Plan Design

October 3, 2023

Webinar Logistics

- After the webinar, we'll circulate the slides, a video recording of this presentation, and other resources. We'll also post everything to the Beyond the Basics website.
- Automated captions have been enabled for this webinar. To view them, click on the "more" option with three dots at the bottom of your screen. There you should have the option to turn on closed captioning.

- All participants are muted and in listen-only mode. If you'd like to ask a question:
  - Click on the Q&A icon at the bottom of your webinar screen and type your question into the box.
  - We will be monitoring questions and will pause for Q&A during the presentation.
  - We may not be able to answer every question asked, but we will have a record of all your questions and will use them as a guide for future resources and presentations.
  - You can also email your questions during and after the webinar to beyondthebasics@cbpp.org

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Celebrating 10 Years of Marketplace Coverage
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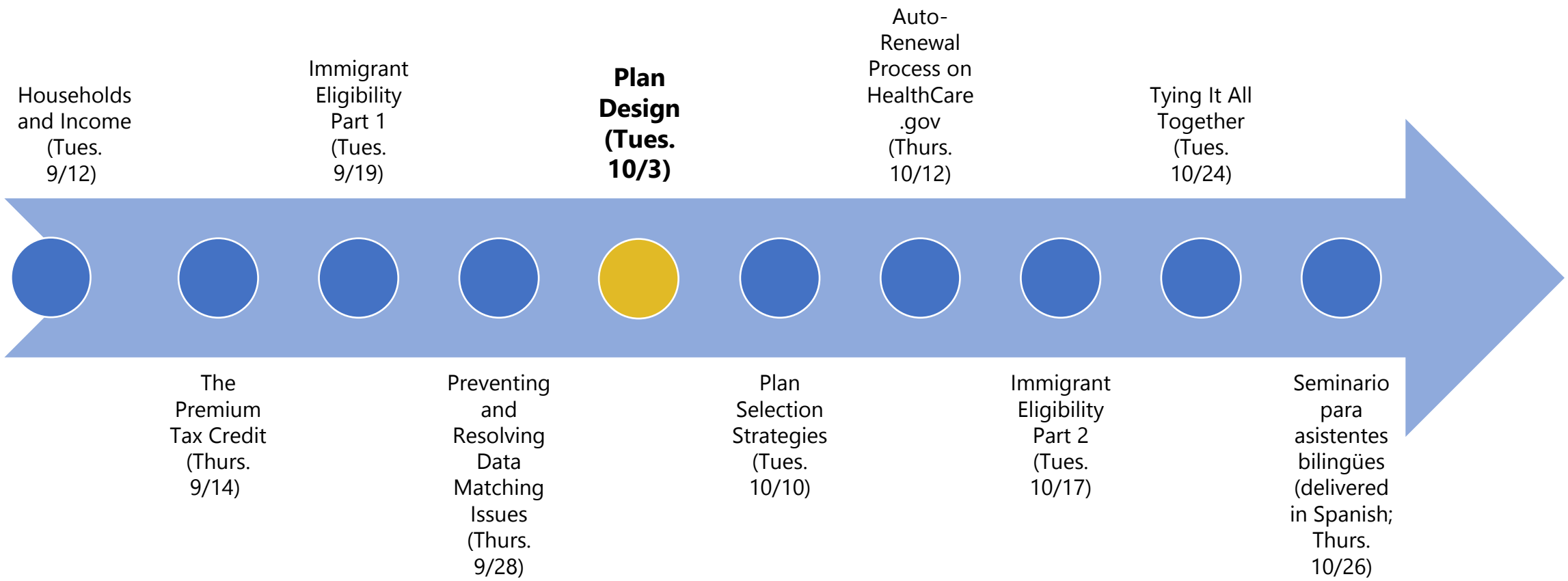
Fall Webinar Series



Register and find recordings and materials from past webinars in the series at: https://www.healthreformbeyondthebasics.org/category/webinars/

Beyond the Basics 3
Celebrating 10 Years of Marketplace Coverage
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Agenda

We'll discuss:

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

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Celebrating 10 Years of Coverage

Josh Newland

Outreach & Enrollment Coordinator, Ohio Association of Foodbanks' Navigator Consortium

Years in Role: 10

"As an assister there is nothing better than seeing the worry leave a consumer's face and be replaced with look of relief. The two most valuable things that I have learned from my experience that I would pass along to new assisters is to always be empathetic to everyone's situation and also to be open and honest. You need to be knowledgeable, but you also need to acknowledge when you need to do more research. You will run into situations that aren't always cookie cutter. Having readily available resources (Like https://www.healthreformbeyondthebasics.org/) is as important as having everything memorized. Never stop collecting resources."

"This Ohio Association of Foodbanks' Navigator project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $2.33 million with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government."

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Celebrating 10 Years of Coverage

Sandra Algarin

Certified Application Counselor | Outreach & Marketing Lead, Community Health Centers (Florida)

Years in Role: Over 5 years

"For me being an effective assister means to be able to understand the needs of the consumers or patients. It also means to be able to go the extra mile to connect that consumer or patient with the right organization, services for them to have a high-quality accessible Health care coverage. Being an effective assister means that one is able to listen, empathize, advocate for the consumer or patient during the most fragile time of their life. It means we are a beacon of light for someone that needs guidance in all aspect of their lives (financial, mental health, social, emotional, etc.). To be an effective Assister, one needs to be a good listener, have compassion, and have the commitment that yes, there is always a way to help someone in need of information and services."

Advice to the new CAC's: Never assume, and be patient!

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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 (ACA)

QHPs must include:

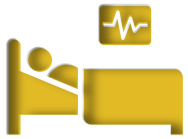
- Coverage for pre-existing conditions
- Coverage of 10 Essential Health Benefits (EHBs)
- Cost-sharing limits that follow federal regulations
- No annual or lifetime benefit limits

QHPs must be certified by the federal Health Insurance Marketplace or a state-based marketplace (SBM)

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

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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.

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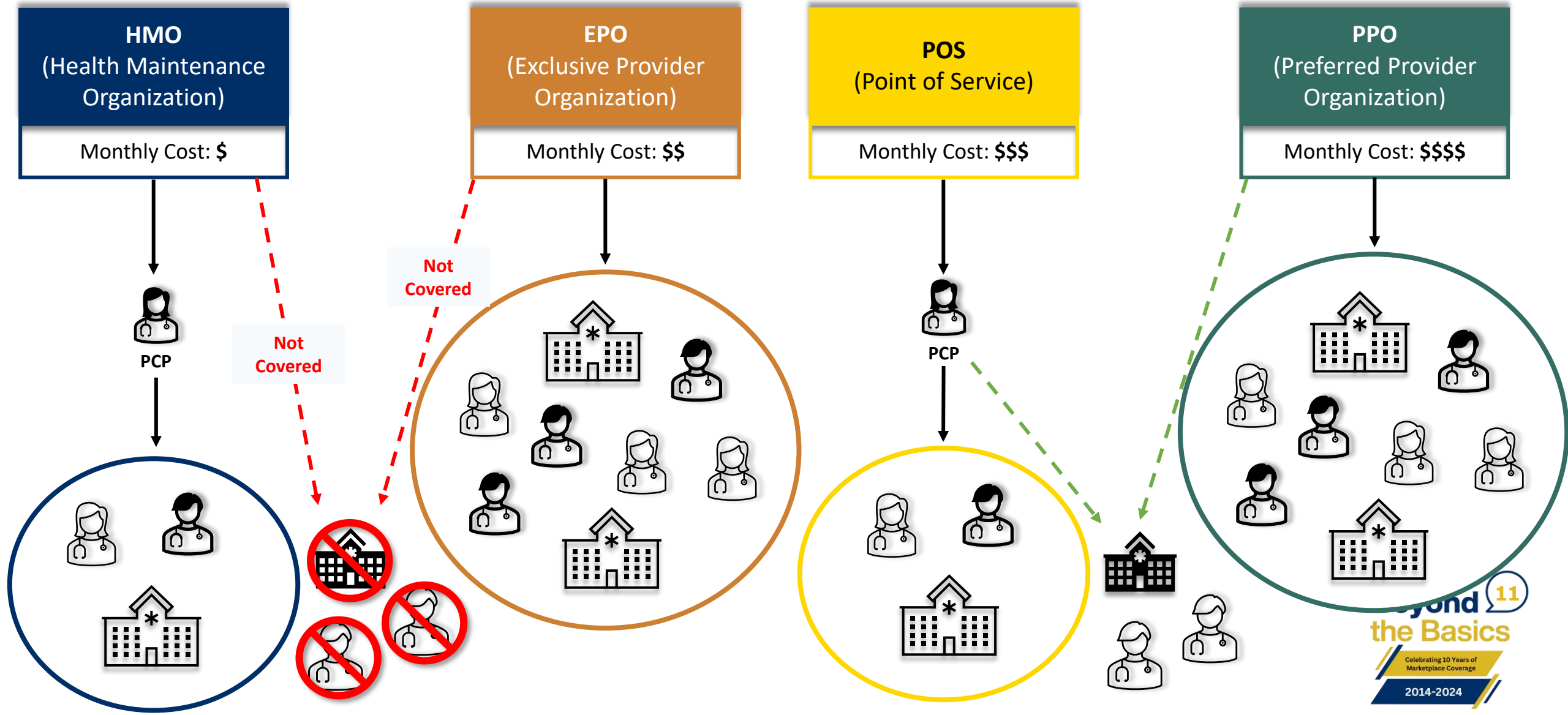
Types of Plan Networks



Basic Elements of QHPs: Formularies

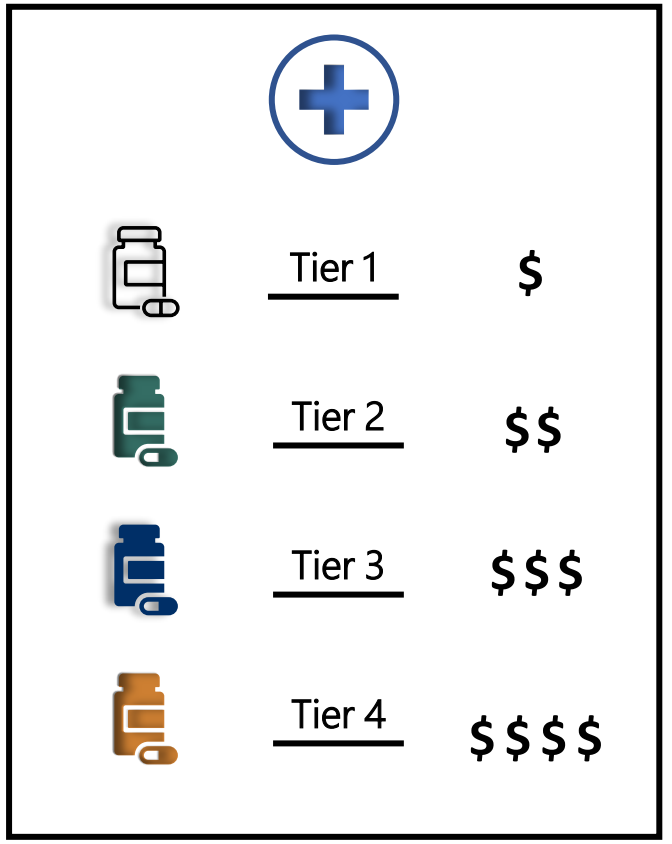
A formulary is a list of medications an insurance plan will pay for

