Proposed Income-Based Standardized Plan Designs for beWellnm's Individual Market

Prepared by the Office of Superintendent of Insurance for the beWellnm Health Benefits Committee

Please note: This document was prepared for the beWellnm Health Benefits Committee in 2021 as the committee deliberated features for the design of Standardized Plans. The Committee ultimately decided to gather additional stakeholder feedback before recommending plan designs. The Committee will hold stakeholder engagement sessions in the Fall of 2023 to gather feedback before submitting plan designs for adoption for the 2024 Benefits Year at the January 2023 beWellnm Board of Directors meeting.

The beWellnm Health Benefits Committee convened throughout 2021 to discuss priorities for standardized plans in New Mexico's Health Insurance Marketplace and learn from efforts in other states. The committee agreed to general objectives, such as minimizing deductibles and maximum out-of-pocket limits, improving cost predictability by using co-payments (fixed dollar amounts) instead of coinsurance (percentage of the cost of services rendered), and encouraging utilization of high-value services, such as primary care, by minimizing out-of-pocket costs for those services.

General Design Features of the Proposed Plans

The following points summarize the general features of the proposed plan:

- Co-payments only (no coinsurance);
- Co-payment values for medical services limited to three levels within each plan: lower, medium, higher co-pays;
- Sets primary care and generic drug co-payments at $0 for the lowest income ranges, and reaches only $10 co-pays for the highest range of cost-sharing recipients;
- Fewer services subject to a deductible: Only two medical services and non-preferred brand drugs are subject to the deductible, except for the lowest income group where the deductible is zero, and for the second lowest income group where the deductible is $50, minimizing the impact of deductibles on deterring healthcare service utilization; and
- All out-of-pocket costs based on household income.

<u>Medical Services</u>

The proposed plans use only three co-payment amounts within each plan for medical services to further the goal of cost predictability for beneficiaries.

- **Lowest Co-payment Category:** Represents high-value services to the individual and society as well as a means of reducing or delaying future morbidity, and increased individual and provider costs.
  - Preventive Care
  - Primary Care
  - Mental Health
- **Medium Co-Payment Category:** More specialized and less frequently utilized services.
  - Specialist Visits

- Imaging (CT/PET Scans, MRIs)
- Speech Therapy
- Occupational and Physical Therapy
- Laboratory Outpatient and Professional Services
- X-Rays and Diagnostic Imaging
- Skilled Nursing Facility
- Urgent Care Facility

- **Highest Co-payment Category:** Typically higher in cost, less frequently relied upon services, including services which consumers should be able to rationalize use of care when facing higher co-pays.
    - Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
    - Outpatient Surgery Physician/Surgical Services
    - Emergency Room Services
    - Inpatient Hospital Services

For the last group of services, the committee requested that the plan design strike a balance between using out-of-pocket costs to encourage use of lower costs services by imposing relatively higher co-pays on higher cost services when an alternative exists. In situations where access to primary care visits or urgent care is not readily available, ER visits for non-emergent conditions would be justified. Balancing these considerations, the proposed copay for ER visits is $25 for the lowest income range and reaches only $100 for the highest.

Prescription Medications

With respect to drug co-payments, OSI proposes a scale that provides generic drug at the lowest cost, followed by the preferred brand drugs, and relatively higher co-payments for non-preferred brand drugs where substitutes exist.

Contrary to typical plan designs that attach percentage coinsurance to specialty drugs, OSI proposes co-payments amounts that increase slightly with individuals' incomes and are not at all a function of the actual price of the drug. The proposed treatment of specialty drug co-pays came in response to legitimate concerns of committee members about the cost burden of such drugs in the absence of treatment substitutes.

Income-Based Cost Sharing Design for Standardized Plans

With the availability of state-funded cost sharing assistance, OSI proposes a plan design that adheres to the general principles explained above while basing the deductible, maximum out-of-pocket, and co-pay amounts on individual or family income. In September, OSI presented a proposal to the beWellnm Board of Directors that would improve and expand cost sharing assistance to New Mexicans with incomes up to 300 percent of the Federal Poverty Level (FPL), which is equivalent to $38,640 for an individual and almost $80,000 for a family of four. Lower income individuals and families typically require higher assistance with out-of-pocket costs given that other livelihood demands compete for their income.

