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
• 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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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

<table>
<thead>
<tr>
<th>Preventive &amp; wellness services &amp; chronic disease management</th>
<th>Emergency services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory services (outpatient medical care)</td>
<td>Maternity &amp; newborn care</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Mental health &amp; substance use disorder services, including behavioral health treatment</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>Rehabilitative &amp; habilitative services &amp; devices</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Pediatric services</td>
</tr>
</tbody>
</table>
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

- **HMO (Health Maintenance Organization)**
  - Monthly Cost: $
  - PCP Not Covered

- **EPO (Exclusive Provider Organization)**
  - Monthly Cost: $$
  - PCP Not Covered

- **POS (Point of Service)**
  - Monthly Cost: $$$

- **PPO (Preferred Provider Organization)**
  - Monthly Cost: $$$$
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

**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

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The amount an enrollee must pay out-of-pocket for health care services before their insurance plan starts paying</td>
<td>- Enrollee pays a set dollar amount for health care services and prescriptions</td>
<td>- Enrollee pays a percentage of the total cost for health care services and prescriptions</td>
</tr>
<tr>
<td>- Resets every year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For definitions of common health insurance terms, visit [www.healthcare.gov/glossary](http://www.healthcare.gov/glossary)
• Certain services may be covered before the deductible is met in some plans
  ▪ This is sometimes referred to as “first dollar coverage”
    o 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:
    o Well-woman visits
    o Screenings for cancer, diabetes, hypertension, etc.
    o Immunizations
    o 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

<table>
<thead>
<tr>
<th>Limit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual OOP Limit</td>
<td>$8,700</td>
</tr>
<tr>
<td><em>(NOTE: applies to each individual in a family plan as well)</em></td>
<td></td>
</tr>
<tr>
<td>Family OOP Limit</td>
<td>$17,400</td>
</tr>
</tbody>
</table>
Example: How Cost-Sharing Works

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

- **Annual Deductible:** $3,000
  - Carl pays full amount for services $3,000
  - Insurer doesn’t pay anything $0

- **Annual Out-of-Pocket Limit:** $7,000
  - Carl pays copayments/coinsurance $4,000
  - Insurer pays the rest of the cost for services $9,300

- **Insurer pays**
  - Carl doesn’t pay anything $0
  - Insurer pays full amount $23,700
Example: Plan Cost-Sharing

AvMed
AvMed Entrust Silver 300
Silver | HMO | Plan ID: 19898FL0340002

Deductible
$3,000 Individual total

Out-of-pocket maximum
$7,000 Individual total

Estimated monthly premium
$174.74
Including a $237 tax credit Was $411.74

Copayments / Coinsurance

Emergency room care
$500 Copay after deductible

Generic drugs
$20

Primary doctor
$40

Specialist doctor
$80

Plan features

Adult Dental
Child Dental

Add medical providers
Add your medical providers and we'll show you which plans cover them

Add prescription drugs
Add your prescription drugs and we'll show you which plans cover them.

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

Beyond the Basics
Example: How Cost-Sharing Works

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

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

Annual Deductible: $3,000
Annual OOP Limit: $7,000

Carl pays
Insurer pays
Insurer pays

$3,000
$500 $900 $720
$4,000 $7,000 $3,000 $2,000 $3,000 $20,000
$1,000 $800 $3,000 $200 $300 $200 $1,180 $2,000 $300 $720 $2,800 $1,700 $2,280 $18,820
Example: How Cost-Sharing Works

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

Hospitalization
- 20% after deductible

ER Visit
- 20% after deductible

Primary Care
- 20% after deductible

Lab Tests
- $200 copay after deductible

Annual Deductible: $5,000

Annual OOP Limit: $7,000
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.
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.
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

<table>
<thead>
<tr>
<th>Plan A</th>
<th>Annual Deductible</th>
<th>Annual OOP Limit</th>
<th>Primary Care Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>$5,000</td>
<td>$8,700</td>
<td>$25</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$10,000</td>
<td>None</td>
<td>50% coinsurance (of allowable charges)</td>
</tr>
</tbody>
</table>

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

### QUALIFIED HEALTH PLAN (QHP) METAL LEVEL PLAN TIERS
QHPs must provide plan designs consistent with actuarial values

<table>
<thead>
<tr>
<th>Metal Tiers</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 does not apply to these plans)
• 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 to the client
• Available in:
  - English
  - Spanish
  - Chinese
  - Vietnamese
  - Korean
  - Tagalog
  - Russian
  - Arabic

