Health Reform: **Beyond the Basics**

healthreformbeyondthebasics.org

Part V:

Plan Design

Coverage Year 2021

October 1, 2020

Presented by the Center on Budget and Policy Priorities

Sarah Lueck, Senior Policy Analyst

Center on Budget and Policy Priorities

Upcoming Webinars

Part VI: Plan Selection Strategies

- Tuesday, October 6| 2 pm ET (11 am PT)

Part VII: Part VII: Auto-Renewal Process

- Thursday, October 8| 2 pm ET (11 am PT)

Part VIII: Special Topics on Assisting Immigrant Communities

- Thursday, October 15| 2 pm ET (11 am PT)

Part IX: Assisting People with Disabilities

- Thursday, October 22| 2 pm ET (11 am PT)

Register for upcoming webinars at
www.healthreformbeyondthebasics.org/events

Webinar Logistics

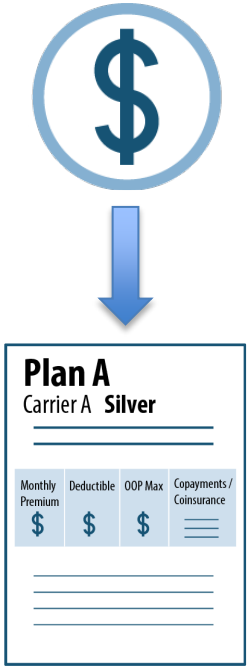
- All attendees are muted and in listen-only mode
- To ask a question:
  - Click on the Q&A icon in the control panel at the bottom of your webinar screen
  - Type your question into the box
- We will monitor questions and pause to answer a few during the presentation
- You can also email questions to beyondthebasics@cbpp.org
- All webinars are recorded and will be available for viewing at www.healthreformbeyondthebasics.org

Elements of Plan Design

Premiums vs Cost-Sharing Charges

Premiums

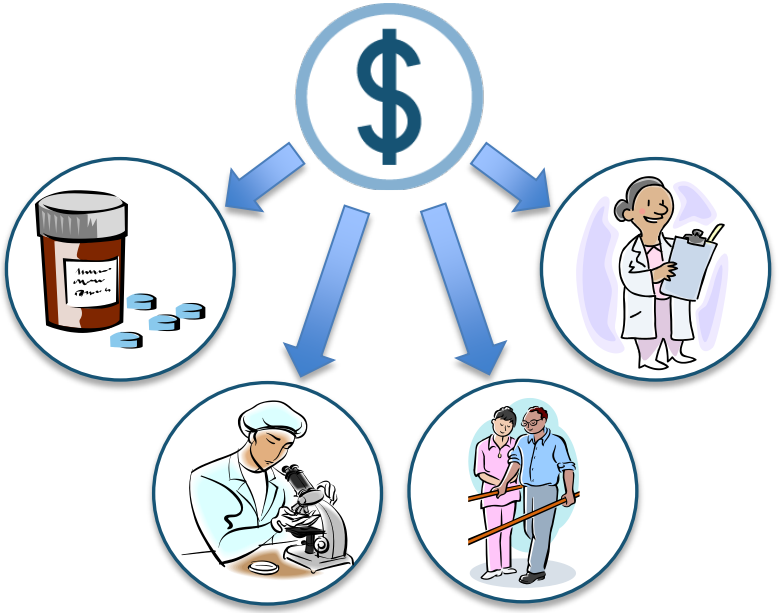
The monthly cost a person pays for a health plan



VS

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

 Ambulatory Patient Services	 Preventive and Wellness Services and Chronic Disease Management
 Emergency Services	 Laboratory Services
 Maternity and Newborn Care	 Prescription Drugs
 Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	 Rehabilitative and Habilitative Services and Devices
 Hospitalization	 Pediatric Services, including Oral and Vision Care

Types of Cost-Sharing Charges

Deductible	Copayments	Coinsurance
• Enrollee must pay the deductible before the plan begins to pay for most benefits • Set on a yearly basis	• Dollar amount for an item or service that enrollees must pay • Many copayments are applicable before the deductible is met	• 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 2021 Coverage	
Individual OOP Limit *(NOTE: applies to each individual in a family plan as well)*	$8,550
Family OOP Limit	$17,100

