Beyond the Basics

Part V: Plan Design

September 30, 2021

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 and once more at the end
- You can also email questions to beyondthebasics@cbpp.org
- All webinars are recorded and will be available for viewing at www.healthreformbeyondthebasics.org

Beyond the Basics

Agenda

- Elements of qualified health plans
- Differences between HMOs, PPOs, EPOs, and POS plans
- How cost-sharing charges work
- Impact of actuarial value on cost-sharing
- Cost-sharing reductions

Part VI: Plan Selection Strategies
Tuesday, October 5 | 1 pm ET (10 am PT)

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Beyond the Basics

Elements of Qualified Health Plans (QHPs)

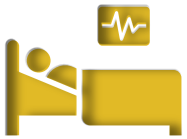
What is a QHP?

- Qualified Health Plans (QHPs) are insurance plans that must meet standards and include the consumer protections outlined in the Affordable Care Act
- QHPs must be certified by the federal Health Insurance Marketplace or a state-based marketplace
- QHPs must include:
  - Coverage for pre-existing conditions
  - Coverage of 10 Essential Health Benefits (EHBs)
  - Cost-sharing limits that follow federal regulations
  - No annual or lifetime benefit limits

Basic Elements of QHPs: 10 EHBs

Preventive & wellness services & chronic disease management

Ambulatory services (outpatient medical care)

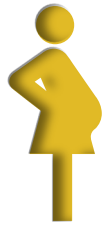


Hospitalization

Laboratory services

Prescription drugs

Emergency services



Maternity & newborn care

Mental health & substance use disorder services, including behavioral health treatment

Rehabilitative & habilitative services & devices

Pediatric services

Beyond the Basics

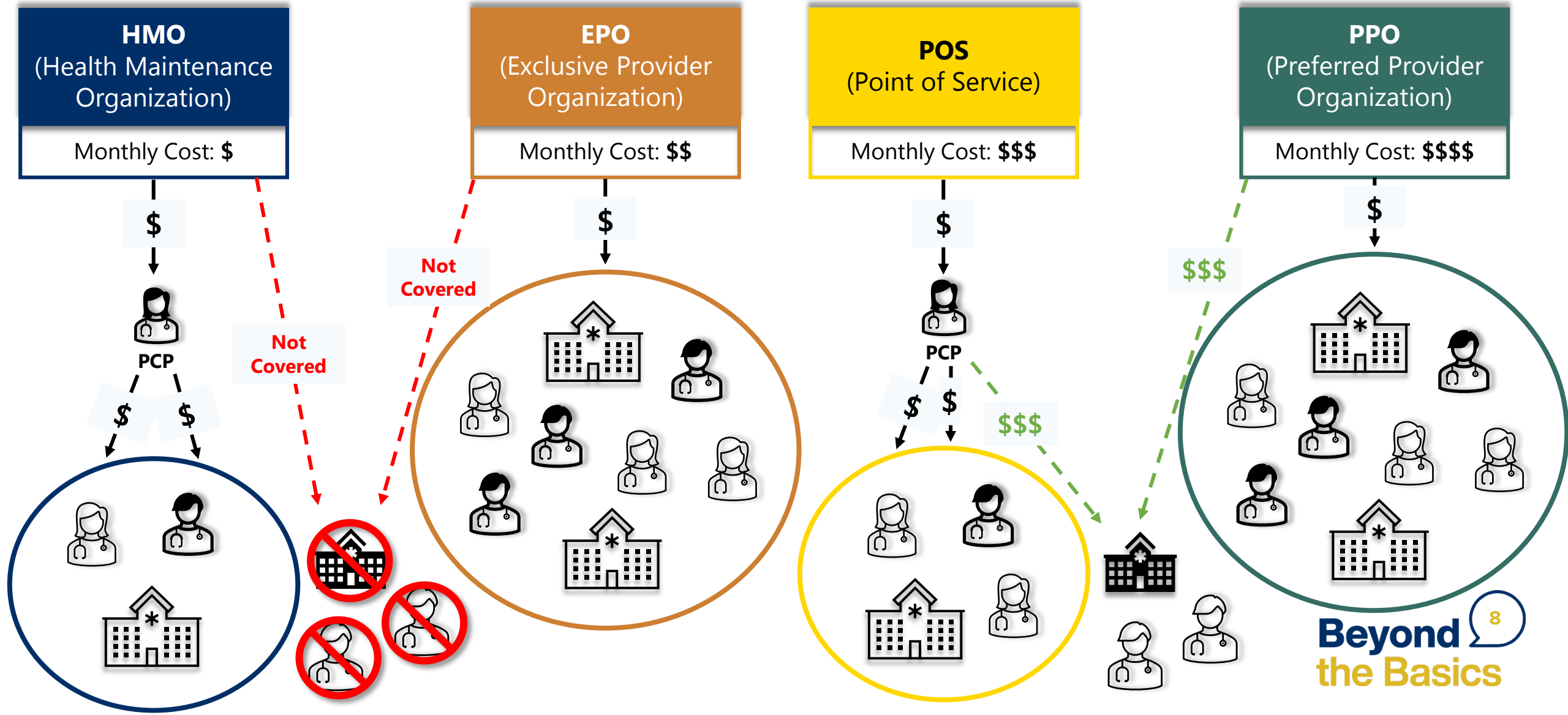
Basic Elements of QHPs: Plan Networks

- Insurance companies contract with physicians, hospitals, and pharmacies to provide services to plan enrollees
  - These contracted providers are the plan's "network"

- Providers the insurance company doesn't contract with are considered "out-of-network"
  - Some plans will cover services the plan enrollee receives from an out-of-network provider, but the enrollee will usually have to pay more out-of-pocket than if they went to an in-network provider
  - Some plans won't cover any services received from an out-of-network provider, except in cases of a medical emergency

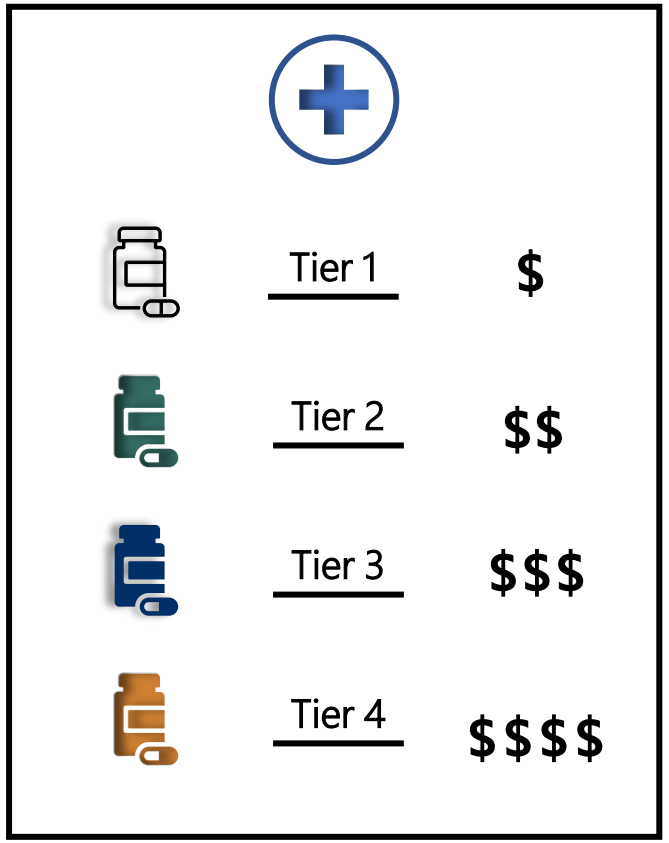
Each plan has its own network, even among plans offered by the same insurance company. Which is why it's important to check each plan's network when comparing options.