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**Marketplace Plan Comparison Worksheet**

<table>
<thead>
<tr>
<th>Main Information</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Projected Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Tax Credit (monthly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household Size</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Tax Credit (annual)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSR Eligible?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Stay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider Network & Formulary**

<table>
<thead>
<tr>
<th>Provider(s)</th>
<th>In Network</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Specialists</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospitals</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Prescriptions on Formulary</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Example: AV Guides Cost-Sharing Charges

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

- **Platinum 90% AV**
  - Estimated monthly premium: $456.45
  - Deductible: $500
  - Out-of-pocket maximum: $1,500
  - Copayments / Coinsurance:
    - Emergency room care: $300
    - Generic drugs: $10
    - Primary doctor: $20
    - Specialist doctor: $40

- **Gold 80% AV**
  - Estimated monthly premium: $417.86
  - Deductible: $1,600
  - Out-of-pocket maximum: $5,400
  - Copayments / Coinsurance:
    - Emergency room care: $15
    - Generic drugs: $25
    - Primary doctor: $65

- **Silver 70% AV**
  - Estimated monthly premium: $369.40
  - Deductible: $4,500
  - Out-of-pocket maximum: $6,900
  - Copayments / Coinsurance:
    - Emergency room care: $35
    - Generic drugs: $125
    - Primary doctor: $175

- **Bronze 60% AV**
  - Estimated monthly premium: $285.90
  - Deductible: $8,550
  - Out-of-pocket maximum: $8,550
  - Copayments / Coinsurance:
    - Emergency room care: No Charge After Deductible
    - Generic drugs: $35
    - Primary doctor: $125
    - Specialist doctor: $175
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:

<table>
<thead>
<tr>
<th>FPL Range</th>
<th>Standard Silver No CSR</th>
<th>CSR Plan</th>
<th>CSR Plan</th>
<th>CSR Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Range</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(HH of 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; $32,200</td>
<td></td>
<td>$25,760 - $32,200</td>
<td>$19,320 - $25,760</td>
<td>&lt; $19,320</td>
</tr>
<tr>
<td>Actuarial Value</td>
<td></td>
<td>70% AV</td>
<td>73% AV</td>
<td>87% AV</td>
</tr>
<tr>
<td>Max OOP Limit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual in 2022</td>
<td>$8,700</td>
<td>$6,950</td>
<td>$2,900</td>
<td>$2,900</td>
</tr>
<tr>
<td>Family in 2022</td>
<td>$17,400</td>
<td>$13,900</td>
<td>$5,800</td>
<td>$5,800</td>
</tr>
</tbody>
</table>
Example Plan: Cost-Sharing Reductions

**Ambetter of Illinois**

**Ambetter Balanced Care 12 (2021)**
Silver | HMO | Plan ID: 27833IL0140022

**No CSR 70% AV**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,500</td>
<td>$8,400</td>
</tr>
</tbody>
</table>

**Copayments / Coinsurance**

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

**Ambetter of Illinois**

**Ambetter Balanced Care 12 (2021)**
Silver | HMO | Plan ID: 27833IL0140022

**200% - 250% FPL 73% AV**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,850</td>
<td>$6,500</td>
</tr>
</tbody>
</table>

**Copayments / Coinsurance**

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

**Ambetter of Illinois**

**Ambetter Balanced Care 12 (2021)**
Silver | HMO | Plan ID: 27833IL0140022

**150% - 200% FPL 87% AV**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$950</td>
<td>$2,250</td>
</tr>
</tbody>
</table>

**Copayments / Coinsurance**

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

**Ambetter of Illinois**

**Ambetter Balanced Care 12 (2021)**
Silver | HMO | Plan ID: 27833IL0140022

**<150% FPL 94% AV**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$1,400</td>
</tr>
</tbody>
</table>

**Copayments / Coinsurance**

- Emergency room care: $10 (25%)
- Generic drugs: No Charge
- Primary doctor: No Charge
- Specialist doctor: $10

Source: Healthcare.gov
2021 silver plan variations, Cook County, IL 60608
### Example Plan: Cost-Sharing Reductions

