Webinar Logistics

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  ▪ 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
Agenda

• Elements of qualified health plans
• Different plan types
• How cost-sharing charges work
• Meaning of metal levels and actuarial value
• Cost-sharing reductions

Part V: Plan Selection Strategies
Thursday September 29, 2022 | 2 pm ET (11 am PT)

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www.healthreformbeyondthebasics.org/events
Elements of Qualified Health Plans (QHPs)
What Is a Qualified Health Plan?

• 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
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: $

- **EPO (Exclusive Provider Organization)**
  - Monthly Cost: $$

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

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

- Not Covered PCP

- Not Covered

- Beyond the Basics
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><strong>Deductible</strong></th>
<th><strong>Copayments</strong></th>
<th><strong>Coinsurance</strong></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 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

<table>
<thead>
<tr>
<th>Maximum OOP Limit for 2023 Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual OOP Limit</td>
</tr>
<tr>
<td><em>(NOTE: applies to each individual in a family plan as well)</em></td>
</tr>
<tr>
<td>Family OOP Limit</td>
</tr>
</tbody>
</table>
Example: How Cost-Sharing Works

In 2022, Carl has $40,000 in medical expenses

- Insurer pays
  - 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 (hospital stay) → $3,000
  - Insurer doesn’t pay anything → $0
Example: Plan Cost-Sharing

### AvMed

**AvMed Entrust Silver 300 (2022)**

<table>
<thead>
<tr>
<th></th>
<th>deductible</th>
<th>out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AvMed</strong></td>
<td>$3,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Individual total</td>
<td>$3,000</td>
<td>$7,000</td>
</tr>
</tbody>
</table>

**Estimated monthly premium**

$272.40

Including a $573 tax credit Was $845.40

**Copayments / Coinsurance**

- **Emergency room care**
  - $500 Copay after deductible
- **Generic drugs**
  - $20
- **Primary doctor**
  - $40
- **Specialist doctor**
  - $80

**Plan features**

- Adult Dental: X
- Child Dental: ✓

**Plan Details**

- Add medical providers
- Add prescription drugs

**Estimated total yearly costs**

- Add yearly cost

**Source:** Healthcare.gov

2022 plan, Miami-Dade County, FL 33101
Example: How Cost-Sharing Works

In 2022, Carl has $34,000 in total medical expenses.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Ambulance</th>
<th>Imaging</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>$900/day after deductible</td>
<td>$200 copay</td>
<td>50% after deductible</td>
<td>$20 generics</td>
</tr>
</tbody>
</table>

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

Carl pays $1000 for Hospital, $200 for Ambulance, $3000 for Imaging, and $3000 for Drugs.

Insurer pays $200 for Ambulance, $2200 for Imaging, and $500 for Drugs.

**Total**

Carl pays $800 for Hospital, $1800 for Ambulance, $1500 for Imaging, and $2000 for Drugs.

Insurer pays $7200 for Hospital, $1500 for Ambulance, $14500 for Imaging, and $3000 for Drugs.

**Total Paid by Insurer:** $22700

**Total Paid by Carl:** $3800

**Total Paid by Both:** $26800

**Remaining Expenses:** $7200

Carl pays the remaining $7200.
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 $9,100 in 2023, which means that, even though the family OOP limit may be much higher than $9,100, no individual family member could pay more than $9,100 in out-of-pocket costs in 2023.
### Example: In-Network vs. Out-of-Network Cost-Sharing

<table>
<thead>
<tr>
<th>Plan A</th>
<th>Carrier A Silver</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>$9,100</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$10,000</td>
<td>None</td>
<td>50% coinsurance (of allowable charges)</td>
<td></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.
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

<table>
<thead>
<tr>
<th>Qualification</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)
Example: AV Guides Cost-Sharing Charges

Source: Healthcare.gov
2022 plans, Dane County, WI 53558

Platinum 90% AV
Gold 80% AV
Silver 70% AV
Bronze 60% AV

Dean Health Plan
Dean Focus Network Bronze Value Copay 8650X
Bronze | EPO | Plan ID: 38345W010080047

- Estimated monthly premium: $243.39
- Deductible: $8,650 (individual total)
- Out-of-pocket maximum: $8,650 (individual total)

Dean Health Plan
Dean Focus Network Silver HSA-E 4500X
Silver | EPO | Plan ID: 38345W010080048

- Estimated monthly premium: $357.71
- Deductible: $4,500 (individual total)
- Out-of-pocket maximum: $7,000 (individual total)

Dean Health Plan
Dean Focus Network Gold Value Copay 3700X
Gold | EPO | Plan ID: 38345W010080045

- Estimated monthly premium: $366.62
- Deductible: $3,700 (individual total)
- Out-of-pocket maximum: $3,700 (individual total)

Group Health Cooperative-SCW
Select Platinum 1000 Ded/4400 MOOP Primary Care Preferred
Platinum | HMO | Plan ID: 94529W0102404069