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



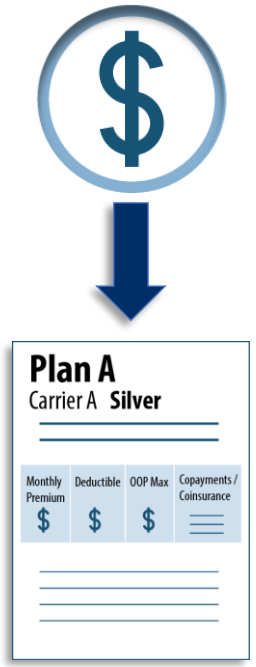
Basic Elements of QHPs: Premiums & Cost-Sharing Charges

Premiums

VS

Cost-Sharing Charges

- 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



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

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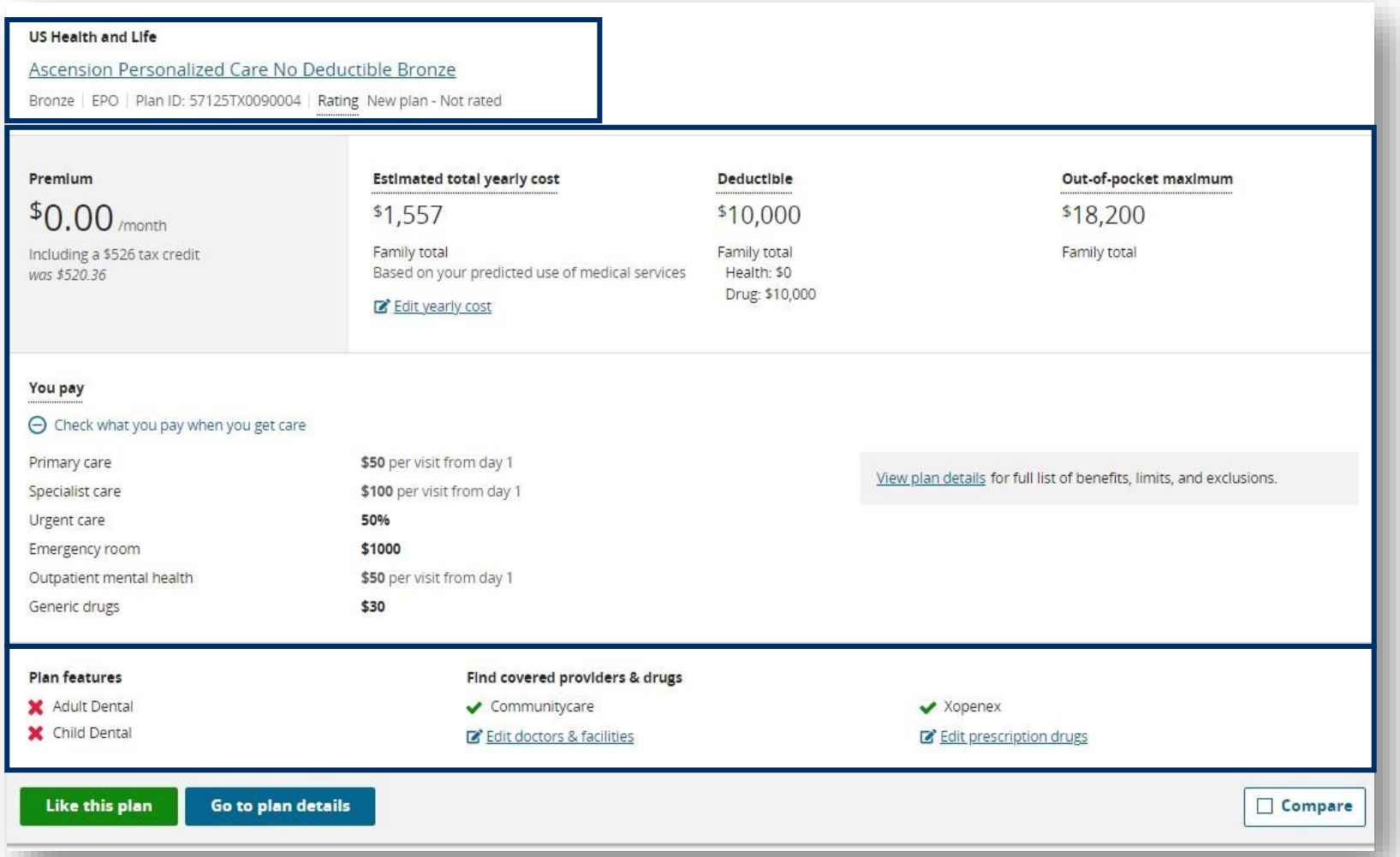
New for 2023: Updated Plan Cards



Basic Plan Information
Name, issuer, metal type, network type

Cost Information
Premium, estimated annual cost, deductible, OOP maximum, cost-sharing for certain services

Dental, Network, and Formulary
Customizable based on a person's provider and medications

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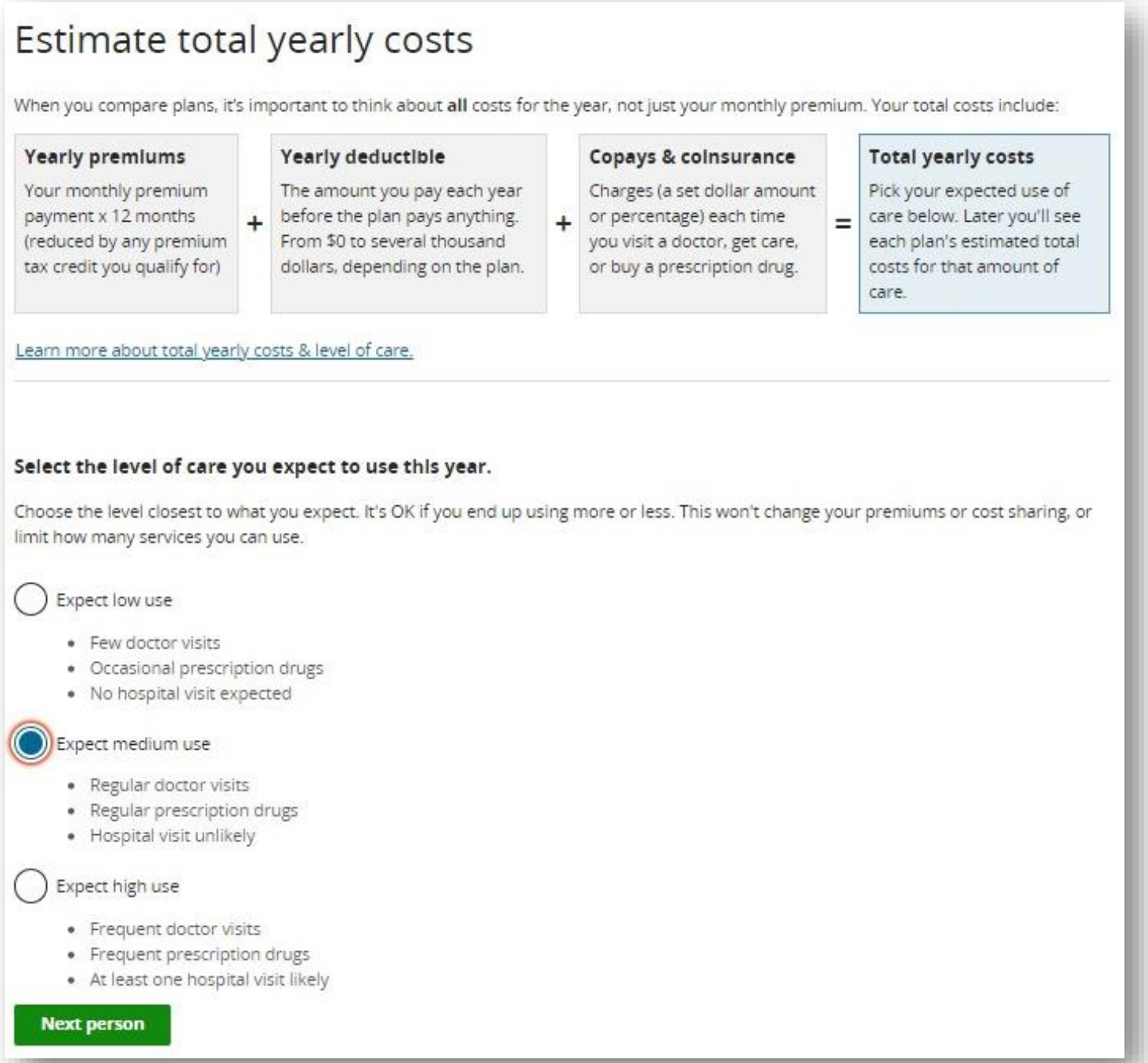
New for 2023: Estimated Total Yearly Costs



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Overview of Cost-Sharing Charges

Types of Cost-Sharing Charges

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

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

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

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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 OOP 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 2024 Coverage	
Individual OOP Limit *(NOTE: applies to each individual in a family plan as well)*	$9,450*
Family OOP Limit	$18,900*