Lower Maximum OOP Limits for Cost-Sharing Reduction Plans (2021 Coverage)			
Household Income	**Up to 150% FPL**	**151 –200% FPL**	**201–250% FPL**
Individual OOP Limit	$2,850	$2,850	$6,800
Family OOP Limit	$5,700	$5,700	$13,600

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

Costs covered by a plan

Premiums paid by consumer

METAL LEVEL PLAN TIERS

QHPs must provide plan designs consistent with actuarial values

Platinum	90% actuarial value
Gold	80% actuarial value
Silver	70% actuarial value
Bronze	60% actuarial value
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

Typical population

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

Actuarial Value Guides Cost-Sharing Charges

Bronze 60% AV

Cigna Health and Life Insurance Company

Cigna Connect 7000

Bronze | EPO | Plan ID: **41921VA0020011**

Deductible	Out-of-pocket maximum
$7,000 Individual total	$8,150 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
50% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible

Kaiser Permanente

KP VA Bronze 5500/50/Dental

Bronze | HMO | Plan ID: **95185VA0530006**

Deductible	Out-of-pocket maximum
$5,500 Individual total	$8,150 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
35% Coinsurance after deductible	$30	$50 Copay after deductible	$70 Copay after deductible

Silver 70% AV

Cigna Health and Life Insurance Company

Cigna Connect 6500

Silver | EPO | Plan ID: **41921VA0020030**

Deductible	Out-of-pocket maximum
$6,500 Individual total	$8,150 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
50% Coinsurance after deductible	$4	$20	30% Coinsurance after deductible

CareFirst BlueChoice

BlueChoice HMO HSA Silver 3000

Silver | HMO | Plan ID: **10207VA0380001**

Deductible	Out-of-pocket maximum
$3,000 Individual total	$6,650 Individual total

Copayments / Coinsurance

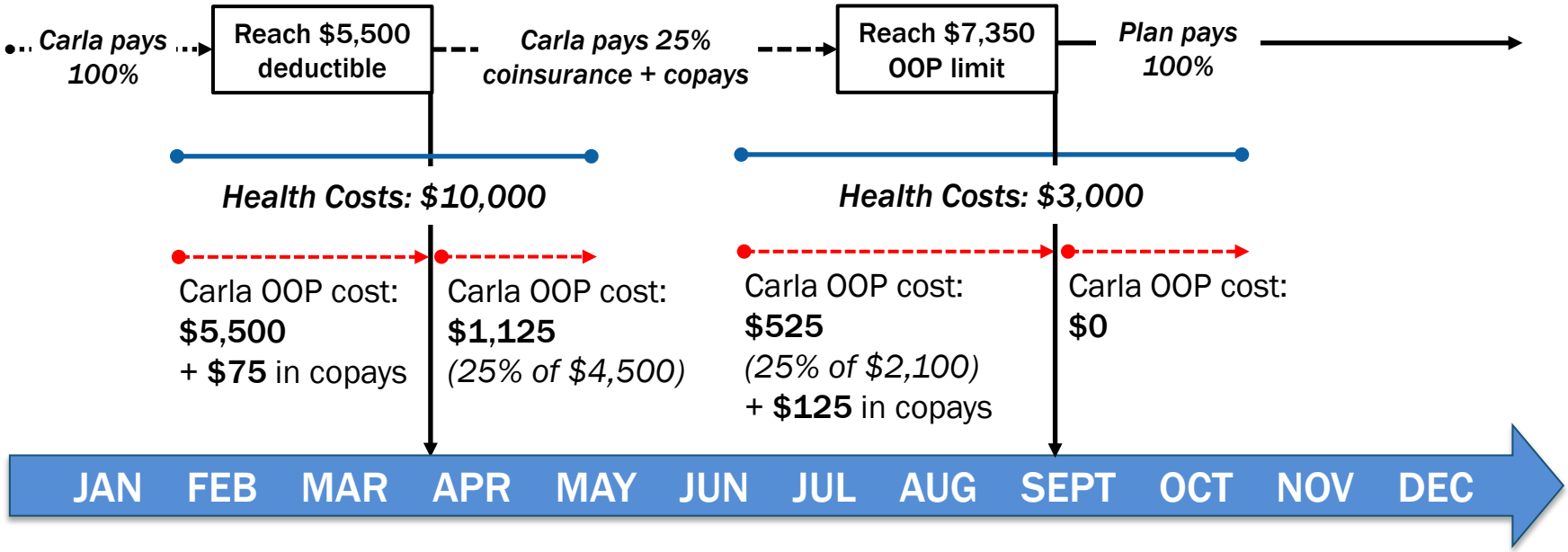
Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$300 Copay after deductible	$10 Copay after deductible	$30 Copay after deductible	$40 Copay after deductible