Types of Plan Networks



Basic Elements of QHPs: Formularies

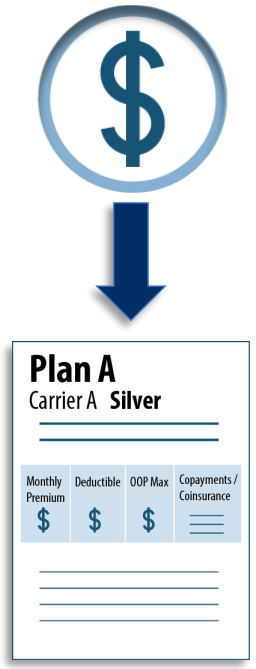
- A formulary is a list of medications an insurance plan will pay for
- The formulary splits up covered medications into categories or tiers to indicate the level of coverage the plan provides and the portion of the cost the enrollee will have to pay for various medications
- The higher the tier of the medication, the more the enrollee will likely have to pay
- Generic medications are usually the lowest tier, which means the enrollee will pay the least for these medications
- Medications not listed in the formulary are generally not covered by the plan, though exceptions apply



Basic Elements of QHPs: Premiums & Cost-Sharing Charges

Premiums

- The monthly cost a person pays for their health insurance plan
- Premiums must be paid every month or the person's plan may be terminated



VS

Cost-Sharing Charges

- The costs a person pays as they use health care services covered by their insurance plan

Overview of Cost-Sharing Charges

Types of Cost-Sharing Charges

Deductible

- The amount an enrollee must pay out-of-pocket for health care services before their insurance plan starts paying
- Resets every year

Copayments

- Enrollee pays a set dollar amount for health care services and prescriptions

Coinsurance

- Enrollee pays a percentage of the total cost for health care services and prescriptions

For definitions of common health insurance terms, visit www.healthcare.gov/glossary

More to Know About Cost-Sharing Charges

- Certain services may be covered before the deductible is met in some plans
  - This is sometimes referred to as “first dollar coverage”
    - Look for terms like “deductible does not apply” or “not subject to deductible” in the Summary of Benefits
- Some plans may have a separate deductible for prescription drugs
- Preventive care services are required to be provided without any cost-sharing (no deductible, copayments, or coinsurance)
  - This includes:
    - Well-woman visits
    - Screenings for cancer, diabetes, hypertension, etc.
    - Immunizations
    - FDA-approved contraceptives for women

For a complete list of preventive care services, visit www.healthcare.gov/preventive-care-adults

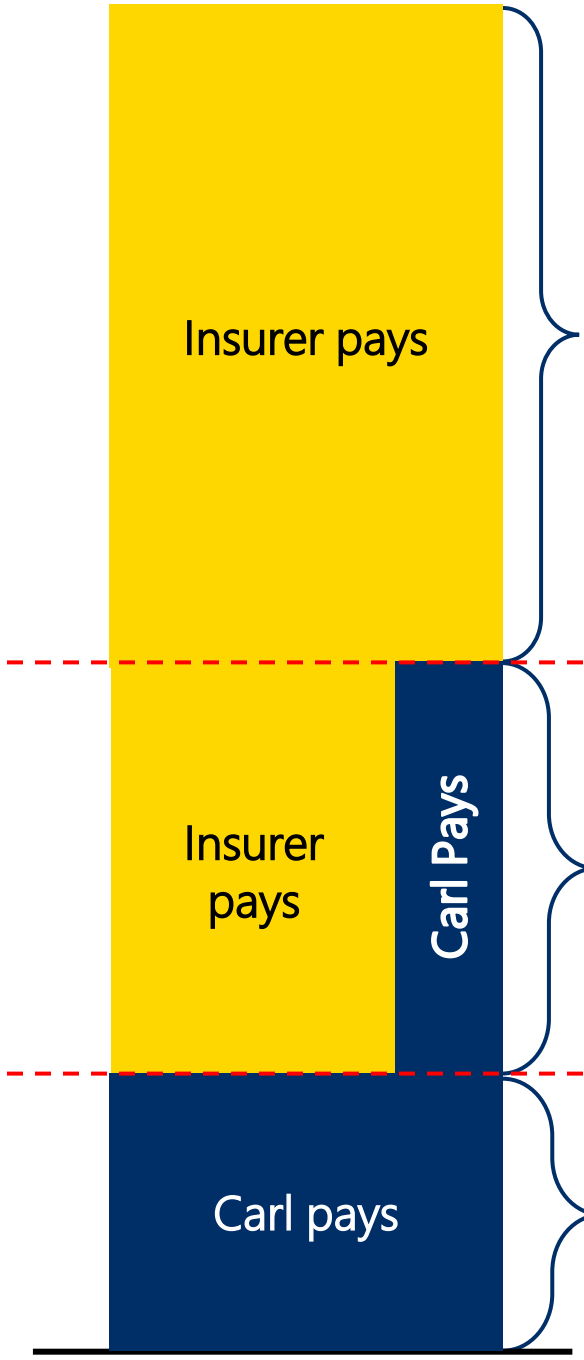
Maximum Out-of-Pocket Limit (OOP)

- Puts a cap on the amount an enrollee can pay in cost-sharing charges in a year, protecting people from very high out-of-pocket costs
  - Set on a yearly basis
  - Applies to in-network services, generally not for out-of-network care
- OOP limit is **not** the amount that an enrollee **must** spend each year, it's the maximum an enrollee *could* spend in a year
- Copays, coinsurance, and the amount an enrollee pays towards their deductible are all counted
  - Premium payments are not counted
- After an enrollee reaches the OOP limit, the insurance plan pays for 100% of in-network health care costs, with no copays or coinsurance
- Some plans will have the maximum OOP limits allowed, while other plans will have lower OOP limits

Maximum OOP Limit for 2022 Coverage	
Individual OOP Limit *(NOTE: applies to each individual in a family plan as well)*	$8,700
Family OOP Limit	$17,400

Example: How Cost-Sharing Works

In 2021, Carl has $40,000 in medical expenses



Carl doesn't pay anything → $0
Insurer pays full amount → $23,700

Annual Out-of-Pocket Limit: $7,000

Carl pays copayments/coinsurance → $4,000
Insurer pays the rest of the cost for services → $9,300