* These amounts are lower for people with lower incomes; see slide 25

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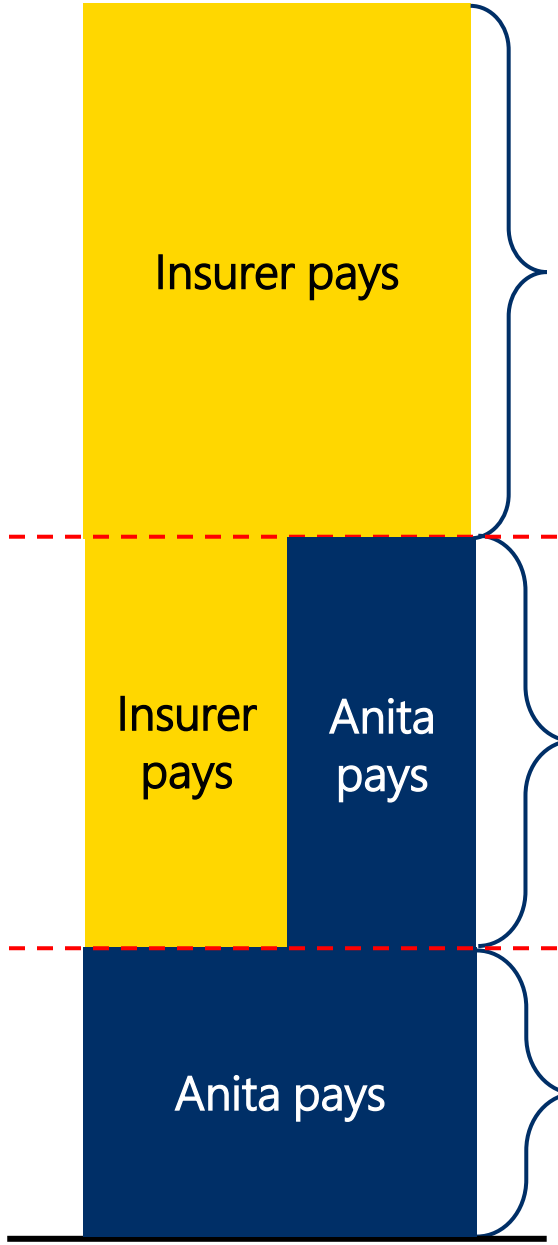
Example: How Cost-Sharing Works

In 2023, Anita has $27,000 in medical expenses



Anita doesn't pay anything → $0

Insurer pays full amount → $18,100

Annual Out-of-Pocket Limit: $7,500*

Anita pays copayments/coinsurance → $1,400

Insurer pays the rest of the cost for services → $1,400

Annual Deductible: $6,100*

Anita pays full amount → $6,100

Insurer doesn't pay anything → $0

* These amounts may be lower for people with lower incomes; see slide 26

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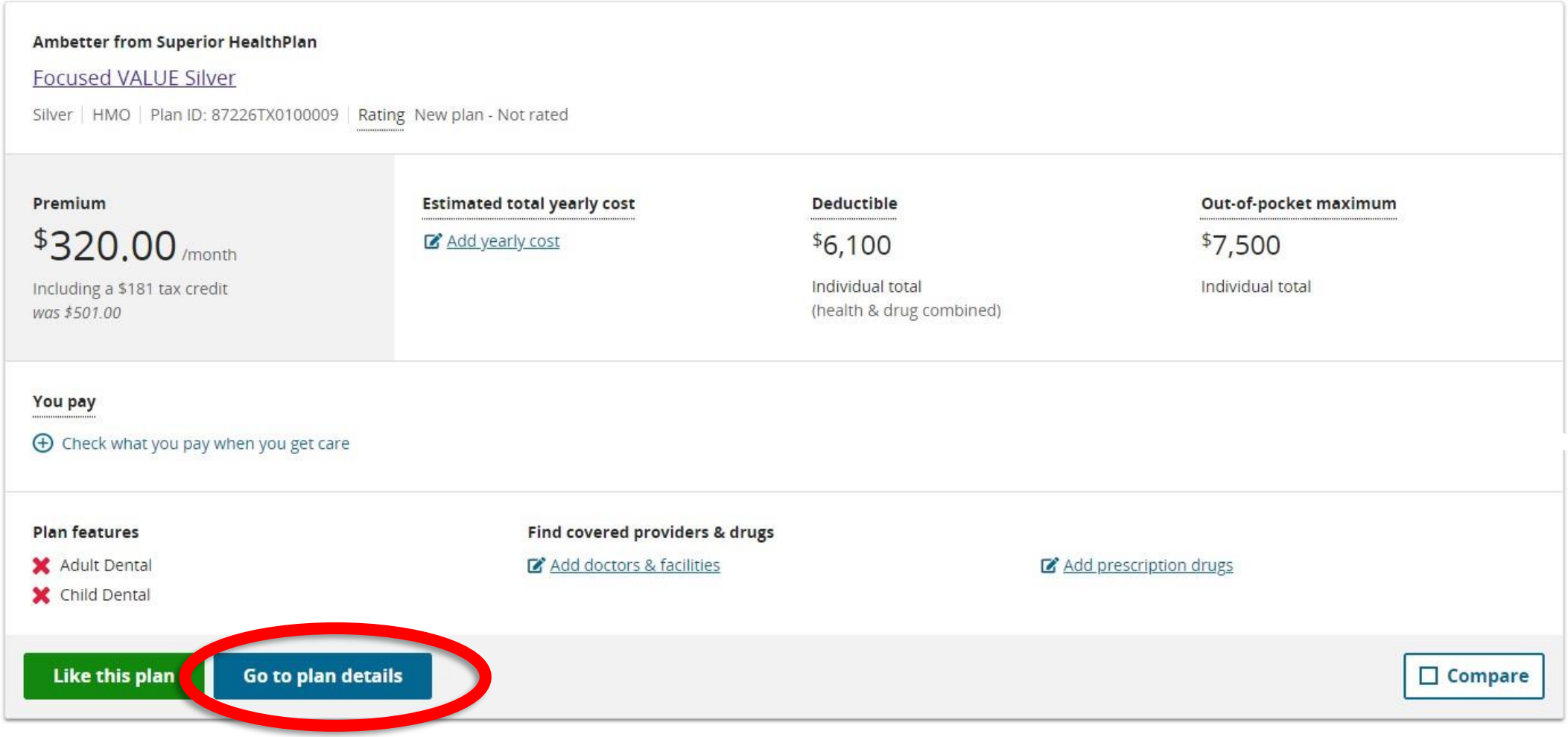
Example: Plan Cost-Sharing

Source: Healthcare.gov 2023 plan, Harris County, TX 77084, 45 y/o non-smoking woman w/$50K income



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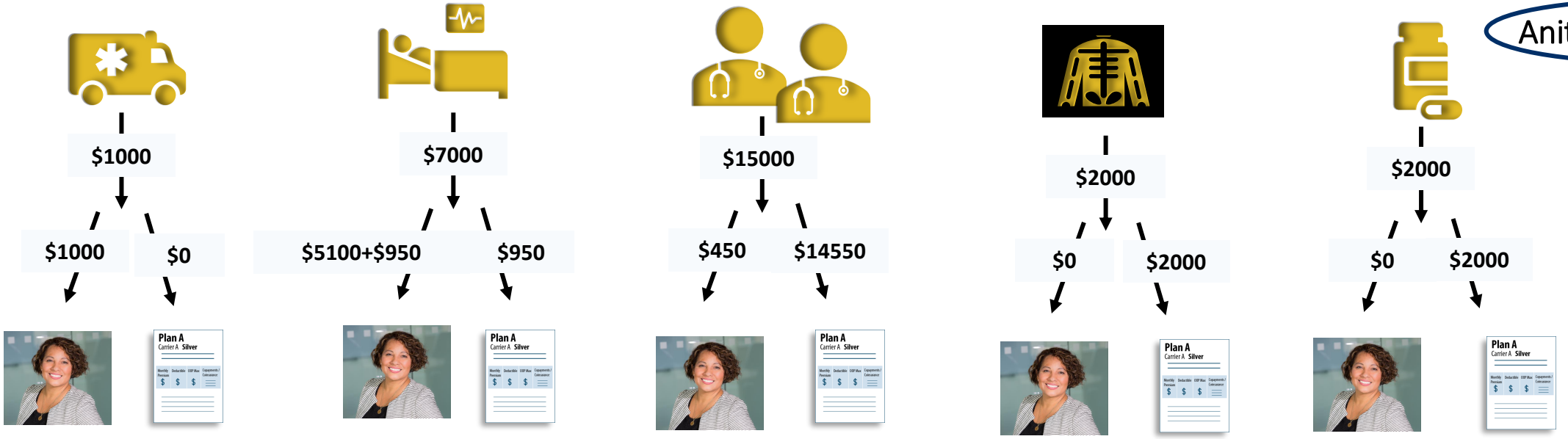
Example: How Cost-Sharing Works

In 2023, Anita has $27,000 in total medical expenses

Ambulance	Hospital Facility Fee	Hospital Physician Fee	Imaging	Drugs
50% after deductible	50% after deductible	50% after deductible	50% after deductible	$30/drug

Anita's total: $7,500



Annual Deductible: $6100

Annual OOP Limit: $7500

Anita Pays

Anita Pays

Insurer Pays

Insurer Pays

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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	$9,100	$25 copay
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

The plan and the patient each pay 50% of the plan's allowed amount ($50+$50=$100)
The plan won't pay more than 50% of the allowed amount, so the remaining $100 is passed on to the patient

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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