Source: HealthCare.gov 2020 plans, Fairfax County, VA 22003

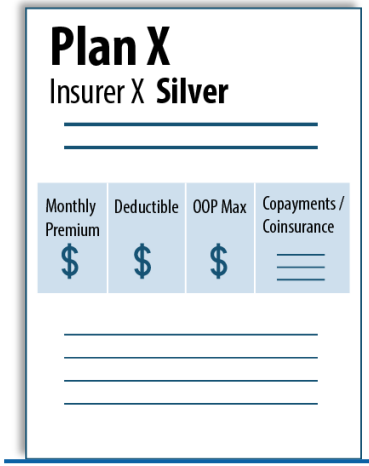
Example: How Cost Sharing Works

Health Plan Y:

Deductible	$5,500	Primary care visit	$35
OOP limit	$7,350	Specialist visit	25%
Inpatient hospital	25%	Generic drug	$25



Individual and Family Cost-Sharing Charges Differ



Deductible	$5,000	$10,000
OOP limit	$7,900	$15,800
Inpatient hospital	35% after deductible	35% after deductible
Primary care visit	$50	$50
Specialist visit	$80	$80
Generic drug cost	$25	$25

Embedded vs. Aggregate Family Cost Sharing

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 ($8,550 per year in 2021, less for people receiving cost-sharing reductions)

Example: In-Network vs. Out-of-Network Cost Sharing

		Annual Deductible	Annual OOP Limit	Hospital Admission	Primary Care Visit	Specialist Visit
Plan A Carrier A Silver	In-Network	$5,000	$7,900	$1,500 (per admission)	$25	30%
	Out-of-Network	$10,000	None	50%	50%	50%
Plan B Carrier B Silver	In-Network	$4,000	$7,900	30%	$60	30%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Plan C Carrier C Silver	Tier I	$2,000	$5,000	30%	$20	$40
	Tier II	$4,000	$7,900	50%	$40	$60
	Tier III	$8,000	$15,800	50%	50%	50%

Example: In-Network vs. Out-of-Network Cost Sharing

Plan A Carrier A **Silver**	**Annual Deductible**	**Annual OOP Limit**	**Hospital Admission**	**Primary Care Visit**
In-Network	$5,000	$7,900	$1,500 (per admission)	$25
Out-of-Network	$10,000	None	50%	50%

Network Physician

Doctor's bill: $200

Plan allowed amount: $100

Plan pays: $75

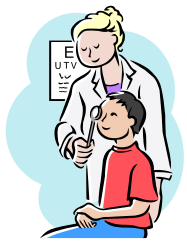
Patient pays: $25 *(copay)*

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:				
	Standard Silver **No CSR**	**CSR Plan** **Level 1**	**CSR Plan** **Level 2**	**CSR Plan** **Level 3**
Income Range	Above 250% FPL	201–250% FPL	151–200% FPL	Up to 150% FPL
Actuarial Value	70% AV	73% AV	87% AV	94% AV
Max OOP Limit ***Individual in 2021***	$8,550	$6,800	$2,850	$2,850
Max OOP Limit ***Family in 2021***	$17,100	$13,600	$5,700	$5,700

Cost-Sharing Reductions: Example Plan A

Geisinger Health Plan

Geisinger Marketplace All-Access

Silver | HMO | Plan ID: **22444PA0010105**

No CSR
70% AV

Deductible	Out-of-pocket maximum
$4,650 Individual total	$7,350 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$350 Copay after deductible	$20	$30	$60

Geisinger Health Plan

Geisinger Marketplace All-Access

Silver | HMO | Plan ID: **22444PA0010105**

201% - 250% FPL
73% AV

Deductible	Out-of-pocket maximum
$3,500 Individual total	$6,500 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$350 Copay after deductible	$20	$30	$60

