

STANDARDIZED PLANS

IN INDIVIDUAL MARKET HEALTH INSURANCE

Key Considerations for Consumer Advocates



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About the Consumers for Quality Care

Consumers for Quality Care (CQC) is a coalition of advocates and former policymakers working to provide a voice for patients in the health care debate as they demand better care. CQC is led by a board of directors that includes the Honorable Donna Christensen, physician and former Member of Congress; Jim Manley, former senior advisor to Senators Edward Kennedy and Harry Reid; and Jason Resendez, community advocate, and health care strategist.

To learn more about Consumers for Quality Care and the issues consumers are experiencing, visit <http://www.consumers4qualitycare.org/>.

AN ADVOCATE'S GUIDE TO STANDARDIZED HEALTH PLANS

The Affordable Care Act (ACA) requires all individual health plans to cover broadly similar benefits, adhere to some limits on cost-sharing, and offer plans within specified metal tiers that cover approximately the same percentage of average medical costs. Standardized cost-sharing designs move a step further, providing advantages for consumers. They can improve consumers' experiences by facilitating apples-to-apples comparisons of plans' premiums, networks, and quality. They are also a vehicle to improve adequacy and affordability of coverage. But there are many considerations for consumer advocates in designing standardized plans. A state cannot design the perfect plan for everybody. But by implementing standardized cost-sharing designs, a state can remove one cognitive hurdle for consumers, thereby simplifying plan choices and coverage use and bringing more value to consumers.

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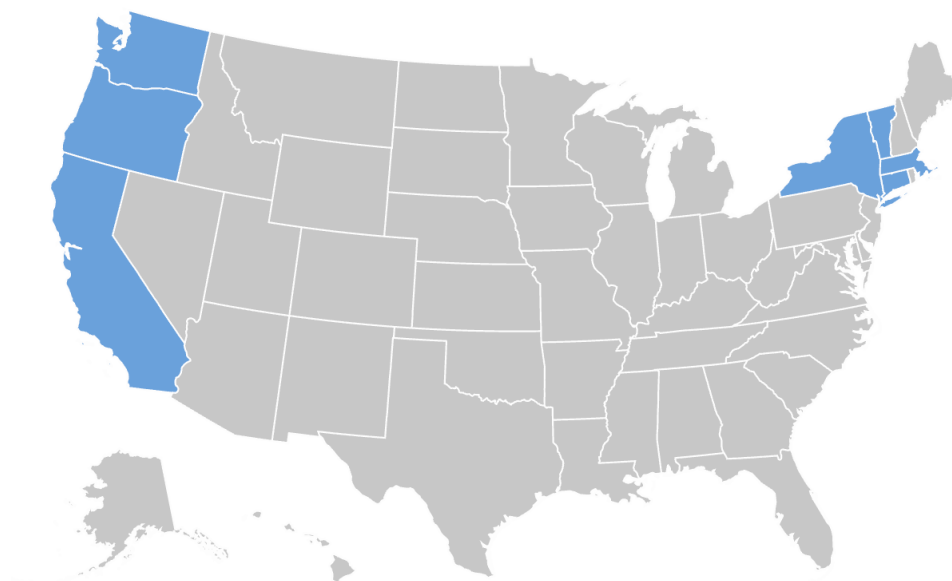
IMPLEMENTATION OF STANDARDIZED HEALTH PLANS

State and Federal Options

Early in ACA implementation, six states and the District of Columbia made the decision to require health insurers to offer plans with standardized cost-sharing parameters, such as uniform deductibles and copayments for certain services.¹ For the 2021 plan year, seven states (California, Connecticut, Massachusetts, New York, Oregon, Vermont, and Washington) and the District of Columbia require some, or all, individual market plans offered through the health insurance marketplaces be standardized plans.² California is the only state that requires all plans sold in the individual health insurance market be standardized. Several states, including Colorado, are considering new legislation or regulations creating standardized plans.³

Standardized plans are also a policy option for the federal government. In 2017 and 2018, the federal government allowed standardized cost-sharing options for private insurers in the federally facilitated marketplace, Healthcare.gov.⁴ In contrast to the approach taken by the states with standardized plans, federal regulators encouraged, but declined to require, participating insurers to offer standardized plans. Under a new administration, standardized plans could be brought back to Healthcare.gov, either as an option or a requirement.