Annual Deductible: $3,000

Carl pays full amount for services → $3,000
Insurer doesn't pay anything → $0

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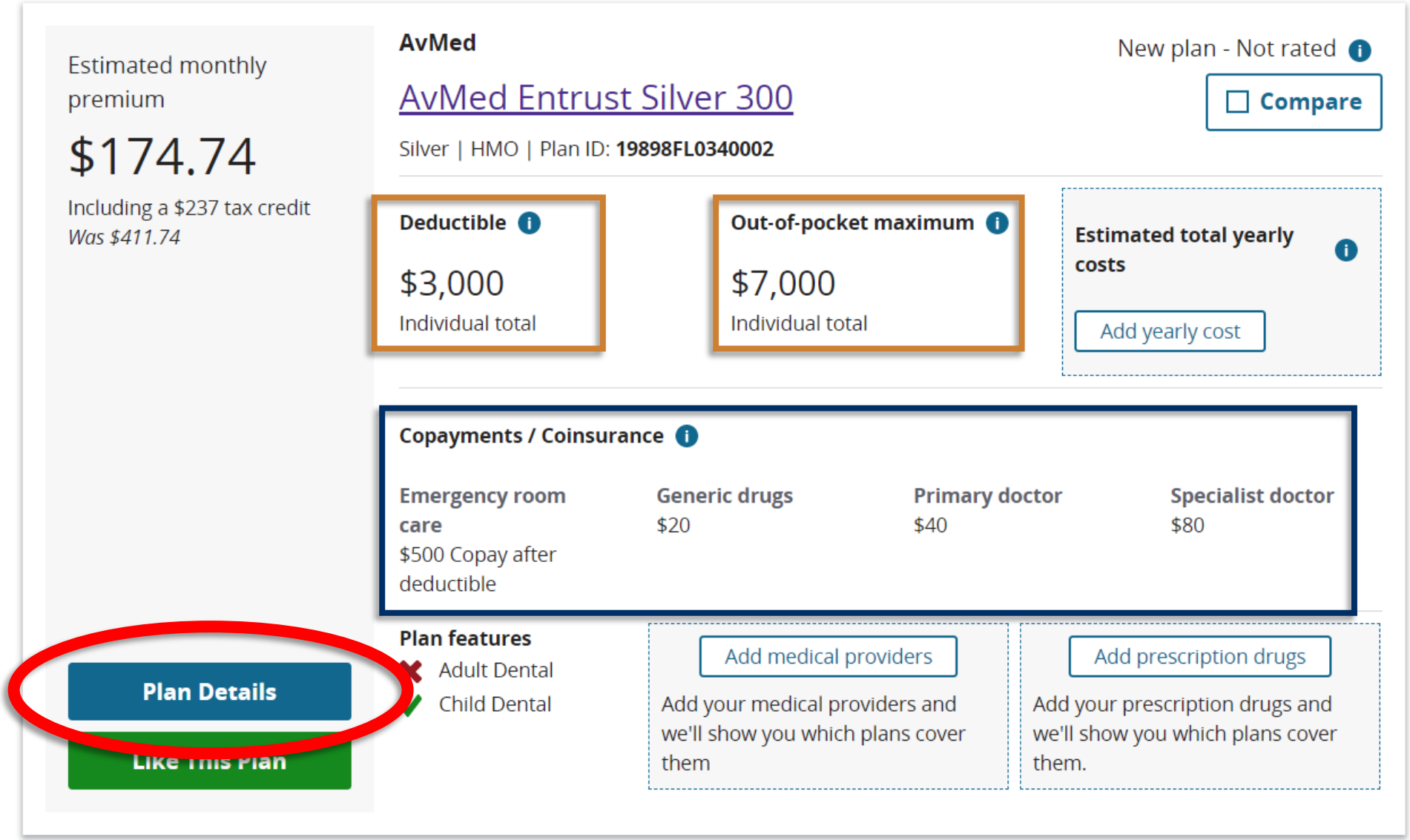
Example: Plan Cost-Sharing

Source: Healthcare.gov 2021 plan, Miami-Dade County, FL 33101



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Summary of Benefits & Coverage (SBC)

AvMed Entrust Silver 300

Silver | HMO | Plan ID: **19898FL0340002**

Highlights

Estimated monthly premium

Deductible

Out-of-pocket maximum

Estimated total yearly costs

Medical providers in-network

Drugs covered/not covered

Star rating

Plan documents

Summary of Benefits

Important Questions	Answers
What is the overall deductible?	$2,000 individual / $6,000 family
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, certain lab tests, certain prescription drugs, ambulance and urgent care, and certain recovery services, e.g., habilitation and rehabilitation services, are covered before you meet your deductible.
Are there other deductibles for specific services?	No. There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	$7,000 individual / $14,000 family Pediatric Dental is limited to $350 per child or $700 for 2 or more children.

Common Medical Event	Services You May Need	What You Will Pay	
		an AvMed In-Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge for first non-preventive visit; $40 copay/ visit thereafter	Not Covered
	Specialist visit	$80 copay/ visit	Not Covered
	Preventive care/screening/ immunization	No Charge	Not Covered
If you have a test	Diagnostic test (x-ray, blood work)	$100 copay/ visit at independent facilities; $200 copay/ visit at hospital-owned or affiliated facilities; $30 copay/ visit at participating labs	Not Covered
	Imaging (CT/PET scans, MRIs)	$300 copay/ visit at independent facilities; $600 copay/ visit at hospital-owned	Not Covered
If you need immediate medical attention	Emergency room care	$500 copay/ visit after deductible	$500 copay/ visit after deductible
	Emergency medical transportation	$200 copay/ one way ground transport	$200 copay/ one way ground transport
If you have a hospital stay	Facility fee (e.g., hospital room)	$900 copay/ day for the first 2 days per admission after deductible	Not Covered

