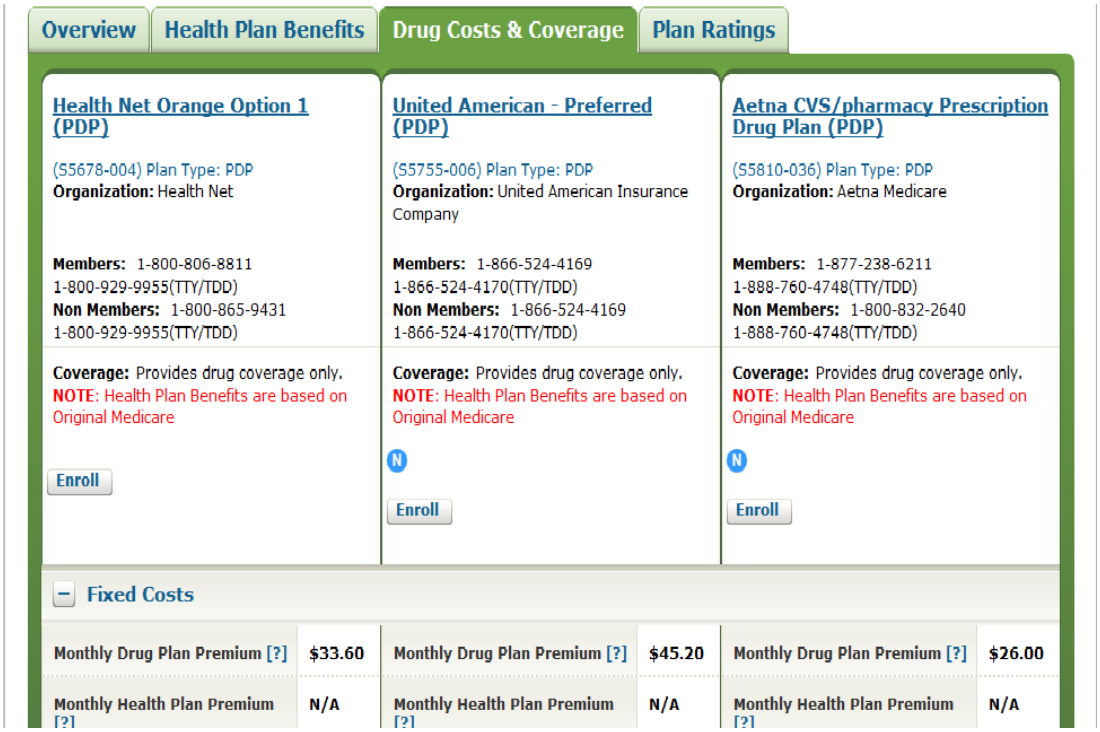
- Refine plans by selecting a PDP or MA-PD
  - There are options to refine coverage options (plan ratings, drug coverage, limiting deductible)



- Example Plan listing



- Example Plan Comparison



- Recommendations
    - In 2008, the Commonwealth Fund recommended that increasing standardization will reduce confusion in making decisions about plan choices. In 2008, 73% of beneficiaries found that the benefit was too complicated. Specifically, the CWF suggests that CMS should require sponsors to clearly label plans with enhanced benefits and define these enhanced benefits. CMS should encourage the use of standard forms and procures (ex. describing the utilization management tools they use) and provide standard descriptions and precise definitions of benefits.[28]
- Conclusion
    - There is evidence that the large number of Medicare drug plan options offered is problematic for beneficiaries because of the complexity of the benefit designs and the barriers that the elderly may face when trying to enroll in a plan. Research has suggested that decision quality deteriorates as the number of plans increases.[29] Although CMS has started to encourage consolidation of the Part D market in order to reduce confusion for seniors, some healthcare policy makers have recommended plan standardization measures to help seniors make informed decisions about Part D plans. However, some policymakers have advocated against CMS standardization because they believe that the market will consolidate on its own.

[28] Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries."
[29] Yaniv Hanoch et al., "How Much Choice Is Too Much? The Case of the Medicare Prescription Drug Benefit," *Health Services Research* 44, no. 4 (August 1, 2009): 1157–1168.

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