

Welcome to the AFFORDABLE CARE ACT BASICS Module



Health Insurance Marketplace®

Health Insurance Marketplace
Plan Year 2021



Job Aids



Help



Glossary

[Text Description of Image or Animation](#)



Long Description

Animated introduction screen containing the following text at the top and left of the screen: Welcome to the Affordable Care Act Basics Module.

Beneath this text on the left is the logo for the Department of Health & Human Services (HHS), which is made up of the profiles of people, stacked on top of each other, resulting in the profile of an eagle. The words "Department of Health & Human Services USA" form a circle that extends out and to the left from the profiles. To the right of the logo are the words "Health Insurance Marketplace®."

Affordable Care Act Basics

Disclaimer

The information in this training was current at the time it was published or uploaded onto the Web. Eligibility policies and Marketplace requirements may change so links to the source documents have been provided within the document for your reference. This training is not intended to grant rights or impose obligations. It may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage learners to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of the requirements.

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.



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Alt Text

A page of text with horizontal lines across it; a red horizontal box containing the word "Disclaimer" within it

Affordable Care Act Basics

Patient Protection and Affordable Care Act

The primary goal of the Patient Protection and Affordable Care Act (Affordable Care Act) is to broaden access to health insurance coverage. To achieve this goal, the Affordable Care Act provides a premium tax credit to help subsidize coverage, gives consumers tools to make informed choices about their health care coverage, and puts in place requirements on the type of coverage health insurers must offer. Agents and brokers play an integral role in helping individuals understand and act on the coverage options that the Affordable Care Act offers.

In this module, you will learn important background information on the Affordable Care Act that you need to know to serve consumers.

Objectives

Upon completion of this module, you should be able to:

- Identify major health care reforms of and consumer protections required under the Affordable Care Act
- Define the term "guaranteed issue"
- Define the term "medical loss ratio" (MLR)
- Identify the services included in the essential health benefits (EHB)
- Identify the four plan categories, define actuarial value (AV), and determine the AV for each category
- Understand the limits on cost sharing
- Understand rating standards based on age, family composition, geographic area, and tobacco usage



Page Text

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- Understand the limits on cost sharing
- Understand rating standards based on age, family composition, geographic area, and tobacco usage

Alt Text

A young woman working on a laptop and writing in a notebook

Affordable Care Act Basics

Accessibility to Care

The Affordable Care Act makes care more accessible by:

- Creating the Health Insurance Marketplace®* through which qualified individuals may compare and purchase plans, and eligible individuals who do not have access to government-sponsored coverage, affordable employer-sponsored coverage, or certain other types of coverage can receive financial assistance
- Providing qualified individuals with Marketplace financial assistance: advance payments of the premium tax credit and cost-sharing reductions
- Expanding Medicaid in states that took this opportunity to cover individuals whose household incomes are at or below 138% of the federal poverty level

*The term "Health Insurance Marketplace®" is a registered trademark of the U.S. Department of Health & Human Services. When used in this document, the term "Health Insurance Marketplace®" or "Marketplace" refers to Federally-facilitated Marketplaces (FFMs), including FFMs where states perform plan management functions, and also refers to State-based Marketplaces on the Federal Platform (SBM-FPs).



Page Text

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Alt Text

A group of people looking up at the camera and smiling

Affordable Care Act Basics

Health Insurance Requirements Under the Affordable Care Act

The Affordable Care Act includes a broad set of health insurance requirements that establish the type of coverage health insurers must make available to consumers. These include:

- Extension of dependent coverage of children up to age 26
- Expansion of the “guaranteed issue” requirement to ensure that health insurance issuers offer group and individual market policies to any eligible employer and individual in a state, regardless of health status, and coverage of recommended preventive services without cost sharing
- Prohibition on coverage limitations or exclusions based on pre-existing conditions
- Prohibition on precluding a qualified individual’s participation in an approved clinical trial, or discriminating against that individual based on such participation
- Introduction of an 80/20 MLR rule to ensure that at least 80% of the premium dollars in the individual and small group markets (and 85% in the large group market) paid to a health insurance issuer are spent on providing health care services or quality improvement activities
- Elimination of annual and lifetime dollar limits on EHB
- Establishment of rating variation standards that permit premium rates in the individual and small group markets to vary based only on age, number of covered family members, geographic location, and tobacco use
- Prohibition on rating individual and small group health insurance policies based on the individual’s health status, or the health status of individuals within a group

Page Text

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- Prohibition on rating individual and small group health insurance policies based on the individual's health status, or the health status of individuals within a group

Affordable Care Act Basics

Young Adult Coverage

Under the Affordable Care Act, health plans that allow coverage of children as dependents must make dependent coverage available to children up to age 26.* These young adults can join or remain on a parent's plan even if they:

- Are married (coverage requirement does not extend to a married child's spouse)
- Are not living with a parent
- Are not attending school
- Are not financially dependent on a parent
- Are eligible to enroll in their own employer's plan
- Have or adopt a child

*Some states require dependent coverage beyond 26 years of age if certain criteria are met.



Page Text

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*Some states require dependent coverage beyond 26 years of age if certain criteria are met.

