What Level of Coverage is Available through the Marketplace?

Standardized Health Plans: Four Levels of Coverage

Beginning in 2014, all new health plans sold to individuals and small businesses will need to meet new requirements for standardization in the scope and value of health insurance coverage. Researchers have found that too many plan choices can confuse consumers and give more power to insurers to use benefit design to attract and enroll healthier people and avoid individuals with high cost health conditions. Standardization of plan levels of coverage will help individuals and businesses make apples-to-apples comparisons among insurance plan options and help guard against insurance company efforts to use benefit design to cherry pick the healthiest people.

Under the Affordable Care Act (ACA) health plans will be required to provide four levels of coverage, sometimes referred to as metal tiers: Bronze, Silver, Gold and Platinum.

All plans offered within the individual and small group markets, both inside and outside of the Health Insurance Marketplace must offer the same comprehensive package of items and services, known as essential health benefits (See Glossary: Essential Health Benefits).

While the scope of benefits will be the same among the plans, the share of the costs the plan will pay for those benefits will vary across the four levels of coverage. Bronze plans will be the least generous, with higher out-of-pocket costs for covered benefits, and platinum plans will be the most generous, with less cost-sharing.

However, no plan will be allowed to impose total out-of-pocket costs – deductibles, copayments or other forms of cost sharing – greater than those imposed by high deductible plans (for 2015, the limit will be $6,600 for an individual and $13,200 for a family). However, it is important to note that the out-of-pocket limit applies to care obtained in-network for essential health benefits. Spending for out-of-network care and services that are outside the essential health benefits will not count toward the out-of-pocket limit.

How will the levels of coverage differ?
The division of health plan versus patient costs is shown below for each category of health insurance plan. This does not necessarily mean that for each individual medical service the patient pays a given co-insurance percentage, but rather the percentage refers to the amount of overall medical and drug costs the patient will be responsible for through deductibles, co-payments and co-insurance.

**Bronze Plan (60-40)**
- Characterized with less expensive premiums
- While the premium may be low, OOP costs are high
- Plan will pay for 60% of the medical and drug benefits and the buyer will pay 40% through deductibles, flat co-pays and/or co-insurance
- Individuals must determine whether this cost structure will work for them – especially if they have a rare and chronic disease requiring on-going and long term treatment
Silver Plan (70-30)
- One step up from the Bronze Plan
- Higher premiums than the Bronze Plan and more benefits
- Plan will pay for 70% of the medical and drug benefits and the buyer will pay 30% through deductibles, flat co-pays and/or co-insurance
- Individuals must determine whether this cost structure will work for them – especially if they have a rare and chronic disease requiring on-going and long term treatment

Gold Plan (80-20)
- Closer to the “average” plan that is currently offered by employers
- Premiums are higher than the Silver Plan and the medical and drug benefits are more generous
- Plan will pay for 80% of the medical and drug benefits and the buyer will pay 20% through deductibles, flat co-pays and/or co-insurance

Platinum Plan (90-10)
- Most generous of all plan offerings
- Premiums are higher than the Gold Plan and medical and drug benefits are more comprehensive
- Plan will pay for 90% of the medical and drug benefits and the buyer will pay 10% through deductibles, flat co-pays and/or co-insurance
- Many platinum plans will have an OOP limit that is lower than Bronze, Silver, and Gold plans. If you anticipate high OOP costs, it is likely that overall health costs, which include premiums and OOP spending, may be lower in such a platinum plan.

There will likely be a variety of plans available that fall under each of the above categories. State and the federal government determine which insurance products qualify to be sold through the Marketplace. All companies participating in the Marketplace must offer at least one silver-level plan and one gold-level plan. The number of choices available for each individual depends both on the state and federal government and on the insurance companies.

In addition to these four levels of coverage, young adults under the age of 30 and individuals exempted from the individual mandate because there is no available affordable coverage will be able to purchase “catastrophic” plans that cover essential benefits but have high deductibles.

Keep in mind that, in general, the lower the premium is the higher the OOP costs will be when a patient needs care. It is necessary for patients to calculate the costs for their current Ig treatment, number of trips to doctors’ offices, emergency room visits, treatments for other conditions and any other costs including drug costs. Once calculated, one needs to investigate how each plan will pay or not pay for those services and Ig products that a patient will need. If one’s expected OOP costs are greater than the premium for any particular plan, that plan is probably not the right plan. It may very well turn out that a Gold or Platinum plan which have higher premiums may be the better buy when OOP costs and premium subsidies are taken into account – especially for those families who have rare and chronic diseases and need on-going and expensive treatments.