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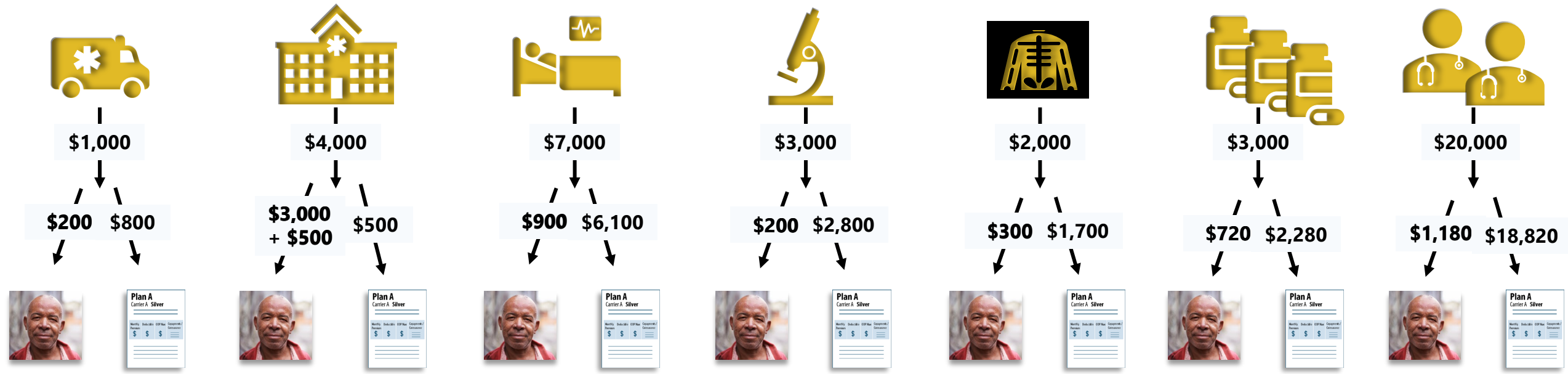
Example: How Cost-Sharing Works

In 2021, Carl has $40,000 in medical expenses

ER Visit	Primary Care	Specialist	Generic Drugs
$500 *after deductible*	$40 copay	$80 copay	$20 copay



Annual Deductible: $3,000

Annual OOP Limit: $7,000

Carl pays

Carl pays

Insurer pays

Insurer pays

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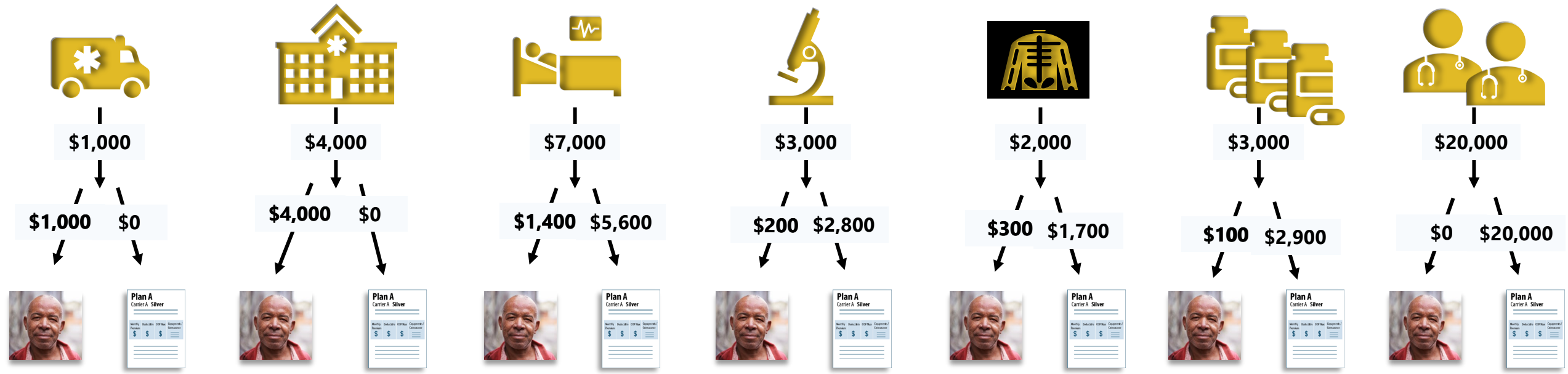
Example: How Cost-Sharing Works

In 2021, Carl has $40,000 in medical expenses

Hospitalization	ER Visit	Primary Care	Lab Tests
20% *after deductible*	20% *after deductible*	20% *after deductible*	$200 copay *after deductible*



Annual Deductible: $5,000

Annual OOP Limit: $7,000

Carl pays

Carl pays

Insurer pays

Insurer pays

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Family Cost-Sharing Charges

- The deductible and maximum out-of-pocket limit for a family of two or more people are generally double what the amount is for an individual
- Family deductibles come in two forms: embedded and aggregate
- A plan with an aggregate deductible (or **family deductible**) will require the family to meet their entire family deductible before their plan begins to pay the health care costs for any family member
- A plan with an embedded deductible (or **individual + family deductible**) will require each family member to meet a smaller deductible, which is counted towards the larger family deductible
  - Once a family member meets their individual deductible, the plan will begin to pay for that family member's health care costs, but the plan will not pay for the health care costs of any other family member until they reach their own individual deductible, or the family reaches their family deductible

Each family member is protected by the individual maximum OOP limit of $8,700 in 2022, which means that, even though the family OOP limit may be much higher than $8,700, no individual family member could pay more than $8,700 in out-of-pocket costs in 2022

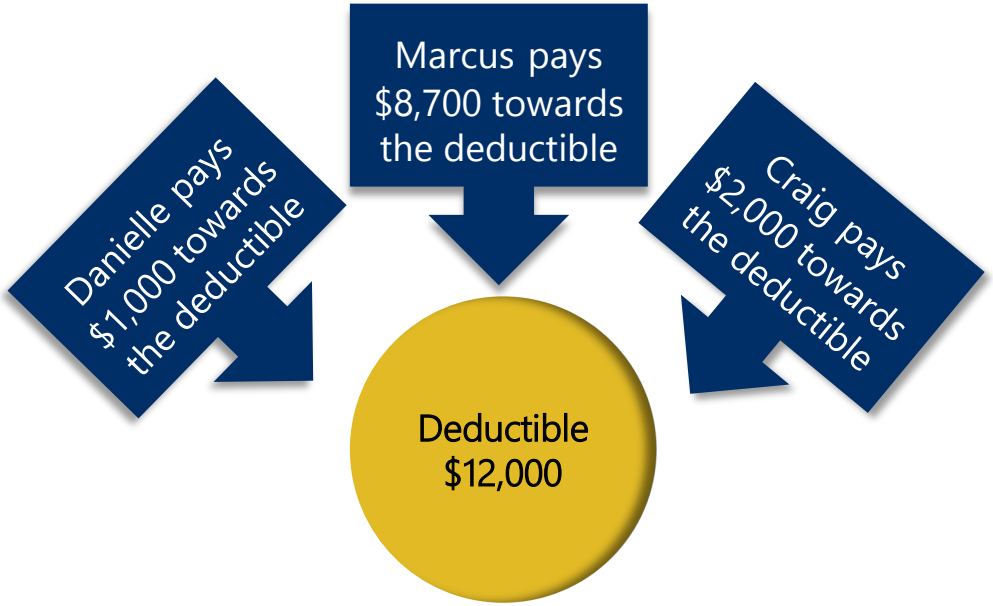
Example: Family Deductible (Aggregate)

The Rashid family enrolls in an **aggregate** (family) deductible plan

Aggregate family deductible = $12,000
Individual OOP limit = $8,700

The Rashid family's medical costs from Jan – Sept 2022:

- Danielle = $1,000
- Marcus = $9,000
- Craig = $2,000



The Rashid family has paid $11,700 towards their aggregate family deductible, but even though they haven't met their $12,000 family deductible yet, their plan will cover 100% of Marcus's health care costs, because he's paid $8,700 towards the family deductible, which is the individual OOP limit.

