Health Reform: **Beyond the Basics**

healthreformbeyondthebasics.org

Part III:

Plan Design

Center on Budget and Policy Priorities

October 22, 2015

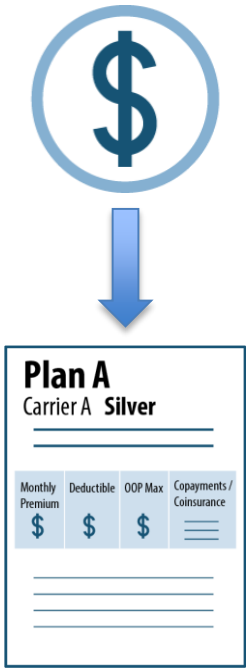
Center on Budget and Policy Priorities

Elements of Plan Design

Premiums vs Cost-Sharing Charges

Premiums

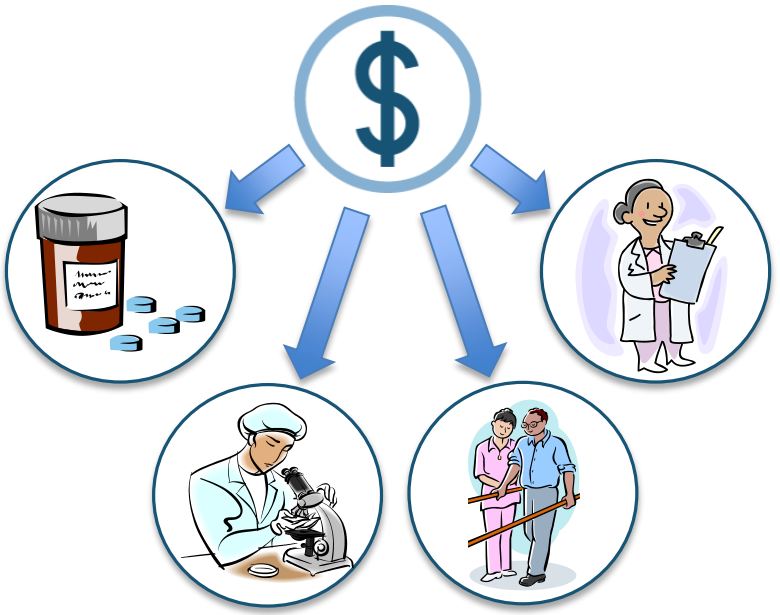
The monthly cost a person pays for a health plan



VS

Cost-Sharing Charges

The charges a person pays as he or she uses benefits covered by a health plan



Basic Elements of Marketplace Plans

- Covered Benefits
  - Essential Health Benefits, including preventive services
  - Additional benefits possible

- Provider Network
  - Insurers contract with physicians, hospitals, and other professionals to provide services to plan enrollees
  - May be broad (with a greater number of providers) or narrow
  - Plan may or may not provide coverage outside its network

Essential Health Benefits (EHBs)

10 "Essential Health Benefits" All Qualified Health Plans Must Provide

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

Types of Cost-Sharing Charges

Deductible	Copayments	Coinsurance
• Enrollee must pay the deductible before the plan begins to pay for most benefits • Set on a yearly basis	• Dollar amount for an item or service that enrollees must pay • Many copayments are applicable before the deductible is met	• Percentage of the cost of an item or service that enrollees must pay

Maximum Out-of-Pocket Limit (OOP)

- Puts a cap on what the enrollee pays in cost-sharing charges each year
  - Set on a yearly basis
  - Applies to in-network services, not out-of-network care
- OOP limit is not the amount that an enrollee must spend each year

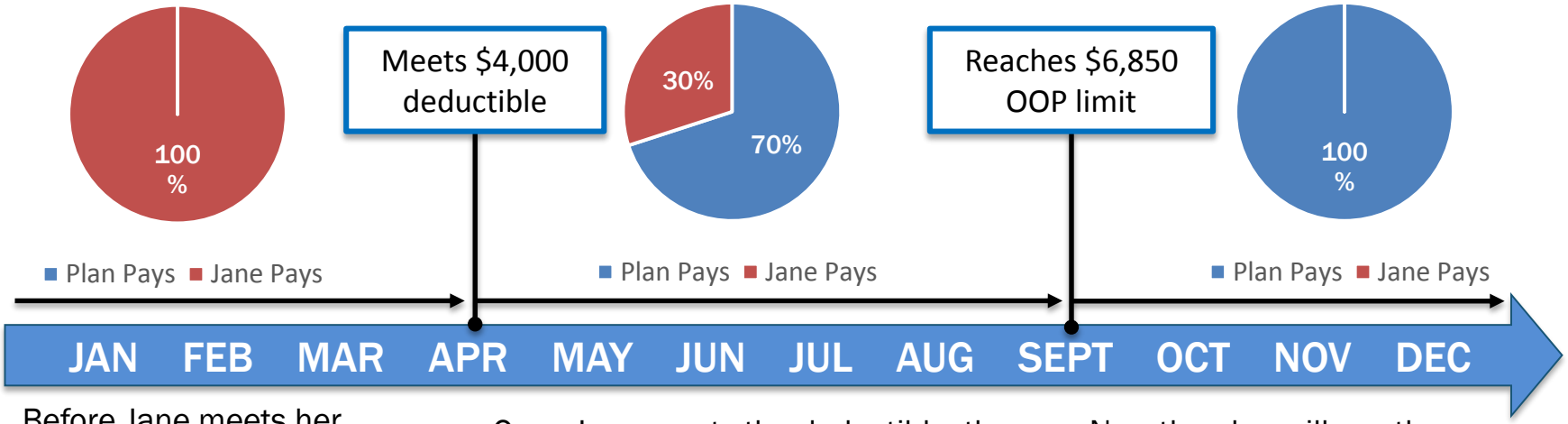
Maximum OOP Limit for 2016 Coverage	
Individual OOP Limit *(NOTE: applies to each individual in a family plan as well)*	$6,850
Family OOP Limit	$13,700

Lower Maximum OOP Limits for Cost-Sharing Reduction Plans (2016 Coverage)		
Household Income	**Up to 200% FPL**	**201–250% FPL**
Individual OOP Limit	$2,250	$5,450
Family OOP Limit	$4,500	$10,900

Example: How Cost-Sharing Works

Health Plan X:

Deductible	$4,000	Primary care visit	30%
OOP limit	$6,850	Specialist visit	30%
Inpatient hospital	30%	Generic drug	30%



Before Jane meets her deductible, her plan doesn't cover any of her costs (except for preventive care)

Once Jane meets the deductible, the plan shares in her costs by covering 70% of covered items and services. Jane pays the remaining 30% coinsurance.

Now the plan will pay the full cost of any additional in-network services she receives during the rest of the year.

More to Know about Cost-Sharing Charges

- Some services may be exempt from the deductible
  - Examples: Coverage of 2 physician visits for a copayment; coverage of generic drugs with a copayment – even when enrollee has not reached the deductible

- Some benefits may have a separate deductible
  - Example: Prescription drugs

Cost-Sharing and the Metal Tiers

Costs covered by a plan

Premiums paid by consumer

METAL LEVEL PLAN TIERS

QHPs must provide plan designs consistent with actuarial values

Platinum	90% actuarial value
Gold	80% actuarial value
Silver	70% actuarial value
Bronze	60% actuarial value
Catastrophic coverage	High deductible health plan available for individuals up to age 30 or some individuals exempted from the individual responsibility requirement

Actuarial value is a measure of the percentage of expected health care costs a health plan will cover and is considered a general summary measure of health plan generosity. It represents an average for a population and does not necessarily reflect the actual cost-sharing experience of an individual.

What is Actuarial Value?

