Part III:

Plan Design

Coverage Year 2019

Center on Budget and Policy Priorities

September 20, 2018
Elements of Plan Design
Premiums vs Cost-Sharing Charges

**Premiums**
The monthly cost a person pays for a health plan

**Cost-Sharing Charges**
The charges a person pays as he or she uses benefits covered by a health plan
Basic Elements of Marketplace Plans

• Covered Benefits
  → Essential Health Benefits, including preventive services
  → Additional benefits possible

• Provider Network
  → Insurers contract with physicians, hospitals, and other professionals to provide services to plan enrollees
  → May be broad (with a greater number of providers) or narrow
  → Plan may or may not provide coverage outside its network
## Essential Health Benefits (EHBs)

### 10 “Essential Health Benefits” All Qualified Health Plans Must Provide

<table>
<thead>
<tr>
<th>Ambulatory Patient Services</th>
<th>Preventive and Wellness Services and Chronic Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Maternity and Newborn Care</td>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment</td>
<td>Rehabilitative and Habilitative Services and Devices</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Pediatric Services, including Oral and Vision Care</td>
</tr>
</tbody>
</table>
### Types of Cost-Sharing Charges

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Copayments</th>
<th>Coincurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Enrollee must pay the deductible before the plan begins to pay for most benefits</td>
<td>• Dollar amount for an item or service that enrollees must pay</td>
<td>• Percentage of the cost of an item or service that enrollees must pay</td>
</tr>
<tr>
<td>• Set on a yearly basis</td>
<td>• Many copayments are applicable before the deductible is met</td>
<td></td>
</tr>
</tbody>
</table>

**Deductible**

- Enrollee must pay the deductible before the plan begins to pay for most benefits
- Set on a yearly basis

**Copayments**

- Dollar amount for an item or service that enrollees must pay
- Many copayments are applicable before the deductible is met

**Coincurrence**

- Percentage of the cost of an item or service that enrollees must pay
Maximum Out-of-Pocket Limit (OOP)

- Puts a cap on the amount an enrollee can pay in cost-sharing charges each year
  - Set on a yearly basis
  - Applies to in-network services, not out-of-network care
- OOP limit is not the amount that an enrollee must spend each year

### Maximum OOP Limit for 2019 Coverage

<table>
<thead>
<tr>
<th></th>
<th>Individual OOP Limit</th>
<th>Family OOP Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOTE:</strong> applies to each individual in a family plan as well</td>
<td>$7,900</td>
<td>$15,800</td>
</tr>
</tbody>
</table>

### Lower Maximum OOP Limits for Cost-Sharing Reduction Plans (2019 Coverage)

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Up to 150% FPL</th>
<th>151–200% FPL</th>
<th>201–250% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual OOP Limit</td>
<td>$2,600</td>
<td>$2,600</td>
<td>$6,300</td>
</tr>
<tr>
<td>Family OOP Limit</td>
<td>$5,200</td>
<td>$5,200</td>
<td>$12,600</td>
</tr>
</tbody>
</table>
More to Know about Cost-Sharing Charges

• Some services may be exempt from the deductible (sometimes referred to as “first dollar coverage”)
  → *Examples*: Coverage of 2 physician visits for a copayment, or coverage of generic drugs with a copayment – even when enrollee has not reached the deductible

• Some benefits may have a separate deductible
  → *Example*: Prescription drugs
### Cost Sharing and the Metal Tiers

QHPs must provide plan designs consistent with actuarial values.

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Actuarial Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platinum</td>
<td>90%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
</tr>
<tr>
<td>Bronze</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Catastrophic coverage**
- High deductible health plan available for individuals up to age 30 or those 30 and older who are granted a hardship exemption (PTC do not apply to these plans).

**Actuarial value** is a measure of the percentage of expected health care costs a health plan will cover and is considered a general summary measure of health plan generosity. It represents an average for a population and does not necessarily reflect the actual cost-sharing experience of an individual.
What is Actuarial Value?