Geisinger Health Plan

Geisinger Marketplace All-Access

Silver | HMO | Plan ID: **22444PA0010105**

151% - 200% FPL
87% AV

Deductible	Out-of-pocket maximum
$1,200 Individual total	$2,700 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$75	$15	$20	$40

Geisinger Health Plan

Geisinger Marketplace All-Access

Silver | HMO | Plan ID: **22444PA0010105**

< 151% FPL
94% AV

Deductible	Out-of-pocket maximum
$300 Individual total	$2,600 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$25	$1	$10	$20

Source: Healthcare.gov 2020 silver plan variations, Lancaster County, PA 17573

Cost-Sharing Reductions: Example Plan B

Capital BlueCross

Silver PPO 6000/20/40

Silver | PPO | Plan ID: **45127PA0020008**

No CSR
70% AV

Deductible	Out-of-pocket maximum
$6,000 Individual total	$8,150 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$400 Copay after deductible	$10	$40	$85

Capital BlueCross

Silver PPO 6000/20/40

Silver | PPO | Plan ID: **45127PA0020008**

201% - 250% FPL
73% AV

Deductible	Out-of-pocket maximum
$5,500 Individual total	$6,500 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$200 Copay after deductible	$5	$10	$20

Capital BlueCross

Silver PPO 6000/20/40

Silver | PPO | Plan ID: **45127PA0020008**

151% - 200% FPL
87% AV

Deductible	Out-of-pocket maximum
$1,500 Individual total	$2,450 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$75 Copay after deductible	$3	$5	$10

Capital BlueCross

Silver PPO 6000/20/40

Silver | PPO | Plan ID: **45127PA0020008**

< 151% FPL
94% AV

Deductible	Out-of-pocket maximum
$450 Individual total	$1,250 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$50 Copay after deductible	$2	$3	$5

Source: Healthcare.gov 2020 silver plan variations, Lancaster County, PA 17573

Comparing Two Insurers' CSR Variations

< 151% FPL
94% AV

Geisinger Health Plan

Geisinger Marketplace All-Access HMO 30/60/4650

Silver | HMO | Plan ID: **22444PA0010105**

Deductible	Out-of-pocket maximum
$300 Individual total	$2,600 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$25	$1	$10	$20

< 151% FPL
94% AV

Capital BlueCross

Silver PPO 6000/20/40

Silver | PPO | Plan ID: **45127PA0020008**

Deductible	Out-of-pocket maximum
$450 Individual total	$1,250 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$50 Copay after deductible	$2	$3	$5

Source: Healthcare.gov 2020 silver plan variations, Lancaster County, PA 17573

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)
  - → Health care sharing ministries
  - → Other types: indemnity plans, combination or “bundled” products

Skimpy Plans vs. ACA-Compliant Plans

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

*Some AHPs that are available to small groups, but not individual self-employed people, are charging more based on health status. All AHPs, unlike ACA-compliant plans, may set rates based on factors such as gender, occupation, and group size, and they may charge older people more due to age.
**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

	Reform	Description	ACA Plans	Short-Term Plans	AHPs	Sharing ministries
ADEQUACY	Preexisting condition exclusions	Prohibits insurers from imposing preexisting condition exclusions with respect to coverage.	✓	✗	✓	✗
	Essential health benefits	Requires coverage of 10 categories of essential benefits defined in the ACA	✓	✗	✗	✗
	Actuarial value	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.	✓	✗	✗	✗
	Annual cost-sharing limits	Requires insurers to limit each enrollee's annual out-of-pocket costs, including copayments, coinsurance, and deductibles.	✓	✗	✓	✗
	Annual dollar limits	Prohibits annual limits on the dollar value of covered essential health benefits.	✓	✗	✓	✗
	Lifetime dollar limits	Prohibits lifetime limits on the dollar value of covered essential health benefits.	✓	✗	✓	✗
	Preventive services without cost-sharing	Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider.	✓	✗	✓	✗

Source: The Commonwealth Fund, State Regulation of Coverage Options Outside of the ACA

Short-Term Plans

- Starting in 2018, federal rules allowed 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
  - → States retain authority to limit and set standards for short-term plans