Few of the states that employ standardized plan designs have statutes that specifically require insurers to offer such plans. Where laws are in place, they typically provide little detail regarding the parameters of the plans. Instead, development of standardized plan designs is often delegated to state-run marketplaces that then rely on recommendations of multi-stakeholder work groups, which usually include consumer advocates. Sometimes, the development process includes input from focus groups. Rarely has it involved detailed quantitative analysis, utilizing claims utilization data or modeling of how changes to cost-sharing are likely to affect consumer behavior. The quantitative analyses are generally limited to those provided by actuaries who help marketplace staff, boards and workgroups develop plan designs within actuarial targets for discussion and approval. Standardized plan designs often change year to year because of increases in medical inflation and accompanying changes in federal guidance used to calculate the actuarial value of plans. The actuarial value is an estimate of the percentage of average medical costs that the plan covers for the average plan enrollee. Plans offered in the individual market must have an actuarial value within a set range for each metal level. The metal levels (bronze, silver, gold, and platinum) provide different generosity of coverage.



States Have Taken a Varied Approach to Standardized Plans

The seven states, and the District of Columbia, that have standardized plans have taken a varied approach to implementation. This provides options for other states as they consider implementing standardized plans. A few of the large-scale decisions that need to be made up-front are:

- Whether to allow insurers to also offer non-standardized plans or to require all standardized cost-sharing plans in the individual market to have standardized cost-sharing;
- Which metal tiers should be standardized, including whether to require standardized plans in the HSA-compatible bronze plans and the platinum tier as well (HSA compatible bronze plans are bronze plans designed to meet federal regulations that allow the enrollee to maintain a health savings account);
- What services should have standardized cost-sharing and whether it should be a set of key services or require all services to be standardized; and
- Whether to have distinct naming conventions for standardized plans to provide some ease of differentiation between standardized plans and other available plan options.

Specific cost-sharing requirements also vary significantly based on the goals of a state's standardized plans, the need to fit within the required actuarial value of each metal tier, or some combination of both. For example, because low actuarial value plans require enrollees to bear a higher share of costs, cost-sharing is particularly high on bronze plans, whether the plan is standardized or non-standardized. Cost-sharing decisions can also influence large policy goals. For example:

- Providing some services before the deductible applies (pre-deductible) for all metal tiers except the HSA compatible bronze (federal law only allows specified preventive services to be pre-deductible in HSA plans, and the allowed preventive services were expanded in 2019⁵), may encourage appropriate usage of primary care;
- Including a separate drug deductible, or not subjecting certain formulary tiers to the deductible, gives enrollees quicker access to prescription drug coverage before reaching the full deductible;
- Choosing between copays and coinsurance, or a combination of both, for covered services helps manage enrollee expectation of medical costs; and
- Prioritizing services that should have lower cost-sharing helps encourage what the marketplace determines is high value.



MAJOR GOALS OF STANDARDIZED HEALTH PLANS

For consumers, standardized plans may offer two primary benefits: simplifying plan choices and usage for consumers as well as improving value for enrollees of these plans. For states and insurers, standardized plans may allow for some administrative efficiencies and easier quality tracking.