A way to estimate and compare the overall generosity of plans

Calculating Actuarial Value:

- Assume entire typical population enrolls
- Estimate the percentage of costs the plan pays for their covered services
- Plan pays 70% of the costs of covered benefits → Silver plan

NOTE: AV does not represent what the plan would pay for a particular individual enrolled in the plan

→ Enrollee OOP costs depend on the medical care a person uses
→ AV does not determine what benefits or prescription drugs are covered nor does it impact the provider network
<table>
<thead>
<tr>
<th></th>
<th>Plan A (Cigna Health Bronze)</th>
<th>Plan B (Kaiser Permanente Bronze)</th>
<th>Plan C (Cigna Health Silver)</th>
<th>Plan D (CareFirst BlueChoice Silver)</th>
<th>Plan E (Kaiser Permanente Gold)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metal tier</td>
<td>Bronze</td>
<td>Bronze</td>
<td>Silver</td>
<td>Silver</td>
<td>Gold</td>
</tr>
<tr>
<td>Actuarial value</td>
<td>60% AV</td>
<td>60% AV</td>
<td>70% AV</td>
<td>70% AV</td>
<td>80% AV</td>
</tr>
<tr>
<td>Deductible</td>
<td>$6,400</td>
<td>$5,500</td>
<td>$6,500</td>
<td>$3,500</td>
<td>$0</td>
</tr>
<tr>
<td>OOP limit</td>
<td>$7,350</td>
<td>$7,350</td>
<td>$7,350</td>
<td>$7,350</td>
<td>$6,850</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>50% (after deductible)</td>
<td>35% (after deductible)</td>
<td>30% (after deductible)</td>
<td>$500 per day (after deductible)</td>
<td>30% (after deductible)</td>
</tr>
<tr>
<td>Primary care visit</td>
<td>50% (after deductible)</td>
<td>$50 (2 visits) + $50 (after deductible)</td>
<td>$15</td>
<td>$30</td>
<td>$20</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>50% (after deductible)</td>
<td>$70 (after deductible)</td>
<td>30% (after deductible)</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Generic drug</td>
<td>50% (after deductible)</td>
<td>$25</td>
<td>$4</td>
<td>$10</td>
<td>$10</td>
</tr>
</tbody>
</table>

*Source: Healthcare.gov 2018 plans, Fairfax County, VA 22003*
Example: How Cost Sharing Works

<table>
<thead>
<tr>
<th>Health Plan Y:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$5,500</td>
<td><strong>Primary care visit</strong></td>
<td>$35</td>
</tr>
<tr>
<td><strong>OOP limit</strong></td>
<td>$7,350</td>
<td><strong>Specialist visit</strong></td>
<td>25%</td>
</tr>
<tr>
<td><strong>Inpatient hospital</strong></td>
<td>25%</td>
<td><strong>Generic drug</strong></td>
<td>$25</td>
</tr>
</tbody>
</table>

- Carla pays 100% deductible
- Reach $5,500 deductible
- Carla pays 25% coinsurance + copays
- Reach $7,350 OOP limit
- Plan pays 100%

**Health Costs: $10,000**

- Carla OOP cost: $5,500
- + $75 in copays
- Carla OOP cost: $1,125
  (25% of $4,500)

**Health Costs: $3,000**

- Carla OOP cost: $525
  (25% of $2,100)
- + $125 in copays
- Carla OOP cost: $0
# Individual and Family Cost-Sharing Charges Differ

<table>
<thead>
<tr>
<th></th>
<th>Plan X (individual)</th>
<th>Plan X (family)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>OOP limit</strong></td>
<td>$7,350</td>
<td>$14,700</td>
</tr>
<tr>
<td><strong>Inpatient hospital</strong></td>
<td>35% after deductible</td>
<td>35% after deductible</td>
</tr>
<tr>
<td><strong>Primary care visit</strong></td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Specialist visit</strong></td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Generic drug cost</strong></td>
<td>$15</td>
<td>$15</td>
</tr>
</tbody>
</table>
Embedded Family Cost Sharing:

- **Embedded deductible**: In addition to a family deductible, smaller individual deductibles apply to each family member.
- **Embedded OOP limit**: In addition to a family out-of-pocket limit, smaller individual out-of-pocket limits apply to each individual.

Aggregate Family Cost Sharing:

- **Aggregate deductible**: All family members’ expenses are pooled toward a combined deductible.
- **Aggregate OOP limit**: All family members’ expenses are pooled toward a combined out-of-pocket limit.

