

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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May 29, 2014

Mandy Cohen  
Director  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

## **RE: Qualified Health Plans and Indian-specific Cost-sharing Variations**

Dear Director Cohen:

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare & Medicaid Services (CMS) to bring to your attention a set of issues involving the qualified health plans (QHPs) offered through the Federally-facilitated Marketplace (FFM).<sup>1</sup> American Indians and Alaska Natives (AI/ANs), with the assistance of Tribes and Tribal health organizations, have been working to enroll in QHPs offered through Marketplaces. **A significant impediment to achieving greater enrollment levels has been the limited and sometimes erroneous information made available through the Marketplace and/or from issuers on the QHP offerings available to AI/ANs.**

The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/ANs) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (referred to as Indian Health Care Providers or I/T/Us).

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<sup>1</sup> It appears that all or most of the issues raised in this letter apply to the State-based Marketplaces. The term "Marketplace" is used when referring to the FFM and State-based Marketplaces.

## Background

American Indians and Alaska Natives looking to enroll in health insurance coverage through a FFM, as well as through State-based Marketplaces, have found it difficult to gain a clear understanding of the cost-sharing requirements and protections under the various Qualified Health Plans (QHPs) offered. For AI/ANs meeting the definition of Indian under the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA), they are eligible for either a “zero cost-sharing plan variation” or a “limited cost-sharing plan variation”, depending on their household income level.<sup>2</sup> Information on Indian-specific cost-sharing protections that is provided by health plan issuers to consumers, if any, is often times confusing if not outright incorrect.<sup>3</sup> Some AI/ANs have chosen not to enroll in coverage through a Marketplace because of this uncertainty. Others, even when choosing to enroll, have found it difficult if not impossible to know what their cost-sharing liabilities are much less have confidence that they are selecting the most advantageous QHP for themselves and their family.

We believe the cause of the deficiencies in the information provided to potential and actual QHP enrollees is the result of two factors:

1. Some issuers of QHPs do not have an accurate understanding of the cost-sharing protections available to AI/ANs and/or are not correctly applying the provisions.
2. The regulations and sub-regulatory guidance issued by the CMS Center for Consumer Information and Insurance Oversight (CCIIO) is not sufficient.

Below, we present information on the impediments with enrollment that is drawn from experiences of AI/ANs, Tribes and Tribal health organizations in interacting with the HealthCare.gov Web site as well as with the Web sites of QHP issuers. We structure the information presented in a question and answer format, citing three questions that have been frequently raised by AI/ANs and representatives of Tribes and Tribal health organizations as they have sought to navigate the new Marketplaces.

Q.1. Is there an “Indian health plan” that is offered through a Marketplace?

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<sup>2</sup> In this letter, the term “American Indians and Alaska Natives” is used to describe all persons eligible for services from an Indian Health Care Provider. The term “Indian” is used to describe individuals who meet the definition of Indian as found in the Affordable Care Act.

<sup>3</sup> See Attachment A for a handout issued by Premera Blue Cross Blue Shield in Washington State describing an “AI/AN plan.” The document indicates – erroneously – that there is substantial cost-sharing for essential health benefits (EHBs) when AI/ANs with household income under 300 percent of the federal poverty level are seen by non-network providers under the AI/AN health plan.

- Q.2. Are issuers required to establish a “zero cost-sharing variation” and a “limited cost-sharing variation” for each QHP offered on a metal level?
- Q.3. What summary information are issuers required to provide on each QHP and QHP variation?

We also offer for your consideration potential remedies to the impediments to enrollment that have been identified.

In addition to the analysis provided here, the TTAG recently submitted comments in response to CMS-10320, an Information Collection Request regarding “Health Care Reform Insurance Portal Requirements.”

### Analysis

This analysis aims to respond to three questions that have repeatedly surfaced among AI/ANs and the Tribes and Tribal health organizations that have assisted them with enrolling in QHPs through the Marketplaces and, in the process, identify significant barriers to greater AI/AN enrollment in QHPs.

#### **Q.1. Is there an “Indian health plan” that is offered through a Marketplace?**

Q.1. Answer: It depends. Or, more specifically, it depends on what the issuer means by describing a QHP as an “Indian health plan.”