Alt Text

A group of young people sitting on a park bench

Affordable Care Act Basics

Guaranteed Issue and Guaranteed Renewability

The Affordable Care Act generally requires [health insurance issuers](#) to offer all of their [non-grandfathered](#) individual market and group market plans to any eligible applicant in the state. It also requires health insurance issuers to accept any eligible employer and individual who applies for those policies, subject to certain exceptions. This provision is called "guaranteed issue" or "guaranteed availability."

Individual market coverage offered through and outside the Marketplace may restrict guaranteed issue coverage to certain specified Open Enrollment and special enrollment periods.

Additionally, the Affordable Care Act generally requires health insurance issuers to renew or continue in force coverage at the option of the policyholder. This is called "guaranteed renewability."

To ensure continuity of coverage for consumers if an issuer is undergoing a corporate reorganization, a product transferred from one issuer to a different issuer within an issuer's [controlled group](#) may be considered to be the same product for purposes of guaranteed renewability if certain criteria are met.



Page Text

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Health Insurance Issuer Pop Up text:

Health insurance issuer or issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is required to be licensed to engage in the business of insurance in a state and that is subject to



state law that regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 [ERISA]). This term does not include a group health plan.

Controlled Group Pop Up text:

A controlled group is a group of two or more related entities that is treated as a single employer under the Internal Revenue Code. For example, a parent company and its subsidiaries may be considered to be within the same controlled group.

Grandfathered Health Plan Pop Up text:

A grandfathered health plan is a group health plan that was created, or an individual health insurance policy that was purchased:

- On or before March 23, 2010,
- Has not changed in certain ways, and
- For which the issuer disclosed to enrollees that the plan is grandfathered.

Grandfathered plans are exempted from many requirements of the Affordable Care Act. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers.

Alt Text

A circular seal; the word "GUARANTEE" is displayed in both the upper and lower borders of the seal; an orange banner with the word "GUARANTEE" is displayed across the center of the seal; four stars are displayed in the upper and lower half of the inner circle.


Affordable Care Act Basics

Knowledge Check

Which of the following are components of the Affordable Care Act?

Select **all that apply** and then click **Check Your Answer**.

- A. Extension of dependent coverage of children up to age 26
- B. Prohibition on charging consumers a higher premium based on health status or gender
- C. Medicaid coverage for all individuals under the age of 65
- D. Prohibition on coverage limitations or exclusions based on pre-existing conditions

 Check Your Answer

Reset

Prompt

Select **all that apply** and then click **Check Your Answer**.

Question

Which of the following are components of the Affordable Care Act?

Options

- A. Extension of dependent coverage of children up to age 26
- B. Prohibition on charging consumers a higher premium based on health status or gender
- C. Medicaid coverage for all individuals under the age of 65
- D. Prohibition on coverage limitations or exclusions based on pre-existing conditions

Correct Answer

A, B, D

Positive Feedback

Correct! The correct answers are A, B, and D. The Affordable Care Act contains a number of provisions aimed at ensuring that most individuals have access to health insurance coverage. Health insurance issuers may not deny coverage or charge higher



premiums based on health status or gender and may not impose coverage limitations or exclusions based on pre-existing conditions. When a plan offers dependent coverage of children, the plan must offer coverage to dependent children up to age 26.

Negative Feedback

Incorrect. The correct answers are A, B, and D. The Affordable Care Act contains a number of provisions aimed at ensuring that most individuals have access to health insurance coverage. Health insurance issuers may not deny coverage or charge higher premiums based on health status or gender and may not impose coverage limitations or exclusions based on pre-existing conditions. When a plan offers dependent coverage of children, the plan must offer coverage to dependent children up to age 26.

Affordable Care Act Basics

Knowledge Check

A consumer worries she may develop chronic asthma because she has a family history of it, but she knows she will not be denied health insurance coverage due to the guaranteed issue provision of the Affordable Care Act. Guaranteed issue means that...

Select the **best answer** and then click **Check Your Answer**.

- A. Health insurance issuers that offer individual policies may deny insurance coverage to individuals with a known family history of a chronic illness.
- B. All individual policies in a state are guaranteed by the federal government.
- C. All individual policies in a state are guaranteed by the state.
- D. Health insurance issuers that offer individual policies in a state generally must offer all of their available individual market plans to all eligible individuals in the state, and must accept all eligible individuals who apply for coverage.

Check Your Answer

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

A consumer worries she may develop chronic asthma because she has a family history of it, but she knows she will not be denied health insurance coverage due to the guaranteed issue provision of the Affordable Care Act. Guaranteed issue means that...

Options

- A. Health insurance issuers that offer individual policies may deny insurance coverage to individuals with a known family history of a chronic illness.
- B. All individual policies in a state are guaranteed by the federal government.
- C. All individual policies in a state are guaranteed by the state.
- D. Health insurance issuers that offer individual policies in a state generally must offer all of their available individual market plans to all eligible individuals in the state, and must accept all eligible individuals who apply for coverage.

Correct Answer

D



Positive Feedback

Correct! Guaranteed issue means that health insurance issuers that offer individual policies in a state generally must offer all available individual coverage products to all eligible individuals in the state, and must accept any eligible individual who applies for those products.

Negative Feedback

Incorrect. The correct answer is D. Guaranteed issue means that health insurance issuers that offer individual policies in a state generally must offer all available individual coverage products to all eligible individuals in the state, and must accept any eligible individual who applies for those products.