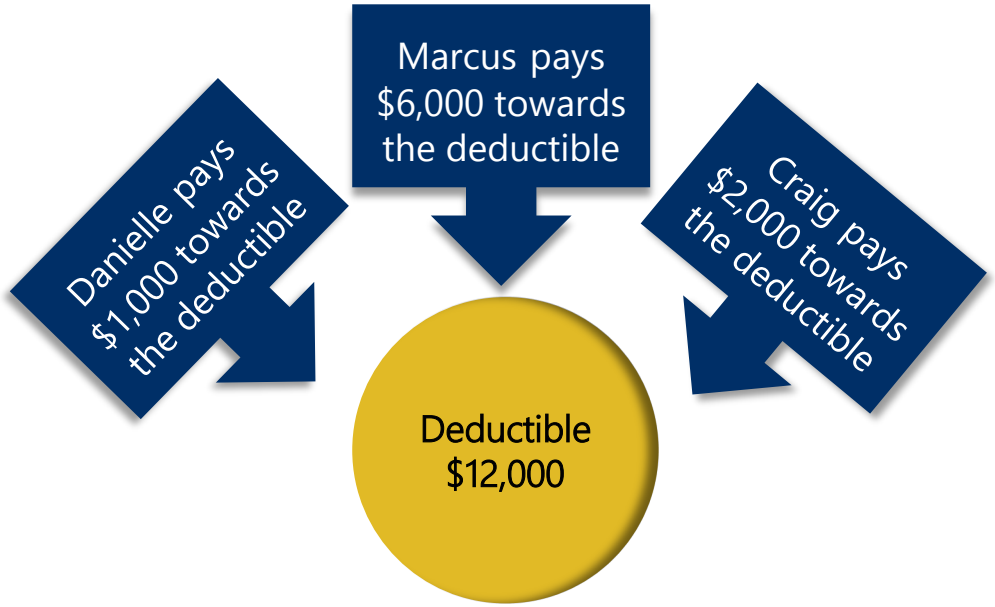
Example: Individual + Family Deductible (Embedded)

The Rashid family enrolls in an **embedded** (individual + family) deductible plan

Embedded family deductible = $12,000
Each family member's individual deductible = $6,000
Individual OOP limit = $8,700

The Rashid family's medical costs from Jan – Sept 2022:

- Danielle = $1,000
- Marcus = $9,000
- Craig = $2,000



The Rashid family has paid $9,000 towards their embedded family deductible so far, but even though they haven't met their family deductible yet, the plan will begin to cover a portion of Marcus's health care costs because he's met his individual deductible.

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

Plan A Carrier A Silver	Annual Deductible	Annual OOP Limit	Primary Care Visit
In-Network	$5,000	$8,700	$25
Out-of-Network	$10,000	None	50% coinsurance (of allowable charges)

Network Physician

Doctor's bill:	$200
Plan allowed amount:	$100
Plan pays:	$75
Patient pays:	$25 *(copay)*

Counts towards 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 OOP limit

This is known as balance billing

Beyond the Basics

New Surprise Billing Protections

- The No Surprises Act (passed in 2020) bans balance billing (also called "surprise billing") and says that someone can only be charged in-network cost-sharing when they:
  - Receive out-of-network emergency care (other than ground ambulance services)
  - Are treated by an out-of-network provider at an in-network facility
- The patient can sign away their balance billing protections in some cases
  - For example, if a specialist asks in advance (as little as 3 hours) and the patient agrees, a patient can sign a consent form and agree to pay whatever the specialist wants to charge, with little or no reimbursement from their insurance
- Some types of out-of-network providers at in-network facilities cannot balance bill or ask someone to give up balance billing protections (meaning the patient always pays in-network cost-sharing)
  - These include: emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services
  - For example, someone chooses an in-network hospital and surgeon for spine surgery, but the radiologist needed immediately prior to surgery is out-of-network. The patient only pays the in-network payment for the out-of-network radiologist because the patient was in an in-network facility.

Cost-Sharing for American Indians & Alaskan Natives

- Special assistance is 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 without needing to qualify for a Special Enrollment Period
- **For AI/AN people between 100% and 300% FPL** who qualify for PTC, zero cost-sharing plans are available
  - Enrollees pay no deductibles, copayments, or other cost-sharing when using in-network covered health care services
  - 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

Actuarial Value

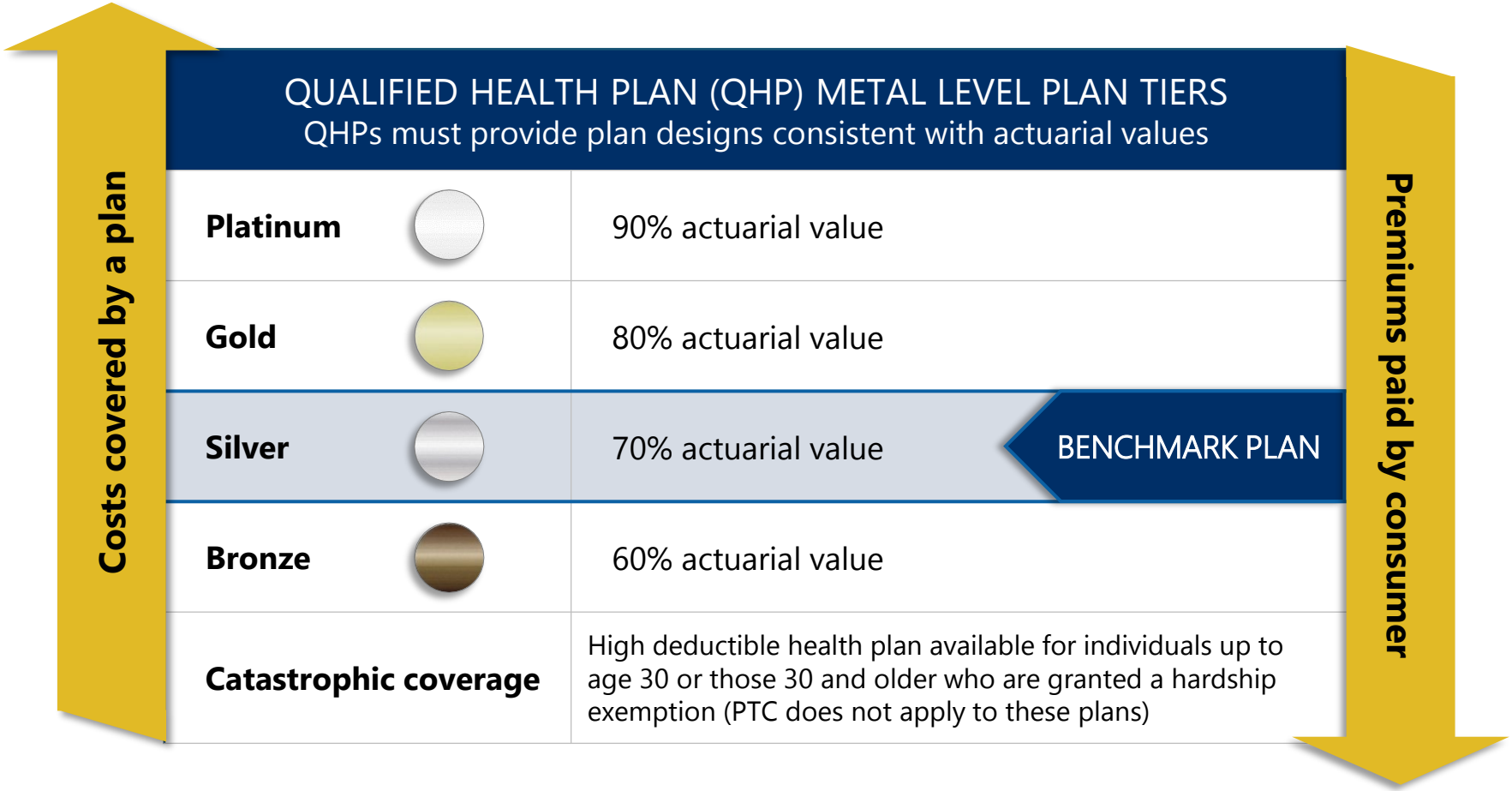
What is Actuarial Value?