However, each family member is also protected by the individual maximum OOP limit of ($7,900 per year in 2019, less for people receiving cost-sharing reductions).
### Example: In-Network vs. Out-of-Network Cost Sharing

<table>
<thead>
<tr>
<th>Tier</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Primary Care Visit</th>
<th>Specialist Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan A</strong></td>
<td>Carrier A, Silver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier I</td>
<td>$2,000</td>
<td>$5,000</td>
<td>30%</td>
<td>$20</td>
</tr>
<tr>
<td>Tier II</td>
<td>$4,000</td>
<td>$7,900</td>
<td>50%</td>
<td>$40</td>
</tr>
<tr>
<td>Tier III</td>
<td>$8,000</td>
<td>$15,800</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Plan B</strong></td>
<td>Carrier B, Silver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier I</td>
<td>$4,000</td>
<td>$7,900</td>
<td>30%</td>
<td>$60</td>
</tr>
<tr>
<td>Tier II</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Plan C</strong></td>
<td>Carrier C, Silver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier I</td>
<td>$2,000</td>
<td>$5,000</td>
<td>30%</td>
<td>$20</td>
</tr>
<tr>
<td>Tier II</td>
<td>$4,000</td>
<td>$7,900</td>
<td>50%</td>
<td>$40</td>
</tr>
<tr>
<td>Tier III</td>
<td>$8,000</td>
<td>$15,800</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Table:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Annual Deductible</th>
<th>Annual OOP Limit</th>
<th>Hospital Admission</th>
<th>Primary Care Visit</th>
<th>Specialist Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$5,000</td>
<td>$7,900</td>
<td>$1,500 (per admission)</td>
<td>$25</td>
<td>30%</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$10,000</td>
<td>None</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
### Example: In-Network vs. Out-of-Network Cost Sharing

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Annual Deductible</th>
<th>Annual OOP Limit</th>
<th>Hospital Admission</th>
<th>Primary Care Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td>Silver</td>
<td>$5,000</td>
<td>$7,900</td>
<td>$1,500 (per admission)</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Out-of-Network</strong></td>
<td></td>
<td>$10,000</td>
<td>None</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Network Physician
- Doctor's bill: $200
- Plan allowed amount: $100
- Plan pays: $75
- Patient pays: $25 (copay)

*Counts towards in-network OOP limit*

#### Out-of-Network Physician
- Doctor's bill: $200
- Plan allowed amount: $100
- Plan pays: $50
- Patient pays: $150 (50% + $100)

*Does not count towards in-network OOP limit*
Cost-Sharing Reductions
What are Cost-Sharing Reductions?

- A federal benefit that reduces the out-of-pocket charges an enrollee pays for medical care covered by the plan
- People with income up to 250% FPL are eligible
- Must enroll in a silver plan through the Marketplace

### 3 Levels of Cost-Sharing Reduction Plans Based on Income:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Standard Silver No CSR</th>
<th>CSR Plan Level 1</th>
<th>CSR Plan Level 2</th>
<th>CSR Plan Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 250% FPL</td>
<td>70% AV</td>
<td>73% AV</td>
<td>87% AV</td>
<td>94% AV</td>
</tr>
<tr>
<td>201–250% FPL</td>
<td>$7,900</td>
<td>$6,300</td>
<td>$2,600</td>
<td>$2,600</td>
</tr>
<tr>
<td>151–200% FPL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 150% FPL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual in 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family in 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Cost-Sharing Reductions: Example Plan A