Simplifying Plan Choices for Consumers

By allowing consumers to compare plans that have identical cost-sharing, standardized plans can empower consumers to draw informed distinctions between plans based on their premiums, networks, and quality. Providing a level playing field on cost-sharing for specific benefits can promote insurer competition on price, quality, and potentially networks. Research of standardized plans in California found that if consumers have easy-to-understand, transparent information, without being overwhelmed by too many choices, they will buy lower-premium products available on their chosen metal tier.⁶

States may be able to facilitate consumer decision-making further by limiting or prohibiting non-standardized plans. Limiting the total number of plans an insurer can offer on the marketplace or limiting the number of non-standardized plans - or barring non-standardized cost-sharing plans altogether - can further simplify plan choices. Some states may be reluctant to limit or prohibit non-standardized plans because there are only a few insurers participating in the marketplace so consumer choice is already limited. But there is still the potential that a small number of insurers will offer so many plan options that it impedes the consumer shopping experience.

Improving Value for Enrollees

Standardized plans provide an opportunity to bring increased “value” to enrollees. The definition of value will vary by each state and may include creating plans with more consumer friendly cost-sharing designs or reducing cost barriers to services that meet policy goals. The design features that bring the most value to consumers will vary state to state. A state’s insurers may already be incorporating features aiming to improve value to consumers. In many instances, states have chosen to designate many services as pre-deductible to maximize affordability for consumers and access to services they believe to provide more value. The aim of pre-deductible services is largely to lower cost barriers to care that exist in non-standardized plans.⁷

There are other ways that some states look to provide increased value in standardized plans. Standardized plans can limit opportunities for discriminatory benefit designs and can reduce cost barriers for treating chronic conditions.⁸ There is potential that plans with standardized cost-sharing can be designed to address issues related to health equity, such as by reducing cost-sharing for diagnostic services or disease treatments for conditions disproportionately affecting vulnerable communities.

Administrative Efficiencies for States and Insurers

Although not as primary a goal as simplifying plan choices and usage decisions for consumers and providing “value” to enrollees, there are efficiencies that standardized plans can bring. For insurers, standardized plans can create more efficient development of plan offerings because there is no need to design cost-sharing for the standardized plans. For state regulators, the form review process may be simplified when insurers submit standardized plans, allowing them to focus on networks, quality outcomes, and other reasons for premium differences. However, efficiencies are not guaranteed as long as insurers retain some flexibility.

CONSIDERATIONS FOR CONSUMER ADVOCATES

Developing plans with consumer-friendly standardized cost-sharing requires consideration of an array of factors. There are multiple policy decisions and benefit design choices that must be made in adopting and designing standardized cost-sharing. Consumer advocates can play an important role in helping to guide these decisions.⁹

Standardized Plan Development Requires Trade-Offs

There is a balancing act that takes place in designing standardized cost-sharing features. It is not possible to meet all desired goals within plan design constraints and the actuarial value targets required under law. Balancing decisions such as which services should be provided pre-deductible and specific cost-sharing amounts (such as deductibles, copays and coinsurance for each benefit category, and maximum out-of-pocket limits) with the actuarial value requirements of each metal tier means that the plan design options are not unlimited. Advocates face numerous trade-offs in helping to design standardized plans. Decreasing one type of cost-sharing, such as copays, means an increase in another type of cost-sharing, such as the deductible. Providing more services pre-deductible may reduce the cost of accessing health care for a greater number of enrollees, but it may also increase overall costs for those with chronic conditions if other cost-sharing, including the maximum out-of-pocket, has to be increased.



LOWER PREMIUMS VERSUS LOWER COST-SHARING

One key policy goal that needs to be determined before designing standardized plan designs is the desire to keep premiums lower versus the desire to keep cost-sharing low. Premium impact will always be a focus of plan design, but states must decide how much weight to give this consideration. States may, or may not, want to formally project premiums during discussions of various standardized plan benefit designs (although actual premiums will vary by insurer based on multiple factors, such as the covered population, networks, and provider rates). A standardized plan designed to reduce premiums likely results in a lower actuarial value (within the required actuarial value range) and higher cost-sharing.

DECIDING WHICH SERVICES SHOULD HAVE LOWER COST-SHARING

One of the most difficult decisions is deciding what services should have the lowest cost-sharing or be provided pre-deductible. This may be based on research of consumer utilization of benefits or data on consumer experience and preference combined with a decision as to what the goal is of providing services pre-deductible. A key decision point is whether standardized plans should focus on reducing costs for the greatest number of enrollees or those with high cost health needs, or encouraging services that will improve enrollee health.