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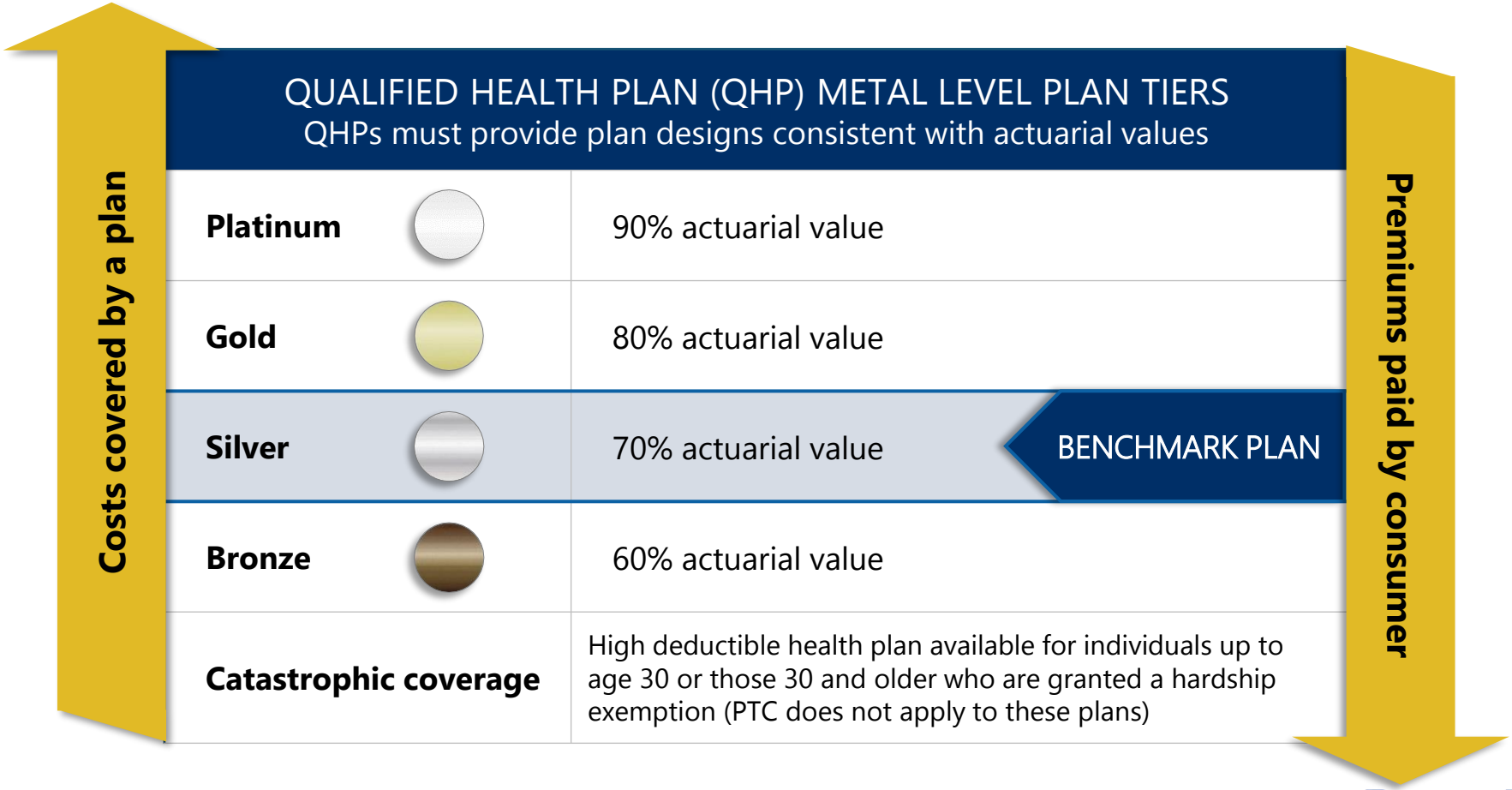
Cost-Sharing & Metal Tiers

Enrollees pay less out-of-pocket with higher AV plans

Premiums are generally higher for high AV plans



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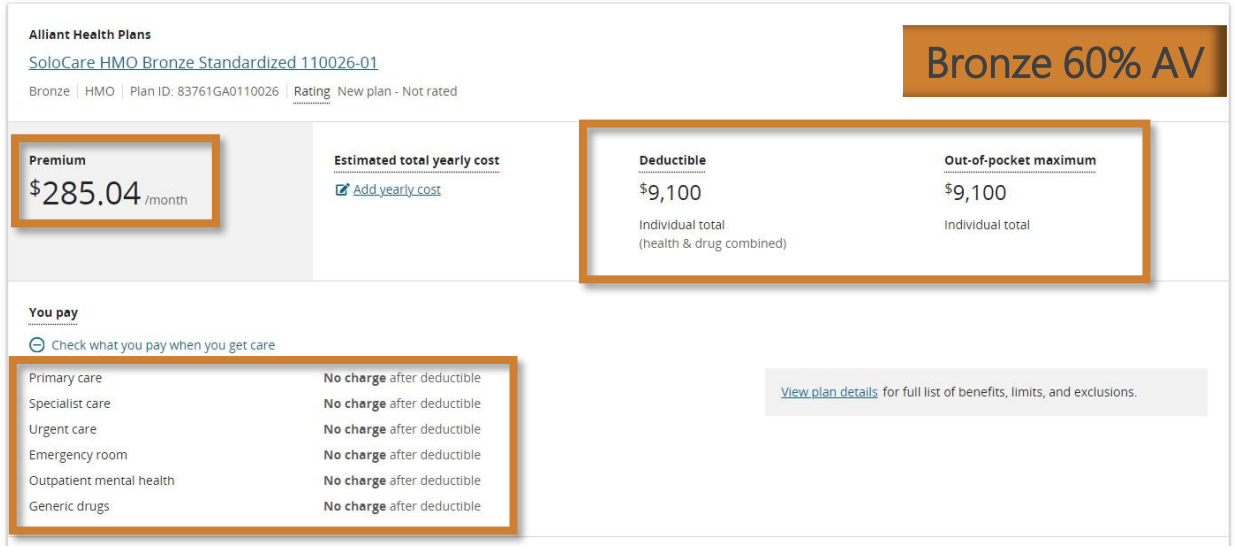
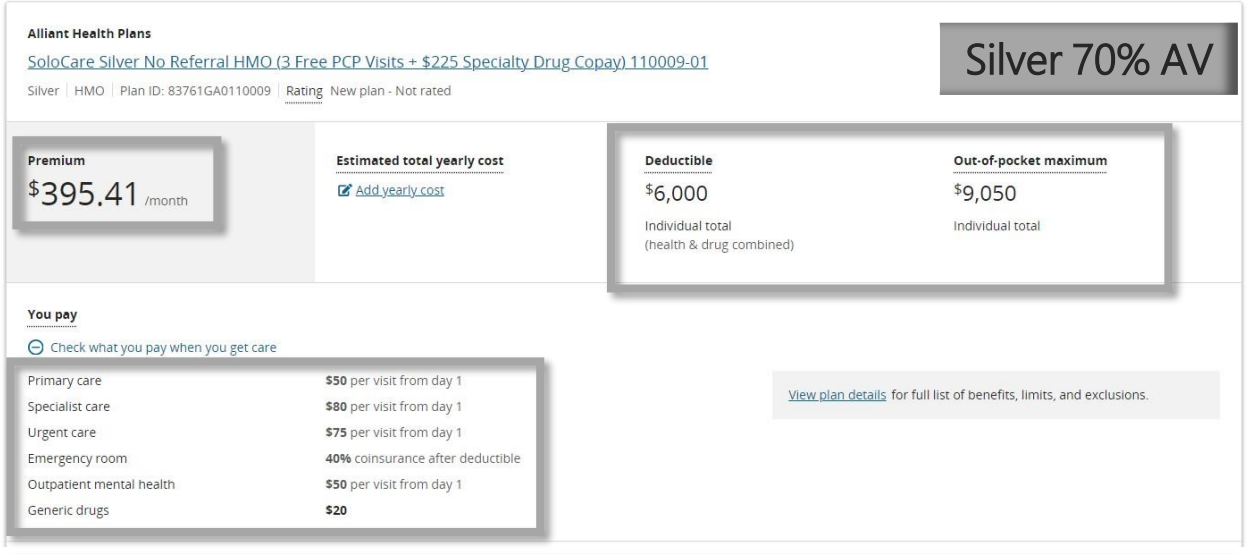
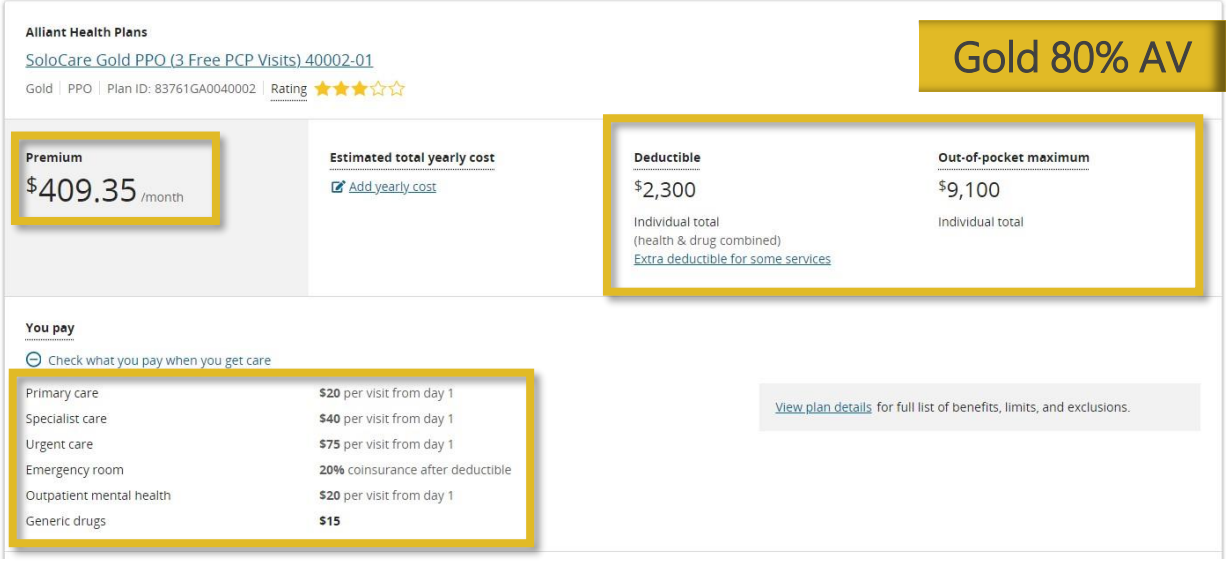
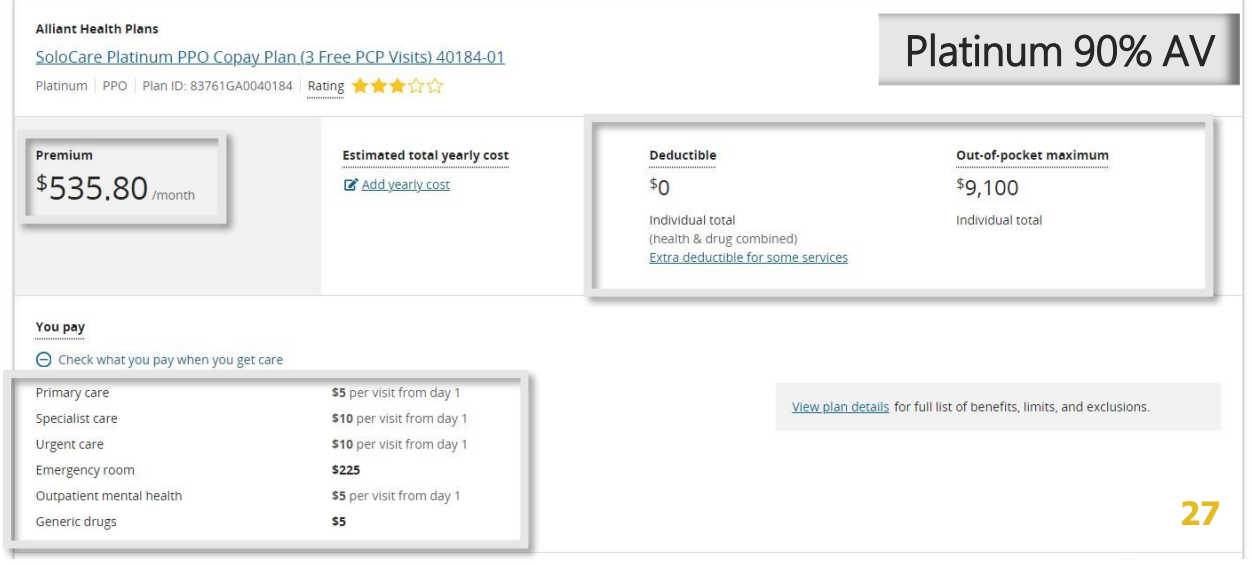
Example: AV Guides Cost-Sharing Charges

Source: Healthcare.gov 2023 plans, Bibb County, GA 31207









Cost-Sharing Reductions for People with Lower Incomes

What Are Cost-Sharing Reductions (CSRs)?