*In general, the issue of an “Indian health plan” is all about cost-sharing. Each QHP offered by an issuer is to have “variations.” These plan variations describe different cost-sharing packages, or sets of protections. For example, there are two Indian-specific variations of a QHP that are required to be made available by issuers for each QHP offered (i.e., zero cost-sharing plan variation and limited cost-sharing plan variation.)*

It is solely the cost-sharing protections that are allowed to differ across plan variations for the same QHP. Plan benefits and provider networks are required to be constant across variations of the same QHP.<sup>4</sup> As well, the premium charged for a QHP offered on a metal level is to be the same no matter which QHP variation is selected.

If an issuer is referring to an “Indian health plan” as a QHP variation that includes one of the two Indian-specific cost-sharing variations, this description fits with the regulations. *But, if an issuer is referring to a single QHP variation as the only QHP that AI/ANs may enroll through a Marketplace, this is erroneous.*

At a minimum, a QHP offered on a Marketplace is to have at least two variations that are Indian-specific: a zero cost-sharing plan variation and a limited cost-sharing plan variation.

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<sup>4</sup> 45 CFR 156.420(d).

As such, there are at least two “Indian health plans” to be offered by each issuer offering QHPs on a Marketplace.

- The zero cost-sharing variation is available to an Indian with income that does not exceed 300% of the federal poverty level (FPL). The limited cost-sharing variation is available to an Indian who does not seek a determination of eligibility based on income or who is not eligible for the zero cost-sharing variation.
- The zero cost-sharing plan variation requires no cost-sharing for essential health benefits (EHBs), whether provided by an in-network provider or not. The limited cost-sharing variation requires no cost-sharing for EHBs provided by an Indian Health Care Provider (IHCP) or through referral from contract health services to a non-IHCP.

An issuer is also required to offer additional variations of a QHP.

- An issuer is required to offer a silver metal level plan and a gold metal level plan for each QHP offered on the Marketplace.
- In addition to the two Indian-specific plan variations to be offered for each QHP offered on a metal level (i.e., bronze, silver, gold and platinum), issuers are required to provide three other cost-sharing variations for the general population for QHPs at the silver plan level.<sup>5</sup>

As a result of these requirements, if an issuer offers one QHP on the Marketplace, there will be at least four Indian health plan variations: one zero cost-sharing variation for each silver and gold plan offered (two Indian health plan variations) and one limited cost-sharing variation for each silver and gold plan offered (two additional Indian health plan variations.) As a result, each issuer on a Marketplace has at least four Indian health plan variations. If an issuer offers bronze and/or platinum versions of a QHP, additional numbers of Indian health plan variations would be offered.<sup>6</sup> And if this issuer offers additional QHPs on a metal level, there will be additional Indian health plan variations of the plans.

We understand this to be the general rule on the offering of Indian-specific health plan variations. We also understand that CCIIO has provided a limited exception to the requirement to offer both a zero cost-sharing variation and limited cost-sharing variation for each QHP on a metal level. This exception is discussed in Q.2. below.

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<sup>5</sup> An issuer is required to provide – in addition to the Indian-specific cost-sharing variations – three variations of the standard silver plan. These variations account for cost-sharing differences under the plans with 73 percent actuarial value (AV), 87 percent AV, and 97 percent AV, versus 70 percent AV under the standard silver plan.

<sup>6</sup> In prior recommendations of the TTAG, TTAG recommended that CCIIO require issuers to offer a QHP at the bronze metal level in addition to the silver and gold levels.

**Q.1. Observations:** Some issuers are communicating to potential enrollees that there is “one Indian health plan.” This is in contrast to the requirements stated above, and the “one Indian health plan” message is causing confusion among plan enrollees and potential enrollees, as well as Navigators and other assisters. Not only do potential Indian QHP enrollees seem to be presented with a restricted set of options for QHP enrollment, potential enrollees are then further confused when viewing the listed health plan options and not seeing any plans that are specific to American Indians and Alaska Natives.