- Estimated monthly premium: $417.99
- Deductible: $1,000 (individual total)
- Out-of-pocket maximum: $4,400 (individual total)

- Emergency room care: $325 Copayment with deductible
- Generic drugs: $15
- Primary doctor: $25 Copayment with deductible
- Specialist doctor: No Charge After Deductible

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

<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 (HH of 1)</td>
<td>Above 250% FPL</td>
<td>200–250% FPL</td>
<td>150–200% FPL</td>
<td>Up to 150% FPL</td>
</tr>
<tr>
<td>Income Range (HH of 1)</td>
<td>&gt; $33,975</td>
<td>$27,180 - $33,975</td>
<td>$20,835 - $27,180</td>
<td>&lt; $20,385</td>
</tr>
<tr>
<td>Actuarial Value</td>
<td>70% AV</td>
<td>73% AV</td>
<td>87% AV</td>
<td>94% AV</td>
</tr>
<tr>
<td>Max OOP Limit Individual in 2023</td>
<td>$9,100</td>
<td>$7,250</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Max OOP Limit Family in 2023</td>
<td>$18,200</td>
<td>$14,500</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>
### Example Plan: Cost-Sharing Reductions

**Source:** Healthcare.gov

**2022 silver plan variations, Cook County, IL 60608**

#### Ambetter of Illinois

<table>
<thead>
<tr>
<th>Plan Details</th>
<th>Premiums</th>
<th>Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambetter Balanced Care 31</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No CSR</td>
<td>$296.80</td>
<td>70% AV</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$5,450</td>
<td>Individual total</td>
</tr>
<tr>
<td></td>
<td>$6,450</td>
<td>Individual total</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add yearly cost</td>
</tr>
<tr>
<td><strong>Estimated total yearly costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add yearly cost</td>
</tr>
</tbody>
</table>

| **Estimated monthly premium** | $82.67 | 73% AV |
| **Deductible** | $3,600 | Individual total |
| | $4,575 | Individual total |
| **Out-of-pocket maximum** | | |
| | | Add yearly cost |
| **Estimated total yearly costs** | | |
| | | Add yearly cost |

| **150% - 200% FPL** | $1.00 | 87% AV |
| **Deductible** | $1,200 | Individual total |
| | $2,200 | Individual total |
| **Out-of-pocket maximum** | | |
| | | Add yearly cost |
| **Estimated total yearly costs** | | |
| | | Add yearly cost |

| **<150% FPL** | | 94% AV |
| **Deductible** | | |
| | | |
| **Out-of-pocket maximum** | | |
| | | |
| **Estimated total yearly costs** | | |
| | | |

**Estimated monthly premium:** $28.67

*Including a $24.7 tax credit: $257.67*

*Extra Savings*

*Source: Healthcare.gov*

[Image of healthcare plan details]

---

**Source:** Healthcare.gov

**2022 silver plan variations, Cook County, IL 60608**

#### Ambetter of Illinois

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<td>Individual total</td>
</tr>
<tr>
<td></td>
<td>$6,450</td>
<td>Individual total</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add yearly cost</td>
</tr>
<tr>
<td><strong>Estimated total yearly costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add yearly cost</td>
</tr>
</tbody>
</table>

| **Estimated monthly premium** | $82.67 | 73% AV |
| **Deductible** | $3,600 | Individual total |
| | $4,575 | Individual total |
| **Out-of-pocket maximum** | | |
| | | Add yearly cost |
| **Estimated total yearly costs** | | |
| | | Add yearly cost |

| **150% - 200% FPL** | $1.00 | 87% AV |
| **Deductible** | $1,200 | Individual total |
| | $2,200 | Individual total |
| **Out-of-pocket maximum** | | |
| | | Add yearly cost |
| **Estimated total yearly costs** | | |
| | | Add yearly cost |

| **<150% FPL** | | 94% AV |
| **Deductible** | | |
| | | |
| **Out-of-pocket maximum** | | |
| | | |
| **Estimated total yearly costs** | | |
| | | |

**Estimated monthly premium:** $28.67

*Including a $24.7 tax credit: $257.67*

*Extra Savings*

*Source: Healthcare.gov*
In 2022, Carl has $34,000 in total medical expenses.