- A way to estimate and compare the overall generosity of plans

Calculating Actuarial Value:

- Assume entire typical population enrolls
- Estimate the percentage of costs the plan pays for their covered services
- Plan pays 70% of the costs of covered benefits → Silver plan

Typical population

NOTE: AV does not represent what the plan would pay for a particular individual enrolled in the plan

→ Enrollee OOP costs depend on the medical care a person uses

→ AV does not determine what benefits or prescription drugs are covered nor does it impact the provider network

Actuarial Value Guides Cost-Sharing Charges

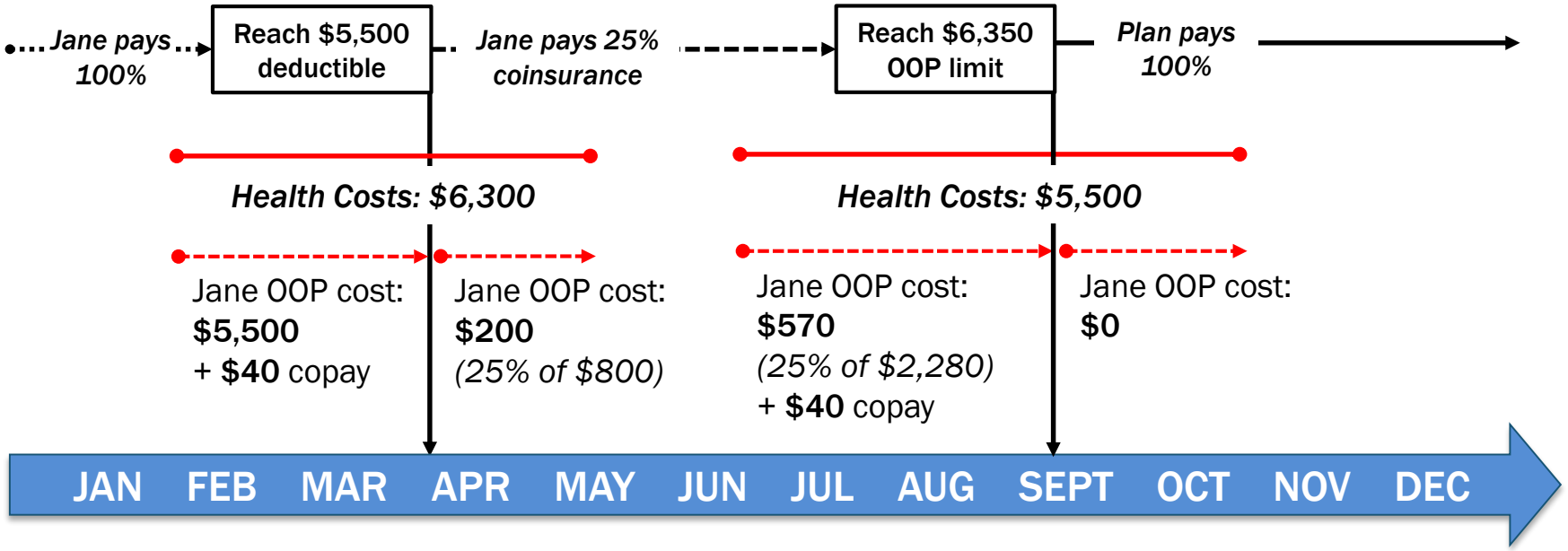
	Plan A Coventry POS **Bronze**	**Plan B** Anthem HMO **Bronze**	**Plan C** Anthem HMO **Silver**	**Plan D** Optima HMO **Silver**	**Plan E** Coventry POS **Gold**
Metal tier	Bronze	Bronze	Silver	Silver	Gold
Actuarial value	60% AV	60% AV	70% AV	70% AV	80% AV
Deductible	$6,300	$5,500	$2,600	$3,500	$1,250
OOP limit	$6,300	$6,350	$5,950	$6,450	$4,200
Inpatient hospital	No charge (after deductible)	25% (after deductible)	20% (after deductible)	20% (after deductible)	20% (after deductible)
Primary care visit	No charge (after deductible)	$40 (2 visits) + 25% (after deductible)	$35 (3 visits) + 20% (after deductible)	$25 (4 visits) + 20% (after deductible)	No charge
Specialist visit	No charge (after deductible)	25% (after deductible)	20% (after deductible)	$25 + 20% (after deductible)	$50
Generic drug	No charge (after deductible)	25% (after deductible)	$15	$15 (after deductible)	$10

Source: Healthcare.gov 2015 plans, Richmond City County, VA 23235

Example: How Cost-Sharing Works

Health Plan Y:

Deductible	$5,500	Primary care visit	$40
OOP limit	$6,350	Specialist visit	25%
Inpatient hospital	25%	Generic drug	25%



Individual and Family Cost-Sharing Charges Differ

	Plan X (individual)	Plan X (family)
Deductible	$4,000	$8,000
OOP limit	$6,850	$13,700
Inpatient hospital	30%	30%
Primary care visit	$60 (first 2 visits)	$60 (first 2 visits)
Generic drug cost	$5	$5

Embedded vs. Aggregate Family Cost-Sharing

Embedded Family Cost-Sharing:

- **Embedded deductible:** In addition to a family deductible, smaller individual deductibles apply to each family member.
- **Embedded OOP limit:** In addition to a family out-of-pocket limit, smaller individual out-of-pocket limits apply to each individual.

Aggregate Family Cost-Sharing:

- **Aggregate deductible:** All family members' expenses are pooled toward a combined deductible.
- **Aggregate OOP limit:** All family members' expenses are pooled toward a combined out-of-pocket limit.

However, each family member is also protected by the individual maximum OOP limit of $6,850.

Example: Embedded Family Cost-Sharing

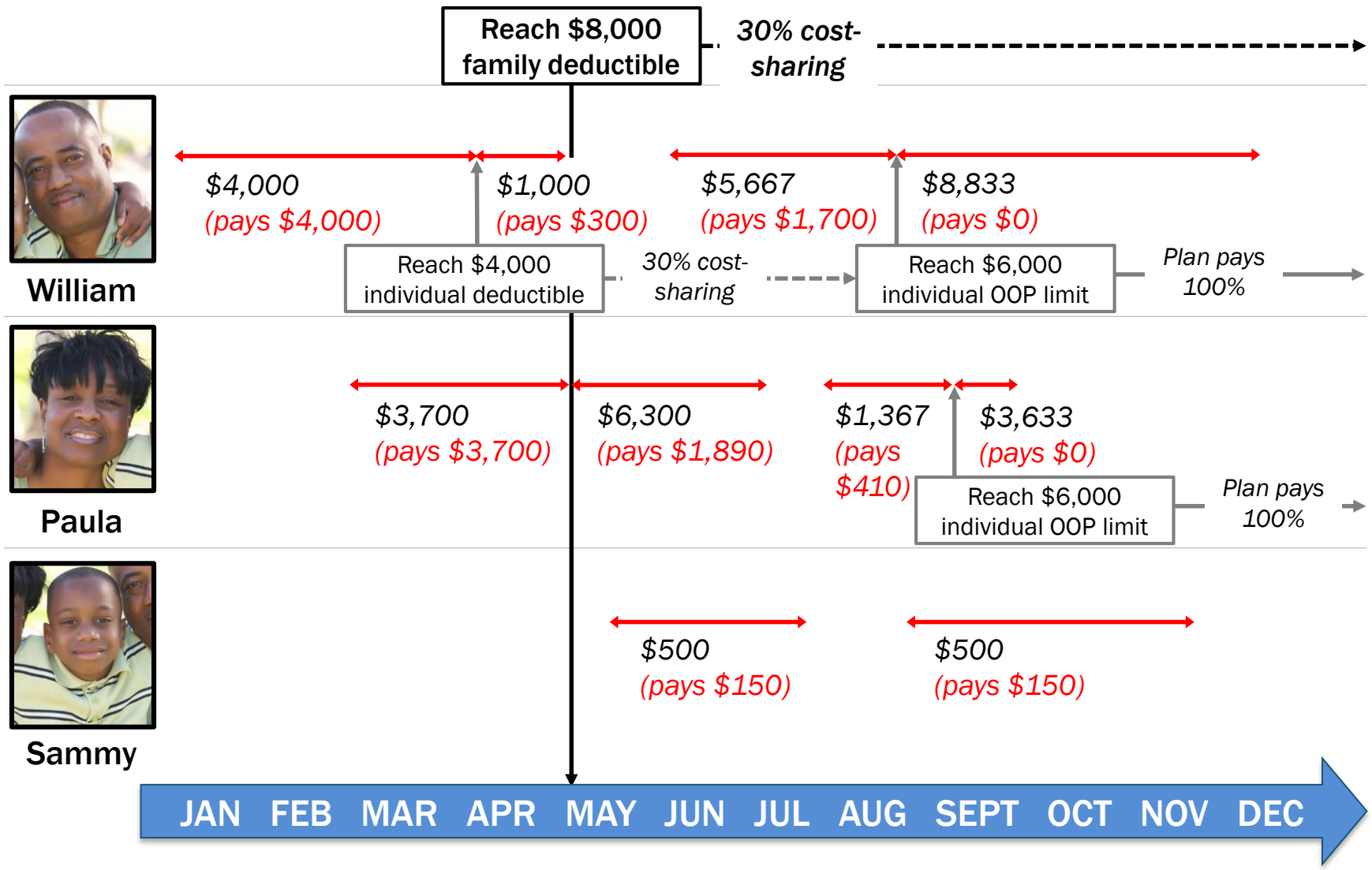
Rogers family health expenditures over the year:

- William: $20,000
- Paula: $15,000
- Sammy: $1,000

Family plan details:

- Metal Level: Bronze
- Plan Deductible: $8,000 (family)/$4,000 (individual)
- Cost-Sharing (coinsurance): Family pays 30%
- Out-of-Pocket (OOP) Limit: $13,700 (family)/$6,000 (individual)

Example: Embedded Family Cost-Sharing



Example: Aggregate Family Cost-Sharing

Rogers family health expenditures over the year:

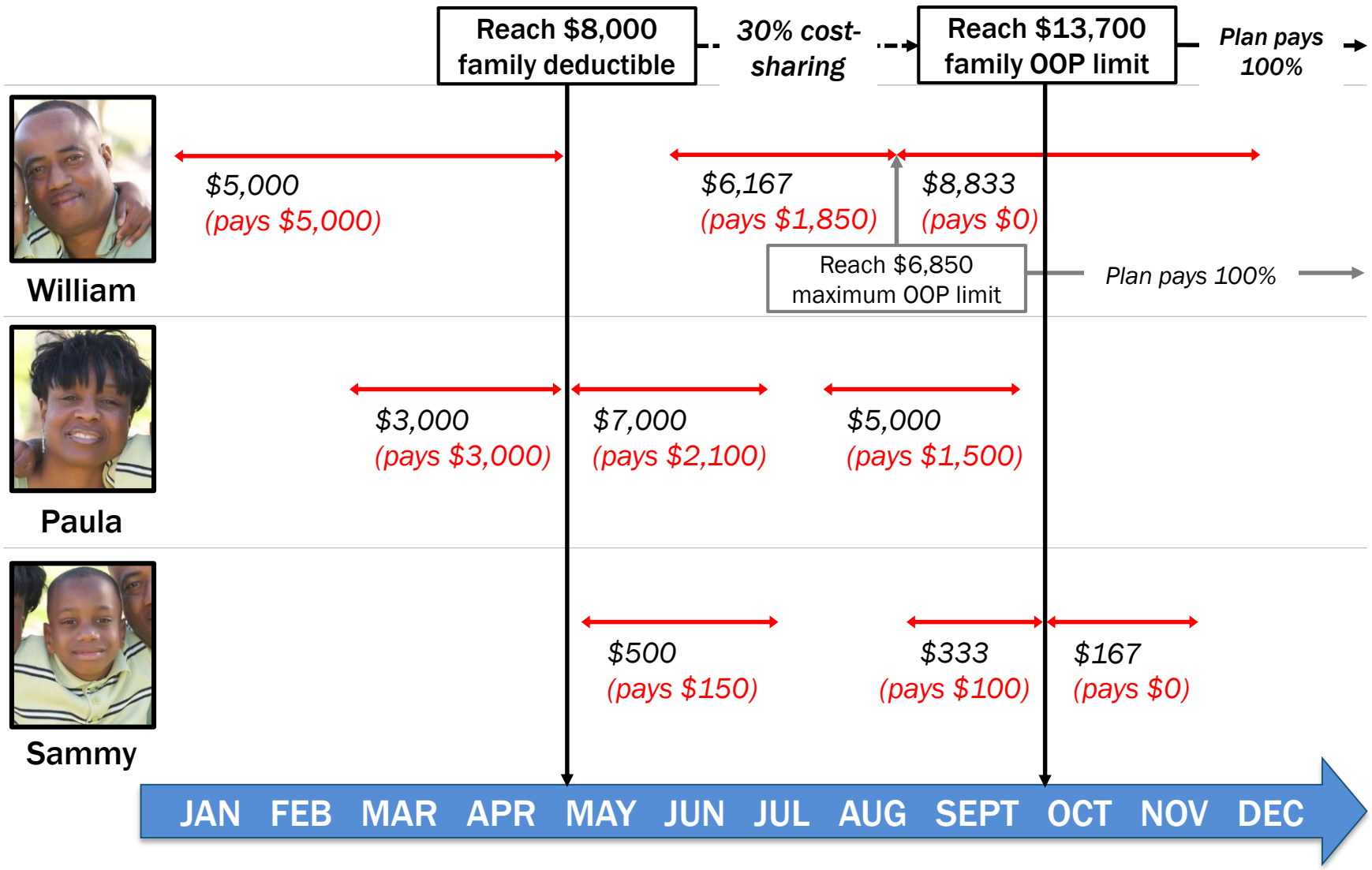
- William: $20,000
- Paula: $15,000
- Sammy: $1,000

Family plan details:

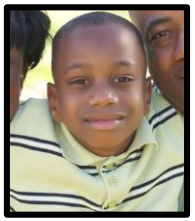
- Metal Level: Bronze
- Plan Deductible (family): $8,000
- Cost-Sharing (coinsurance): Family pays 30%
- Family Out-of-Pocket (OOP) Limit: $13,700

Reminder: Each family member is protected by the individual maximum OOP limit of $6,850.

Example: Aggregate Family Cost-Sharing



Comparing Embedded vs. Aggregate Cost-Sharing

	Embedded Cost-Sharing Plan	Aggregate Cost-Sharing Plan
 William	Total OOP Costs: **$6,000**	Total OOP Costs: **$6,850**
 Paula	Total OOP Costs: **$6,000**	Total OOP Costs: **$6,600**
 Sammy	Total OOP Costs: **$300**	Total OOP Costs: **$250**
	Total OOP Cost for Family: **$12,300**	Total OOP Cost for family: **$13,700**

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

		Annual Deductible	Annual OOP Limit	Hospital Admission	Primary Care Visit	Specialist Visit
Plan A Carrier A Silver	In-Network	$4,000	$6,350	30%	$60	30%
	Out-of-Network	$8,000	$12,700	50%	50%	50%
Plan B Carrier B Silver	In-Network	$4,000	$6,350	30%	$60	30%
	Out-of-Network	N/A	N/A	N/A	N/A	N/A
Plan C Carrier C Silver	Tier I	$2,000	$5,000	30%	$20	$40
	Tier II	$4,000	$6,350	50%	$40	$60
	Tier III	$8,000	$12,700	50%	50%	50%

Cost-Sharing for Care Provided In- vs Out-of-Network

Plan A Carrier A **Silver**	**Annual Deductible**	**Annual OOP Limit**	**Hospital Admission**	**Primary Care Visit**
In-Network	$5,000	$6,350	$1,500 (per admission)	$25
Out-of-Network	$10,000	None	50%	50%

Network Physician

Doctor's bill: $200

Plan allowed amount: $100

Plan pays: $75

Patient pays: $25 *(copay)*

Counts towards in-network OOP limit

Out-of-Network Physician

Doctor's bill: $200

Plan allowed amount: $100

Plan pays: $50

Patient pays: $150 *(50% + $100)*

Does not count towards in-network OOP limit

Cost-Sharing Reductions

What are Cost-Sharing Reductions?

- A federal benefit that reduces the out-of-pocket charges an enrollee pays for medical care covered by the plan
- People with income up to 250% FPL are eligible
- Must enroll in a silver plan through the Marketplace

3 Levels of Cost-Sharing Reduction Plans Based on Income:				
	Standard Silver **No CSR**	**CSR Plan** **Level 1**	**CSR Plan** **Level 2**	**CSR Plan** **Level 3**
Income Range	Above 250% FPL	201–250% FPL	151–200% FPL	Up to 150% FPL
Actuarial Value	70% AV	73% AV	87% AV	94% AV
Max OOP Limit ***Individual in 2016***	$6,850	$5,450	$2,250	$2,250
Max OOP Limit ***Family in 2016***	$13,700	$10,900	$4,500	$4,500

Cost-Sharing Reductions: Example Plan A

	Plan A Blue Cross HMO Silver	Plan A Blue Cross HMO Silver	Plan A Blue Cross HMO Silver	Plan A Blue Cross HMO Silver
CSR Level	No CSR	201–250% FPL	151–200% FPL	<150% FPL
Actuarial value	70% AV	73% AV	87% AV	94% AV
Deductible	$4,500	$3,000	$750	$250
OOP limit	$6,300	$5,200	$2,250	$2,250
Inpatient hospital	No charge (after ded.)	No charge (after ded.)	No charge (after ded.)	No charge (after ded.)
Primary care visit	$10	$8	$5	$3
Specialist visit	$20	$18	$10	$5
Generic drugs	$5 (after ded.)	$4 (after ded.)	$3 (after ded.)	$2 (after ded.)
Specialty drugs	$285 (after ded.)	$250 (after ded.)	$150 (after ded.)	$150 (after ded.)