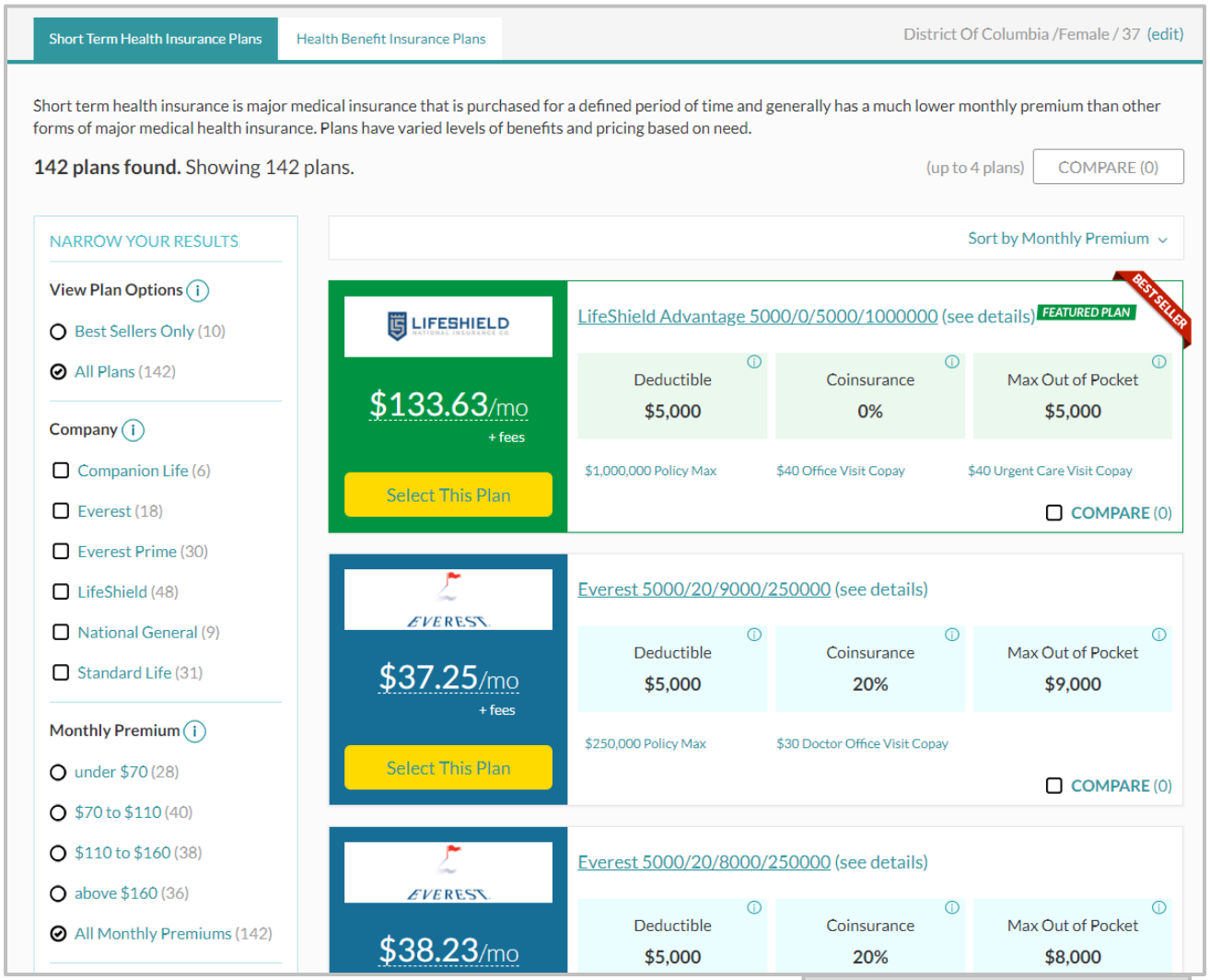
- Healthy people who enroll in these plans may find themselves facing gaps in coverage and exposed to catastrophic costs if they get sick and need care
  - → May look like a comprehensive health plan (with a premium, deductible, and a provider network) but leave out key protections and coverage
  - → 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