Under the Affordable Care Act, cost sharing assistance only applies to Silver plans. This makes it difficult to explain which plans offer the best value, since the extent of cost sharing depends on the person's income. People intuitively think Gold plans have lower out of pocket costs than Silver plans, which is not

necessarily the case. To make the plan choices more straightforward, OSI proposes removing the original Metal Tier for plans with cost sharing assistance. We propose that any plan with cost sharing assistance gets tagged as a “Turquoise Plan”. When people shop for coverage on the Marketplace, any plan with cost sharing assistance applied will display as “Turquoise” instead of its underlying metal level, making it easier to see which plan offers the highest level of coverage. Turquoise plans would range from “Turquoise 1” to “Turquoise 4” to indicate varying levels of income-based cost sharing assistance. (Please note that this was adopted for the 2023 Benefits Year.)

The following income-based plan designs are based on the proposal OSI presented to the beWellnm Board of Directors in September 2021. The state cost sharing assistance program will require appropriation by the legislature. Depending on funding levels, these parameters may need to be adjusted. (Please note the legislature approved appropriations sufficient to fund the Actuarial Value targets described in this report. However, plan designs will need to be updated using the newest version of the federal Actuarial Value Calculator to ensure they still meet these targets.)

Table 1: Proposed Cost Sharing Reductions (CSR) Variants with Healthcare Affordability Fund (HCAF) Assistance

Standard Plans with Cost Sharing Reductions Applied					Metal Tier Comparison	
Plan	**Turquoise 1**	**Turquoise 2**	**Turquoise 3**	**Turquoise 4**	**Gold 80**	**Silver 70**
FPL	100-150%	150-200%	200-250%	250-300%	Benchmarks	
Deductible	$0	$50	$750	$1,500	$3,000	$4,500
Max Out of Pocket	$200	$1,500	$2,000	$3,000	$4,500	$8,000
Actuarial Value	99% AV	95% AV	90% AV	85% AV	80% AV	70% AV
Max Income Spent on OOP	1%	7%	7%	8%		
Medical					**Medical**	
Low Co-Pay Medical Services					**Low Co-Pay Medical Services**	
Preventive Care/Screening/Immunization	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	$0.00	$3.00	$5.00	$10.00	$15.00	$30.00
Mid Co-Pay Medical Services					**Mid Co-Pay Medical Services**	
Specialist Visit	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
Imaging (CT/PET Scans, MRIs)	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
Speech Therapy	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
Occupational and Physical Therapy	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
Laboratory Outpatient and Professional Services	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
X-rays and Diagnostic Imaging	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
Skilled Nursing Facility	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
Urgent Care Facility	$3.00	$10.00	$20.00	$30.00	$50.00	$70.00
Higher Co-Pay Medical Services					**High Co-Pay Medical Services**	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$5.00	$25.00	$50.00	$80.00	$100.00	$200.00
Outpatient Surgery Physician/Surgical Services	$5.00	$25.00	$50.00	$80.00	$100.00	$200.00
Emergency Room Services	$25.00	$30.00	$50.00	$100.00	$150.00	$300.00
All Inpatient Hospital Services (inc. MH/SUD)	$25.00	$30.00	$50.00	$100.00	$150.00	$300.00
Prescription Medications					**Prescription Medications**	
Generics	$0.00	$3.00	$5.00	$10.00	$20.00	$35.00
Preferred Brand Drugs	$3.00	$10.00	$10.00	$20.00	$30.00	$50.00
Non-Preferred Brand Drugs	$15.00	$50.00	$100.00	$100.00	$100.00	$250.00
Specialty Drugs (i.e. high-cost)	$10.00	$25.00	$50.00	$50.00	$50.00	$100.00

