
pennie®

2024 Plan Certification Policy (Proposed)

January 13, 2023

Today's Agenda

- Overview
- Proposed Requirements
- Other Provisions Already Adopted
- Next Steps

Overview

Overview

Applies to qualified health plans (QHPs) and qualified dental plans (QDPs). offering coverage through Pennie for 2024 plan year

Plan certification requirements are in addition to all federal and state regulations or other guidance related to offering QHPs and QDPs.

Process:

- Feedback will be sought from variety of stakeholders
- Staff will review feedback and prepare recommendations for Board
- Board will review and approve policy

Proposed Requirements for 2024 Plan Certification

#1: Coverage for COVID-19

Provide coverage for COVID-19 vaccination, testing, diagnosis, and treatment in a manner consistent with the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, §§ 3201-03.

Proposal	Policy Goal(s)	Benefits	Challenges
Coverage for COVID-19 vaccination, testing, diagnosis, and treatment	Ensure access to quality health care	Ensure Pennsylvanian's have access to necessary health care in public health crisis	N/A

Feedback:

- Any concerns about continuing to incorporate this requirement for PY24?

#2: Commissions Disclosure to Producers

Producers serve a critical and unique role for customers

Important to have a robust diverse pool of producers to serve Pennie customers

Recommend continuing PY23 policy (see next slides) requiring advanced notice of commissions prior to OEP.

Note: Per CMS guidance June 2022, insurers are not allowed to have different commissions for OEP enrollments and SEP enrollments, therefore changing commissions after OEP removed from policy.

Proposal	Policy Goal(s)	Benefits	Challenges
• Advanced notice of commissions prior to OEP • Consistent commissions throughout the plan year	Ensure Pennsylvanians have access to a robust pool of licensed producers to provide expert assistance	• Advanced notice for brokers to decide whether to participate • Consistency of commissions allows producers to commit and invest in support Pennie customers	• Operational timing difficulties for some insurers to disclose commissions a month prior to OEP

Feedback:

- Any concerns about continuing this requirement for PY24?

#2: Commissions Disclosure to Producers

Applicability: insurers who pay commissions; 2024 plans sold through Pennie

- *"If an insurer pays producer commissions, then the commission payment schedules for 2024 Plan Year QHPs & QDPs sold through the Exchange Authority's platform must satisfy the following conditions:"*

Advanced Notice of Commissions 30 days in advance of OEP

- *"1. The producer commission payment schedule must be made available to the Exchange Authority and to producers at least 30 days in advance of the start of the Open Enrollment Period or within 72 hours of final rates being released if final rates are released less than 30 days before OEP."*

No Changes to Commissions unless extenuating circumstances (e.g. late approval of rates by PID, statutory or regulatory changes)

- *"2. Changes to the producer commission payment schedule can be made prior to the end of the plan year only in extenuating circumstances as permitted by CMS (see guidance here) and with Pennie's approval."*

#3: Renewal Plan Mapping

In prior plan years, Pennie has adopted the federal standard for renewal plan mapping with no modifications.

For PY24, we are proposing to continue using the federal standard with two modifications.

What is renewal plan mapping?

When a current customer is autorenewed for the upcoming plan year, renewal plan mapping tells us which plan to autorenew the customer into by identifying the same or most comparable plan to their current plan.

The goal of renewal plan mapping is to allow for customers to have continuous enrollment into the upcoming plan year with plan benefits, plan type, and provider network that are most comparable to current benefits.

Changes to premiums are not a consideration in renewal plan mapping.

What is the current federal standard for renewal plan mapping?

If the customer's current plan is offered in the upcoming plan year, they will be autorenewed in the same plan.

If the customer's current plan is not offered in the upcoming plan year, there are a set of rules that define which plan is the most comparable plan to autorenew the customer into.