There are numerous cost-sharing options that need to be balanced. The size of the deductible and maximum out-of-pocket will have a significant impact on the amount of cost-sharing for numerous medical services. If there is a desire to provide services pre-deductible, there needs to be a choice of which services. Focusing on services that are not major cost drivers, such as outpatient office visits, may improve access for the most enrollees without creating as much struggle to work within the constraints of the actuarial value requirements. In comparison, focusing on higher cost drivers can improve compliance with treatments and make accessing expensive care more affordable, but with more of an impact on the actuarial value.

There are very few options for pre-deductible services for bronze plans because of the low actuarial value, with some states only providing generic prescriptions and office visits pre-deductible. In comparison, the actuarial value is high enough for platinum and gold plans that they may not require any deductible for most – if not all – outpatient services. Office visits and prescription drug coverage must also be balanced with higher cost outpatient services such as imaging and emergency care.

COPAYS OR COINSURANCE

Another decision point is adopting copays versus coinsurance, or a combination of both. Copays provide certainty to the enrollee when they access care and are often easier for enrollees to understand. In addition to uncertainty for the cost of accessing care, coinsurance can result in higher cost-sharing for higher-cost services (as well as possibly lower cost-sharing for lower-cost services). Coinsurance can make it simpler to adjust cost-sharing design each year since coinsurance is a set percentage of the cost of service so the amount enrollees pay for services automatically increases with medical inflation. However, making significant updates to the standardized cost-sharing design every year, as required by a copay based design, may very well be worth the effort so that enrollees better understand the cost-sharing of their plan and have more certainty about costs when accessing health care. In some instances, consumers forgo care, such as diagnostic tests, because of the uncertainty created by coinsurance.¹⁰

EQUITY AND AFFORDABILITY

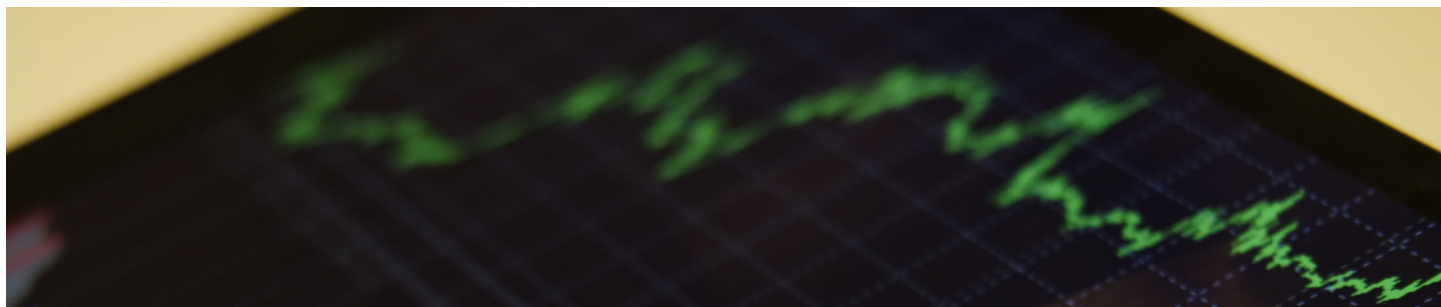
Equity can play an important role as states need to balance the needs of healthy enrollees with minimal health care needs, those with chronic conditions who need regular care, and those with high-cost acute incidents. Advocates must consider how to balance an interest in promoting equitable plan designs with the goal of preserving or improving affordability for specific populations. For example, lowering copays and increasing the maximum out-of-pocket will likely make health services more affordable for a greater number of enrollees. But this affordability is gained at the expense of enrollees with high-cost chronic or acute conditions who face thousands of dollars in annual costs and are more likely to benefit from the out-of-pocket limit. The higher the metal tier, and therefore the actuarial value, the easier it is to balance the needs of various populations. But with silver and bronze plans, the cost-sharing may have to be extremely high, limiting choices and requiring difficult trade-offs.