<table>
<thead>
<tr>
<th>CSR Level</th>
<th>No CSR</th>
<th>201–250% FPL</th>
<th>151–200% FPL</th>
<th>&lt;150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial value</td>
<td>70% AV</td>
<td>73% AV</td>
<td>87% AV</td>
<td>94% AV</td>
</tr>
<tr>
<td>Deductible</td>
<td>$4,650</td>
<td>$3,500</td>
<td>$1,000</td>
<td>$300</td>
</tr>
<tr>
<td>OOP limit</td>
<td>$7,350</td>
<td>$5,850</td>
<td>$2,450</td>
<td>$2,450</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>20% (after deductible)</td>
<td>20% (after deductible)</td>
<td>No charge (after deductible)</td>
<td>No charge (after deductible)</td>
</tr>
<tr>
<td>Primary care visit</td>
<td>$30</td>
<td>$30</td>
<td>$20</td>
<td>$10</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$60</td>
<td>$60</td>
<td>$40</td>
<td>$20</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$20</td>
<td>$20</td>
<td>$15</td>
<td>$1</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: Healthcare.gov 2018 silver plan variations, Lancaster County, PA 17573
<table>
<thead>
<tr>
<th>CSR Level</th>
<th>No CSR</th>
<th>201–250% FPL</th>
<th>151–200% FPL</th>
<th>&lt;150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial value</td>
<td>70% AV</td>
<td>73% AV</td>
<td>87% AV</td>
<td>94% AV</td>
</tr>
<tr>
<td>Deductible</td>
<td>$7,150</td>
<td>$4,500</td>
<td>$800</td>
<td>$250</td>
</tr>
<tr>
<td>OOP limit</td>
<td>$7,350</td>
<td>$5,700</td>
<td>$1,700</td>
<td>$550</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>30% (after deductible)</td>
<td>30% (after deductible)</td>
<td>10% (after deductible)</td>
<td>10% (after deductible)</td>
</tr>
<tr>
<td>Primary care visit</td>
<td>$70</td>
<td>$30</td>
<td>$10</td>
<td>$5</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$90</td>
<td>$50</td>
<td>$40</td>
<td>$20</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Source: Healthcare.gov 2018 silver plan variations, Lancaster County, PA 17573
## Comparing Two Insurers’ CSR Variations

<table>
<thead>
<tr>
<th></th>
<th>Deductible</th>
<th>OOP limit</th>
<th>Inpatient hospital</th>
<th>Primary care visit</th>
<th>Specialist visit</th>
<th>Generic drugs</th>
<th>Specialty drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan A</strong></td>
<td>$300</td>
<td>$2,450</td>
<td>No charge</td>
<td>$10</td>
<td>$20</td>
<td>$1</td>
<td>20%</td>
</tr>
<tr>
<td>Geisinger Health</td>
<td></td>
<td></td>
<td>(after ded.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AV: 94%</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Plan B</strong></td>
<td>$250</td>
<td>$550</td>
<td>10% (after ded.)</td>
<td>$5</td>
<td>$20</td>
<td>15%</td>
<td>50%</td>
</tr>
<tr>
<td>Highmark Silver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AV: 94%</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Healthcare.gov 2018 silver plan variations, Lancaster County, PA 17573
Termination of CSR Payments

• Last year, the federal government terminated reimbursements to insurance companies for cost-sharing reduction (CSR) plans

  ! People who are eligible for CSRs are still eligible for assistance and can enroll in a plan with reduced cost-sharing charges

  ! Plan designs for CSR plans are not affected by this change

• To cover the costs resulting from the termination of CSR payments, insurers increased premiums, most often (depending on the state) by loading the costs onto the premiums for silver Marketplace plans ("silver loading")

  → Because PTC calculations are tied to silver plans, PTC amounts rose with premium increases

  → Silver loading led to much higher unsubsidized Marketplace premiums for silver plans relative to premiums for bronze or gold plans

  → In many areas, the unsubsidized premium of the lowest-cost gold plan in 2018 has a comparable cost to lowest-cost silver plan, and bronze plans can be near zero cost after PTC
Cost Sharing for American Indians and Alaska Natives

• Special assistance available to members of federally-recognized Native American tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders (AI/AN)
• They can enroll in or change Marketplace plans each month

• For AI/AN people between 100% and 300% FPL who qualify for PTC, zero cost-sharing plans are available
  → Enrollees pay no deductibles, co-payments, or other cost-sharing when using in-network medical care
  → Some out-of-network care is also available with zero cost-sharing

• For AI/AN people with incomes below 100% FPL or above 300% FPL, there is a “limited” cost-sharing plan available
  → Enrollee pays no cost-sharing charges to receive services from an Indian Health Services (IHS) provider or from another provider if referred from an IHS provider
Skimpy Plans
What are skimpy plans?