To see different multiples of the poverty guidelines for 2023, visit https://www.healthreformbeyondthebasics.org/reference-guide-yearly-thresholds/

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

3 Levels of Cost-Sharing Reduction Plans Based on Income:				
FPL Range	**Above 250% FPL**	**200–250% FPL**	**150–200% FPL**	**Up to 150% FPL**
Eligible for:	Standard Silver No CSR	73% AV CSR Plan	87% AV CSR Plan	94% AV CSR Plan
Income Range *(HH of 1)*	> $45,525	$36,420 - $45,525	$21,315 - $36,420	< $21,315
Max OOP Limit *Individual in 2023*	$9,450	$7,550	$3,150	$3,150
Income Range *(HH of 4)*	> $93,750	$75,000 - $93,750	$56,250 - $75,000	< $56,250
Max OOP Limit *Family in 2023*	$18,900	$15,100	$6,300	$6,300

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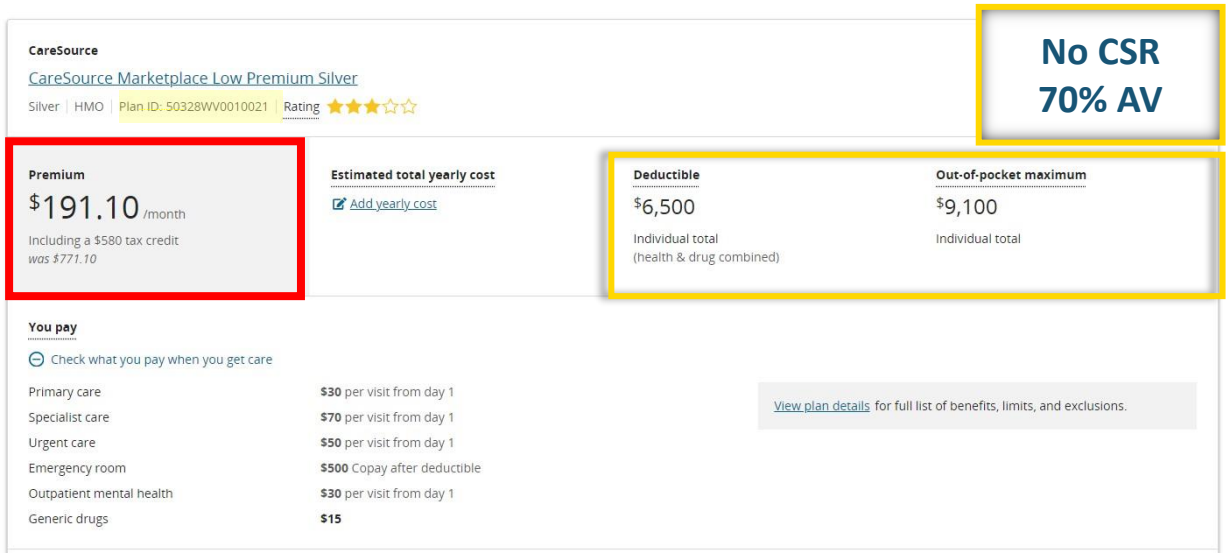
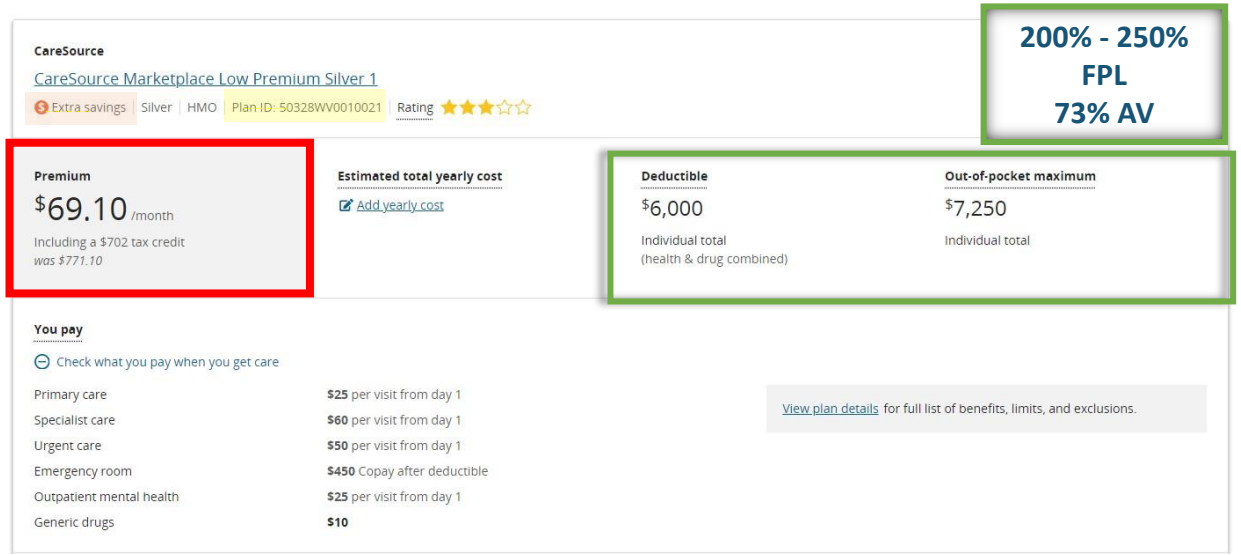
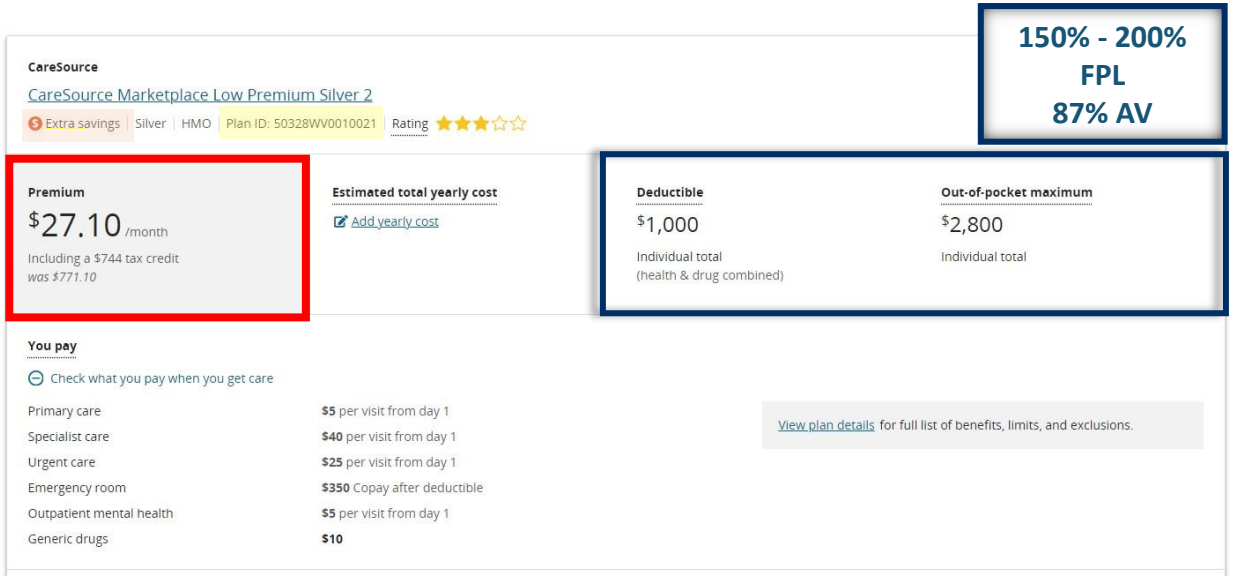
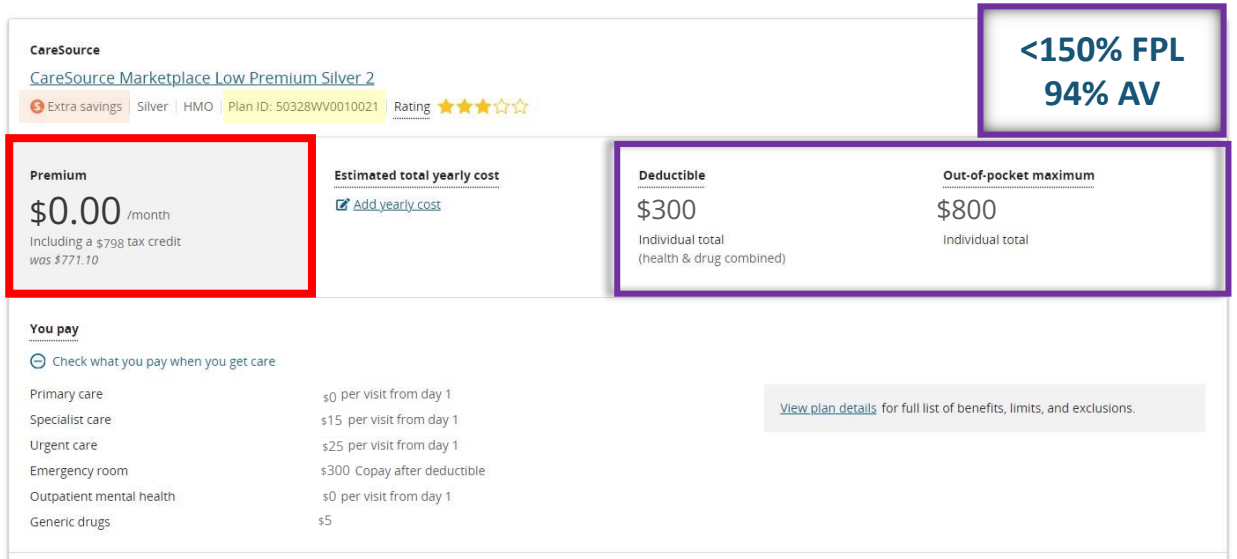
Example Plan: Cost-Sharing Reductions