Proposal	Policy Goal(s)	Benefits	Challenges
Avoid disruption due to renewal plan mapping	Seamless autorenewals for customers into appropriate comparable plans	Ensure customers are autorenewed into the most appropriate comparable plan without surprises of significant changes	Limited experience to know which improvements needed to develop new standard

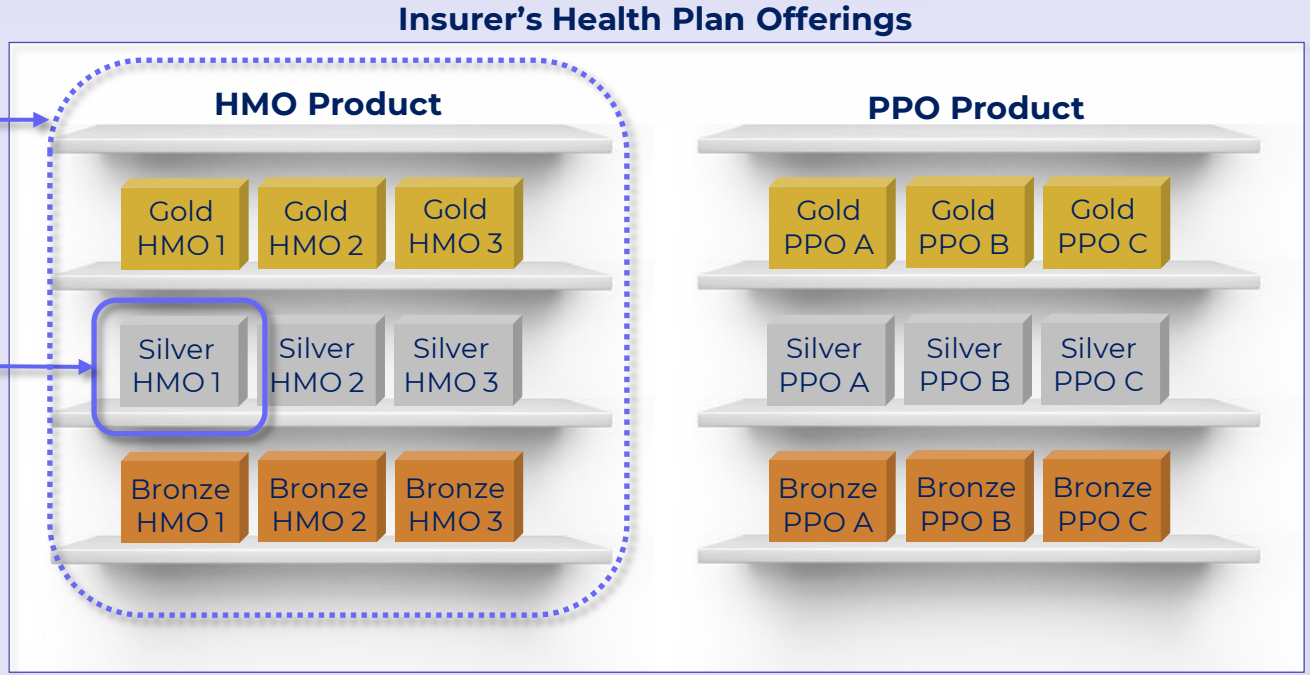
#3: Renewal Plan Mapping

Definitions

"Product" = Package of benefits offered via particular network type (e.g. PPO, EPO, POS, HMO)

"Plan" = the specific cost sharing for the product benefits

"Metal Level" = overall actuarial value of the plan (e.g. Gold, Silver, Bronze)