Affordable Care Act Basics

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Coverage of Pre-existing Health Conditions Regardless of Health Status

Effective for plan years beginning on or after January 1, 2014, the Affordable Care Act prohibits group health plans and non-grandfathered health insurance plans from limiting or excluding coverage related to pre-existing health conditions, regardless of the age of the covered individual.

A pre-existing condition is any health condition or illness that was present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.



Health Insurance Marketplace®
Plan Year 2021



Job Aids



Help



Glossary



Pause



Mute



Transcript



Page Text

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Alt Text

A person having his blood pressure taken

Affordable Care Act Basics

Nondiscrimination Regarding Clinical Trial Participation

The Affordable Care Act prohibits group health plans and health insurance issuers from:

- Precluding participation of [qualified individuals](#) in an approved clinical trial
- Denying, limiting, or placing additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in an approved clinical trial
- Discriminating against qualified individuals on the basis of their participation in an approved clinical trial



Page Text

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- Discriminating against qualified individuals on the basis of their participation in an approved clinical trial

Qualified Individuals Pop Up text:

The Affordable Care Act defines “qualified individual,” for purposes of this provision, as an individual who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening diseases or conditions. A qualified individual either has a referral from a participating health care provider who has concluded that the individual’s participation in the clinical trial is appropriate, or has provided medical and scientific information establishing that the individual’s participation in the clinical trial would be appropriate.

Alt Text

Laboratory technicians working in a lab

Affordable Care Act Basics

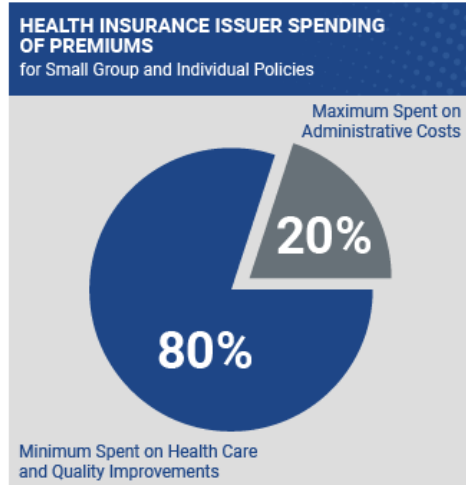
Medical Loss Ratio

The Affordable Care Act limits the proportion of premiums that a health insurance issuer can spend on things other than medical claims and improving the quality of the health care of its enrollees.

MLR is a basic financial measurement that generally shows how much of the premium dollars a health insurance issuer spends on health care expenses, as opposed to profits or administrative costs. A health insurance issuer that does not spend enough of its premium dollars on health care services or quality improvement activities must provide rebates to individuals and employers.

In general, if a health insurance issuer uses an average of 80 cents out of every premium dollar to pay customers' medical claims and to conduct activities that improve the quality of care, the company has an MLR of 80%. MLR is not calculated at the individual policy level, but at the state level for each issuer and separately for the small group, large group, and individual markets. An MLR of 80% indicates that the health insurance issuer is using the remaining 20 cents of each premium dollar for profits and administrative costs, including salaries and other expenses.

The Affordable Care Act sets minimum MLR standards for different markets, as do some state laws. Federal law requires health insurance issuers in the large group market (in most states, more than 50 employees) to spend at least 85% of premium dollars on medical care. The Affordable Care Act also requires issuers in the small group market (in most states, 50 or fewer employees) and individual market to spend at least 80% of premiums on medical care.



Page Text

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In general, if a health insurance issuer uses an average of 80 cents out of every premium dollar to pay customers' medical claims and to conduct activities that improve the quality of care, the company has an MLR of 80%. An MLR of 80% indicates that the health insurance issuer is using the remaining 20 cents of each premium dollar for profits and administrative costs, including salaries and other expenses.

MLR is not calculated at the individual policy level, but at the state level for each issuer and separately for the small group, large group, and individual markets.

The Affordable Care Act sets minimum MLR standards for different markets, as do some state laws. Federal law requires health insurance issuers in the large group market (in most states, more than 50 employees) to spend at least 85% of premium dollars



on medical care. The Affordable Care Act also requires issuers in the small group market (in most states, 50 or fewer employees) and individual market to spend at least 80% of premiums on medical care.

Alt Text

A chart titled "Health Insurance Issuer Spending of Premiums for Small Group and Individual Policies;" Three-dimensional pie chart with two parts (labeled "80%" and "20%"); Text associated with 80% piece is: "Minimum Spent on Health Care and Quality Improvements." Text associated with 20% piece is: "Maximum Spent on Administrative Costs."

Affordable Care Act Basics

Knowledge Check

When signing up for insurance, a consumer understands that if a health insurance issuer does not spend enough of its premium dollars on health care services or quality improvement activities, that issuer must provide...

Select the **best answer** and then click **Check Your Answer**.

- A. Proof of qualification status to the state Department of Insurance
- B. A rebate to refund the excess back to the consumer or employer
- C. Proof of license to the state Department of Insurance

Check Your Answer

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

When signing up for insurance, a consumer understands that if a health insurance issuer does not spend enough of its premium dollars on health care services or quality improvement activities, that issuer must provide...