Source: Healthcare.gov 2015 silver plan variations, Lancaster County, PA 17573

Cost-Sharing Reductions: Example Plan B

	Plan B Highmark PPO Silver	Plan B Highmark PPO Silver	Plan B Highmark PPO Silver	Plan B Highmark PPO Silver
CSR Level	No CSR	201–250% FPL	151–200% FPL	<150% FPL
Actuarial value	70% AV	73% AV	87% AV	94% AV
Deductible	$2,100	$1,750	$500	$100
OOP limit	$6,350	$4,500	$1,500	$500
Inpatient hospital	$950 + 30%	$950 + 30%	$500 + 20%	$100 + 10%
Primary care visit	$45	$45	$20	$5
Specialist visit	$90	$90	$40	$10
Generic drugs	$8	$8	$8	$8
Specialty drugs	25%	25%	25%	25%

Source: Healthcare.gov 2015 silver plan variations, Lancaster County, PA 17573

Comparing Two Insurers' CSR Variations

	Deductible	OOP limit	Inpatient hospital	Primary care visit	Specialist visit	Generic drugs	Specialty drugs
Plan A Blue Cross HMO **Silver** **AV: 94%**	$250	$2,250	No charge (after ded.)	$3	$5	$2 (after ded.)	$150 (after ded.)
Plan B HIghmark PPO **Silver** **AV: 94%**	$100	$500	$100 + 10%	$5	$10	$8	25%

Source: Healthcare.gov 2015 silver plan variations, Lancaster County, PA 17573

Evaluating Qualified Health Plans

Summary of Benefits and Coverage (SBC)

Every health plan inside and outside the Marketplace must provide a Summary of Benefits and Coverage (SBC):

- The SBC standard form includes plan details and costs

Insurance Company 1: Plan Option 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com or call 1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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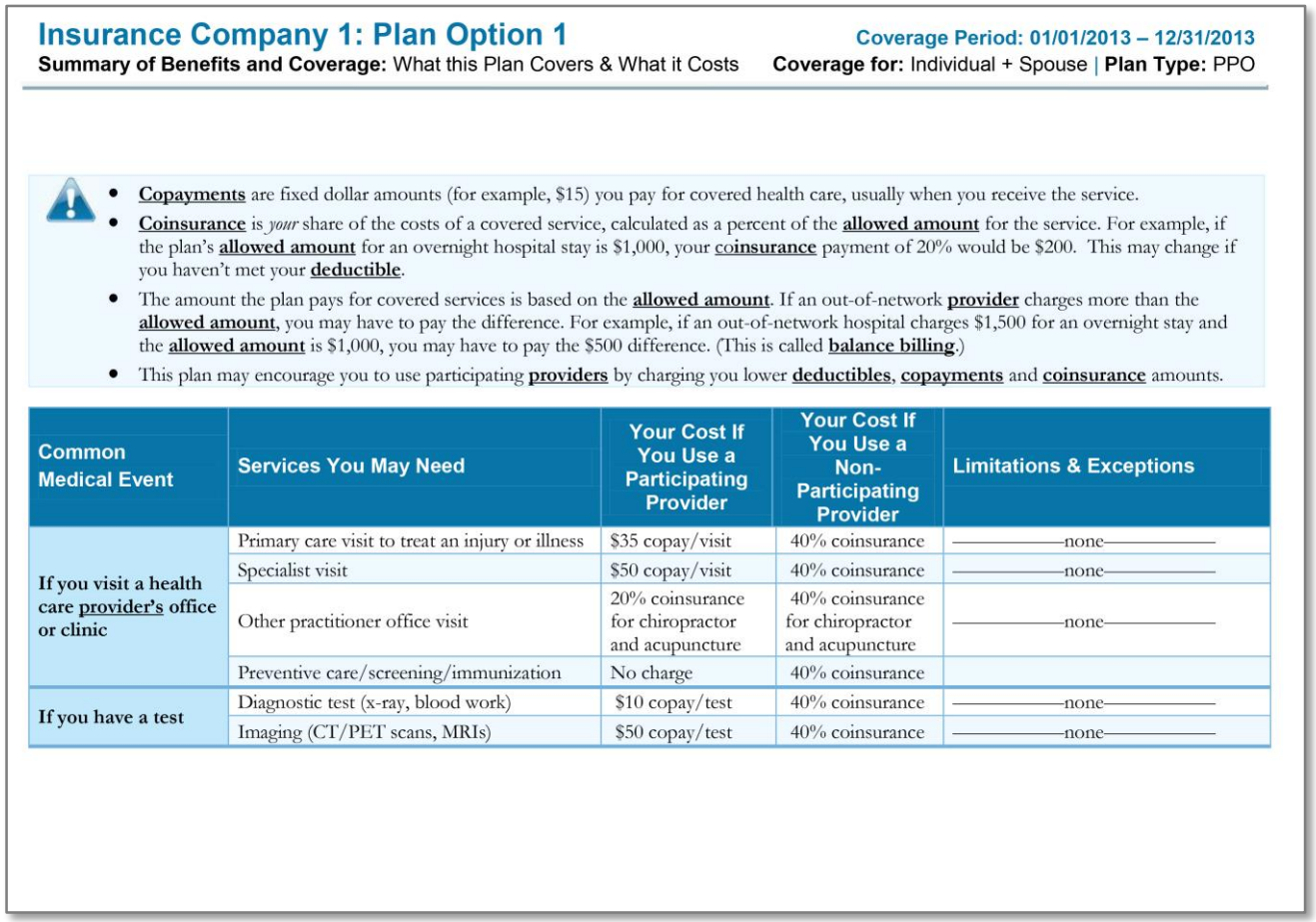

Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | **Plan Type:** PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	——none——
	Specialist visit	$50 copay/visit	40% coinsurance	——none——
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	40% coinsurance for chiropractor and acupuncture	——none——
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	——none——

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Coverage for: Individual + Spouse | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs	$10 copay/ prescription (retail and mail order)	40% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% coinsurance (retail and mail order)	40% coinsurance	——————none——————
	Non-preferred brand drugs	40% coinsurance (retail and mail order)	60% coinsurance	——————none——————
	Specialty drugs	50% coinsurance	70% coinsurance	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	——————none——————

Things to Consider When Comparing QHPs

Monthly Premium

Plan Design

- Deductible
- Out-of-pocket Maximum
- Copays and coinsurance

Covered Benefits

- Visit limits on covered services
- Pediatric Dental Benefit
- Other Covered Services

Prescription Drug Formulary

- List of covered drugs
- Drug tier for each drug

Provider Network

- Network type (HMO, PPO, POS, EPO)
- List of in-network provider

Visit Limits on Covered Services

BlueCross BlueShield of Texas

Blue Advantage Bronze HMO 006℠

Coverage Period: 01/01/2015-12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	No Charge	No Charge	---none---
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	$75 copay/visit	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	---none---
	Physician/surgeon fee	No Charge	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	---none---
	Mental/Behavioral health inpatient services	No Charge	Not Covered	
	Substance use disorder outpatient services	No Charge	Not Covered	
	Substance use disorder inpatient services	No Charge	Not Covered	
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	---none---
	Delivery and all inpatient services	No Charge	Not Covered	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to 60 visits per year.
	Rehabilitation services	No Charge	Not Covered	Limited to combined 35 visits per year, including Chiropractic.
	Habilitation services	No Charge	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Limited to 25 days per year.
	Durable medical equipment	No Charge	Not Covered	---none---
	Hospice service	No Charge	Not Covered	
If your child needs dental or eye care	Eye exam	No Charge	Reimbursed up to $30	One visit per calendar year. Up to age 19.
	Glasses	No Charge	Reimbursed up to $30 frames/$25 single vision lenses	One pair per calendar year. Up to age 19.
	Dental check-up	Not Covered	Not Covered	---none---

***Source**: SBC, BlueCross BlueShield of Texas Blue Advantage Bronze HMO 006 in Austin, TX*

Visit Limits on Covered Services

	Plan A Carrier A **Silver**	Plan B Carrier B **Silver**	Plan C Carrier C **Silver**
Home Health Aide	Limit 60 visits/year	No limit listed (referral required)	Limit 42 visits (of up to 4 hours)/year
Rehabilitation Services	Limit combined 35 visits/year, including Chiropractic	No limit listed (referral required)	Limit 60 visits/year for each Limit 90 days/year for extended active rehab facility and skilled nursing facility services combined
Habilitation Services		No limit listed (referral required)	
Skilled Nursing Care	Limit 25 days/year	No limit listed (referral required)	
Hospice service	No limit listed	No limit listed (referral required)	Limit 5 days for respite care/15 days combined for respite and continuous