Some states are looking at Value Based Insurance Design (VBID) as a way to increase the value of plans while also reducing costs for some enrollees with chronic health needs. VBID uses financial incentives, such as lower cost-sharing, to promote cost efficient health care services and consumer choices. There is particular interest by state-based marketplaces in VBID design of prescription drug cost-sharing. However, it is important to note that because the standardized plan designs must fit into set actuarial value ranges, any reduction in cost-sharing for some services must be balanced by an increase in cost-sharing for other services. Thus a decrease in cost-sharing for specific health services targeting a subset of chronic conditions could lead to increased cost-sharing on enrollees with other health conditions that are not targeted by VBID. Implementing a VBID design also brings administrative complexities, in large part because it creates additional actuarial burdens and the need for special certification since the federal process to estimate actuarial value does not account for VBID designs.

DESIGNING PRESCRIPTION DRUG COVERAGE

Another key decision is designing prescription drug coverage. Prescription drugs are a substantial cost driver for health insurance and are a large focus in standardized cost-sharing design. Some states have chosen to have prescription drug deductibles that are lower than the overall medical deductible in order to make prescription drugs more affordable or to have about the same percentage of prescription costs covered as the percentage of medical costs covered. But such a choice will result in increases in other cost-sharing, including potentially a higher medical deductible. Another priority is making prescription drug coverage pre-deductible, or choosing to make lower tiers of prescription drug coverage pre-deductible. Cost-sharing can also be designed to lower the costs of prescription drugs for enrollees needing high cost drugs. States may choose to limit the costs of specialty drugs or other high cost drugs combined with a small increase in other cost-sharing or an increase in premiums.¹¹ Advocates should also remain aware that what drugs are on a plan's formulary and what tiers specific drugs are placed in on the formulary are not directly factored into actuarial value calculations.

Barriers in Actuarial Value and Data Collection



States cannot design standardized plans without actuarial calculations and some data on the market. Because health plans sold on the marketplaces need to meet specific ranges of actuarial value at every metal tier, it is vital that states have access to accurate actuarial value calculations. The federal actuarial value calculator, which is updated annually, is used to demonstrate compliance with actuarial value requirements. It is a necessary tool in design and maintenance of standardized plans to ensure that each year the benefit designs fit within the required actuarial value ranges for each metal tier. States also need quantifiable data, such as data on how much various services are utilized by enrollees and how utilization varies with differences in cost-sharing, to help design standardized cost-sharing that meets specified policy goals. Consumer advocates, as well, need access to such data in order to responsibly shape benefit designs that meet consumer needs.

LIMITATIONS OF THE FEDERAL ACTUARIAL VALUE CALCULATOR IMPOSE HURDLES

Historically, there have been delays in releasing annual updates to the actuarial value calculator and the accompanying federal regulations, including updates to the maximum allowed out-of-pocket spending limit. These delays have often left states with very little time to finalize the design of standardized plans and have limited their ability to pursue policy goals and make data-driven changes. If the calculator was released earlier in the year, it would give states more time to make informed decisions on cost-sharing design.

There are also aspects of the federal calculator that reduce its benefit and make it harder to design standardized plans. For example, the calculator uses broader categories of services than insurers use in their internal actuarial value calculators and gives insurers discretion to determine how to characterize their categories and applicable cost-sharing when running their plan designs through the federal calculator. This leads to greater variation in plan actuarial values based not on plan designs but on how insurers use the calculator. The federal calculator is also based on the health care usage of a national population, which can differ greatly from a state's population mix.