- Actuarial value (AV) is a way to compare the overall generosity of plans
  - Marketplace plans are organized into 4 metal levels: Bronze, Silver, Gold, Platinum
  - Each metal level is associated with different AVs
- The higher the AV, the less cost-sharing the enrollee must pay
- AV does not represent what the plan would pay for a particular individual enrolled in the plan
  - An enrollee's actual out-of-pocket costs depend on the medical services they use
- **AV shouldn't be confused with coinsurance**, meaning that if a plan has 70% AV, that doesn't mean that the enrollee will have to pay a 30% coinsurance charge for services

Actuarial value is **not** meant to represent the **quality** of the plan, the quality of the care provided under the plan, or the size of the plan's network

Cost-Sharing & Metal Tiers

- Enrollees pay less out-of-pocket with higher AV plans
- Premiums are generally higher for high AV plans



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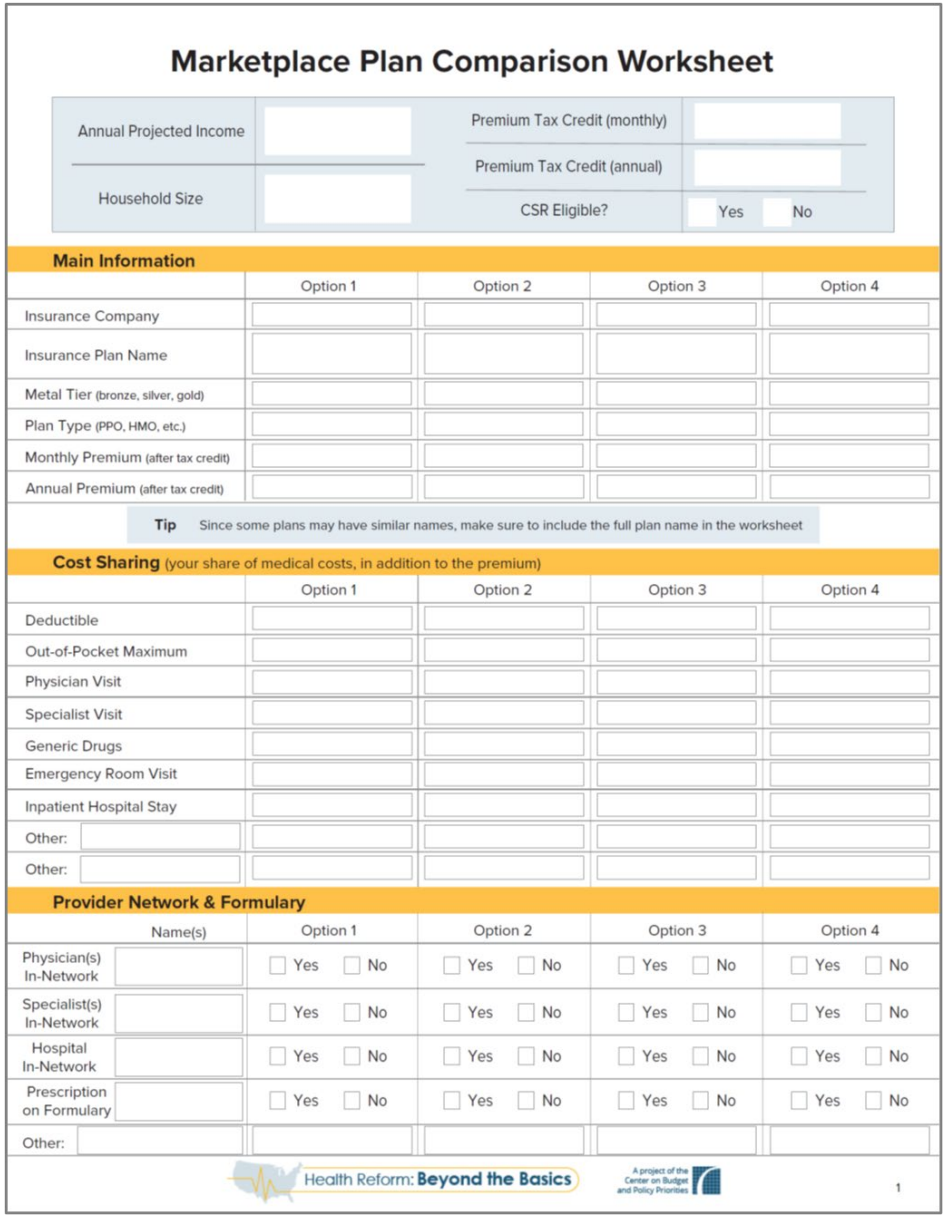
Plan Comparison Worksheet

- This worksheet lets you compare up to 4 plans side-by-side
- You can fill it out on your computer and then print it or email it the client
- Available in:
  - English
  - Spanish
  - Chinese
  - Vietnamese
  - Korean
  - Tagalog
  - Russian
  - Arabic



Marketplace Plan Comparison Worksheet

Annual Projected Income		Premium Tax Credit (monthly)	
		Premium Tax Credit (annual)	
Household Size		CSR Eligible?	Yes No

Main Information

	Option 1	Option 2	Option 3	Option 4
Insurance Company				
Insurance Plan Name				
Metal Tier (bronze, silver, gold)				
Plan Type (PPO, HMO, etc.)				
Monthly Premium (after tax credit)				
Annual Premium (after tax credit)				

Tip Since some plans may have similar names, make sure to include the full plan name in the worksheet