Pediatric Dental

Some plans provide pediatric dental as a covered benefit:

Innovation Health Insurance Company · Innovation Health Aetna-INOVA Silver $10 Copay

- Summary of Benefits
- Plan brochure
- Provider directory
- List of covered drugs

Silver | **PPO**
Plan ID: 12028VA0010015

Adult Dental Coverage

Routine Dental Services (Adult)	*Benefit not covered*
Basic Dental Care - Adult	*Benefit not covered*
Orthodontia - Adult	*Benefit not covered*
Major Dental Care - Adult	*Benefit not covered*
Find Dentist	*N/A*

Child Dental Coverage

Dental Check-Up for Children	*Benefit not covered*
Basic Dental Care - Child	*Benefit not covered*
Orthodontia - Child	*Benefit not covered*
Major Dental Care - Child	*Benefit not covered*

Kaiser Permanente · KP VA Silver 1750/25%/HSA/Dental/Ped Dental

- Summary of Benefits
- Plan brochure
- Provider directory
- List of covered drugs

Silver | **HMO**
Plan ID: 95185VA0530005

Adult Dental Coverage

Routine Dental Services (Adult)	*$30*
Basic Dental Care - Adult	*39%*
Orthodontia - Adult	*55%*
Major Dental Care - Adult	*45%*
Find Dentist	*N/A*

Child Dental Coverage

Dental Check-Up for Children	*No charge*
Basic Dental Care - Child	*39%*
Orthodontia - Child	*55%*
Major Dental Care - Child	*45%*

Source: Healthcare.gov 2015 plans, Fairfax County, VA

Other Covered Services

SBCs must include a list of excluded services and other covered services:

Plan A
Carrier A **Silver**

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.[insert]
- Weight loss programs

Plan B
Carrier B **Silver**

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Long Term Care
- Routine Eye Care (Adult)
- Dental Care (Adult and Child)
- Non-emergency care when traveling outside the U.S
- Hearing aids (Adult)
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Infertility Treatment
- Bariatric surgery
- Routine Foot Care (diabetics only)
- Chiropractic care
- Weight Loss Programs

Prescription Drug Formulary

- Are the consumer's prescription drugs covered?
- What tier is the drug in?

Plan A

illinicare health

PRODUCT DESCRIPTION	BRAND/GEN	TIER	LIMITS & RESTRICTIONS
CYCLOSET TAB 0.8 MG	BRAND	3	MDD 6 per day
glimepiride (tab 1 mg, tab 2 mg)	generic	1	MDD 1 per day
glimepiride tab 4 mg	generic	1	MDD 2 per day
glipizide (tab 24hr 2.5 mg, tab 24hr 5 mg, tab 24hr 10 mg)	generic	1	MDD 2 per day
GLYBURIDE TAB 5 MG	BRAND	1	MDD 4 per day
glyburide-metformin (tab 1.25-250 mg, tab 2.5-500 mg)	generic	1	QL 60 / 30 days
glyburide-metformin tab 5-500 mg	generic	1	QL 120 / 30 days
GLYSET (TAB 25 MG, TAB 50 MG, TAB 100 MG)	BRAND	3	MDD 3 per day
HUMALOG (SOLN CART 100, SOLUTION 100)	BRAND	2	QL 50 / 30 days
HUMALOG KWIKPEN SOLN PEN 100 UNIT/ML	BRAND	2	QL 50 / 30 days
HUMALOG MIX 50/50 KWIKPEN SUSP PEN (50-50) 100 UNIT/ML	BRAND	2	QL 50 / 30 days
HUMALOG MIX 50/50 PEN SUSP PEN (50-50) 100 UNIT/ML	BRAND	2	QL 50 / 30 days
HUMALOG MIX 50/50 SUSPENSION (50-50) 100 UNIT/ML	BRAND	2	QL 50 / 30 days
HUMALOG MIX 75/25 KWIKPEN SUSP PEN (75-25) 100 UNIT/ML	BRAND	2	QL 50 / 30 days
HUMALOG MIX 75/25 PEN SUSP PEN (75-25) 100 UNIT/ML	BRAND	2	QL 50 / 30 days

Plan B

BlueCross BlueShield of Illinois

Drug Name	Drug Tier	Prior Authorization	Step Therapy	Dispensing Limits
NOVOLIN R RELION - insulin regular (human) inj 100 unit/ml	2			•
RELION R - insulin regular (human) inj 100 unit/ml	3			•
Intermediate-Acting Insulins				
HUMALOG MIX 50/50 - insulin lispro prot & lispro (human) inj 100 unit/ml (50-50)	4	•		•
HUMALOG MIX 50/50 KWIKPEN - insulin lispro prot & lispro sus pen-inj 100 unit/ml (50-50)	4	•		•
HUMALOG MIX 75/25 - insulin lispro prot & lispro (human) inj 100 unit/ml (75-25)	4	•		•
HUMALOG MIX 75/25 KWIKPEN - insulin lispro prot & lispro sus pen-inj 100 unit/ml (75-25)	4	•		•
HUMULIN N - insulin isophane (human) inj 100 unit/ml	4	•		•
HUMULIN N KWIKPEN - insulin isophane (human) susp pen-injector 100 unit/ml	4	•		•

Source: Coverage of Humalog in different drug formularies, Chicago IL

Prescription Drug Formulary

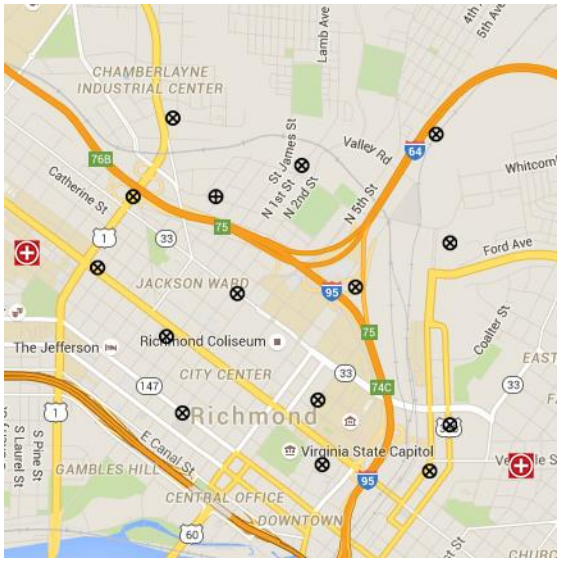
	Plan A Carrier A **Silver**	**Plan B** Carrier B **Silver**
	Prescription drug deductible: N/A	Prescription drug deductible: $500
Drug X  *Full cost: $50/month ($600/year)*	Tier 1: $10 copay *annual cost: $120*	Tier 2: $40 copay (deductible waived) *annual cost: $480*
Drug Y  *Full cost: $400/month ($4800/year)*	Not covered *annual cost: $4,800*	Tier 3: 40% coinsurance after deductible *annual cost: $500 +$2,150*
	Total Annual Cost: $4,920	***Total Annual Cost: $3,130***

Health Plan Network Types

Type	Name	PCP Required?	Referrals Required?	Out-of-Network Coverage?
PPO	**Preferred Provider Organization**	No	No	Yes
POS	**Point of Service**	Yes	Maybe	Yes
HMO	**Health Maintenance Organization**	Yes	Yes	No*
EPO	**Exclusive Provider Organization**	No	No	No*
**except for emergency care*				