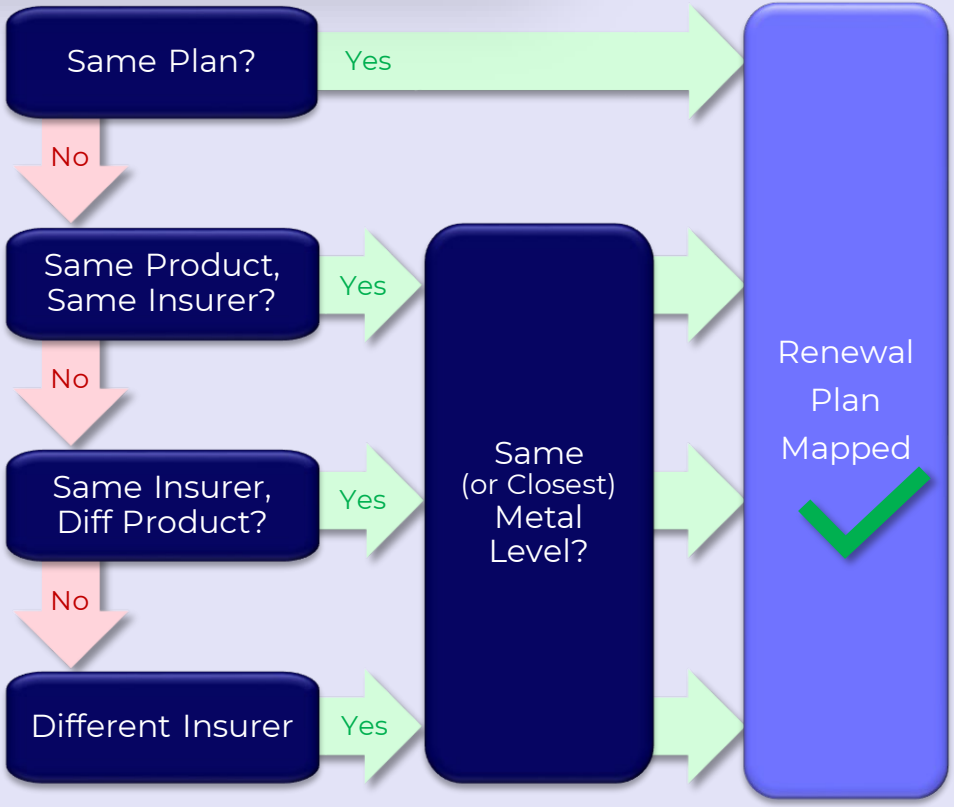


**See 45 CFR 144.103 for definitions

#3: Renewal Plan Mapping

Federal renewal mapping rules (45 CFR § 155.335(j)):

1. Same plan, if available (j)(1)(i)
2. Same product from same insurer, if available
    a. Same product, same metal level (j)(1)(ii)
    b. If current plan Silver, then different Silver product from same insurer (j)(1)(iii)(A)
    c. If current plan Bronze/Gold, then same product at Silver level** (j)(1)(iii)(B)
    d. Same product, any metal level (j)(1)(iv)
3. Different product from same insurer, if available
    a. Different product, same metal level (j)(2)(i)
    b. Different product, +/- 1 metal level (j)(2)(ii)
    c. Different product, any metal level
4. If insurer not available, different insurer (if permitted by state)



**Since no Platinum plans have historically been offered through Pennie.

#3: Renewal Plan Mapping

Current Plan: Gold EPO 1

Same plan? Not offered in renewal year

Example 1: Same Product, Same Metal Level

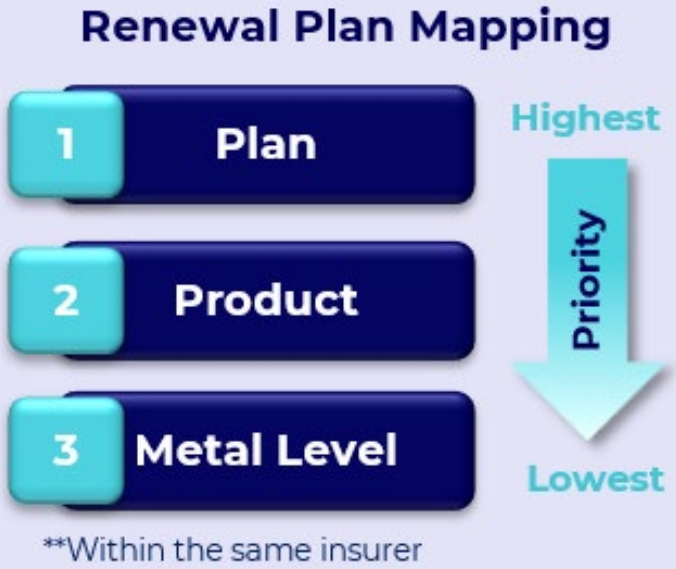
- Same product? Yes, other EPOs offered at all metal levels
- Renewal Mapping: Gold EPO 1 -> Gold EPO 2

Example 2: Different Product, Same Metal Level

- Same product? No EPOs offered.
- Same metal level (different product)? Yes, Gold PPOs offered
- Renewal Mapping: Gold EPO 1 -> Gold PPO 1

Example 3: Same Product, Different Metal Level

- Same product? Yes, other EPOs offered, only at Bronze metal level
- Renewal Mapping: Gold EPO 1 -> Bronze EPO 1