Options

- A. Proof of qualification status to the state Department of Insurance
- B. A rebate to refund the excess back to the consumer or employer
- C. Proof of license to the state Department of Insurance

Correct Answer

B

Positive Feedback

Correct! Health insurance issuers that do not meet the minimum MLR requirements must provide rebates back to consumers or employers (in the case of employer-sponsored coverage).



Negative Feedback

Incorrect. The correct answer is B. Health insurance issuers that do not meet the minimum MLR requirements must provide rebates back to consumers or employers (in the case of employer-sponsored coverage).

Affordable Care Act Basics

Essential Health Benefits

The Affordable Care Act requires that non-grandfathered health plans offered in the individual and small group markets offer a comprehensive package of benefits, known as EHB. EHB include items and services within 10 benefit categories. The Affordable Care Act requires that EHB:

- Reflect appropriate balance among the 10 EHB categories
- Do not discriminate based on age, disability, or expected length of life
- Take into account the health care needs of diverse segments of the population

Specific health care benefits may vary by state. Even within the same state, there can be differences between health insurance plans. When a consumer fills out an application and compares plans, he or she will see the specific health care benefits each plan offers. Select the **Job Aids** button for a list of the EHB.



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Alt Text

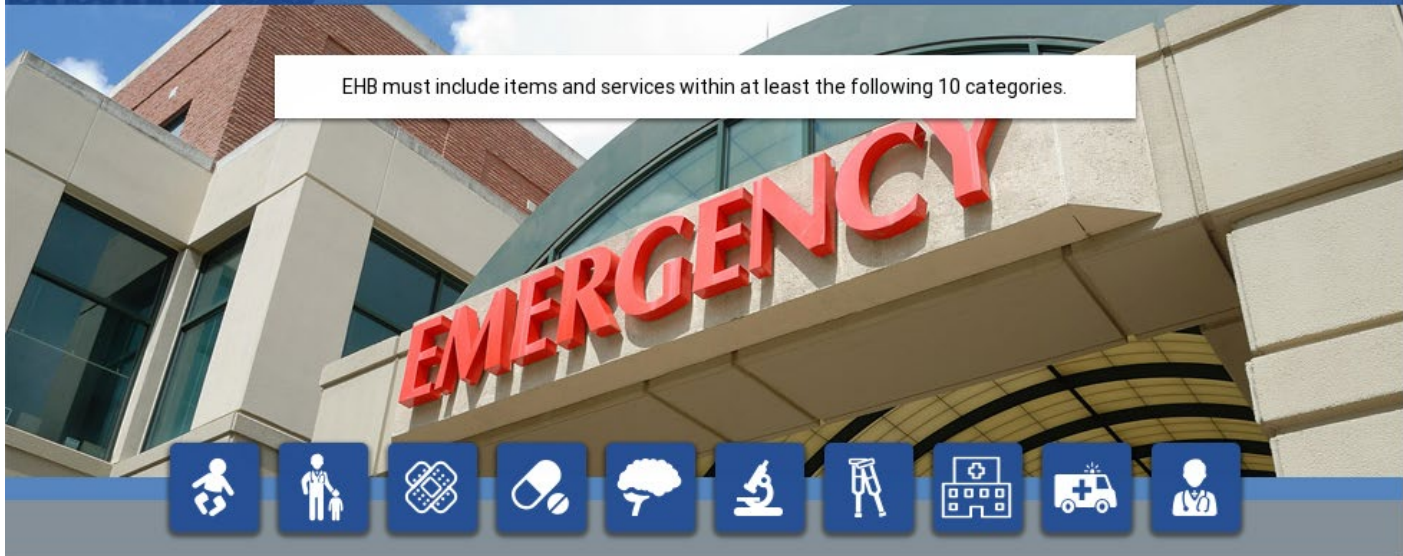
A woman touching a touchscreen with illuminated symbols representing essential health benefits

Affordable Care Act Basics

Essential Health Benefits (Continued)

Select each of the points of interest below to see these items and their services.

EHB must include items and services within at least the following 10 categories.



Long Description

Interactive graphic. An image of a hospital's Emergency entrance is displayed in the center of the screen. At the bottom of the image are ten icons which can be selected. When each one is selected, a pop-up screen appears with an image of the icon and text for each of the Essential Health Benefits. After each icon is selected, and the pop-up box is closed, the icon color changes from blue to green, and a checkmark appears to indicate the action is complete.

Prompt Text: Select each of the points of interest below to see these items and their services. EHB must include items and services within at least the following 10 categories.

Icons and associated text which appear are:

From left to right:

Baby: Maternity and newborn care

Child with doctor: Pediatric Services (under certain circumstances, pediatric oral care may be excluded, if available as part of a Marketplace-certified stand-alone dental plan)

Band-aids: Preventive and wellness services and chronic disease management



Pills: Prescription drugs

Brain: Mental health and substance use disorder services, including behavioral health treatment

Microscope: Laboratory services

Two syringes: Rehabilitative and habilitative services and devices

Building with medical cross: Hospitalization

Ambulance: Emergency services

Doctor: Ambulatory patient services, such as doctor visits

Affordable Care Act Basics

The Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable financial requirements (such as coinsurance) and treatment limitations (such as visit limits) on those benefits than they do on medical/surgical benefits.