**Q.1. Recommendations:** The TTAG recommends that CCIIO:

1. Require issuers to document that they indeed have two Indian-specific variations for each QHP offered and communicate this to AI/AN consumers.
2. Require HealthCare.gov and other Marketplace Web sites to modify the current information posted to include a straight-forward explanation that health care services will be provided to an Indian under any QHP offered through a Marketplace without liabilities to the Indian for cost-sharing for essential health benefits when seen at a Indian Health Care Provider (IHCP) and potentially when served by a non-IHCP.<sup>7</sup>

**Q. 2. Are issuers required to establish a “zero cost-sharing variation” and a “limited cost-sharing variation” for each QHP offered on a metal level (bronze, silver, etc.)?**

**Q.2. Answer:** Yes, but there is a limited exception.

Pursuant to the CMS regulation at 45 CFR 156.420(b), an issuer is to comply with the following:

*“(b) Submission of zero and limited cost sharing plan variations.* For each of its health plans at any level of coverage that an issuer offers, or intends to offer in the individual market on an Exchange, the issuer must submit to the Exchange for certification the health plan and two variations of the health plan, as follows—

(1) For individuals eligible for cost-sharing reductions under §155.350(a) of this subchapter, a variation of the health plan with all cost sharing eliminated; and

(2) For individuals eligible for cost-sharing reductions under §155.350(b) of this subchapter, a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through referral under contract health services.”

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<sup>7</sup> <https://www.healthcare.gov/if-im-an-american-indian-or-alaska-native-what-do-i-need-to-know-about-the-marketplace/>

The CMS regulation continues under 45 CFR 156.420(d) with the requirement that the same benefits and providers be covered in each variation:<sup>8</sup>

“(d) *Benefit and network equivalence in zero and limited cost sharing plan variations.* A QHP and each zero cost sharing plan variation or limited cost sharing plan variation thereof must cover the same benefits and providers...”

The regulation continues with a detailed description of the application of cost-sharing protections for non-EHBs, including a revision to the current regulation that is to be effective as of May 12, 2014.<sup>i ii</sup> Deciphering the nuances in the cost-sharing protections for non-EHBs is difficult, but in the preamble to a different regulation, CMS summarized these provisions in the following way:

“[W]e proposed in § 156.420(d) that the out-of-pocket spending required of enrollees in the zero cost sharing plan variation of a QHP for a benefit that is not an EHB from a provider (including a provider outside the plan’s network) may not exceed the corresponding out-of-pocket spending required in the limited cost sharing plan variation of the QHP, which in turn may not exceed the corresponding out-of-pocket spending required in the QHP with no cost sharing reductions.”<sup>9</sup>

As stated in 45 CFR 156.420(d), an issuer must provide the same set of benefits and the same providers under the Indian-specific variations of a QHP as is provided under the standard variation of the same QHP. And as stated clearly in the CCIIO 2015 Issuer Letter issued in March 2014, “In accordance with 45 C.F.R. 156.420(b)(1), zero cost sharing plan variations do not have positive cost sharing for any EHB, whether in or out-of-network.”<sup>10</sup> A limited cost-sharing plan variation has the same protections for EHBs as a zero cost-sharing plan variation, subject to the requirement under the limited cost sharing variation to receive a referral from contract health services for services provided by non-Indian Health Care Providers in order to receive 100 percent cost-sharing protections for these services.

CMS has provided an exception to the requirement that an issuer provide a zero cost-sharing variation for each QHP offered on a Marketplace. The exception was discussed in a CCIIO guidance document issued on March 14, 2014:<sup>11</sup>

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<sup>8</sup> Paragraph (d) shown here was established in an amendment published March 11, 2014 in CMS-9954, Payment Parameters (at 79 Fed Reg 13840) and is effective May 12, 2014.

<sup>9</sup> 79 Fed Reg 13804 – 05.

<sup>10</sup> The CCIIO 2015 Issuer Letter also stated, “Under 45 C.F.R. 155.20, cost sharing means any expenditure required by or on behalf of an enrollee with respect to EHB, including deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.”