ACTUARIAL VALUE CONSTRAINTS MAKE DESIGNING PLANS DIFFICULT

The actuarial value requirements provide significant constraints on cost-sharing design, particularly at the bronze and silver tiers. Federal regulations allow for a range in actuarial value at each tier in order to adjust for slight variations in benefit design and the difficulty in designing bronze plans that meet a 60 percent actuarial value. Due to the low actuarial value, the bronze plans cannot have an actuarial value above 65 percent and silver plans cannot have an actuarial value above 72 percent. Options for cost-sharing are particularly limited in bronze plans because of the federal limits in out-of-pocket costs. Some standardized bronze plans are designed with less than a thousand dollars in difference between the deductible and maximum out-of-pocket.

DATA IS IMPORTANT

Quantifiable data and actuarial analysis is imperative to ensure standardized plan designs are meeting the policy goal of delivering greater plan value. But many states do not have an adequate quantifiable method or data bank to make such determinations. For example, some states do not have public data on the utilization of pre-deductible services of enrollees with marketplace plans to understand whether enrollees are using the pre-deductible coverage. Without this type of analysis, states are limited in their ability to design ideal standardized plans. Insurers have much of this data and use it to inform the development of non-standardized plans, and may share it with actuaries assisting on standard benefit design, but the data is not necessarily available or used by workgroups designing standardized plans. There may be opportunities for state-based marketplaces to receive this data from insurers and to find a way to provide some form of the data, or analysis of the data, to workgroups designing standardized cost-sharing. There may also be data available in some states through all payer claims databases that could help inform the standardized plan design process, but there are significant costs to analyzing such data.

Deciding to Limit Non-Standardized Plans

Most states with standardized plans limit the number of non-standardized plans that can be sold by an insurer in the individual market. California prohibits the sale of non-standardized plans in the individual market. The decision most states have made is to cap the total number of plans that an insurer can offer or the total number of non-standardized plans. This decision can have an impact beyond the standardized plans themselves by reducing the number of options consumers need to compare before making a choice. If a state has no caps, then insurers can offer as many plans as they want. This may be a state's preference in a state with very few insurers participating in the market, although it may not be the best approach for consumers.

Marketing and Display of Standardized Plans

States are still struggling with determining the best way to promote and display standardized plans. This problem does not exist if non-standardized plans are prohibited. In states that allow both, standardized plans are not always displayed in ways that allow them to be easily distinguished from other plans or compared by consumers. Although broad consensus exists among state officials and stakeholders that a fundamental goal of plan standardization is to facilitate “apples-to-apples” plan comparisons, these states’ policy choices and website interfaces have, in the past, curtailed their ability to achieve these stated goals.¹² This continues to be an issue in some states where interfaces curtail the ability to display standardized plans in a way that allows an easy comparison. Marketplace websites are generally not designed to permit consumers to sort or filter plan options by whether the plan is standardized. Most marketplaces do require standard naming conventions for standardized plans, but it is unclear whether consumers notice these conventions or understand what they mean.

The Opportunity for Federal Standardized Plans

With a new incoming administration, there is a potential for the federal marketplace, Healthcare.gov, to once again allow – or require – insurers to offer standardized plan designs. When federal standardized plan designs were last incorporated into Healthcare.gov, they were an option for insurers and not a requirement. In designing plans, the Department of Health and Human Services chose to base the standardized plans on the most popular designs purchased on the federal marketplace in order to minimize disruption. A new federal standardized plan policy could take a different approach that is informed by state experience and work through the decision points detailed above in developing standardized cost-sharing.



HOW ADVOCATES CAN BE PREPARED

Consumer advocates need to be prepared in order to play a meaningful role in designing standardized plan options. Advocates should enter the process with clear goals. Actuarial analysis plays an important role in any benefit design, and advocates need to press for and understand the analysis and ensure that actuaries assist the process. Finally, it is important to push for a transparent and public process for designing standardized plans.



Enter the Process with Clear Goals, and Be Prepared to Adjust as You Learn

Development of standardized plan designs is time intensive. The process includes detailed policy discussions and often further research and analysis. Those engaged in the development of standardized plans are often working on a tight calendar because of when the actuarial value calculator and updated maximum out-of-pocket are released. It is helpful to lay the groundwork on big policy ideas as early in the process as possible to gather research and anticipate objections from insurers and other stakeholders.