Example: How a CSR Plan Works

**Ambulance**
- $200 copay
- $1000 total

**Hospital**
- $500 copay
- $7000 total

**Imaging**
- $200 copay
- $3000 total

**Doctors**
- No charge in hospital
- $20,000

**Drugs**
- $15 generic
- $3000

Carl’s total: $1105

Annual Deductible: $0

Annual OOP Limit: $2500
Comparing Two 87% AV CSR Plans

**Ambetter of Illinois**

**Ambetter Balanced Care 4**

- Estimated monthly premium: $60.94
- Including a $247 tax credit/Was $307.94
- Extra Savings

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,100 Individual total</td>
<td>$2,100 Individual total</td>
</tr>
</tbody>
</table>

**Copayments / Coinsurance**

- Emergency room care: No Charge
- Generic drugs: No Charge
- Primary doctor: No Charge
- Specialist doctor: $5

**Brightness HealthCare**

**Silver 200**

- Estimated monthly premium: $59.45
- Including a $247 tax credit/Was $306.45
- Extra Savings

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Out-of-pocket maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200 Individual total</td>
<td>$2,900 Individual total</td>
</tr>
</tbody>
</table>

**Copayments / Coinsurance**

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

Source: Healthcare.gov 2022 silver plan variations, Cook County, IL 60608
• 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
Plan Design Resources
# Summary of Benefits & Coverage (SBC)

**AvMed Entrust Silver 300**

<table>
<thead>
<tr>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated monthly premium</td>
</tr>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
</tr>
<tr>
<td>Estimated total yearly costs</td>
</tr>
<tr>
<td>Medical providers in-network</td>
</tr>
<tr>
<td>Drugs covered/not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Star rating</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Plan documents</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room care</td>
<td>$500 copay/visit after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$200 copay/one way ground transport</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>$900 copay/day for the first 2 days per admission after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive care/screening immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$100 copay/visit at independent facilities; $200 copay visit at hospital-owned or affiliated facilities; $30 copay visit at participating labs</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$300 copay/visit at hospital-owned or affiliated facilities; $600 copay visit at hospital-owned or affiliated facilities</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$60 copay/visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge for first non-preventive visit; $40 copay</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Important Questions**

- **What is the overall deductible?**
  - $9,000 individual / $18,000 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 cost/deductibles for specific services?**
  - No. There are no other out-of-pocket 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.
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

Available at: [http://www.healthreformbeyondthebasics.org/plan-comparison/](http://www.healthreformbeyondthebasics.org/plan-comparison/)
• New in 2023: Marketplace insurers are required to offer plans with standardized cost-sharing amounts.
  
  ▪ Required for every network type and at every metal level for which an insurer has a QHP in a given service area.
    
    o If an insurer offers a gold HMO plan in a service area, then it must also offer a gold HMO standardized plan throughout that area.
  
  ▪ Doesn't apply in SBMs, Delaware, Louisiana, or Oregon.
  
  ▪ Can aid plan comparisons.

<table>
<thead>
<tr>
<th></th>
<th>Bronze</th>
<th>Expanded Bronze</th>
<th>Standard Silver</th>
<th>Silver 73 CSR</th>
<th>Silver 87 CSR</th>
<th>Silver 94 CSR</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actuarial Value</td>
<td>59.86%</td>
<td>64.06%</td>
<td>70.04%</td>
<td>73.10%</td>
<td>87.04%</td>
<td>94.02%</td>
<td>78.00%</td>
<td>88.00%</td>
</tr>
<tr>
<td>Deductible</td>
<td>$9,100</td>
<td>$7,500</td>
<td>$5,800</td>
<td>$5,700</td>
<td>$800</td>
<td>$0</td>
<td>$2,000</td>
<td>$0</td>
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<tr>
<td>Annual Limitation on Cost Sharing</td>
<td>$9,100</td>
<td>$9,000</td>
<td>$8,900</td>
<td>$7,200</td>
<td>$3,000</td>
<td>$1,700</td>
<td>$8,700</td>
<td>$3,000</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>No charge after deductible</td>
<td>50%</td>
<td>40%</td>
<td>40%</td>
<td>30%</td>
<td>25%*</td>
<td>25%</td>
<td>$100*</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>No charge after deductible</td>
<td>50%</td>
<td>40%</td>
<td>40%</td>
<td>30%</td>
<td>25%*</td>
<td>25%</td>
<td>$350*</td>
</tr>
</tbody>
</table>

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 may:
  - 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 essential benefits
  - Pay out limited amounts for health care

- They expose people to high costs.
- And they’re not that cheap!
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
"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
• Key Facts:
  ▪ Cost-Sharing Charges
  ▪ Cost-Sharing Reductions
  ▪ No Surprises Act

• 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 V: Plan Selection Strategies
  ▪ Thursday, September 29 | 2 pm ET (11 am PT)

Part VI: Preventing and Resolving Data Matching Inconsistencies
  ▪ Tuesday, October 4 | 2 pm ET (11 am PT)

Part VII: The Autorenewal Process
  ▪ Thursday, October 6 | 2 pm ET (11 am PT)

Part VIII: Tying It All Together
  ▪ Thursday, October 13 | 2 pm ET (11 am PT)

Part IX: Asistiendo a consumidores hispanos a obtener cobertura médica: consejos y mejores prácticas (en Español)
  ▪ Thursday, October 20 | 2 pm ET (11 am PT)

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

View OE10 recordings and resources: https://www.healthreformbeyondthebasics.org/category/oe10-webinar-series/
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www.cbpp.org