The Affordable Care Act amended the MHPAEA to also apply to individual health insurance coverage, and its requirements are applied indirectly to small group health insurance plans in connection with the EHB requirement described on the previous page (coverage of MH/SUD services is one of the 10 EHB categories).

For more information, please visit:

- [The Mental Health Parity and Addiction Equity Act](#)
- [Frequently Asked Questions about Affordable Care Act Implementation and Mental Health Parity Implementation](#)



Page Text

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The Affordable Care Act amended the MHPAEA to also apply to individual health insurance coverage, and its requirements are applied indirectly to small group health insurance plans in connection with the EHB requirement described on the previous page (coverage of MH/SUD services is one of the 10 EHB categories).

For more information, please visit:

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Alt Text

Four puzzle pieces with a blue background are sitting on top of a pile of blank white puzzle pieces. The blue pieces are connected to form a white image of a head with blue gears inside.


Affordable Care Act Basics

Knowledge Check

What are EHB?

Select the **best answer** and then click **Check Your Answer**.

- A. Essential health benefits, a comprehensive package of 10 benefit categories that all non-grandfathered individual and small group health plans must offer
- B. The exact health insurance coverage that all Americans must have, which does NOT vary by state
- C. A minimum set of health conditions that all Americans must meet

 Check Your Answer

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

What are EHB?

Options

- A. Essential health benefits, a comprehensive package of 10 benefit categories that all non-grandfathered individual and small group health plans must offer
- B. The exact health insurance coverage that all Americans must have, which does NOT vary by state
- C. A minimum set of health conditions that all Americans must meet

Correct Answer

A

Positive Feedback

Correct! EHB are essential health benefits, a comprehensive package of 10 benefit categories that all non-grandfathered individual and small group health plans must offer.



Negative Feedback

Incorrect. The correct answer is A. EHB are essential health benefits, a comprehensive package of 10 benefit categories that all non-grandfathered individual and small group health plans must offer.

Affordable Care Act Basics

Knowledge Check

Which of the following are categories of EHB?

Select **all that apply** and then click **Check Your Answer**.

- A. Ambulatory patient services
- B. Emergency services, hospitalization, and prescription drugs
- C. Adult oral care
- D. Adult vision care

 Check Your Answer

Reset

Prompt

Select **all that apply** and then click **Check Your Answer**.

Question

Which of the following are categories of EHB?

Options

- A. Ambulatory patient services
- B. Emergency services, hospitalization, and prescription drugs
- C. Adult oral care
- D. Adult vision care

Correct Answer

A, B

Positive Feedback

Correct! Ambulatory patient services, emergency services, hospitalization, and prescription drugs are all categories of EHB.



Negative Feedback

Incorrect. The correct answers are A and B. Ambulatory patient services, emergency services, hospitalization, and prescription drugs are all categories of EHB.

Affordable Care Act Basics

Plan Categories

In addition to covering EHB and limiting cost sharing (including maximum out-of-pocket costs), non-grandfathered coverage in the individual and small group markets must also provide certain plan categories.

The plan categories are Bronze, Silver, Gold, and Platinum in ascending order. These categories, sometimes referred to as “metal levels,” help consumers, and the agents and brokers who assist them, to compare coverage options and determine which plans best fit the consumers’ needs. There are some limitations on a qualified individual changing plan categories,* so consumers should be aware of the restrictions of each coverage option. Health insurance issuers do not have to offer plans within all plan categories.

These categories are determined by the AV of the plan design. Plans cover each of the 10 EHB categories differently, but AV is calculated based on the average portion of the cost of providing EHB that is estimated to be paid by the health insurance plan for a standard population. The AV calculation is expressed in percentages. Usually, the higher the AV, the more the enrollee pays in monthly premiums and the less he or she could pay in out-of-pocket costs. Because the AV of a plan design is calculated based on a standard population, it may not be indicative of all individuals’ experiences.



* You will learn more about plan category limitations in the Individual Marketplace Enrolling in a Qualified Health Plan Module.

Page Text

In addition to covering EHB and limiting cost sharing (including maximum out-of-pocket costs), non-grandfathered coverage in the individual and small group markets must also provide certain plan categories.

The plan categories are Bronze, Silver, Gold, and Platinum in ascending order. These categories, sometimes referred to as “metal levels,” help consumers, and the agents and brokers who assist them, to compare coverage options and determine which plans best fit the consumers’ needs. There are some limitations on a qualified individual changing plan categories,* so consumers should be aware of the restrictions of each coverage option. Health insurance issuers do not have to offer plans within all plan categories.

These categories are determined by the AV of the plan design. Plans cover each of the 10 EHB categories differently, but AV is calculated based on the average portion of the cost of providing EHB that is estimated to be paid by the health insurance plan for a standard population. The AV calculation is expressed in percentages. Usually, the higher the AV, the more the enrollee pays in monthly premiums and the less he or she could pay in out-of-pocket costs. Because the AV of a plan design is calculated based on a standard population, it may not be indicative of all individuals’ experiences.

* You will learn more about plan category limitations in the Individual Marketplace Enrolling in a Qualified Health Plan Module.