#### Bright HealthCare

**Silver 5000**
- **Silver | HMO | Plan ID:** 44522IL0010002
- **No CSR**
- **70% AV**

<table>
<thead>
<tr>
<th>Copayments / Coinsurance</th>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room care</td>
<td>$5,000</td>
<td>$8,550</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$30</td>
<td>$40</td>
</tr>
<tr>
<td>Primary doctor</td>
<td>$40</td>
<td>$80</td>
</tr>
<tr>
<td>Specialist doctor</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**200% - 250% FPL**
- **73% AV**

<table>
<thead>
<tr>
<th>Copayments / Coinsurance</th>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room care</td>
<td>$3,800</td>
<td>$6,800</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$20</td>
<td>$35</td>
</tr>
<tr>
<td>Primary doctor</td>
<td>$35</td>
<td>$70</td>
</tr>
</tbody>
</table>

#### Bright HealthCare

**Silver 3800**
- **Silver | HMO | Plan ID:** 44522IL0010002

<table>
<thead>
<tr>
<th>Copayments / Coinsurance</th>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room care</td>
<td>$1,500</td>
<td>$2,850</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Primary doctor</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Specialist doctor</td>
<td>$30</td>
<td>$60</td>
</tr>
</tbody>
</table>

#### Bright HealthCare

**Silver 1500 + $0 Primary Care**
- **Silver | HMO | Plan ID:** 44522IL0010002
- **150% - 200% FPL**
- **87% AV**

<table>
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<td>No Charge</td>
</tr>
<tr>
<td>Specialist doctor</td>
<td>No Charge</td>
<td>$30</td>
</tr>
</tbody>
</table>

#### Bright HealthCare

**Silver $0 Deductible + $0 Primary Care**
- **Silver | HMO | Plan ID:** 44522IL0010002
- **<150% FPL**
- **94% AV**

<table>
<thead>
<tr>
<th>Copayments / Coinsurance</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Emergency room care</td>
<td>$0</td>
<td>$1,500</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Primary doctor</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td>Specialist doctor</td>
<td>No Charge</td>
<td>$10</td>
</tr>
</tbody>
</table>

Source: Healthcare.gov
2021 silver plan variations, Cook County, IL 60608
### Comparing Two 87% AV CSR Plans

**Ambetter of Illinois**

**Ambetter Balanced Care 12 (2021)**

- Silver | HMO | Plan ID: 278331L0140022

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$950</td>
<td>$2,250</td>
</tr>
</tbody>
</table>

- Individual total  
- Individual total

**Copayments / Coinsurance**

<table>
<thead>
<tr>
<th>Emergency room care</th>
<th>Generic drugs</th>
<th>Primary doctor</th>
<th>Specialist doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>40% Coinsurance after deductible</td>
<td>$10</td>
<td>$5</td>
<td>$30</td>
</tr>
</tbody>
</table>

**Bright HealthCare**

**Silver 1500 + $0 Primary Care**

- Silver | HMO | Plan ID: 445221L0010002

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<th>Deductible</th>
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**Copayments / Coinsurance**

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</thead>
<tbody>
<tr>
<td>30% Coinsurance after deductible</td>
<td>No Charge</td>
<td>No Charge</td>
<td>$30</td>
</tr>
</tbody>
</table>
Skimpy Plans
Skimpy 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

- Short-term, limited duration plans
- Association health plans
- Health care sharing ministries
- Indemnity plans
The High Cost of Cheap Insurance

Reuters
Florida company must face class action over 'fraudulent' health insurance

Propublica
He Bought Health Insurance for Emergencies. Then He Fell Into a $33,601 Trap.
Since the Trump administration deregulated the health insurance industry, there's been an explosion of short-term plans that leave patients with surprise bills and providers with huge revenue.

Brookings
Fixed indemnity health coverage is a problematic form of “junk insurance”

The Washington Post
Critics say ‘junk plans’ are being pushed on ACA exchanges
"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

- State bans short-term plans or restricts to less than 3 months
- State sets other standards that bar or sharply restrict the plans
- State restricts short-term plans to between 3 and 11 months
- State allows short-term plans to last 11 months or longer
- State has strengthened limits since Administration announced loosening of federal rules in 2018

"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
Contact

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  ➔ Twitter: @TaraStraw
• General inquiries: beyondthebasics@cbpp.org

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