These policy goals may include a variety of goals discussed above. What is the desired balance between lower premiums and lower-cost sharing? Do you want to aim to reduce the use of coinsurance in plan designs? Which services are important to have pre-deductible? What services should be provided at the lowest cost-sharing level? Should standardized plans aim to make outpatient services affordable for the most enrollees or overall cost-sharing lower for those with high cost medical conditions? And is ease of comparing standardized plans a major policy goal? Many times, the questions are not an either-or situation but a more complicated determination of the goals of the overall package. Answering these questions before the benefit design begins can help advocates play a stronger role in directing the benefit design process.

Be Ready to Talk About Trade-Offs

Intertwined with the policy goals is preparation to discuss the trade-offs that need to be made in benefit design. It is a balancing act to design standardized plans. Generally, any time one area of cost-sharing is decreased, another area needs to be increased. Advocates need to be prepared that there is very limited flexibility at the bronze level and, regardless of trade-offs, the cost-sharing will be extremely high. But there is more room to play with cost-sharing at the higher actuarial value levels. You may learn that some services are less expensive to insurers, or less utilized, than expected. And in order to play with benefit design, advocates need to be prepared to discuss and decide whether the aim should be reducing the deductibles, the maximum out-of-pocket, cost-sharing on specific services, or providing services pre-deductible, or limiting premium increases. Granular decisions, such as whether emergency room visits should be hundreds of dollars, how much higher specialist visits should be compared to primary care visits, and the affordability of diagnostic testing need to be made. Be prepared to advocate on them.

Be Prepared for Actuarial Analysis

The design and pricing of health plans requires the interplay of multiple actuarial concepts. To engage effectively in the design of standardized plans, it is critical to come to the table with a sound understanding of actuarial principles. At a minimum, advocates should understand the concept of actuarial value and the trade-offs between benefits and cost-sharing to achieve specific actuarial values. They should be steeped in understanding basic concepts of the actuarial value calculator, including what cost-sharing options plans need to fill in. Consumer advocates could benefit from an actuarial sciences primer or “Actuarial 101” in order to get smart on the actuarial process. It could also be beneficial to have actuaries assisting advocates that can be tapped to answer ongoing technical questions. Having actuaries available would help consumer advocates be prepared to effectively engage in policy discussions with insurers or regulators when the data presented does not support going in a direction that is best for consumers.

The stated-based marketplaces typically engage an internal or consulting actuary to support those working on designing standardized plans or modifying existing standardized plans. These actuaries can serve as a neutral party on the impact of various design features under consideration. Actuaries can also inform policy discussions related to the impact of standardized plans on premiums, adverse selection, and discriminatory benefit design. Advocates should be prepared to push for actuaries to play a greater role in advising the standardized cost-sharing design process to provide more than calculations of the actuarial value of various options and recommendations to fit within an actuarial value. Advocates should also be prepared to push for more data to inform design choices.

Embrace A Transparent and Public Process

A transparent, public process that engages a broad spectrum of stakeholders can help bring clarity to choices and their impacts related to standardized plans. This was the approach taken in multiple states in the formation of their standardized plan designs. By formally engaging all the stakeholders with an interest in the standardized plan designs, including consumer advocates, there is less of a chance of challenges in the end process or surprises as stakeholders raise concerns after major policy choices have been agreed upon. Engaging a public process also provides an opportunity for broader participation from consumer advocates that are not members of a workgroup.

CONCLUSION

Standardized cost-sharing plans are a tool that can have large advantages for consumers, including improving the shopping experience and increasing value in health plans. As more states consider the opportunity to adopt standardized plans, and as a new administration reopens the door for standardized plans at the federal level, consumer advocates can learn from other states' experiences. These experiences can arm consumer advocates to be prepared to inform policy decisions and play a strong role in standardized plan design.



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