Alt Text

Four rectangles with a caduceus in the center. The background colors match the plan categories: top left: Platinum; top right: Gold; bottom left: Silver; bottom right: Bronze

Page: 20 of 31: Plan Categories (Continued)



Long Description

Interactive graphic of four caduceus displayed in a rectangle. Each rectangle is colored to match the plan categories, from left to right: Platinum, Gold, Silver, Bronze. When each rectangle is selected, a pop-up box with accompanying text is displayed. When the pop-up box is closed, the label on each rectangle turns from blue to green and a checkmark appears to indicate the action is complete.

Prompt Text at the top of the overall image: Select an image below for the AV percentage of each plan level.

Text for each rectangle is: Platinum - 90% AV (the health insurance plan pays approximately 90% of the average cost of all EHB for an average person) Gold - 80% AV (the health insurance plan pays approximately 80% of the average cost of all EHB for an average person) Silver - 70% AV (the health insurance plan pays approximately 70% of the average cost of all EHB for an average person) Bronze - 60% AV (the health insurance plan pays approximately 60% of the average cost of all EHB for an average person)

Affordable Care Act Basics

Catastrophic Plans

In addition to four plan categories, issuers in the individual market can offer catastrophic plans. Eligibility for catastrophic plans is limited to:

- Individuals under age 30 before the plan year begins
- Individuals age 30 or older who have a certification from the Marketplace that they qualify for a hardship or affordability exemption

There is no specific AV for catastrophic plans. Catastrophic plans have specific cost-sharing requirements related to the annual cost-sharing limit that do not apply to plans in the four plan categories. Nevertheless, catastrophic plans have several benefits. They:

- Offer lower premiums, on average, than Bronze, Silver, Gold, or Platinum plans
- Cover at least three primary care visits before reaching the deductible
- Cover recommended preventive services without cost sharing
- Protect enrollees with a maximum out-of-pocket cost limit* (The limit changes annually; for 2021, the maximum annual out-of-pocket limitation on cost sharing is \$8,550 for an individual and \$17,100 for a family.)



*Beginning with plan year 2021, when consistent with state law, the issuer or plan may, but is not required to count direct support offered by drug manufacturers for specific prescription drugs towards the consumer's annual cost-sharing limit.

Page Text

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* Beginning with plan year 2021, when consistent with state law, the issuer or plan may, but is not required to count direct support offered by drug manufacturers for specific prescription drugs towards the consumer's annual cost-sharing limit.

Alt Text

Doctors running with a gurney in a hospital

Affordable Care Act Basics

Knowledge Check

True or False:

A 34-year-old woman is looking for health insurance coverage that is more affordable than the coverage offered by her employer. She does not qualify for a hardship or affordability exemption, but is eligible for catastrophic coverage.

Select the **best answer** and then click **Check Your Answer**.

- A. True
- B. False

Check Your Answer

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

True or False: A 34-year-old woman is looking for health insurance coverage that is more affordable than the coverage offered by her employer. She does not qualify for a hardship or affordability exemption, but is eligible for catastrophic coverage.

Options

- A. True
- B. False

Correct Answer

B

Positive Feedback

Correct! If the woman is over age 30 or has not received a hardship or affordability exemption, she is not eligible for catastrophic coverage.



Negative Feedback

Incorrect. The statement is false. If the woman is over age 30 or has not received a hardship or affordability exemption, she is not eligible for catastrophic coverage.


Affordable Care Act Basics

Knowledge Check

Actuarial variable (AV) can be defined as...

Select the best answer and then click **Check Your Answer**.

- A. The calculation of the average portion of the cost of providing EHB estimated to be paid by the health insurance plan for a standard population
- B. The average value of benefits in a catastrophic plan
- C. The average risk of employees enrolled in a health insurance plan
- D. The average risk of individuals under 65 enrolled in a health insurance plan

 Check Your Answer

Reset

Prompt

Select the best answer and then click **Check Your Answer**.

Question

AV can be defined as...

Options

- A. The calculation of the average portion of the cost of providing EHB estimated to be paid by the health insurance plan for a standard population
- B. The average value of benefits in a catastrophic plan
- C. The average risk of employees enrolled in a health insurance plan
- D. The average risk of individuals under 65 enrolled in a health insurance plan

Correct Answer

A

Positive Feedback

Correct! AV is a calculation of the average portion of the cost of providing EHB estimated to be paid by the plan for a standard population.



Negative Feedback

Incorrect. The correct answer is A. AV is a calculation of the average portion of the cost of providing EHB estimated to be paid by the plan for a standard population.

Affordable Care Act Basics

Knowledge Check

Which plan category corresponds to an average AV of approximately 70%?

Select the **best answer** and then click **Check Your Answer**.

- A. Bronze
- B. Silver
- C. Gold
- D. Platinum
- E. Catastrophic

 **Check Your Answer**

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

Which plan category corresponds to an average AV of approximately 70%?

Options

- A. Bronze
- B. Silver
- C. Gold
- D. Platinum
- E. Catastrophic

Correct Answer

B



Positive Feedback

Correct! The Silver Plan category has an average AV of approximately 70%. The average AV of the other plan categories are as follows: Bronze 60%, Gold 80%, and Platinum 90%. The Catastrophic Plan category does not meet a specific AV, but must comply with the maximum out-of-pocket cost limits.