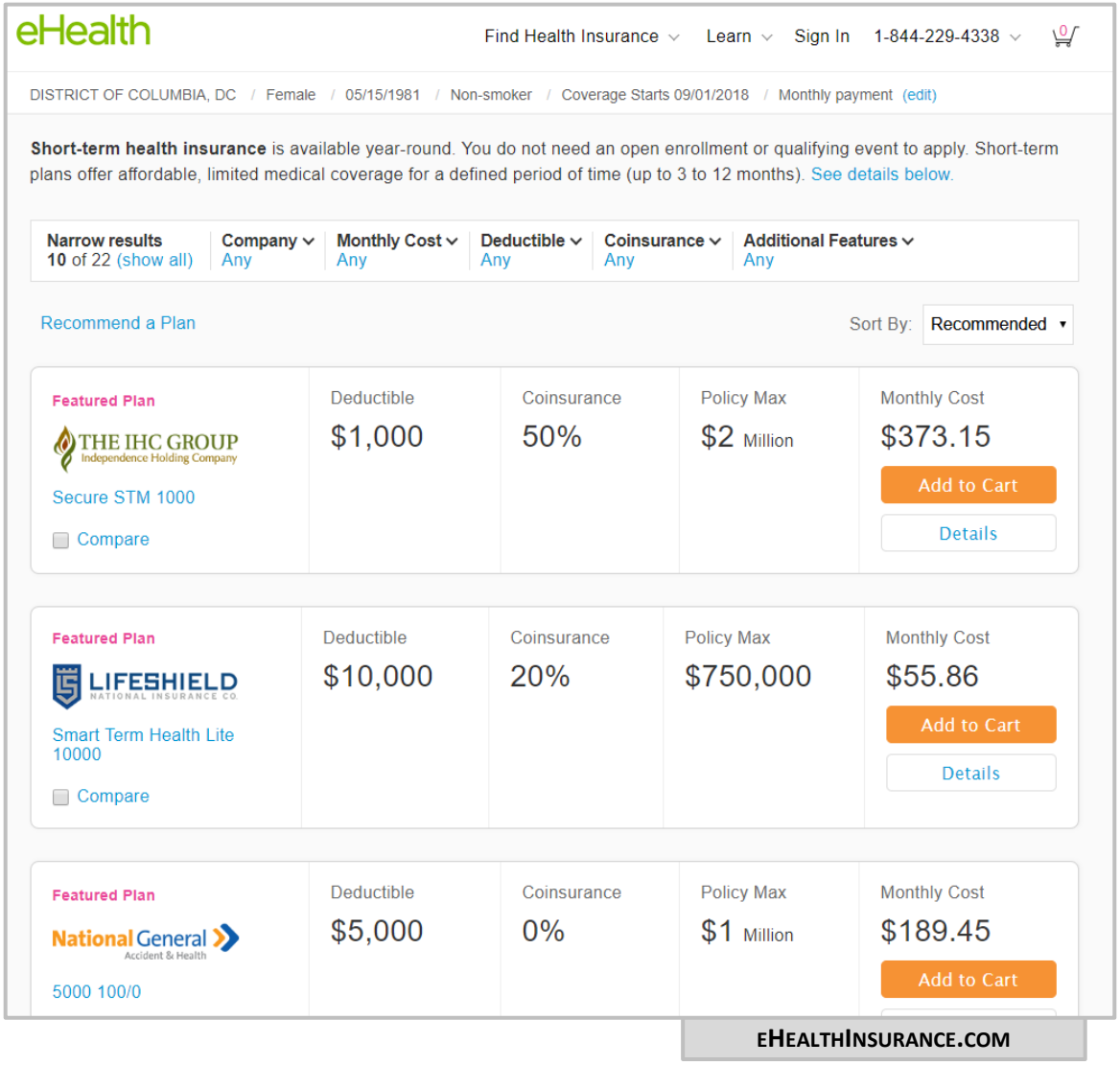
- Typically exclude coverage for pre-existing conditions
  - → People with pre-existing conditions may be denied a policy outright
  - → Insurers broadly exclude coverage of pre-existing conditions and then deny claims related to such conditions
  - → Insurers may conduct "post-claims underwriting" or "claims eligibility reviews," 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