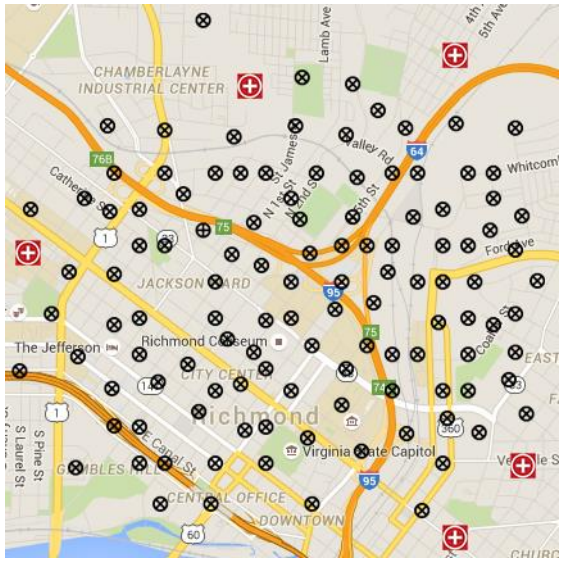
Provider Networks

Plan A
Carrier A HMO



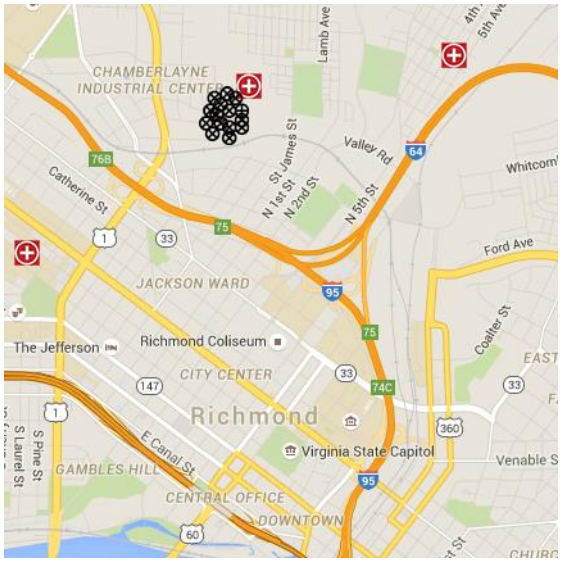
Narrower network
- Fewer doctors
- Several hospitals

Plan B
Carrier A HMO



Broader network
- More doctors
- Many hospitals

Plan C
Carrier B Integrated HMO



Integrated network
- All doctors in one office
- Several hospitals

⊗ In network primary care physician (PCP)
⊕ In network hospital

Comparing Plan Options

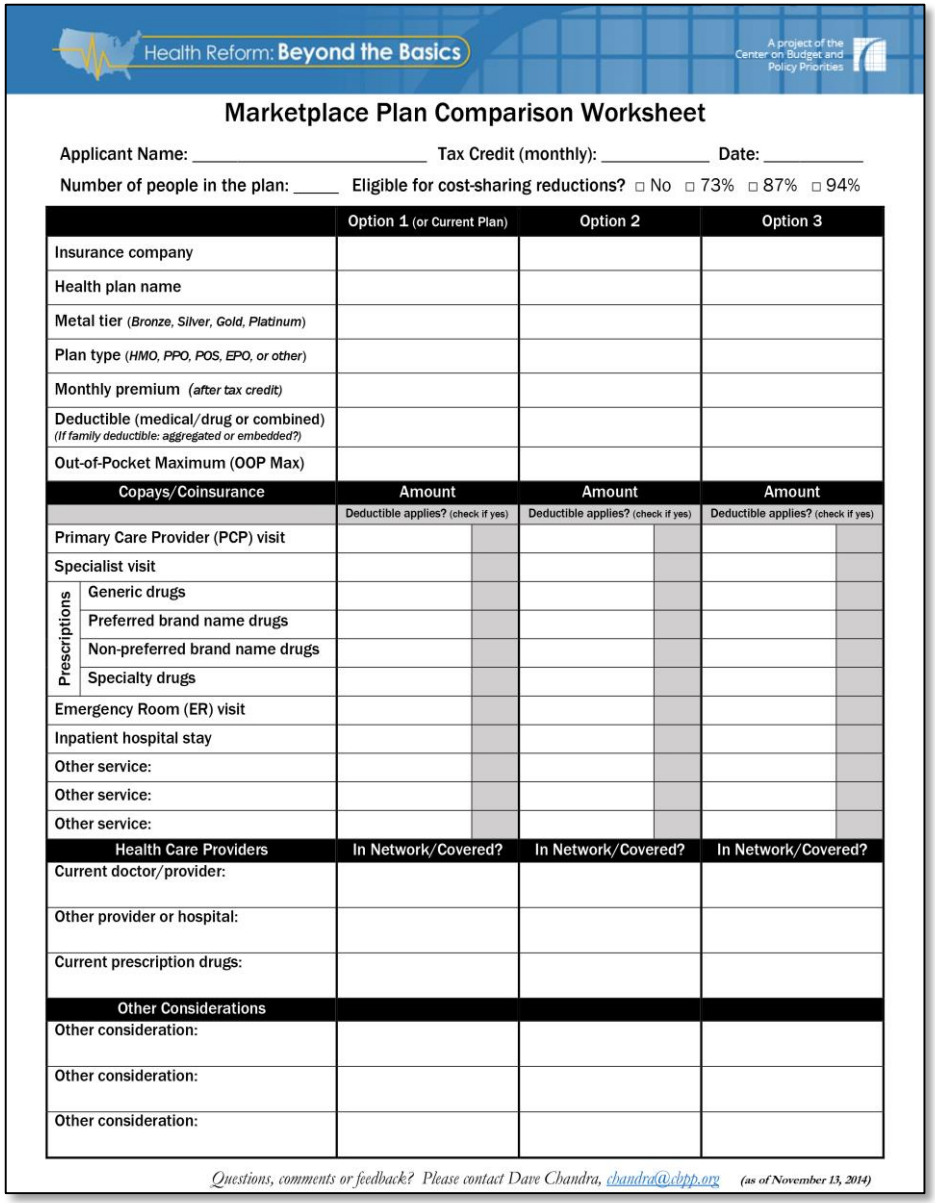
Evaluating Plan Design: Key Questions to ask Consumers

- What are the consumer's priorities for health coverage?
- How much care does the consumer expect to use next year?
- Does the consumer have a current provider they wish to continue seeing?
- Does the consumer currently take any prescription drugs?

CBPP Marketplace Plan Comparison Worksheet

- Resource for assisters to help consumers evaluate and select a QHP
- Available in both English and Spanish:

  Marketplace Plan Comparison Worksheet



Health Reform: Beyond the Basics

A project of the Center on Budget and Policy Priorities

Marketplace Plan Comparison Worksheet

Applicant Name: _____ Tax Credit (monthly): _____ Date: _____

Number of people in the plan: _____ Eligible for cost-sharing reductions? □ No □ 73% □ 87% □ 94%

	Option 1 (or Current Plan)	Option 2	Option 3
Insurance company			
Health plan name			
Metal tier (*Bronze, Silver, Gold, Platinum*)			
Plan type (*HMO, PPO, POS, EPO, or other*)			
Monthly premium (*after tax credit*)			
Deductible (medical/drug or combined) (*If family deductible: aggregated or embedded?*)			
Out-of-Pocket Maximum (OOP Max)			
Copays/Coinsurance	**Amount**	**Amount**	**Amount**
	Deductible applies? (check if yes)	Deductible applies? (check if yes)	Deductible applies? (check if yes)
Primary Care Provider (PCP) visit			
Specialist visit			
Prescriptions: Generic drugs			
Prescriptions: Preferred brand name drugs			
Prescriptions: Non-preferred brand name drugs			
Prescriptions: Specialty drugs			
Emergency Room (ER) visit			
Inpatient hospital stay			
Other service:			
Other service:			
Other service:			
Health Care Providers	**In Network/Covered?**	**In Network/Covered?**	**In Network/Covered?**
Current doctor/provider:			
Other provider or hospital:			
Current prescription drugs:			
Other Considerations			
Other consideration:			
Other consideration:			
Other consideration:			

Questions, comments or feedback? Please contact Dave Chandra, chandra@cbpp.org (as of November 13, 2014)

Scenario 1: Comparing Plan Options

Joe and Danielle Fraser

- Live in Miami, FL
- Joe, 33
  - Income: $24,000
  - No ESI offer
- Danielle, 31
  - Income: $17,000
  - No ESI offer
- Combined income: $41,000 (257% FPL)
- PTC Eligibility: $2,616 ($218/month)

Main concerns when evaluating QHPs:

- Joe has asthma
- Joe and Danielle want to keep their current primary care physician

Scenario 1: Comparing Plan Options

Joe and Danielle's 2015 Marketplace Plan Options

Carrier	Plan Name	Metal Tier	Monthly Premium	Deductible	OOP Max
Ambetter	Essential Care 1	Bronze	$194	$13,000	$13,000
Ambetter	Essential Care 2	Bronze	$199	$10,000	$13,000
Ambetter	Essential Care 3 with 3 free PCP visits	Bronze	$201	$12,000	$12,700
Molina	Marketplace Bronze	Bronze	$212	$9,000	$13,200
Coventry	Bronze Ded Only HSA Eligible Carelink	Bronze	$219	$12,600	$12,600
Ambetter	Essential Care 4 with 3 free PCP visits	Bronze	$220	$,8,000	$12,700
Ambetter	Balanced Care 2	Silver	$287	$10,000	$10,000
Molina	Marketplace Silver	Silver	$287	$4,000	$13,200
Ambetter	Balanced Care 1	Silver	$308	10,000	$12,700
Ambetter	Balanced Care 4	Silver	$314	$4,000	$12,700
Ambetter	Balanced Care 3	Silver	$328	$5,000	$12,700
Humana	Silver 4600/South Florida HUMx	Silver	$337	$9,200	$12,600