<sup>11</sup> In the “CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the Premium Tax Credit...”, it was noted that “In the 2014 HHS Notice of Benefit and Payment Parameters, published on March 11, 2013 at 78 Fed Reg 15511, the preamble to the final rule indicates, “In paragraph (b), we further establish

- “For Indians, 45 CFR 156.420(b) requires a QHP issuer to submit a zero cost sharing plan and limited cost sharing plan variation for each of its health plans (at each level of coverage) an issuer offers, or intends to offer in the individual market on a Marketplace.”

This CMS guidance goes on to indicate in a footnote:

- “The 2014 HHS Notice of Benefit and Payment Parameters clarifies that a Marketplace is adequately enforcing this requirement if, within a set of standard plans offered by an issuer that differ only by the cost-sharing or premium, it allows an issuer to submit one zero cost sharing plan variation for only the standard plan with the lowest premium within the set. (78 Fed Reg 15511)” (Emphasis added.)

As such, an issuer is allowed to limit the offering of a zero cost-sharing variation to one QHP for each “set” of QHPs when the QHPs differ only with respect to the QHP’s cost-sharing or premium.<sup>12</sup> Other than potential differences in cost-sharing and premiums, a “set” of QHPs must offer the same benefit package and the same provider networks.

*QHPs within a set of standard plans may involve QHPs at the same metal level as well as QHPs at different metal levels.*<sup>13</sup> The zero cost-sharing variation for this QHP set is to be issued for the QHP in the set that has the lowest premium. In the case of a QHP set that involves QHPs in different metal levels, the QHP at the lowest metal level (silver or bronze) would be the QHP with the lowest premium, and as such would be the QHP that offers the zero cost-sharing variation.

In order to provide more clarity to potential enrollees on which QHP variations apply to them, in March of 2013, CMS included the following statement in the preamble to a final regulation:<sup>14</sup>

“Comment: One commenter specifically suggested that Exchanges only display the plan variation of each QHP for which the consumer is eligible to avoid confusion.

Response: The standards set forth in § 156.420 ensure that consumers will be best

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that a QHP issuer must, for each of its health plans at any metal level of coverage, submit a zero cost sharing plan variation and a limited cost sharing plan variation of each health plan offered or proposed to be offered in the individual market on the Exchange. However, in this final rule, we clarify that an Exchange is adequately enforcing this requirement if, within a set of standard plans offered by an issuer that differ only by the cost sharing or premium, it allows an issuer to submit one zero cost sharing plan variation for only the standard plan with the lowest premium within the set.”

<sup>12</sup> A “set of standard plans” refers to QHPs with the same benefits and providers, but the QHPs in the set can have different cost-sharing and premium amounts.

<sup>13</sup> Given issuers are required to offer a QHP at the silver and gold levels, each “set” of standard plans are to incorporate QHPs on at least two metal levels.

<sup>14</sup> CMS-9954-F, Notice of Benefit and Payment Parameters for 2014, March 11, 2013 (78 Fed Reg 15481).

served by being assigned to the most generous plan variation for which they are eligible. Therefore, we encourage Exchanges to only display the variation of each QHP for which the consumer is eligible.”<sup>15</sup>

**Q.2. Observations:** Although the QHPs listed on the FFM and/or on the issuer Web pages are available to Indians (as all QHPs are), the QHPs are not shown with a general description of the cost-sharing variations that apply to Indians. Nor do the QHPs shown for potential enrollment by an Indian contain a link to a Summary of Benefits and Coverage that describes in greater detail what the Indian-specific cost-sharing protections are.

When searching for a QHP on a Marketplace, the information presented to enrollees and potential enrollees typically does not indicate: a) that the two Indian-specific cost-sharing variations apply to each QHP, b) which QHPs, if any, are considered part of a “set” and therefore the applicable premium for the lowest cost QHP in the set is not known, and c) which QHP variations apply to a particular applicant. Without this information, potential AI/AN enrollees are likely to be – and have been – left with the impression that the plans available on a Marketplace require substantial cost-sharing, even though the applicant may be eligible for a zero or limited cost-sharing variation.