Negative Feedback

Incorrect. The correct answer is B. The Silver Plan category has an average AV of approximately 70%. The average AV of the other plan categories are as follows: Bronze 60%, Gold 80%, and Platinum 90%. The Catastrophic Plan category does not meet a specific AV, but must comply with the maximum out-of-pocket cost limits.

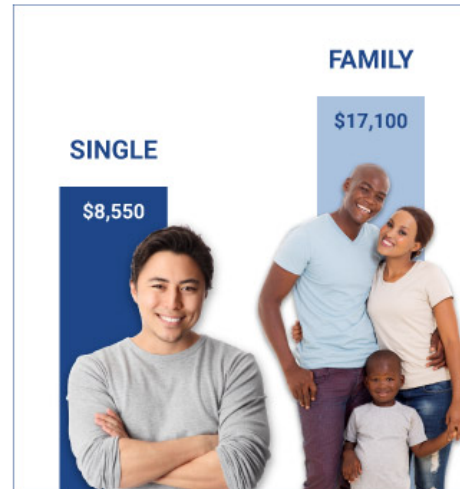
Affordable Care Act Basics

Out-of-Pocket Cost Limits

Generally, all non-grandfathered health plans must limit cost sharing for enrolled individuals in the following ways:

- Deductibles, coinsurance, and copayments cannot be applied to certain recommended preventive services.
- Annual cost-sharing limits cannot exceed specified amounts.* (For 2021, the maximum annual limitation on cost-sharing is \$8,550 for an individual and \$17,100 for families enrolled in individual or group market plans.)

*Beginning with plan year 2021, when consistent with state law, the issuer or plan may, but is not required to count direct support offered by drug manufacturers for specific prescription drugs towards the consumer's annual cost-sharing limit.



Page Text

Generally, all non-grandfathered health plans must limit cost sharing for enrolled individuals in the following ways:

- Deductibles, coinsurance, and copayments cannot be applied to certain recommended preventive services.
- Annual cost-sharing limits cannot exceed specified amounts.* (For 2021, the maximum annual limitation on cost-sharing is \$8,550 for an individual and \$17,100 for families enrolled in individual or group market plans.)

*Beginning with plan year 2021, when consistent with state law, the issuer or plan may, but is not required to count direct support offered by drug manufacturers for specific prescription drugs towards the consumer's annual cost-sharing limit.

Alt Text

Bar graph with two bars from left to right: dark blue bar, labeled "Single, \$8,550," individual person image; light blue bar, tallest, labeled "Family \$17,100," family image

Affordable Care Act Basics

Varying Rates

Select each button to see how premium rates in the individual and small group markets may vary based on different standards.



Age Rating Standards



Family Rating Standards



Geographic Rating Standards



Tobacco Rating Standards

Long Description

Interactive Graphic with four boxes stretched across the screen containing images, which are, from left to right: a middle-aged man, a family, a partial map of the United States, and cigarettes. When the image is selected, a pop-up box is displayed with accompanying text. When the pop-up box is closed, the label on the image turns from blue to green and a checkmark appears to indicate the action is complete.

Prompt Text: Select each button to see how premium rates in the individual and small group markets may vary based on different standards.

When the image of the middle-aged man is selected, the following text appears:

Age Rating Standards

- Health insurance issuers selling non-grandfathered coverage in the individual and small group markets generally are not allowed to charge an older adult more than three times the rate of a 21-year-old based on age.
- States can establish their own age curve or default to the federal age curve.
- Federal age bands:
 - 0-14
 - One-year bands between ages 15-63



- 64 and older

When the image of the family is selected, the following text appears: Family Rating Standards Family premiums are based on the premiums for each family member, including each family member's age and tobacco use (subject to state law). The total family premium includes premiums for up to three dependent children under the age of 21 and per-member rates for adults. In the case of enrollment groups with more than three children, only the oldest three children are rated. However, under certain circumstances, states may require the use of uniform family tiers and multipliers.

When the image of the map is selected, the following text appears:

Geographic Rating Standards

- Premiums reflect geographic rating areas, which are set by the state.
- For the individual market, the rating area is based on the primary policyholder's address.
- For the small group market, rating area is based on:
 - The group policyholder's principal business address; or
 - In some circumstances, the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year; or
 - If there is no such business address, the rating area where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

When the image of the cigarettes is selected, the following text appears:

Tobacco Rating Standards

- Health insurance issuers in the individual and small group markets generally cannot charge an individual who legally uses tobacco products more than 1.5 times the non-tobacco user's rate based on tobacco use.
- Tobacco rating can vary based on age (e.g., 1.2:1 for those under age 35).
- For employer insurance plans, issuers may impose the tobacco rating factor only if a tobacco-related wellness program (such as a tobacco cessation program) that complies with federal rules regarding nondiscriminatory wellness programs is also offered. Enrollees are able to avoid the tobacco surcharge by participating in such a wellness program.

The rating variation permitted for tobacco use can only be applied to the portion of the premium attributed to the individual family member. If one member of a family smokes, only the portion of the premium attributed to his or her own coverage will be affected—the portion of the premium for the other family members' coverage is not affected.

Affordable Care Act Basics

Knowledge Check

In which of the following ways must non-grandfathered health plans limit cost sharing for enrolled individuals?