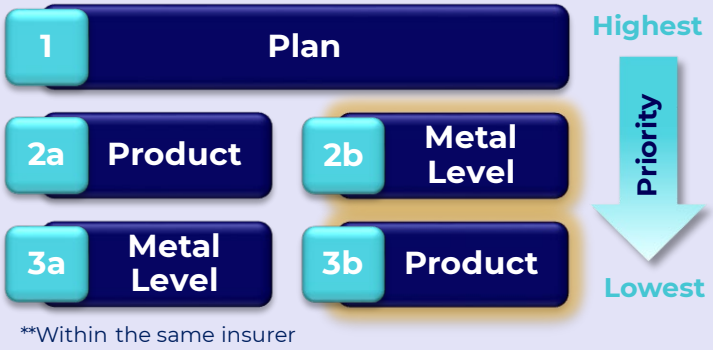
#3: Renewal Plan Mapping

Proposed Modification #1: Prior to mapping same product two or more metal levels different (155.335(j)(1)(iv)), insurers should identify if a different product is available at the current metal level that has similar benefits and similar provider network as the current plan which would be more comparable renewal plan.

Example 3. Current Plan: Gold EPO 1

- Current Mapping: **Gold** EPO 1 -> **Bronze** EPO 1
- Per Modification #1: Gold **EPO** 1 -> Gold **PPO** 1
  - Gold PPO has very similar benefits & provider network to Gold EPO, and same metal level.

Renewal Plan Mapping (modification #1)



**Within the same insurer

Proposal	Policy Goal(s)	Benefits	Challenges
Avoid disruption due to renewal plan mapping	Seamless autorenewals for customers into appropriate comparable plans	Ensure customers are autorenewed into the most appropriate comparable plan without surprises of significant changes	Adds subjectivity to some potential mapping scenarios

Feedback:

- Are there any other considerations beyond similarity of benefits and provider network that should be taken into account when assessing whether it's better to map a customer to a different product rather than map to same product two metal levels different?

#4: Renewal Plan Mapping – Bronze to Silver CSR

In 2024 Notice of Benefit and Payment Parameters (NBPP) proposed rule, CMS proposes a new renewal plan mapping rule for HealthCare.gov that would be based on a customer's eligibility for cost sharing reductions (CSR).

Purpose: Autorenewing into plans with richer benefits and lower out-of-pocket costs with the same or lower cost would lower health insurance costs for lower-income customers

Proposed New Renewal Plan Mapping:

- If currently enrolled in Bronze plan AND CSR-eligible…
- Then autorenew into a Silver plan…
- But ONLY if Silver plan's net premium after APTC is same or lower than Bronze plan

Note: This rule would apply even if the customer's current Bronze plan is available for autorenewal.

Renewal Plan Mapping (modification #2)

**Within the same insurer

**2024 NBPP proposed rule does not require states to adopt the new rule for renewal mapping based on CSR eligibility

#4: Renewal Plan Mapping – Bronze to Silver CSR

Examples (Customer CSR-Eligible)

Ex 1	Current Plan	Renewal Plan Mapping	
		(Current Rules)	(Bronze to Silver CSR Rule)
Insurer	HealthCo	HealthCo	HealthCo
Product	EPO	EPO	EPO
Metal Level	Bronze	Bronze	Silver (CSR)
Net Premium	--	$50 ✗	$20 ✓

Renew in Silver CSR since net premium less than Bronze renewal

Ex 2	Current Plan	Renewal Plan Mapping	
		(Current Rules)	(Bronze to Silver CSR Rule)
Insurer	HealthCo	HealthCo	HealthCo
Product	EPO	EPO	EPO
Metal Level	Bronze	Bronze	Silver (CSR)
Net Premium	--	$75 ✓	$80 ✗

Don't renew in Silver CSR since net premium $5 more than Bronze renewal

Renewal Plan Mapping (modification #2)

**Within the same insurer

#4: Renewal Plan Mapping – Bronze to Silver CSR

Due to premium rating rules and APTC calculation rules, we expect few customers would have Silver plan with same or lower net premium and therefore limited customers would benefit from the rule, as proposed.

We are proposing an **alternative** that would allow mapping to Silver CSR plan if the net premium is **no more than $10 more per month more** than the Bronze net premium. The small increase in net premium would result in significantly richer benefits.

Reminder, customers always have the ability to actively change plans during open enrollment if they don't like their autorenewal plan.