AGILE HEALTH INSURANCE

Plans Appear Similar to ACA Plans



EHEALTHINSURANCE.COM

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

	FLEX	ADVANTAGE
Coinsurance	80/20, or 100/0	80/20, or 100/0
Deductible	$1,000, $2,500, $5,000	$1,000, $2,500, $5,000
Out-Of-Pocket Maximum	$2,000, $3,000, $4,000	$2,000, $3,000, $4,000
Coverage Period Maximum	$750,000, $1,000,000	$750,000, $1,000,000
Unless specified otherwise, the following benefits are for Insured and each Covered Dependent subject to the plan Deductible, Coinsurance Percentage, Out-Of-Pocket Maximum and Policy Maximum chosen. Benefits are limited to the Maximum Allowable Expense or each Covered Expense, in addition to any specific limits stated in the policy.		
Doctor Office Consultation		
Copay	$30 Copay, maximum 3	$40, unlimited
Wellness Benefit Copay	$50 Copay, maximum 1	$50 copay, maximum 1
Inpatient Hospital Services		
Average Standard Room Rate	$1,000 per day	Average Standard Room Rate
Hospital ICU	$1,250 per day	Average Standard Room Rate
Doctor Visits	$50 per day, maximum $500	Subject to Coinsurance and Deductible
Outpatient Services		
Surgical Facility	$1,250 per day	Subject to Coinsurance and Deductible
Outpatient Surgery Deductible	N/A	$500 Additional deductible applies, maximum 3
Emergency Room - Deductible	N/A	$500 Additional deductible applies
Emergency Room - Benefit	$250 per visit	Subject to Coinsurance and Deductible
Advanced Diagnostic Studies Deductible	N/A	$500 Additional deductible applies, maximum 3
Ambulance	Injury and Sickness: $250 per transport	Injury and Sickness: $250 per transport
Extended Care Facility	$150 per day, maximum 30 days	$150 per day, maximum 30 days
Home Health Care	$50 per visit, maximum 30 days	$50 per visit, maximum 30 days
Physical, Occupational and Speech Therapy	$50 per day, maximum 20 visits	$50 per day, maximum 20 visits
Mental Disorders		
Inpatient	$100 per day, maximum 31 days	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits	$50 per day, maximum 10 visits
Substance Abuse		
Inpatient	$100 per day, maximum 31 days	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits	$50 per day, maximum 10 visits

LIFESHIELD

Pre-Existing Conditions Excluded from Short-Term Plans

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 60-0month period immediately prior to the Covered Person's Certificate Effective Date of coverage under the Policy.

LIFESHIELD

Pre-existing condition limitation

Secure STM will not provide benefits for any loss caused by or resulting from a pre-existing condition. A pre-existing condition is any medical condition or sickness for which medical advice, care, diagnosis, treatment, consultation or medication was recommended or received from a doctor within five years immediately preceding the covered person's effective date of coverage; or symptoms within the five years immediately prior to the coverage that would cause a reasonable person to seek diagnosis, care or treatment.

THE IHC GROUP

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 date 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.

GENERAL

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 post natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)

LIFESHIELD

- 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

THE IHC GROUP

- 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.

NATIONAL GENERAL

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 post natal care. (This exclusion does not apply to "Complications of Pregnancy").

COMPANION LIFE

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.

NATIONAL GENERAL

- Learning disabilities, attention deficit disorder, hyperactivity or autism
- Mental illness or nervous disorders, suicide or attempted suicide
- Alcohol or drug dependency and disorders