Source: Healthcare.gov 2015 plans, Miami-Dade County, FL 33138

Scenario 1: Comparing Plan Options

		Option 1		Option 2		Option 3	
Insurance company		Ambetter		Molina		Humana	
Health plan name		Essential Care 2		Marketplace Silver Plan		4600/S Florida HUMx	
Metal tier (*Bronze, Silver, Gold, Platinum*)		Bronze		Silver		Silver	
Plan type (*HMO, PPO, POS, EPO, or other*)		HMO		HMO		HMO	
Monthly premium *(after tax credit)*		$199		$287		$337	
Deductible *(medical/drug or combined)*		$10,000		$4,000 / $400		$9,200	
Out-of-Pocket Maximum (OOP Max)		$13,000		$13,200		$12,600	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (✓ if yes)		**Deductible applies? (✓ if yes)**		**Deductible applies? (✓ if yes)**	
Primary Care Provider (PCP) visit		40%	✓	$25		$25	
Specialist visit		40%	✓	$35		$35	
Prescriptions	Generic drugs	$25		$15		$10/$20	
	Preferred brand name drugs	$50	✓	$50		$50	✓
	Non-preferred brand name drugs	$100	✓	30%	✓	50%	✓
	Specialty drugs	40%	✓	30%	✓	50%	✓
Emergency Room (ER) visit		40%	✓	$250		20%	
Inpatient hospital stay		40%	✓	30%	✓	20%	✓
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider:	Dr. Orange	Yes		Yes		No	
Current prescription drugs:	Asthma Rx	Yes (tier 1)		Yes (tier 2)		Yes (tier 1)	

Source: Healthcare.gov 2015 plans, Miami-Dade County, FL 33138

Scenario 1: Comparing Plan Options

Joe and Danielle's priorities for insurance:

- Low monthly premium?
- Manageable deductible?
- Low- copay/coinsurance?
- Access to primary care pre-deductible?
- Current doctor in network?
- Prescription medication covered?

Scenario 2: Comparing Annual Out-of-Pocket Costs

The Greens

- Live in Springfield, MO
- Rosa, 43, Dan, 43, and Jennifer, 20, are all eligible for coverage
  - Jennifer is claimed as a tax dependent
- Kristy, 16, and Cara, 10, are enrolled in Medicaid
- Combined income: $45,000 (158% FPL)
- PTC Eligibility: $6,631 ($552 /month), CSR Eligibility: 87% AV

Scenario 2: Comparing Annual Out-of-Pocket Costs

The Greens's 2015 Marketplace Plan Options

Carrier	Plan Name	Metal Tier	Monthly Premium	Deductible	OOP Max
Coventry	Bronze Deductible Only HSA Elig PPO	Bronze	$11	$12,600	$12,600
Coventry	Bronze $20 Copay PPO	Bronze	$43	$11,800	$13,200
Anthem BCBS	Bronze Pathway X 0 for HSA	Bronze	$96	$12,400	$12,900
Humana	Bronze 6300/SW Missouri PPOx	Bronze	$120	$12,600	$12,600
Anthem BCBS	Bronze Pathway X 20 for HSA	Bronze	$122	$8,000	$12,900
Anthem BCBS	Bronze Pathway X 6050 25	Bronze	$142	$12,100	$13,200
Coventry	Silver HSA Eligible PPO	Silver	$155	$2,000	$3,700
Coventry	Silver $10 Copay PPO	Silver	$170	$2,500	$4,200
Coventry	Silver $5 Copay 2750 PPO	Silver	$183	$2,500	$3,700
Humana	Silver 4600/SW Missouri PPOx	Silver	$240	$1,800	$2,900
Anthem	Silver Pathway X 10 for HSA	Silver	$251	$2,300	$2,300
Anthem	Silver Pathway X 1850 20	Silver	$317	$1,400	$2,700

Source: Healthcare.gov 2015 plans, Greene County, MO 65807

Scenario 2: Comparing Annual Out-of-Pocket Costs

		Option 1		Option 2		Option 3	
Insurance company		Coventry		Coventry		Humana	
Health plan name		HSA Eligible PPO		Silver $10 Copay PPO		4600/SW MO PPOx	
Metal tier (*Bronze, Silver, Gold, Platinum*)		Bronze		Silver		Silver	
Plan type (*HMO, PPO, POS, EPO, or other*)		PPO		PPO		PPO	
Monthly premium *(after tax credit)*		$11		$170		$240	
Deductible *(medical/drug or combined)*		$12,600		$2,500 / $0		$1,800 / $1,000	
Out-of-Pocket Maximum (OOP Max)		$12,600		$4,200		$2,900	
Copays/Coinsurance		Amount		Amount		Amount	
		Deductible applies? (✓ if yes)		Deductible applies? (✓ if yes)		Deductible applies? (✓ if yes)	
Primary Care Provider (PCP) visit		No charge	✓	$5		$25	
Specialist visit		No charge	✓	$40		$35	
Prescriptions	Generic drugs	No charge	✓	$5		$17	
	Preferred brand name drugs	No charge	✓	$30		$50	✓
	Non-preferred brand name drugs	No charge	✓	$55		50%	✓
	Specialty drugs	No charge	✓	30%	✓	50%	✓
Emergency Room (ER) visit		No charge	✓	$100		20%	✓
Inpatient hospital stay		No charge	✓	10%	✓	20%	✓

Source: Healthcare.gov 2015 plans, Greene County, MO 65807

Scenario 2: Comparing Annual Out-of-Pocket Costs

How can the Greens compare out-of-pocket costs?

Let's look at the Green family's experience with using health care last year:

- **Asthma medicine (generic):** 2 inhalers per year for Jennifer ($60 each)
- **Primary care physician:** 4 visits per year for the family ($100/visit)
- **Orthopedic surgeon (specialist):** 4 visits per year for Dan's back ($300/visit)
- **Emergency room:** 1 visit ($2,000/visit)

Scenario 2: Comparing Annual Out-of-Pocket Costs

		Option 1		Annual Cost	Option 2		Annual Cost
Insurance company		Coventry			Coventry		
Health plan name		HSA Eligible PPO			Silver $10 Copay PPO		
Metal tier (*Bronze, Silver, Gold, Platinum*)		Bronze			Silver		
Plan type (*HMO, PPO, POS, EPO, or other*)		PPO			PPO		
Monthly premium *(after tax credit)*		$11		$132	$170		$2,040
Deductible *(medical/drug or combined)*		$12,600			$2,500 / $0		
Out-of-Pocket Maximum (OOP Max)		$12,600			$4,200		
Copays/Coinsurance		**Amount**			**Amount**		
		Deductible applies? (✓ if yes)			Deductible applies? (✓ if yes)		
Primary Care Provider (PCP) visit		No charge	✓	$400	$5		$20
Specialist visit		No charge	✓	$1,200	$40		$120
Prescriptions	Generic drugs	No charge	✓	$120	$5		$10
	Preferred brand name drugs	No charge	✓		$30		
	Non-preferred brand name drugs	No charge	✓		$55		
	Specialty drugs	No charge	✓		30%	✓	
Emergency Room (ER) visit		No charge	✓	$2,000	$100		$100
Inpatient hospital stay		No charge	✓		10%	✓	
				$3,852			***$2,290***

Family Health Needs:

2 generic prescriptions ($60 each)
4 PCP visits ($100/visit)
4 specialist visits ($300/visit)
1 ER visit ($2,000/visit)

Source: Healthcare.gov 2015 plans, Greene County, MO 65807

Scenario 2: Comparing Annual Out-of-Pocket Costs

		Option 1		Annual Cost	Option 2		Annual Cost
Insurance company		Coventry			Coventry		
Health plan name		HSA Eligible PPO			Silver $10 Copay PPO		
Metal tier (*Bronze, Silver, Gold, Platinum*)		Bronze			Silver		
Plan type (*HMO, PPO, POS, EPO, or other*)		PPO			PPO		
Monthly premium *(after tax credit)*		$11		$132	$170		$2,040
Deductible *(medical/drug or combined)*		$12,600			$2,500 / $0		
Out-of-Pocket Maximum (OOP Max)		$12,600			$4,200		
Copays/Coinsurance		Amount			Amount		
		Deductible applies? (✓ if yes)			Deductible applies? (✓ if yes)		
Primary Care Provider (PCP) visit		No charge	✓	$400	$5		$20
Specialist visit		No charge	✓	$1,200	$40		$120
Prescriptions	Generic drugs	No charge	✓	$120	$5		$10
	Preferred brand name drugs	No charge	✓		$30		
	Non-preferred brand name drugs	No charge	✓		$55		
	Specialty drugs	No charge	✓		30%	✓	
Emergency Room (ER) visit		No charge	✓		$100		
Inpatient hospital stay		No charge	✓		10%	✓	
				$1,852			***$2,190***