Ex 2 – Alternative Proposal	Current Plan	Renewal Plan Mapping	
		(Current Rules)	(Bronze to Silver CSR Rule)
Insurer	HealthCo	HealthCo	HealthCo
Product	EPO	EPO	EPO
Metal Level	Bronze	Bronze	Silver (CSR)
Net Premium	--	$75 ✗	$80 ✓

Renew in Silver CSR since net premium only $5 more than Bronze renewal

Renewal Plan Mapping (modification #2)

**Within the same insurer

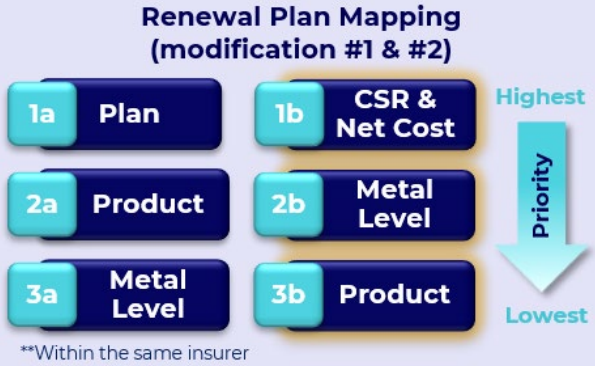
#4: Renewal Plan Mapping – Bronze to Silver CSR

Proposed Modification #2: Similar to 2024 NBPP proposed rule, autorenew CSR-eligible customers currently enrolled in Bronze to a Silver plan with the same product, the same insurer, and the net premium is no more than $10 more per month, regardless of whether the enrollee's current plan is available.

Proposal	Policy Goal(s)	Benefits	Challenges
Autorenew customers currently in Bronze to Silver CSR if net premium up to $10 more than Bronze autorenewal	Seamless autorenewals for customers into appropriate comparable plans Help customers maximize financial assistance to lower their costs	Autorenewing customers into plans with richer benefits and lower out-of-pocket costs with the same or lower cost would lower health insurance costs for lower-income customers	Change to current mapping rules Mapping would be based on customer eligibility System implementation LOE

Feedback:

- Do you think there will be any customer abrasion due to autorenewing into Silver CSR plan instead of the same Bronze plan (regardless of net premiums)?
- Do you prefer the 2024 NBPP proposed rule approach which would only map Bronze to Silver CSR when the net premium is no more than the net premium to renew into Bronze plan?
- Is there a different amount of net premium increase that would be a better threshold than $0 increase (2024 NBPP proposed rule approach) or Pennie's alternative $10 increase?
- Do you have any other proposals for how we can help customers enrolled in Bronze plans leverage the benefits of CSR eligibility?



#5: Meaningful Difference

- Choice is important for customers to find the right plan for their needs and their budget.
- Too much choice can be overwhelming to customers.
- Meaningful difference standard is intended to prevent a customer from having to choose between seemingly identical plans from the same insurer.
  - Not intended to exclude plans from one insurer because of plans offered by another insurer

Meaningful Difference Standard from PY21 & PY22 & PY23 definition (adopted previous federal standard)

"a. Whether a specific plan is meaningfully different from other plans offered by the same insurer within the service area and level of coverage. The goal of the meaningful difference standard is to ensure plans provide added value to the customers of differentiated features, and sufficient but not overwhelming choice.

i. In general, a plan is considered meaningfully different from another plan in the same service area and metal level if a reasonable consumer would be able to identify one or more material differences among the following characteristics between the plan and other plan offerings:

(1) Cost sharing; (2) Provider networks; (3) Covered benefits; (4) Plan type; or (5) child-only versus non-child-only plan offerings.

For example, plans are not meaningfully different if the only difference between the two plans is a de minimis difference in the deductible amount.

ii. Additional consideration may be made for plans offered in service areas with limited plan availability."

#5: Meaningful Difference

CMS raises concerns about choice overload in the 2024 NBPP proposed rule citing research:

- 2016 report by the RAND Corporation reviewing over 100 studies which concluded that having too many health plan choices can lead to poor enrollment decisions due to the difficulty consumers face in processing complex health insurance information[1]
- Study of consumer behavior in Medicare Part D, Medicare Advantage, and Medigap that demonstrated that a choice of 15 or fewer plans was associated with higher enrollment rates, while a choice of 30 or more plans led to a decline in enrollment rates[2]

2024 NBPP proposes to mitigate choice overload of health plans on HealthCare.gov:

1. Insurers cannot offer more than 2 plans per product network type and metal level in a service area

2. Insurer's plans offerings must have at least $1,000 difference in deductible to be meaningfully different
    - Deductible difference would compare plans with same issuer id, county, metal level, product type (e.g. HMO, PPO, EPO), and deductible integration type

**2024 NBPP proposed rule would only apply to HealthCare.gov. States would not be required to adopt these proposals. In addition, standardized plans required to be offered on HealthCare.gov would not be counted towards plan limits. Standalone dental plans (SADPs) not subject to plan limits.