• Skimpy plans may be exempt from some or all insurance market standards and consumer protections. Some can:
  → Charge higher premiums based on age, gender, and health status
  → Deny coverage based on pre-existing conditions
  → Deny claims for pre-existing conditions
  → Leave out coverage of essential health benefits

• Availability of several different types of skimpy plans is likely to increase:
  → Short-term, limited-duration plans
  → Association health plans (AHPs)
    o Expanded to cover more small businesses and self-employed people, form more easily, and avoid standards and protections that would otherwise apply to health plans that cover individuals and small groups
  → Health care sharing ministries
  → Other types: indemnity plans, combination or “bundled” products
## Skimpy Plans vs. ACA-Compliant Plans

<table>
<thead>
<tr>
<th>Reform</th>
<th>Description</th>
<th>ACA Plans</th>
<th>Short-Term Plans</th>
<th>AHPs</th>
<th>Sharing ministries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESSIBILITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guaranteed issue</td>
<td>Requires insurers to accept every individual who applies for coverage.</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Dependent coverage to age 26</td>
<td>Requires plans that already provide dependent coverage to make it available until the dependent turns 26.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Rescissions</td>
<td>Prohibits plans from retroactively canceling coverage (except in the case of a subscriber’s fraud or intentional misrepresentation of material fact).</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td><strong>AFFORDABILITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating requirements</td>
<td>Prohibits plans from charging a higher premium based on health status and gender.</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Medical loss ratio (MLR)</td>
<td>Individual health insurers must spend at least 80 percent of premiums on health care and quality improvement.</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td><strong>TRANSPARENCY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary of benefits and coverage</td>
<td>Requires insurers to provide standardized, easy-to-understand summaries of the benefits, cost-sharing, limitations, and exclusions of a plan.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td><strong>RISK MITIGATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single risk pool</td>
<td>Each insurer must consider the claims experience of all of their enrollees in all of their individual market plans when setting premium rates.</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Risk-adjustment program</td>
<td>Transfers funds from insurers with relatively low-risk enrollees to insurers with relatively high-risk enrollees.</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

*AHPs formed under the new federal rules will be allowed to charge higher rates based on factors such as age, gender, occupation, and group size, but will not be able to charge more for health status.

**Self-funded AHPs are exempt from the ACA’s MLR requirements, but large-group market standards (85% MLR) apply to large-group policies sold to fully insured AHPs.

Source: The Commonwealth Fund, *State Regulation of Coverage Options Outside of the ACA*
## Skimpy Plans vs. ACA-Compliant Plans

<table>
<thead>
<tr>
<th>Reform</th>
<th>Description</th>
<th>ACA Plans</th>
<th>Short-Term Plans</th>
<th>AHPs</th>
<th>Sharing ministries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preexisting condition exclusions</td>
<td>Prohibits insurers from imposing preexisting condition exclusions with respect to coverage.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Essential health benefits</td>
<td>Requires coverage of 10 categories of essential benefits defined in the ACA</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Actuarial value</td>
<td>Requires plans to meet a minimum actuarial value standard of at least 60 percent of total plan costs; requires plans to meet one of four actuarial value tiers — bronze (60%), silver (70%), gold (80%), or platinum (90%) — as a measure of how much of a consumer’s medical costs are covered by the plan.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Annual cost-sharing limits</td>
<td>Requires insurers to limit each enrollee’s annual out-of-pocket costs, including copayments, coinsurance, and deductibles.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Annual dollar limits</td>
<td>Prohibits annual limits on the dollar value of covered essential health benefits.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Lifetime dollar limits</td>
<td>Prohibits lifetime limits on the dollar value of covered essential health benefits.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Preventive services without cost-sharing</td>
<td>Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider.</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
</tbody>
</table>

**Source:** The Commonwealth Fund, *State Regulation of Coverage Options Outside of the ACA*
Short-Term Plans

• New federal rules allow short-term plans exempt from pre-existing condition protections and benefit standards to last for up to one year and to be renewed
  → Used to be less than 3 months
  → Allows a parallel market for skimpy plans operating alongside market for comprehensive coverage
  → Effective October 2, 2018
  → States retain authority to limit and set standards for short-term plans