THE IHC GROUP

Or limit benefits

Mental Illness

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

COMPANION LIFE

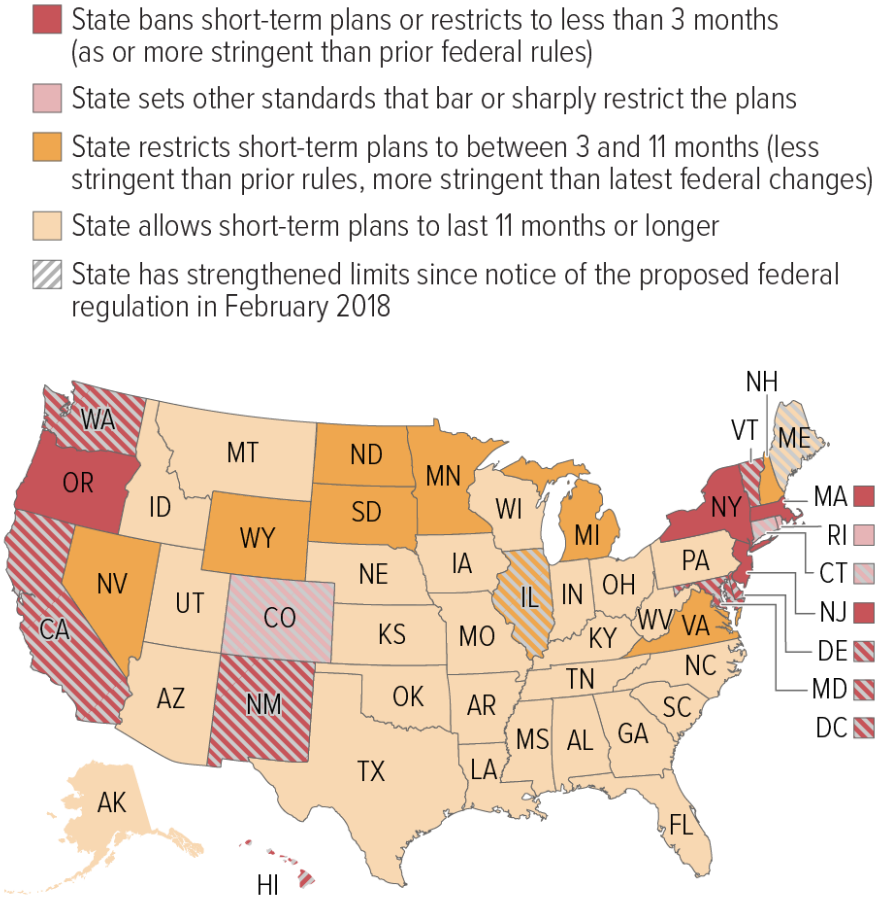
Mental Disorders	
Inpatient	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits
Substance Abuse	
Inpatient	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits

LIFESHIELD

State Actions to Limit Short-Term Plans

- States have the authority to set their own standards for short-term plans and other types of skimpy plans.
- A dozen states have strengthened their protections against short-term plans since the new rules were announced.
- Most states allow short-term plans to last 11 months or longer.

State Limitations on Short-Term Health Insurance Plans, July 2019



Source: CBPP research and Palanker et al, "States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans," Commonwealth Fund, May 2019.

For more info, see States Protecting Residents Against Skimpy Short-Term Health Plans

"Direct Enrollment" websites

- The FFM is expanding use of "direct enrollment" and "enhanced direct enrollment."
- This is when insurers and brokers (including web brokers) use their own sites, rather than the FFM site, to help people apply for and enroll in Marketplace plans and receive subsidies.
  - → Direct enrollment sends the consumer to the FFM for an eligibility determination and then back to the DE site for plan selection.
  - → Enhanced direct enrollment allows an insurer or broker to keep the consumer at the non-FFM site for the entire process.
- Some DE and EDE sites sell short-term and other subpar plans. Federal rules bar these plans from being displayed alongside QHPs, but some sites heavily promote them.

What Can You Do?

- Promote open enrollment for plans that meet ACA standards
- 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 coverage gaps
- Continue to use the Marketplace website (as required); help consumers avoid the risks of direct enrollment
- 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
- **Send us stories of people you meet who have been impacted by skimpy plans**

Resources

- Key Facts:
  - → Cost-Sharing Charges
  - → Cost-Sharing Reductions
- Papers and Blogs:
  - → Key Flaws of Short-Term Health Plans Pose Risks to Consumers
  - → More States Protecting Residents Against Skimpy Short-Term Health Plans
  - → Expanding Skimpy Health Plans Is the Wrong Solution for Uninsured Farmers and Farm Workers
  - → "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm

---

- 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

Upcoming Webinars

Part VI: Plan Selection Strategies

- Tuesday, October 6| 2 pm ET (11 am PT)

Part VII: Part VII: Auto-Renewal Process

- Thursday, October 8| 2 pm ET (11 am PT)

Part VIII: Special Topics on Assisting Immigrant Communities

- Thursday, October 15| 2 pm ET (11 am PT)

Part IX: Assisting People with Disabilities

- Thursday, October 22| 2 pm ET (11 am PT)

Register for upcoming webinars at
www.healthreformbeyondthebasics.org/events

Contact Info

- Sarah Lueck, lueck@cbpp.org
  - → Twitter: @sarahL202
- General inquiries: beyondthebasics@cbpp.org

Please send consumer stories you collect about skimpy plans to: beyondthebasics@cbpp.org

For more information and resources, please visit:

www.healthreformbeyondthebasics.org

This is a project of the Center on Budget and Policy Priorities, www.cbpp.org