Family Health Needs:

2 generic prescriptions ($60 each)
4 PCP visits ($100/visit)
4 specialist visits ($300/visit)
~~1 ER visit ($2,000/visit)~~

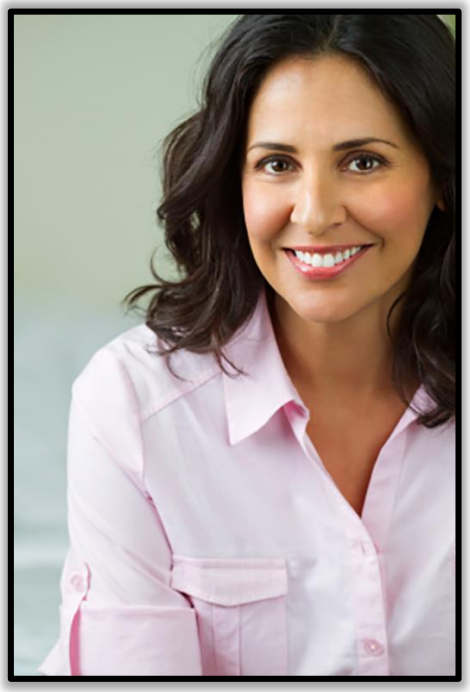
Source: Healthcare.gov 2015 plans, Greene County, MO 65807

Scenario 2: Comparing Annual Out-of-Pocket Costs

Green family's priorities for insurance:

- Low monthly premium?
- Manageable deductible?
- Low- copay/coinsurance?
- Access to primary care pre-deductible?
- Current doctor in network?
- Prescription medication covered?
- Total annual out-of-pocket costs (premium + expected cost-sharing)

Scenario 3: Renewing Coverage



Carla, 40

- Lives in Flagstaff, AZ
- Income: $32,000 (272% FPL)
- PTC Eligibility: $778 ($65/month)

Main concerns when evaluating QHPs:

- Carla was enrolled last year and wants to know the changes in her plan for this year
- She also would like to look at plans with a lower deductible

Scenario 3: Renewing Coverage

		2014 Plan		2015 Plan	
Insurance company		Blue Cross Blue Shield		Blue Cross Blue Shield	
Health plan name		Essential PPO 4000		Essential PPO 4000	
Metal tier (*Bronze, Silver, Gold, Platinum*)		Silver		Silver	
Plan type (*HMO, PPO, POS, EPO, or other*)		PPO		PPO	
Monthly premium *(after tax credit)*		$240		$271	
Deductible *(medical/drug or combined)*		$4,000		$4,000/$400	
Out-of-Pocket Maximum (OOP Max)		$6,350		$6,350	
Copays/Coinsurance		Amount		Amount	
		Deductible applies? (✓ if yes)		Deductible applies? (✓ if yes)	
Primary Care Provider (PCP) visit		$25 for 3 visits/20%	~	$25 for 3 visits/20%	~
Specialist visit		$25 for 3 visits/20%	~	$50 for 3 visits/20%	~
Prescriptions	Generic drugs	$10		$10	
	Preferred brand name drugs	$25		$30	✓
	Non-preferred brand name drugs	$85		$90	✓
	Specialty drugs	50%		50%	
Emergency Room (ER) visit		20%	✓	20%	✓
Inpatient hospital stay		20%	✓	20%	✓

Source: Healthcare.gov 2015 plans, Coconino County, AZ 86001

Scenario 3: Renewing Coverage

Carla's 2015 Marketplace Plan Options

Carrier	Plan Name	Metal Tier	Monthly Premium	Deductible	OOP Max
2014 Plan					
BCBS of AZ	Essential PPO 4000	Silver	$240	$4,000	$6,350
2015 plans					
Health Net	PPO Silver 30%/30%/$1500	Silver	$230	$1,500	$6,350
Health Net	PPO Silver 30%/30%/1500 w. ped dental	Silver	$235	$1,500	$6,350
Health Choice	Essential Silver	Silver	$244	$1,600	$6,600
BCBS of AZ	Blue Portfolio HSA PPO 3500 Statewide	Silver	$269	$3,500	$3,500
BCBS of AZ	Blue Essential PPO 4000- Statewide net	Silver	$271	$4,000	$6,350
Aetna	Banner Health Network Silver $10 copay	Silver	$290	$3,750	$6,600
BCBS of AZ	Blue EverydayHealth PPO4000 Statewide	Silver	$294	$4,000	$6,350
Meritus Mutual	Meritus Saver Silver PPO HSA Plus 2000	Silver	$306	$2,000	$4,500
Meritus Mutual	Meritus Choice Silver PPO Plus 4000	Silver	$311	$4,000	$6,600

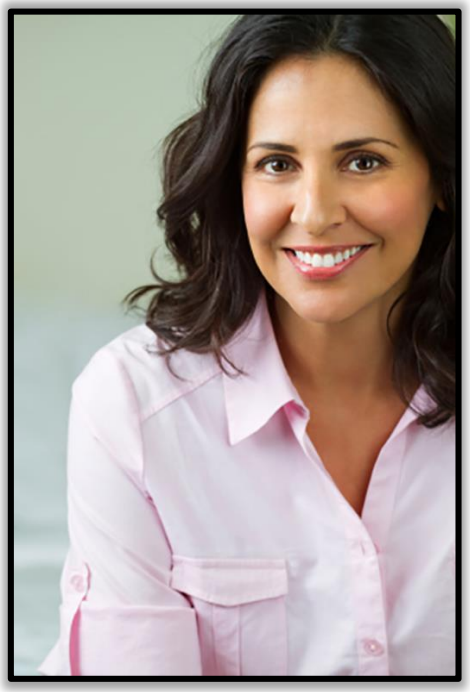
Source: Healthcare.gov 2015 plans, Coconino County, AZ 86001

Scenario 3: Renewing Coverage

		Option 1		Option 2		Option 3	
Insurance company		Health Choice		Blue Cross Blue Shield		Aetna	
Health plan name		Essential Silver		Essential PPO 4000		Banner $10 Copay	
Metal tier (*Bronze, Silver, Gold, Platinum*)		Silver		Silver		Silver	
Plan type (*HMO, PPO, POS, EPO, or other*)		HMO		PPO		POS	
Monthly premium *(after tax credit)*		$244		$271		$290	
Deductible *(medical/drug or combined)*		$1,600 (combined)		$4,000/$400		$3,750/$500	
Out-of-Pocket Maximum (OOP Max)		$6,600		$6,350		$6,600	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (✓ if yes)		**Deductible applies?** (✓ if yes)		**Deductible applies?** (✓ if yes)	
Primary Care Provider (PCP) visit		$15	✓	3 for $25, then 20%		$10	
Specialist visit		$40	✓	3 for $50, then 20%		$75	
Prescriptions	Generic drugs	$10		$10		$15	
	Preferred brand name drugs	$45		$30	✓	$45	✓
	Non-preferred brand name drugs	50%		$90	✓	$75	✓
	Specialty drugs	50%		50%		40%	✓
Emergency Room (ER) visit		$500	✓	20%	✓	$500/$30	✓
Inpatient hospital stay		20%	✓	20%	✓	30%	✓

Source: Healthcare.gov 2015 plans, Coconino County, AZ 86001

Scenario 3: Renewing Coverage



Carla's priorities for insurance:

- Low monthly premium?
- Manageable deductible?
- Low- copay/coinsurance?
- Access to primary care pre-deductible?
- Current doctor in network?
- Prescription medication covered?
- Total annual out-of-pocket costs (premium + expected cost-sharing)
- How did her current plan change for the coming year?
- Have her priorities changed based on changes in her health care needs?
- Are there other plans this year that are cheaper and/or better meet her needs?

Contact Info

- Sarah Lueck, lueck@cbpp.org
  - Twitter: @sarahL202
- Dave Chandra, chandra@cbpp.org
- Halley Cloud, cloud@cbpp.org
- General inquiries: beyondthebasics@cbpp.org

For more information and resources, please visit:

www.healthreformbeyondthebasics.org

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