• Healthy people who enroll in these plans may find themselves facing gaps in coverage and exposed to catastrophic costs if they get sick and need care
  → May look like a comprehensive health plan (with a premium, deductible, and a provider network) but leave out key protections and coverage
  → Doesn’t count as minimum essential coverage, so when the plan ends, it does not trigger a special enrollment period for the enrollee

For more info, see Key Flaws of Short-Term Health Plans Pose Risks to Consumers
Short-Term Plans: Exempt from Most Standards

• Typically exclude coverage for pre-existing conditions
  → People with pre-existing conditions may be denied a policy outright
  → Insurers broadly exclude coverage of pre-existing conditions and then deny claims related to such conditions
  → Insurers may conduct "post-claims underwriting," in which an insurer investigates the health history of an enrollee with costly claims, in order to find a link to a "pre-existing" health condition
  → Plans may consider a condition "pre-existing" even if it was not previously diagnosed or treated and even if the enrollee was not aware of the condition (varies by state)

• Not required to cover essential health benefits, and often don’t cover:
  → Prescription drugs
  → Maternity care
  → Mental health benefits
  → Substance-use disorder treatment

• Can impose overall limits on plan benefits, lifetime limits, and per-service limits

• Not subject to cost-sharing limits
Plans Appear Similar to ACA Plans

Short term health insurance is major medical insurance that is purchased for a defined period of time and generally has a much lower monthly premium than other forms of major medical health insurance. Plans have varied levels of benefits and pricing based on need.

142 plans found. Showing 142 plans.
Plans Appear Similar to ACA Plans

Short-term health insurance is available year-round. You do not need an open enrollment or qualifying event to apply. Short-term plans offer affordable, limited medical coverage for a defined period of time (up to 3 to 12 months). See details below.

Featured Plan
- **THE IHC GROUP**
  - Secure STM 1000
  - Deductible: $1,000
  - Coinsurance: 50%
  - Policy Max: $2 Million
  - Monthly Cost: $373.15
  - Add to Cart
  - Details

Featured Plan
- **LIFESHIELD**
  - Smart Term Health Lite 10000
  - Deductible: $10,000
  - Coinsurance: 20%
  - Policy Max: $750,000
  - Monthly Cost: $55.86
  - Add to Cart
  - Details

Featured Plan
- **National General**
  - Deductible: $5,000
  - Coinsurance: 0%
  - Policy Max: $1 Million
  - Monthly Cost: $189.45
  - Add to Cart
Coverage Limitations are Common in Short-Term Plans

- Plans generally include:
  - Deductibles
  - Out-of-pocket maximums
  - Coinsurance and copays

- But...
  - Benefits may provide a specified amount of coverage per day or per visit
  - Plan may cap total amount plan it will pay (i.e., the coverage period maximum)
  - Deductible and out-of-pocket maximum generally apply to a shorter period of time
1. Pre-Existing Conditions:
   a. Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice within the 60-month period immediately preceding such person’s Certificate Effective Date are excluded for the first 12 months of coverage hereunder.
   b. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonable prudent person to seek diagnosis, care or treatment within the 60-month period immediately prior to the Covered Person’s Certificate Effective Date of coverage under the Policy.

Pre-existing condition exclusion

Charges resulting directly from a pre-existing condition are excluded from coverage. Pre-existing conditions are referred to as conditions for which medical advice, diagnosis, care, or treatment (including services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 12 months immediately preceding the effective date, unless a lesser period is required by state regulation.

This exclusion does not apply to a newborn or newly adopted child who is added in accordance with the coverage eligibility and effective data sections within the certificate of coverage.

This exclusion also does not apply to routine follow-up care for breast cancer to determine whether a breast cancer has recurred in a covered person who has been previously diagnosed with breast cancer, unless evidence of breast cancer is found during or as a result of follow-up care.
Some Essential Health Benefits are Not Covered

No coverage for prescription drugs or maternity care

7. Outpatient Prescription Drugs, unless specifically covered under the Policy as an Eligible Expense.

8. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a doctor.

17. Routine pre-natal care, Pregnancy, child birth, and postnatal care. (This exclusion does not apply to “Complications of Pregnancy” as defined.)