**Q.2. Recommendations:** The TTAG recommends:

1. Require – rather than “encourage” – Marketplaces to “only display the variation of each QHP for which the consumer is eligible” along with an explanation that Indians are eligible to enroll in all QHPs offered, that each QHP is offered with a zero cost-sharing plan variation and a limited cost-sharing plan variation, but the QHP variations shown are the lowest premium variations for each QHP “set”.
2. Require issuers to provide on their Web sites displaying QHP options an explanation that Indians are eligible to enroll in all QHPs offered and that each QHP is offered with a zero cost-sharing plan variation and a limited cost-sharing plan variation.
3. Require issuers to include on their Web sites displaying QHP options the lowest premium option for each QHP “set” offered and an explanation of which Indian-specific cost-sharing variation the applicant is eligible to enroll.

**Q.3. What summary information are issuers required to provide on each QHP and QHP variation?**

**Q.3. Answer:** Issuers are required to prepare statements of benefits and coverage, as indicated at 45 CFR §147.200, and make these available to applicants within seven days of the issuer receiving an application from a potential enrollee. The regulation reads, in part:

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<sup>15</sup> 78 Fed Reg 15481.



An issuer “is required to provide a written summary of benefits and coverage (SBC) for each benefit package...”<sup>16</sup> A “benefit package” appears to equate to the “base” or “standard” QHP. The SBC summary document is to indicate in a standardized format what a QHP covers and what it will cost an enrollee for select services.

A template of the SBC is provided at <http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf>. While the information included on the SBC is only in summary form, the information provides answers to many of the threshold questions that a (potential) enrollee may wish to have answered before selecting a health plan.

The CCIIO 2015 Issuer Letter (issued in final form on March 14, 2014) explains a caveat to these requirements on issuers. Issuers are not required to prepare a SBC for each health plan variation. The 2015 Issuer Letter states: “*While QHP issuers are not required to create separate SBCs to reflect different levels of cost-sharing reductions for each plan variation, QHP issuers should create an SBC that represents the base plan, consistent with the requirements set forth in §147.200.*”<sup>17</sup> QHPs may not combine information about multiple plan variations in one SBC. However, *QHP issuers are permitted, and encouraged, to create separate SBCs for each plan variation.*”<sup>18</sup> (Emphasis added.)

In summary, under the CCIIO guidance enrollees in a QHP are to receive, at a minimum, a SBC for a QHP that summarizes the coverage and cost-sharing provisions in a standard format, and provides examples of estimated costs for an illustrative set of conditions. But, this information is required to be provided by an issuer only for the base QHP and not for each QHP variation (*i.e.*, zero cost-sharing variation, limited cost-sharing variation, silver level variations.) As a result, unless an issuer goes beyond the minimum requirements a QHP enrollee will not be able to determine from the SBC the actual cost-sharing protections and requirements under the particular QHP variation in which the individual is eligible to enroll.

**Q.3. Observations:** AI/ANs who are considering enrolling in a QHP are often times uncertain as to the cost-sharing protections they will receive in a QHP. Despite a Marketplace determination letter indicating that an applicant “can choose a health plan with lower copayment, coinsurance, and deductibles,” the SBC for the QHPs offered on the Marketplace and/or on the issuer’s Web site do not present this information. Potential QHP

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<sup>16</sup> 45 CFR §147.200 “Summary of benefits and coverage and uniform glossary. (a) *Summary of benefits and coverage-* (1) *In general.* A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package...”

<sup>17</sup> 45 CFR §147.200.

<sup>18</sup> CCIIO Final 2015 Issuer Letter, page 45.

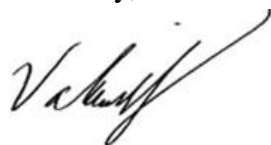
applicants have exited the QHP application process when the plan information presented on the Marketplace or on an issuer's Web site identified substantial cost-sharing requirements.

Q.3. Recommendations: The TTAG recommends that CCIIO:

1. Require Marketplaces to create a template SBC for the zero cost-sharing plan variation and the limited cost-sharing plan variation indicating what the cost-sharing protections are and how they generally apply to covered services.
2. Require issuers to create a SBC for each cost-sharing variation of a QHP.
3. Require issues to provide access to the SBC to potential QHP enrollees by making the cost-sharing variation-specific SBC accessible on the issuer's Web site that displays the QHP options without requiring the use of passwords or other barriers.
4. Require issuers to proactively provide the cost-sharing specific-SBC to enrollees within seven days of receiving an application from a potential enrollee.