1 -Taylor EA, Carman KG, Lopez A, Muchow AN, Roshan P, and Eibner C. Consumer Decision making in the Health Care Marketplace. RAND Corporation. 2016.
2- Chao Zhou and Yuting Zhang, "The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans That Meet Their Medication Needs." Health Affairs, 31, no.10 (2012): 2259–2265.

#5: Meaningful Difference

Pennie is proposing to limit plan offerings based on customer interest, measured through prior year enrollments.

Proposed Modification: Insurers would be prohibited from continuing to offer a plan in a service area after two consecutive plan years with very low enrollment in that service area. Very low enrollment is defined as less than 50 unique enrollees over the two-year period.

Proposal	Policy Goal(s)	Benefits	Challenges
Prohibit plans from being offered after 2 consecutive years with very low enrollment.	Provide high quality, affordable, comprehensive health coverage to Pennsylvanians	Ensure plans provide added value to customers with differentiated features and sufficient, but not overwhelming, choice	Can be a difficult standard to quantify

Feedback:

- Do you think the very low enrollment threshold policy is an effective policy to mitigate choice overload for customers?
- Do you think 50 unique enrollees is a reasonable threshold for very low enrollment? Any concerns about this threshold even in the most rural service areas with the lowest enrollment volumes?
- Do you think the very low enrollment threshold should be measured within each individual service area or across all service areas?
- Are there any other metrics we could use to identify plans with insufficient customer interest and therefore do not warrant continuing to be offered in future plan years?
- Do you think there should be an exception process to allow a plan to continue to be offered even after failing to satisfy the threshold? If so, what factors should be considered?
- For insurers, please share how you currently assess plans with very low enrollment to determine whether or not you will continue to offer a plan in the upcoming year.
- Do you think Pennie should consider a limit on plan offerings similar to the 2024 NBPP proposal for HealthCare.gov?
- Do you think Pennie should consider a $1,000 deductible difference policy, similar to 2024 NBPP proposal?

New

#6: Standard Plans

HealthCare.gov implemented standard plan designs in all FFM states for 2023 plan year.

Many state-based marketplaces also have standard plan designs for PY23: WA, CA, OR, CO, ME, VT, NY, MA, CT, DC

Standardized plan designs can improve customer experience, simplify plan selection process, advance health equity, and combat discriminatory benefit designs that disproportionately impact disadvantaged populations

Proposal	Policy Goal(s)	Benefits	Challenges
Implement standard plan design for PY25	Provide high quality, affordable, comprehensive health coverage to Pennsylvanians Address inequities in access to health care for marginalized and underserved Pennsylvanians	Simplify plan selection process Plan designs incorporating a range of stakeholder input	Development of standard plan design Regional variations in current plan designs Ongoing process for updating standard plan design

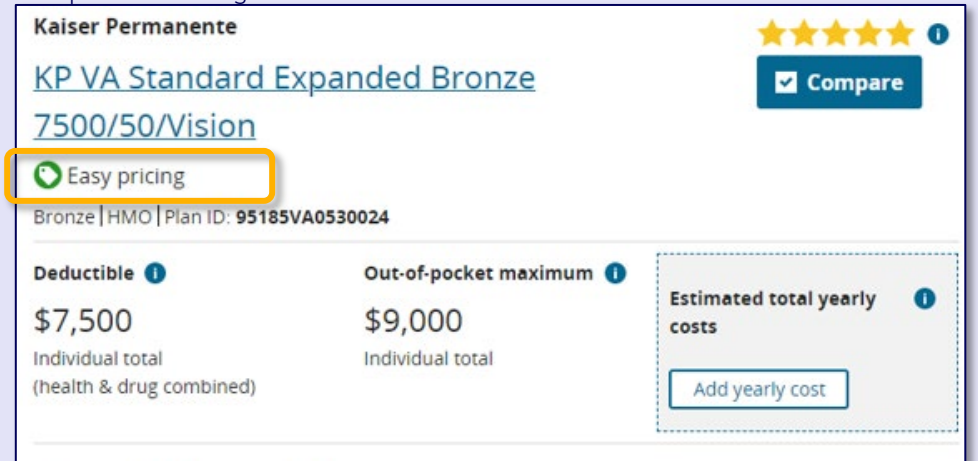
New

#6: Standard Plans

HealthCare.gov Standard Plans for PY23:

- Insurers must offer a standardized plan for each product type at each metal level in each service area they offer a non-standardized QHP
- No limit on number of non-standard plans an insurer can offer
- Customer plan shopping displays a special icon next to standard plans to allow customers to easily identify and compare standard plans (called “Easy Pricing”)

Sample HealthCare.gov Standard Plan



HealthCare.gov Customer Information on Standard Plans

Consider plans with easy pricing

Marketplace plans marked **easy pricing**:

- Include some benefits before you reach the deductible. As soon as coverage starts, you’ll pay only a copayment for:
  - Doctor and specialist visits, including mental health
  - Urgent care
  - Physical, speech, and occupational therapy
  - Generic and **most** preferred drugs
- Are easier to compare because they have the same out-of-pocket costs within their health plan category, like:
  - Deductibles
  - Out-of-pocket maximums
  - Copayments/coinsurance

View and compare only easy pricing plans:

1. Select **Add filters**.
2. Pick a health plan category, then select **with easy pricing**.
3. Select **Apply filters**.

New

#6: Standard Plans

HealthCare.gov Standard Plans for PY23:

- Standard plan design created based on the cost sharing for the most popular health plans (PY21)
  - Same deductible, OOP max, and copays/coinsurance per metal level
  - Benefits not subject to deductible, including office visits, urgent care, PT/ST/OT, generic drugs across all metal levels

	Expanded Bronze	Silver	Gold	Subject to deductible?
Deductible	$ 7,500	$ 5,800	$ 2,000	--
Primary Care Visit	$ 50	$ 40	$ 30	No
Specialist Visit	$ 100	$ 80	$ 60	No
Urgent Care	$ 75	$ 60	$ 45	No
PT/OT/ST	$ 50	$ 40	$ 30	No
Generic Drugs	$ 25	$ 20	$ 15	No
Lab / Xray / Imaging	50%	40%	25%	Yes
Emergency Room	50%	40%	25%	Yes
Inpatient / Outpatient	50%	40%	25%	Yes

Excerpt of benefits and cost sharing design of HealthCare.gov standard plans for PY23

**Full plan details available in Appendix

New

#6: Standard Plans

Feedback:

- **Standard Plans in PA:** Should PA implement standard plans? What value do you think standard plans would provide to Pennie customers? What challenges do you think would result from standard plans in PA?

If standard plans are implemented, please provide feedback on specific aspects of standard plans:

- **Metal Levels:** Should require standard plan designs be offered at all metal levels that an insurer offers plans? Or just certain metal levels (e.g. Silver only)?

- **Regional or Statewide Plan Designs:** Should standard plan design be the same across PA? Or should there be regional standard plan designs?

- **Limits on Plan Offerings:** What types of limits, if any, should there be on how many non-standard plans an insurer can offer to avoid too much choice? A maximum number of plans per insurer per plan type per metal level? No limits on non-standard plan offerings?

- **Strategic Cost Sharing Design:** Are there any types of benefits/services that we should target in the cost sharing design for the standard plan design?
  - Ex. DC standard plan design included little to no cost sharing for mental health/substance abuse services for children.
  - Ex. HealthCare.gov included specific services not subject to deductible across all plan designs.

- **Development of Standard Plan Design:** What process should we use to define the policies, benefits, and cost sharing for standard plan designs? (see options on next slide)

New

#6: Standard Plans

Development of Standard Plan Design: What process should we use to define the standard plan policy, benefits, and cost sharing designs?

Approach #1 – Stakeholder Workgroup (with broad stakeholder feedback):

- Workgroup of diverse stakeholders and PID & Pennie agency staff will develop recommendations for plan design, engage broader stakeholder community for feedback on decisions, to develop plan design recommendations.
- Time commitment from stakeholder workgroup participants would be significant.
- Broad stakeholder feedback opportunities will be incorporated for non-workgroup participants
- Ongoing annual process to update plan design for regulatory changes and compliance
- Implementation Timeline: Plan design finalized by end of 2023 for standard plans offered in 2025 PY

Approach #2 - Joint PID & Pennie Workgroup (with broad stakeholder feedback):