- Outpatient prescription or legend drugs and medications

- Pregnancy or childbirth, except for complications of pregnancy; newborn treatment prior to discharge from the hospital, unless the charges are medically necessary to treat premature birth, congenital injury or sickness, or sickness or injury sustained during or after the birth; any infertility or sterilization treatments

- Outpatient prescription drugs, medications, vitamins, mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a doctor except as provided in the Benefits section for diabetes.

- Normal pregnancy or childbirth; routine well baby care including hospital nursery charges at birth; or abortion, except for complications of pregnancy, as defined herein.

For Pivot Health Economy plan, outpatient prescription drugs, medications, vitamins, and supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a doctor.

Routine pre-natal care, pregnancy, childbirth, and postnatal care. (This exclusion does not apply to “Complications of Pregnancy”).
Some Essential Health Benefits are Not Covered

May exclude coverage of mental health or treatment of substance use disorders

- Treatment of mental health conditions, substance use disorders; and outpatient treatment of mental and nervous disorders, except as specifically covered.

Or limit benefits

**Mental Illness**

Outpatient: $50 per visit; 10 visit max; inpatient: $100 per day, 31 day max

**Mental Disorders**

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>$100 per day, maximum 31 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>$50 per day, maximum 10 visits</td>
</tr>
</tbody>
</table>

**Substance Abuse**

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>$100 per day, maximum 31 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>$50 per day, maximum 10 visits</td>
</tr>
</tbody>
</table>
Short-Term Plans: Important to Read the Fine Print

LifeShield Flex
- $62.19/mo. + $19.99 monthly fee
- Coverage period: 3 months

LifeShield Advantage
- $133.63/mo. + $19.99 monthly fee
- Coverage period: 3 months

Medical Expenses Not Covered (cont.)
- Joint or Tendon Surgery
- Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV)
- Gallbladder Surgery
- Mental, emotional or nervous disorders or counselling of any type, except as specifically covered as an Eligible Expense.
- Treatment for Substance Abuse, unless specifically covered under the Policy as an Eligible Expense.
- Outpatient Prescription Drugs, unless specifically covered under the Policy as an Eligible Expense.
- Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
- Any drug, treatment or procedure that either promotes or prevents conception including but not limited to artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
- Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.
- Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
- Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery where expressly covered under the Policy.
- Weight modification or surgical treatment of obesity.
- Eye surgery, such as LASIK, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
- Dental treatment and dental surgery except as necessary to restore or replace sound and natural teeth lost or damaged as a result of a covered injury.
- Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMD). TMD pain syndromes, cranio-mandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, unless specifically covered under the Policy as an Eligible Expense.
- Routine pre-natal care, Pregnancy, child birth, and post-natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined).
- Hypnotherapy when used to treat conditions that are not recognized as Mental Disorders by the American Psychiatric Association, and biotechnology and non-medical self-care or self-help programs.

Medical Expenses Not Covered (cont.)
- Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered under the Policy as an Eligible Expense.
- Amounts in excess of the usual and customary charges made for covered services or supplies.
- Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
- Expenses to the extent that they are paid or payable under other valid or collectible group insurance or medica prepayment plan.
- Charges that are eligible for payment by Medicare or any other government program except Medicaid. Costs for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.
- Expenses for which benefits are paid or payable under workers’ compensation or similar laws.
- Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

Health Reform: Beyond the Basics
Examples: Limitations and Exclusions

No coverage for injuries resulting from "hazardous activities" or organized sports...

48. Participating in hazardous occupations or other activity including participating, instructing, demonstrating, guiding or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by an airline, professional or semi-professional sports, extreme sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding, parasailing, parakiting, rock or mountain climbing, cave exploration, parkour, racing including stunt show or speed test of any motorized or non-motorized vehicle, rodeo activities, or similar hazardous activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity.

49. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports. This does not include dependent children participating in local community sports activities.

- Participation in school or organized competitive sports or any high-risk sport, including riding an all-terrain vehicle, snowmobile or go-cart

• Treatment or services required due to injury sustained while participating in any inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.

• Treatment or services required due to injury received while engaging in any hazardous occupation or other activity, including the following: participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, professional or semi-professional contact sports of any kind. Also excluded are treatment and services required due to injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.