Services Highlighted in Blue are Subject to Deductible

Turquoise 1 Plan: Up to 150% FPL

Targeting the lowest income range, this plan offers a $0 deductible and $200 annual maximum out-of-pocket spending (MOOP), beyond which 100% of the cost of any additional services is covered. Under this plan, an individual will pay a maximum of 1% of income if they reach the MOOP limit. This greatly minimizes exposure to medical costs and improves financial security for lower income individuals. In addition to offering no-cost preventive mental health/substance use treatment (which is required by federal and state law, respectively), the plan provides access to primary care visits at no cost under the

low-co-pay category of services. The mid-level co-pay value that encompasses many of the more frequently needed services is $3. Outpatient facility and surgeon feels are $5. The higher-level co-pay category applies a $25 co-pay to ER visits and in-hospital services. For this plan, the highest drug co-pay is for non-preferred brand drugs at $15, with lower co-pays for preferred brand and specialty drugs; $3 and $10 respectively.

Turquoise 2 Plan: 150-200% FPL

The proposed plan has a deductible of only $50 and a maximum out of pocket limit of $1,500, which is 7% of the average income in the range. Primary care visits and generic drugs require a $3 co-pay. The mid-level co-pay for medical services is set at $10 for many of the frequently used services as well as for the preferred brand drugs. Co-payments for outpatient facilities and physician and surgical services are at $25, while co-pays for ER and inpatient stays are slightly higher at $30. The co-payment for specialty drugs is $25, while non-preferred brand drugs have a $50 co-pay and are subject to the deductible.

Turquoise 3 Plan: 200-250% FPL

The deductible for this income group is $750 for an individual and the maximum out of pocket limit is $2,000. A scenario in which an individual reaches their out-of-pocket limit would cost 7% of annual income, compared to 24% of household income for a current mid-level Silver plan with federal cost sharing assistance. Primary care and generic drugs require a minimal co-pay of $5 each. The mid-level co-pay is $20. Co-payment for preferred brand drugs is $10. Outpatient, Inpatient, and ER services and specialty drugs carry $50 co-pays. Non-preferred brand drugs have a $100 co-pay.

Turquoise 4 Plan: 250-300% FPL

The plan has a deductible of $1,500 and a maximum out of pocket limit of $3,000. Primary care visits and generic drugs' co-pays are $10 each. The mid-level co-pay is at $30. Preferred-brand drugs' co-payment is $20. Specialty drug and non-preferred brand drugs' co-pays are unchanged from the previous income range at $50 and $100, respectively.

How do these out-of-pocket costs compare with current plans?

OSI selected a mid-level Silver plan offered on the Marketplace in 2022 to compare deductibles and maximum out-of-pocket limits to this proposal. These changes represent plan design priorities and the availability of state-funded cost sharing assistance.

Federal Poverty Level	100-150%	150-200%	200-250%	250-300%
Example of CURRENT Plan Out-of-Pocket Limits				
Deductible	$400	$750	$3,000	$4,000
Max Out of Pocket	$1,000	$2,900	$6,950	$8,700
Maximum Percent of Income Spent on Out-of-Pocket Costs	6%	13%	24%	25%
Example of OSI Proposed Out-of-Pocket Limits				
Deductible	$0	$50	$750	$1,500
Max Out of Pocket	$200	$1,500	$2,000	$3,000
Maximum Percent of Income Spent on Out-of-Pocket Costs	1%	7%	7%	8%

Compared to current offerings, the maximum out-of-pocket exposure for enrollees would be reduced significantly. OSI looked at the portion of income that could be potentially spent on out-of-pocket costs at the middle of each income cohort for a Silver plan with federal cost sharing assistance (when applicable) compared to OSI's proposal. For the cohort below 150% FPL, the MOOP would reach just 1% of household income, compared to 6% in the existing plan identified by OSI. In the 150-200% FPL range, MOOP exposure would go from 13% of household income to 7%. Those between 200-300% FPL would see their potential financial exposure drop from 24-25% of annual income to just 7-8%. These effects are largely due to improvements in cost sharing assistance but also reflect the goal to minimize the MOOP.