Cost Sharing (your share of medical costs, in addition to the premium)

	Option 1	Option 2	Option 3	Option 4
Deductible				
Out-of-Pocket Maximum				
Physician Visit				
Specialist Visit				
Generic Drugs				
Emergency Room Visit				
Inpatient Hospital Stay				
Other:				
Other:				

Provider Network & Formulary

Name(s)	Option 1	Option 2	Option 3	Option 4
Physician(s) In-Network	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Specialist(s) In-Network	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hospital In-Network	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prescription on Formulary	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other:				

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Example: AV Guides Cost-Sharing Charges

Source: Healthcare.gov 2021 plan, Dane County, WI 53558

Estimated monthly premium
$285.90

Group Health Cooperative-SCW

Select Bronze 8550 Ded/8550 MOOP

Bronze | HMO | Plan ID: **94529WI0240056**

Deductible	Out-of-pocket maximum
$8,550 Individual total	$8,550 Individual total

Bronze 60% AV

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
No Charge After Deductible	$35	$125	$175

Estimated monthly premium
$369.40

Eligible for a Health Savings Account

Dean Health Plan

Dean Focus Network Silver HSA-E 4500X

Silver | EPO | Plan ID: **38345WI0080048**

Deductible	Out-of-pocket maximum
$4,500 Individual total	$6,900 Individual total

Silver 70% AV

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible

Estimated monthly premium
$417.86

Group Health Cooperative-SCW

Gold Simple Choice 1600 Ded/5400 MOO

Gold | HMO | Plan ID: **94529WI0240049**

Deductible	Out-of-pocket maximum
$1,600 Individual total	$5,400 Individual total

Gold 80% AV

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
20% Coinsurance after deductible	$15	$25	$65

Estimated monthly premium
$456.45

Group Health Cooperative-SCW

Select Platinum 500 Ded/1500 MOOP

Platinum | HMO | Plan ID: **94529WI0210028**

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

Platinum 90% AV

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
$100	$10	$20	$40

Cost-Sharing Reductions

What are Cost-Sharing Reductions (CSRs)?

- A Marketplace subsidy that reduces the out-of-pocket costs an enrollee has to pay for medical care
- People with income up to 250% FPL are eligible
- **Must enroll in a silver-level plan through the Marketplace**

3 Levels of Cost-Sharing Reduction Plans Based on Income:				
	Standard Silver No CSR	CSR Plan	CSR Plan	CSR Plan
FPL Range	Above 250% FPL	200–250% FPL	150–200% FPL	Up to 150% FPL
Income Range (HH of 1)	> $32,200	$25,760 - $32,200	$19,320 - $25,760	< $19,320
Actuarial Value	70% AV	73% AV	87% AV	94% AV
Max OOP Limit *Individual in 2022*	$8,700	$6,950	$2,900	$2,900
Max OOP Limit *Family in 2022*	$17,400	$13,900	$5,800	$5,800

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Example Plan: Cost-Sharing Reductions

Source: Healthcare.gov
2021 silver plan variations,
Cook County, IL 60608

Ambetter of Illinois

Ambetter Balanced Care 12 (2021)

Silver | HMO | Plan ID: **27833IL0140022**

No CSR
70% AV

Deductible	Out-of-pocket maximum
$6,500 Individual total	$8,400 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
40% Coinsurance after deductible	$25	$35	$70

Ambetter of Illinois

Ambetter Balanced Care 12 (2021)

Silver | HMO | Plan ID: **27833IL0140022**

200% - 250% FPL
73% AV

Deductible	Out-of-pocket maximum
$3,850 Individual total	$6,500 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
40% Coinsurance after deductible	$25	$25	$50

Ambetter of Illinois

Ambetter Balanced Care 12 (2021)

Silver | HMO | Plan ID: **27833IL0140022**

150% - 200% FPL
87% AV

Deductible	Out-of-pocket maximum
$950 Individual total	$2,250 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
40% Coinsurance after deductible	$10	$5	$30

Ambetter of Illinois

Ambetter Balanced Care 12 (2021)

Silver | HMO | Plan ID: **27833IL0140022**

<150% FPL
94% AV

Deductible	Out-of-pocket maximum
$0 Individual total	$1,400 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
25%	No Charge	No Charge	$10

Example Plan: Cost-Sharing Reductions

Source: Healthcare.gov
2021 silver plan variations,
Cook County, IL 60608

Bright HealthCare

Silver 5000

Silver | HMO | Plan ID: 44522IL0010002

No CSR
70% AV

Deductible	Out-of-pocket maximum
$5,000 Individual total	$8,550 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
40% Coinsurance after deductible	$30	$40	$80

Bright HealthCare

Silver 3800

Silver | HMO | Plan ID: 44522IL0010002

200% - 250% FPL
73% AV

Deductible	Out-of-pocket maximum
$3,800 Individual total	$6,800 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
40% Coinsurance after deductible	$20	$35	$70

Bright HealthCare

Silver 1500 + $0 Primary Care

Silver | HMO | Plan ID: 44522IL0010002

150% - 200% FPL
87% AV

Deductible	Out-of-pocket maximum
$1,500 Individual total	$2,850 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
30% Coinsurance after deductible	No Charge	No Charge	$30

Bright HealthCare

Silver $0 Deductible + $0 Primary Care

Silver | HMO | Plan ID: 44522IL0010002

<150% FPL
94% AV

Deductible	Out-of-pocket maximum
$0 Individual total	$1,500 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
20%	No Charge	No Charge	$10

Beyond the Basics

Comparing Two 87% AV CSR Plans

Ambetter of Illinois

Ambetter Balanced Care 12 (2021)

Silver | HMO | Plan ID: **27833IL0140022**

Deductible	Out-of-pocket maximum
$950 Individual total	$2,250 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
40% Coinsurance after deductible	$10	$5	$30

Bright HealthCare

Silver 1500 + $0 Primary Care

Silver | HMO | Plan ID: **44522IL0010002**

Deductible	Out-of-pocket maximum
$1,500 Individual total	$2,850 Individual total

Copayments / Coinsurance

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
30% Coinsurance after deductible	No Charge	No Charge	$30