Source: Healthcare.gov 2023 silver plan variations, Monongalia County, WV 26505



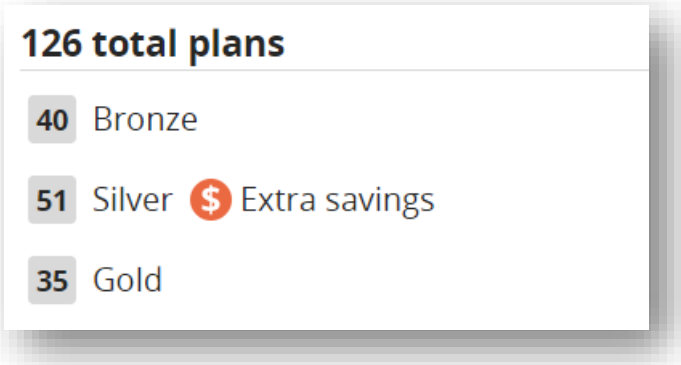




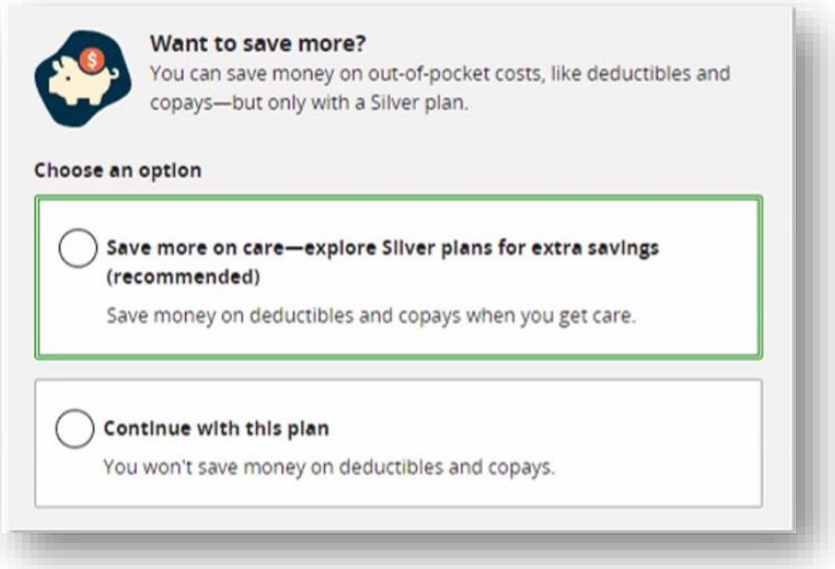


Increasing Uptake of Silver CSR Plans

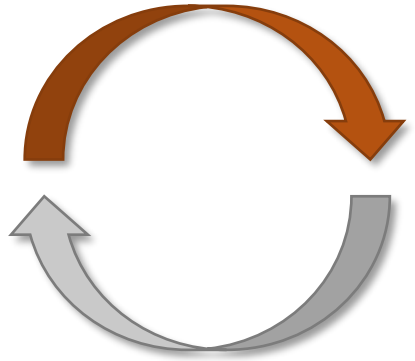
"Extra Savings" Icon



"Nudge" for people who are eligible for CSRs but select a non-silver plan



CSR-eligible people enrolled in a bronze plan who do not actively select a new plan during Open Enrollment will be automatically re-enrolled into a silver plan



ONLY IF there is a silver plan within the same product, with the same provider network, and with a lower or equivalent premium after accounting for the premium tax credit (PTC)

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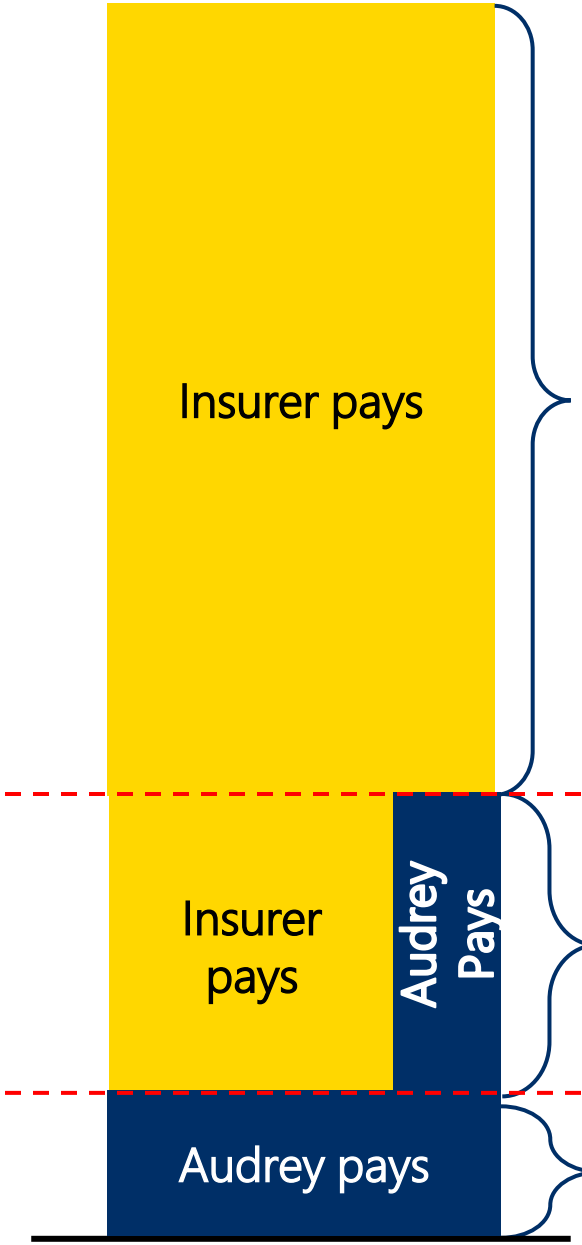
Example: How A CSR Plan Works

In 2023, Audrey has $27,000 in medical expenses

She has a silver plan and qualifies for CSRs



Audrey doesn't pay anything → $0

Insurer pays full amount → $26,200

Annual Out-of-Pocket Limit: $800

Audrey pays copayments/coinsurance → $500

Insurer pays the rest of the cost for services → $500

Annual Deductible: $300

Audrey pays full amount → $300

Insurer doesn't pay anything → $0

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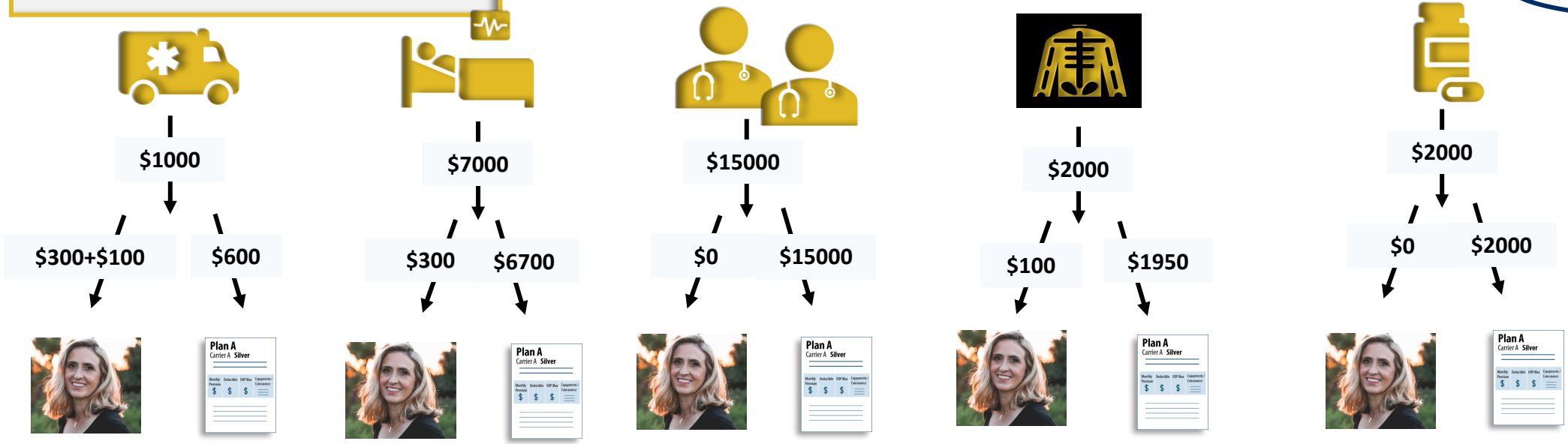
Example: How a CSR Plan Works

In 2023, Audrey has $27,000 in total medical expenses.

Because she has a silver plan and qualifies for CSRs.