Select the **best answer** and then click **Check Your Answer**.

- A. Plans may increase cost-sharing limits based on smoking status.
- B. Plans may increase cost-sharing requirements annually based on age.
- C. Annual cost-sharing limits for essential health benefits cannot exceed specified amounts.
- D. Plans must cover all adult dental care.

✓ Check Your Answer

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

In which of the following ways must non-grandfathered health plans limit cost sharing for enrolled individuals?

Options

- A. Plans may increase cost-sharing limits based on smoking status.
- B. Plans may increase cost-sharing requirements annually based on age.
- C. Annual cost-sharing limits for essential health benefits cannot exceed specified amounts.
- D. Plans must cover all adult dental care.

Correct Answer

C

Positive Feedback

Correct! Annual cost-sharing limits for essential health benefits cannot exceed specified amounts.

Negative Feedback

Incorrect. The correct answer is C. Annual cost-sharing limits for essential health benefits cannot exceed specified amounts.

Affordable Care Act Basics

Knowledge Check

True or False:

The total family premium generally includes per-member rates for all members, but limits per-member premiums for covered children to up to three dependent children under the age of 21.

Select the **best answer** and then click **Check Your Answer**.

- A. True
- B. False

✓ Check Your Answer

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

True or False: The total family premium generally includes per-member rates for all members, but limits per-member premiums for covered children to up to three dependent children under the age of 21.

Options

- A. True
- B. False

Correct Answer

A

Positive Feedback

Correct! The total family premium for non-grandfathered coverage generally includes per-member rates for all members, but limits per-member premiums for covered children to up to three dependent children under the age of 21.



Negative Feedback

Incorrect. The statement is true. The total family premium for non-grandfathered coverage generally includes per-member rates for all members, but limits per-member premiums for covered children to up to three dependent children under the age of 21.


Affordable Care Act Basics

Knowledge Check

What is the allowable maximum surcharge for non-grandfathered coverage for an individual who legally uses tobacco?

Select the **best answer** and then click **Check Your Answer**.

- A. The maximum surcharge is three times the non-tobacco user's rate.
- B. The maximum surcharge is one and a half times the non-tobacco user's rate.
- C. The maximum surcharge is five times the non-tobacco user's rate.
- D. Health insurance issuers are not allowed to add an additional surcharge for tobacco use under federal law.

 Check Your Answer

Reset

Prompt

Select the **best answer** and then click **Check Your Answer**.

Question

What is the allowable maximum surcharge for non-grandfathered coverage for an individual who legally uses tobacco?

Options

- A. The maximum surcharge is three times the non-tobacco user's rate.
- B. The maximum surcharge is one and a half times the non-tobacco user's rate.
- C. The maximum surcharge is five times the non-tobacco user's rate.
- D. Health insurance issuers are not allowed to add an additional surcharge for tobacco use under federal law.

Correct Answer

B

Positive Feedback

Correct! Non-grandfathered coverage in the individual and small group markets generally cannot cost an individual who uses tobacco products more than one and a half times the non-tobacco user's rate.



Negative Feedback

Incorrect. The correct answer is B. Non-grandfathered coverage in the individual and small group markets generally cannot cost an individual who uses tobacco products more than one and a half times the non-tobacco user's rate.

Affordable Care Act Basics

Module Summary

Select each button and review the key points of this lesson.

Consumer Protections

Plan Categories

Cost Limits and Rates

Health Insurance Marketplace
Plan Year 2021



Job Aids



Help



Glossary

Text Description of Image or Animation



Long Description

Interactive graphic: A collage of icons representing module-specific concepts is displayed; three equally-sized rectangular buttons are shown from left to right across the bottom of the page. Each rectangular button has a label that corresponds to a key module topic or concept. When each button is selected a pop up box appears and displays accompanying text.

Prompt text: Select each button and review the key points of this lesson.

Consumer Protections

Health insurance issuers must:

- Offer all of their available non-grandfathered group and individual market policies to any eligible individual or employer in the state (this reform is called "guaranteed issue");
- Not limit or exclude coverage related to pre-existing health conditions, regardless of the age of the covered individual;
- Spend the required percentage of premium dollars on medical care or provide a rebate to the individuals and employers; and
- When offering non-grandfathered health insurance plans in the individual and small group markets, cover benefits in at least the 10 EHB categories.

Plan Categories



- There are four plan categories for non-grandfathered individual and small group health insurance plans: Bronze, Silver, Gold, and Platinum. Each of these levels is determined by the AV of the plan design.
- In addition to the four plan categories, issuers in the individual market can offer catastrophic plans to individuals under age 30 before the plan year begins, and to individuals age 30 and older who have a certification from the Marketplace that they qualify for a hardship or affordability exemption.

Cost Limits and Rates

- All non-grandfathered health plans must limit cost sharing and out-of-pocket costs.
- Rates for non-grandfathered coverage in the individual and small group markets can only vary with respect to the particular plan or coverage by age, family composition, geographic area, and tobacco use.

Affordable Care Act Basics

Module Completion

Congratulations! You have completed the module on Affordable Care Act Basics.



Page Text

Congratulations! You have completed the module on Affordable Care Act Basics.

Alt Text

A person standing on a mountain peak with arms outstretched