- Leverage agency staff and expertise to develop recommendations for plan design, engage stakeholders for feedback on plan design decisions, to develop plan design recommendations.
- Review best practices used by other SBMs in establishing their standard plan policies.
- Ongoing annual process to update plan design for regulatory changes and compliance
- Implementation Timeline: Plan design finalized by end of 2023 for standard plans offered in 2025 PY

Approach #3 - Adopt HealthCare.gov Plan Design:

- Would allow for potentially earlier implementation since the plan designs have already been established. But would not reflect PA-specific plan designs
- Implementation Timeline: Plan offerings as early as 2024 PY (if feasible)

New

#6: Standard Plans

Proposal	Policy Goal(s)	Benefits	Challenges
Implement standard plan design for PY25	Provide high quality, affordable, comprehensive health coverage to Pennsylvanians Address inequities in access to health care for marginalized and underserved Pennsylvanians	Simplify plan selection process Plan designs incorporating a range of stakeholder input	Development of standard plan design Regional variations in current plan designs Ongoing process for updating standard plan design

Proposed Policy: If there is sufficient interest in implementing standard plans in PA, establish an implementation workgroup that will incorporate broad stakeholder feedback to develop a recommended standard plan policy, for an earliest availability of standard plans in PY25.

Other Provisions Already Adopted

NCQA Health Equity Accreditation

In August 2022, Pennie's Board authorized Pennie to promulgate regulations requiring insurers selling qualified health and dental plans on the exchange to obtain NCQA Health Equity Accreditation, with a target effective date of Plan Year 2025.

Aligns with Pennie's strategic goal of "…reducing inequities experienced by vulnerable populations."

Regulatory process would allow options to provide flexibility (e.g. define process, permit accreditation or proof of progress towards accreditation).

For more information, see August 2022 Board Meeting Materials.

Proposal	Policy Goal(s)	Benefits	Challenges
• Require insurers have NCQA Health Equity Accreditation for PY25 Plan Certification	• Health equity - Reduce health disparities in underserved populations in PA	• Reducing health disparities reduces overall health care costs • Leverage expertise of national organization defined standards	• Extensive process to achieve accreditation • May require regulations

Next Steps

Next Steps

- Pennie to seek stakeholder feedback
- Stakeholder feedback due **by 2/15/2023**
- Staff recommendations and stakeholder feedback presented to Board on **2/24/2023**
- Pennie to finalize memo and distribute to insurers **by end of March**

Appendix

HealthCare.gov Standard Plan Design PY23

TABLE 12: 2023 Final Standardized Plan Options Set One (For All FFE and SBE-FP Issuers, Excluding Issuers in Delaware, Louisiana, and Oregon)

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	59.86%	64.18%	70.06%	73.11%	87.05%	94.02%	78.00%	88.00%
Deductible	$9,100	$7,500	$5,800	$5,700	$800	$0	$2,000	$0
Annual Limitation on Cost Sharing	$9,100	$9,000	$8,900	$7,200	$3,000	$1,700	$8,700	$3,000
Emergency Room Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services (Including Mental Health and Substance Use Disorder)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Urgent Care	No charge after deductible	$75*	$60*	$45*	$30*	$5*	$45*	$15*
Specialist Visit	No charge after deductible	$100*	$80*	$60*	$40*	$10*	$60*	$20*
Mental Health and Substance Use Disorder Outpatient Office Visit	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	No charge after deductible	$50*	$40*	$30*	$20*	$0*	$30*	$10*
Laboratory Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*

(continued on next slide)

HealthCare.gov Standard Plan Design PY23

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TABLE 12: 2023 Final Standardized Plan Options Set One (For All FFE and SBE-FP Issuers, Excluding Issuers in Delaware, Louisiana, and Oregon)

	Bronze	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Laboratory Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
X-rays and Diagnostic Imaging	No charge after deductible	50%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician and Services	No charge after deductible	50%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	No charge after deductible	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	No charge after deductible	$50	$40*	$40*	$20*	$15*	$30*	$10*
Non-Preferred Brand Drugs	No charge after deductible	$100	$80	$80	$60	$50*	$60*	$50*
Specialty Drugs	No charge after deductible	$500	$350	$350	$250	$150*	$250*	$150*

*Benefit category not subject to the deductible

Note: 2024 NBPP proposed rule would eliminate the non-expanded bronze standard plan, along with other minor modifications to PY23 standard plan designs.

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