We appreciate the opportunity to engage with CCIO on these issues and the specific recommendations being made by the TTAG. We believe progress on the issues identified here will make substantial improvements in the ability of AI/ANs to successfully enroll in coverage through a Marketplace and to ultimately receive the benefits and protections for which they are eligible. Please contact Richard Litsey (rlitsey@nihb.org), Director of Policy and Advocacy at the National Indian Health Board, with any questions you may have. We look forward to discussing these issues, and the TTAG-recommended remedies, at your convenience.

Sincerely,



Valerie Davidson  
Chair, TTAG

Attached: Attachment A: Washington State Premera Blue Cross Blue Shield Bronze 5500-6350 AI-AN Plan Summary

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs  
Dr. Yvette Roubideaux, Director, IHS  
Lisa Wilson, CCIIO  
Nancy Goetschius, CCIIO  
Stacy Bohlen, Executive Director, NIHB

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<sup>i</sup> “...**The out-of-pocket spending required of enrollees in the zero cost sharing plan variation of a QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the limited cost sharing plan variation of the QHP and the corresponding out-of-pocket spending required in the silver plan variation of the QHP for individuals eligible for cost-sharing reductions under §155.305(g)(2)(i) of this subchapter in the case of a silver QHP...**

[NOTE: “§155.305(g)(2)(i) of this subchapter” refers to “An individual who is expected to have a household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested.”]

**... The out-of-pocket spending required of enrollees in the limited cost sharing plan variation of the QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the QHP with no cost-sharing reductions.** A limited cost sharing plan variation must have the same cost sharing for essential health benefits not described in paragraph (b)(2) of this section as the QHP with no cost-sharing reductions. Each zero cost sharing plan variation or limited cost sharing plan variation is subject to all requirements applicable to the QHP (except for the requirement that the plan have an [actuarial value] as set forth in §156.140(b)).”<sup>i</sup> (Emphasis added. Bold indicates additional language, to be effective May 12, 2014, which replaced the following phrase in current regulations “and require the same out-of-pocket spending for benefits other than essential health benefits.”)

[NOTE: Paragraph (d) previously read: “(d) *Benefit and network equivalence in zero and limited cost sharing plan variations.* A QHP and each zero cost sharing plan variation or limited cost sharing plan variation thereof must cover the same benefits and providers, and require the same out-of-pocket spending for benefits other than essential health benefits. A limited cost sharing plan variation must have the same cost sharing on items or services not described in paragraph (b)(2) of this section as the QHP with no cost-sharing reductions. Each zero cost sharing plan variation or limited cost sharing plan variation is subject to all requirements applicable to the QHP (except for the requirement that the plan have an AV as set forth in §156.140(b)).”]

[NOTE: “Paragraph (b)(2) of this section” refers to the cost-sharing that applies when essential health benefits are provided by a non-I/T/U provider when no referral for services from an I/T/U provider is issued.]

<sup>ii</sup> In addition to the requirements for providing the same benefits and providers for all variations of the same QHP, with regard to out-of-pocket (OOP) spending for non-essential health benefits, as indicated in 45 CFR 156.420(d), the following rules apply (effective May 12, 2014) –

- For enrollees in non-silver level plans who are in a zero cost-sharing variation of a QHP and who seek non-essential health benefits, OOP spending for non-EHBs must not exceed the OOP spending required under the limited cost-sharing plan variation of the QHP.
- For enrollees in silver plans who seek non-EHB services, OOP spending for non-EHBs may not exceed the corresponding OOP spending required in the 94 percent actuarial value silver plan variation of the QHP (which corresponds to OOP protections for persons defined under §155.305(g)(2)(i), which is designed for persons with income between 100 and 150 percent FPL.)
- And, for enrollees in the limited cost-sharing variation of a QHP, cost-sharing for non-EHBs must not exceed the corresponding OOP spending required in the same QHP for persons with no cost-sharing reductions (*i.e.*, the OOP spending required for these services cannot exceed the OOP spending for these services in the applicable bronze, silver, gold or platinum standard plans.)