Source: Healthcare.gov 2021 silver plan variations, Cook County, IL 60608

Beyond the Basics

Skimpy Plans

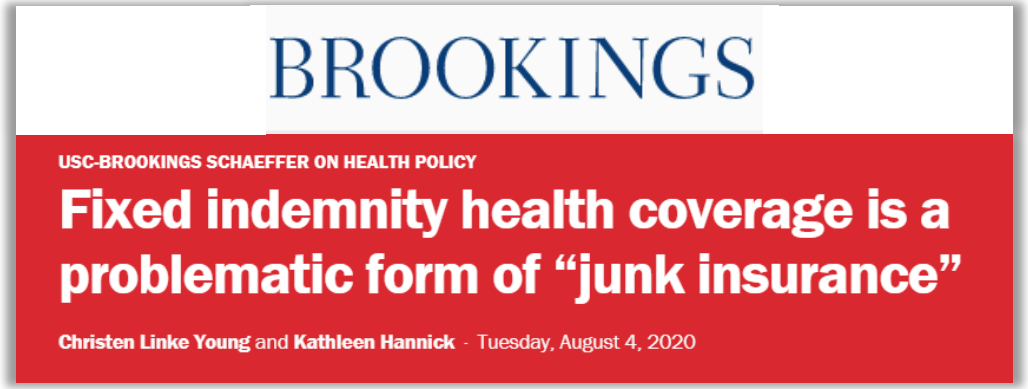
Skimpy Plans

- Short-term, limited duration plans
- Association health plans
- Health care sharing ministries
- Indemnity plans

- Skimpy plans are **not** QHPs, meaning they do not have to meet standards outlined in the Affordable Care Act and are not certified by the federal Health Insurance Marketplace or state-based marketplaces
- Skimpy plans don't have to include consumer protections, so they can:
  - Charge higher premiums based on gender and pre-existing conditions
  - Deny coverage based on pre-existing conditions
  - Impose annual or lifetime coverage limits
  - Deny claims for pre-existing conditions
  - Exclude coverage of EHBs
- **Simply put – they're junk**

Beyond the Basics

The High Cost of Cheap Insurance



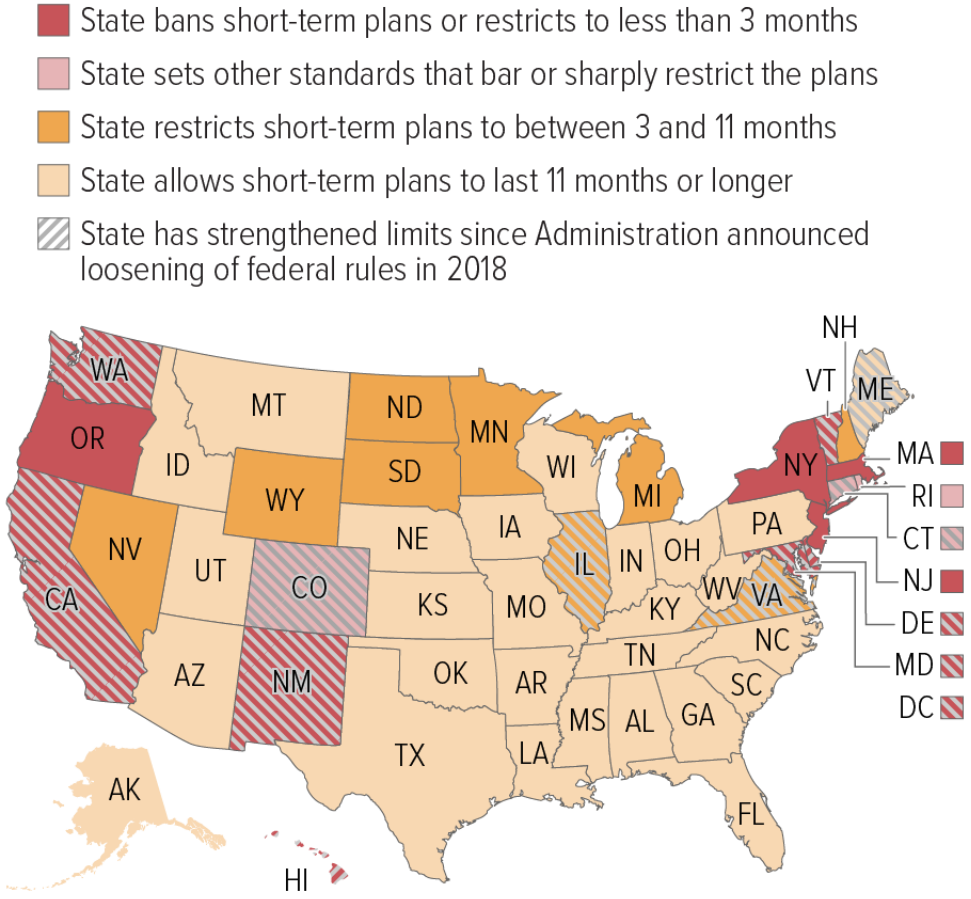
"Features" of Short-Term Plans

- Short-term, limited duration (STLD) plans typically exclude coverage for pre-existing conditions and deny claims related to such conditions
  - Insurers 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
  - 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 condition
  - People with pre-existing conditions may be denied a policy outright
- Short-term plans are not required to cover essential health benefits, and often don't cover:
  - Prescription drugs
  - Maternity care
  - Mental health benefits and substance-use disorder treatment
- Short-term plans can impose overall limits on plan benefits, lifetime limits, and per-service limits; they are not subject to cost-sharing limits
- A short-term plan may look like a comprehensive health plan (with a premium, deductible, and a provider network)
- Short-term plans don't count as minimum essential coverage, so when the plan ends, it **does not trigger a special enrollment period for the enrollee**

State Actions to Limit Short-Term Plans

- Many states have the authority to set their own standards for short-term plans and other types of skimpy plans
- Some states have strengthened their protections against short-term plans, but not all states have the authority to conduct oversight of STLD plans
- There is no federal oversight of STLD plans or skimpy plans more generally

State Limitations on Short-Term Health Insurance Plans, October 2020



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.

"Direct Enrollment" Websites

- The federal marketplace allows the use of "direct enrollment" (DE) and "enhanced direct enrollment" (EDE) sites
- This is when insurers and brokers (including web brokers) use their own websites, rather than HealthCare.gov, to let people apply for and enroll in marketplace plans and receive subsidies
  - Direct enrollment websites send the consumer to HealthCare.gov 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 their own website for the entire process, without sending them to HealthCare.gov
- Some DE and EDE sites sell short-term and other skimpy plans
  - Federal rules bar these plans from being displayed alongside QHPs, but some sites still heavily promote them
- Some DE and EDE sites try to sell skimpy plans to people eligible for Medicaid, instead of helping direct them to the right resources to enroll in Medicaid

What You Can Do to Help

- Promote open enrollment and HealthCare.gov (or your state-based marketplace)
- Understand and inform people about the risks of short-term plans and other skimpy plans
  - Help people see past the low premiums of skimpy plans and understand the high costs they may face down the road
- Promote special enrollment periods for people who face 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

Q & A

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
- HealthCare.gov:
  - Glossary of Health Insurance Terms

Upcoming Webinars

Part VI: Plan Selection Strategies

- Tuesday, October 5 | 1 pm ET (10 am PT)

Part VII: Redetermination & Renewal Process

- Thursday, October 7 | 1 pm ET (10 am PT)

Part VIII: Tying It All Together

- Tuesday, October 12 | 1 pm ET (10 am PT)

Part IX: Best Practices for Assisting People with Disabilities

- Thursday, October 14 | 1 pm ET (10 am PT)

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

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