Ambulance	Hospital Facility Fee	Hospital Physician Fee	Imaging	Drugs
10% after deductible	$300 after deductible	$0 after deductible	$50 after deductible	$5/drug

Audrey's total: $800



Annual Deductible: $300

Annual OOP Limit: $800

Audrey pays

Audrey pays

Insurer pays

Insurer pays

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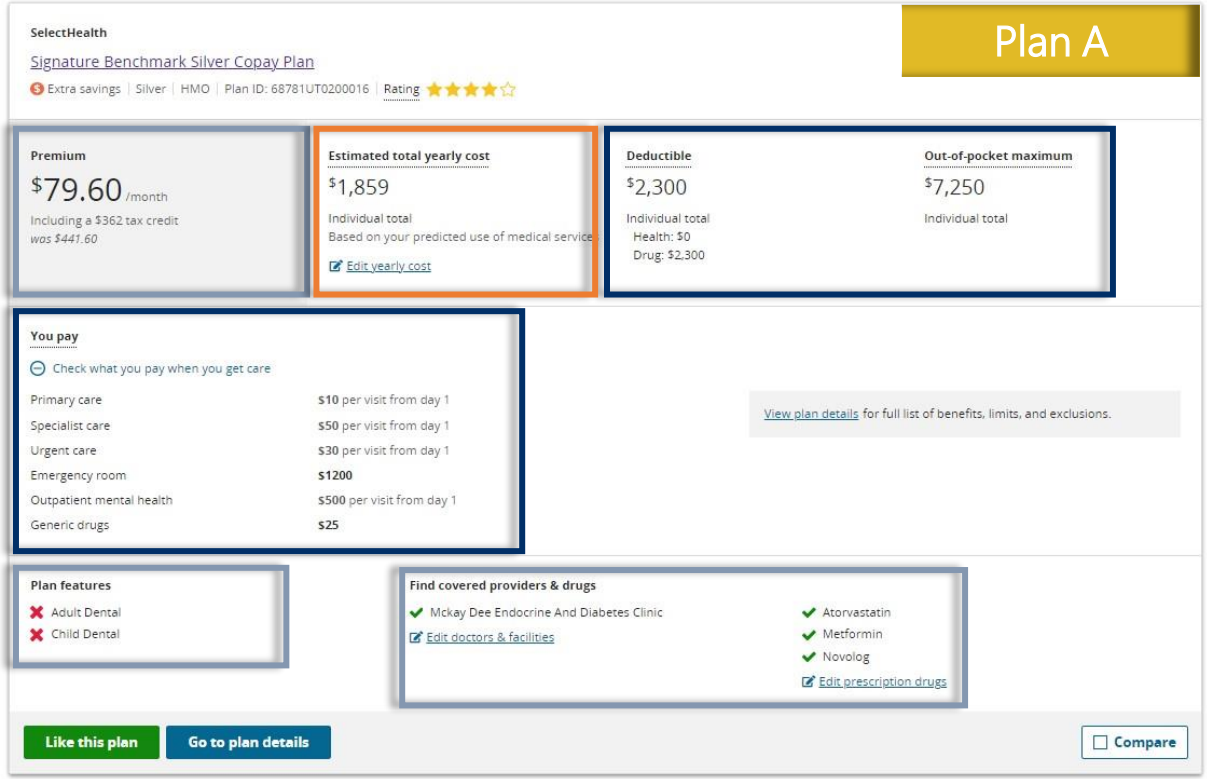
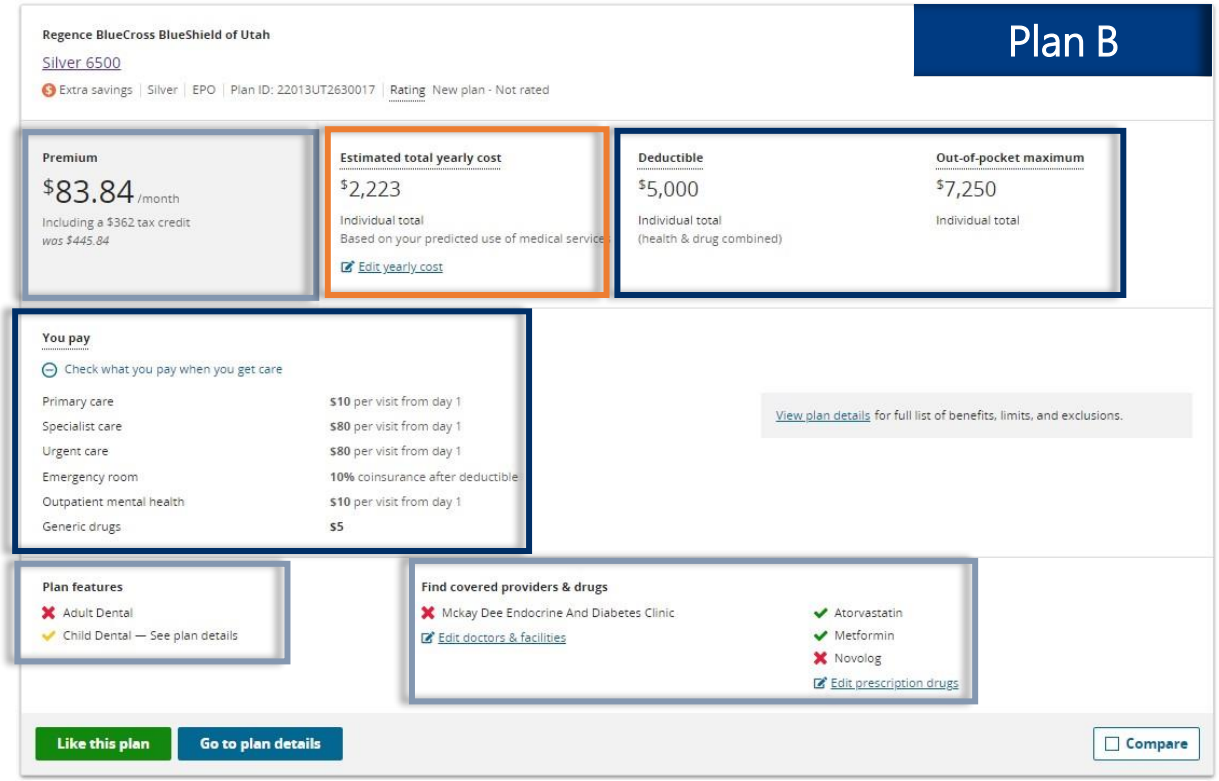
Example: Comparing Two CSR Plans





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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 the PTC, plans with zero cost-sharing are available

- Enrollees pay no deductibles, copayments, or other cost-sharing when using in-network, covered essential health benefits
- 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

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Plan Design Resources

Summary of Benefits & Coverage (SBC)

Regence BlueCross BlueShield of Utah

Silver 6500

Extra savings

Silver | EPO | Plan ID: 22013UT2630017

Like this plan? Take the next step

Highlights

- Estimated monthly premium
- Deductible
- Out-of-pocket maximum
- Estimated total yearly costs
- Medical providers in-network
- Drugs covered/not covered

Star rating

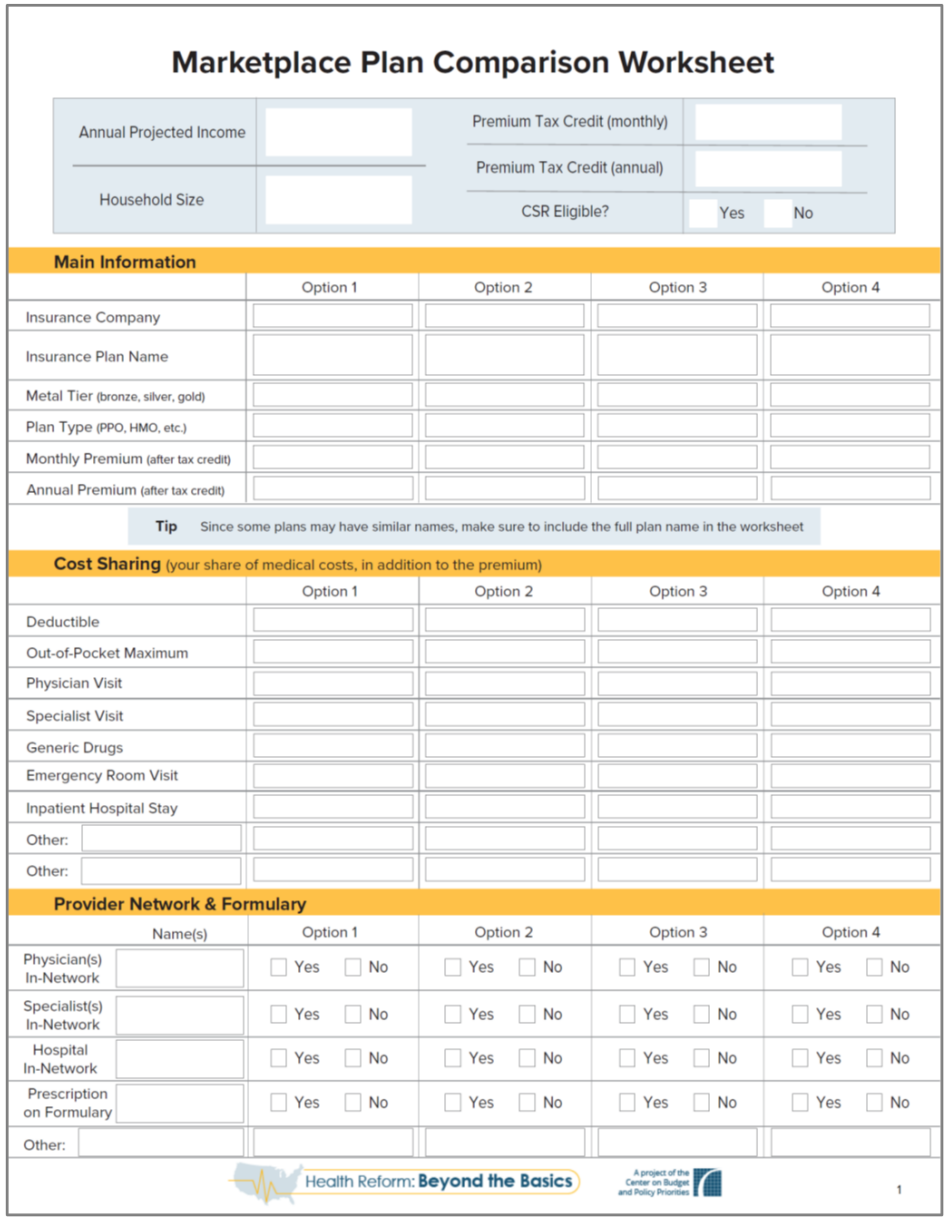
Plan documents

Summary of Benefits

Important Questions	Answers
What is the overall deductible?	$5,000 individual / $10,000 family per calendar year.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."
Are th[illegible] other deductibles for specific ser[illegible]	No.
What is the out-of-pocket limit for this plan?	$7,250 individual / $14,500 family per calendar year.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's offic or clinic	Primary care visit to treat an injury or illness	$10 copay / office visit, deductible does not apply; [illegible]insurance for all other services	Not covered	Copayment applies to each in-network office visit only. All other services are covered at the coinsurance specified, after deductible.
	Specialist visit	$80 copay / office visit, deductible does not apply; 10% coinsurance for all other services	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	

Plan Comparison Worksheet



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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A project of the Center on Budget and Policy Priorities

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Available at: http://www.healthreformbeyondthebasics.org/plan-comparison/