• Treatment or services required due to injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.
Examples: Limitations and Exclusions

...or any coverage for injuries sustained while someone is intoxicated or that are self-inflicted

50. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.

51. Willfully self-inflicted Injury or Sickness.

48. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.

49. Willfully self-inflicted Injury or Sickness.

- Resulting from intoxication, as defined by state law where the illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a doctor.
Examples: Limitations and Exclusions

Waiting periods and per-illness deductibles

Waiting Periods

Waiting Period: Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, at least 5 days following the Covered Person’s Effective Date of coverage under the policy. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment at least 30 days following the Covered Person's Effective Date of coverage under the policy.

2. Waiting Period:
   a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, more than 5 days following the Covered Person’s Certificate Effective Date of coverage under the policy.
   b. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment more than 30 days following the Covered Person’s Certificate Effective Date of coverage under the policy.

Per injury or illness deductible

If you selected a per injury or illness deductible, the deductible must be satisfied for each separate covered injury or illness before covered benefits under the policy are paid. The deductible applies per covered person for each period of treatment. However, if multiple covered persons in a family are injured in the same accident, only one deductible must be satisfied for each period of treatment.

Period of treatment

A period of treatment begins for a covered injury or illness (1) when a covered person is initially admitted to the hospital, (2) when services are provided in an outpatient surgical facility or (3) when chemotherapy or radiation therapy is received on an outpatient basis. The period of treatment ends 180 consecutive days following that date for the same or related injury or illness. If treatment extends past 180 days for the same injury or illness, a new period of treatment will begin and a new per injury or illness deductible will be required. A separate period of treatment will apply to each covered injury or illness.

Exclusions Within First 6 Months

- Total or partial hysterectomy, unless it is medically necessary due to a diagnosis of carcinoma;
- Tonsillectomy;
- Adenoidectomy;
- Myringotomy;
- Tympanotomy;
- Repair of deviated nasal septum or any type of surgery involving the sinus;
- Herniorraphy;
- Cholecystectomy.

3. Expenses during the first 6 months after the Certificate Effective Date of coverage for a Covered Person for the following:
   a. Total or partial hysterectomy, unless it is Medically Necessary due to diagnosis of carcinoma;
   b. Tonsillectomy;
   c. Adenoidectomy;
   d. Repair of deviated nasal septum or any type of surgery involving the sinus;
   e. Myringotomy;
   f. Tympanotomy;
   g. Herniorraphy;
   h. Cholecystectomy.

Per Injury Deductible and Period of Treatment
States have the authority to set their own standards for short-term plans and other types of skimpy plans.

Maryland, Vermont and Hawai’i all enacted protections against short-term plans since the new rules were announced.

California and Washington state are moving to ban or limit the plans in their states.

For more info, see [With Federal Rules Weakened, States Should Act to Protect Against Short-Term Health Plans](#)
What Can You Do?

- Promote open enrollment for plans that meet ACA standards and are eligible for federal subsidies

- Understand and inform people about the risks of short-term plans and other skimpy coverage
  → Help people see past low premiums

- Promote special enrollment periods for people who face short or long coverage gaps

- Track and report what is happening on the ground
  → Look for misleading or fraudulent marketing tactics
  → Monitor accuracy of information provided to consumers
  → Track the experiences of consumers who enroll in these plans
  → Inform insurance regulators about potential fraud and misinformation
  → Inform individuals about their right to complain about wrongdoing and misinformation
Resources

• Key Facts:
  → Cost-Sharing Charges
  → Cost-Sharing Reductions

• Papers and Blogs:
  → Key Flaws of Short-Term Health Plans Pose Risks to Consumers
  → With Federal Rules Weakened, States Should Act to Protect Against Short-Term Health Plans
  → Expanding Skimpy Health Plans Is the Wrong Solution for Uninsured Farmers and Farm Workers

• Kaiser Family Foundation:
  → Understanding Short-Term Limited Duration Health Insurance

• The Commonwealth Fund:
  → Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market
  → State Regulation of Coverage Options Outside of the ACA
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For more information and resources, please visit:
www.healthreformbeyondthebasics.org

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