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

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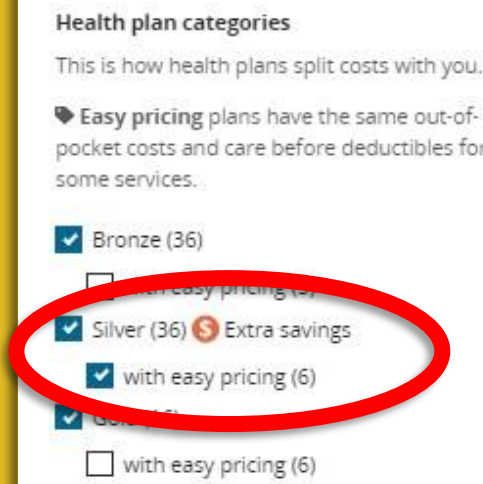
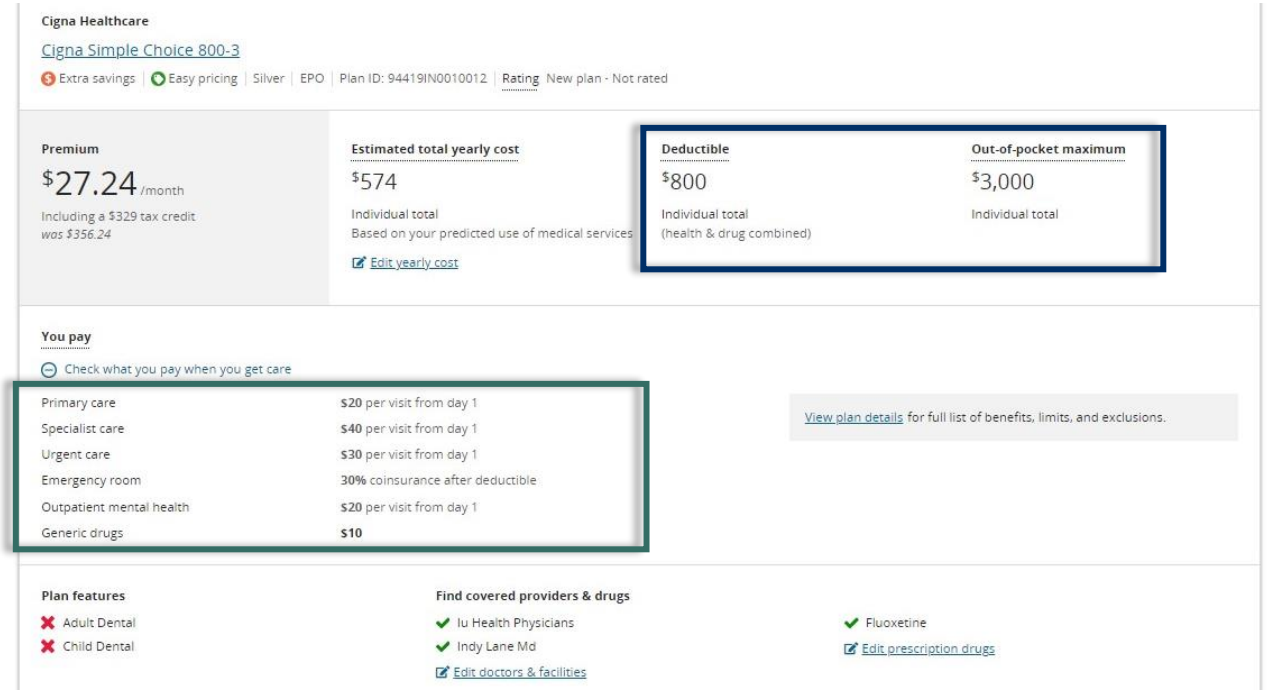
Easy Pricing Plans

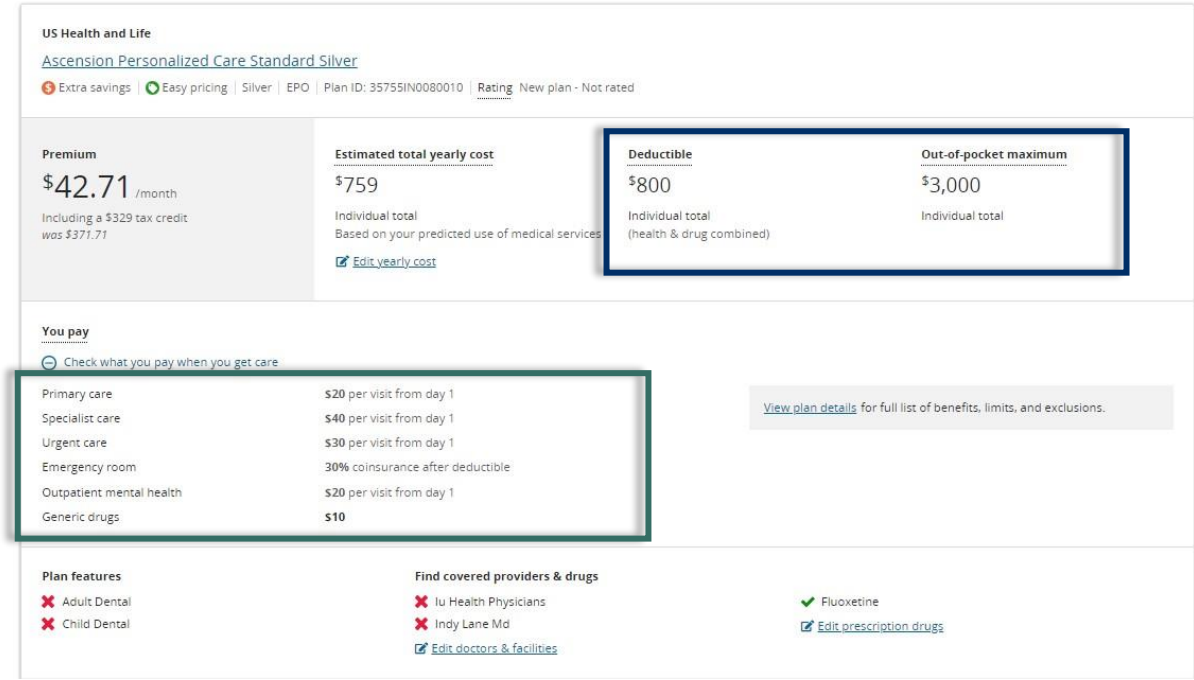
Marketplace insurers are required to offer plans with standardized cost-sharing amounts

- Required for every network type and at every metal level for which an insurer has a QHP in a given service area
  - 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
- Marked as " Easy pricing "
  - Because cost-sharing is the same across plans, consumers can focus on other plan features, like in-network providers, when comparing plans

Comparing Easy Pricing Plans







Source: Healthcare.gov 2023 standardized plans, Indiana, 46250

Subpar Plans

Subpar Plans

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

- Subpar plans are those that do not meet standards outlined in the ACA for plans sold to individuals and are not certified by the federal Health Insurance Marketplace or state-based marketplaces.
- Subpar 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 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 insurance (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**

2023 Proposed Rule

The Biden Administration has proposed federal regulations that would strengthen consumer protections for some subpar plans and differentiate them from comprehensive insurance

The proposed rule would:

- Limit the initial term of short-term plans to three months, with the option to renew for one month
- Prohibit "plan stacking" (selling short-term plans with successive end and start dates)
- Prohibit fixed indemnity plans from mimicking benefit designs used by comprehensive health insurance plans
- Strengthen consumer notices that clarify that short-term plans and fixed indemnity plans are not comprehensive insurance

This rule has not been finalized and is not yet in effect

Proposed rule: Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance, July 12, 2023

"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 subpar 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 subpar plans to people eligible for Medicaid, instead of helping direct them to the right resources to enroll in Medicaid

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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 subpar plans
  - Help people see past the low premiums of subpar 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
- 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

Contact

Claire Heyison, cheyison@cbpp.org

General inquiries: beyondthebasics@cbpp.org

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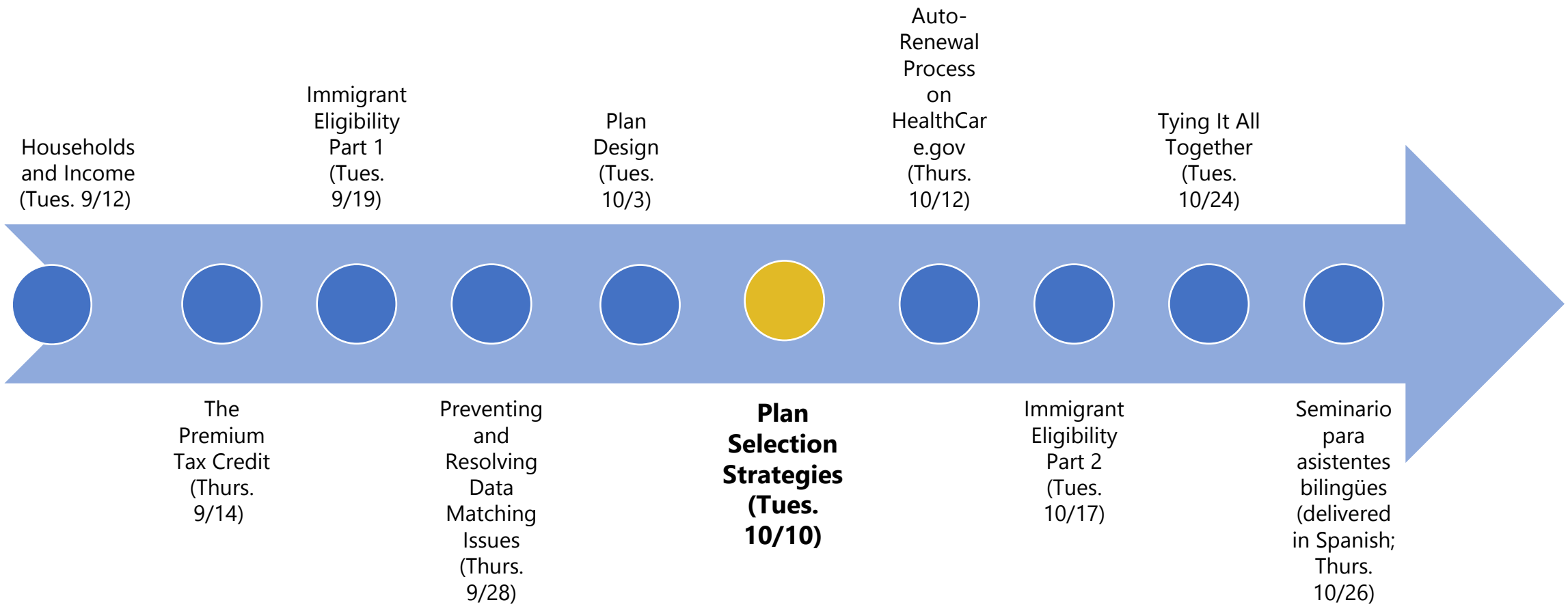
Upcoming Webinars



Register and find recordings and materials from past webinars in the series at: https://www.healthreformbeyondthebasics.org/category/webinars/

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