Overview
Essential Health Benefits in the Affordable Care Act

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Essential Health Benefits

Minimum floor of benefits in coverage for:

- Qualified health plans for individuals and small groups in the Exchange
- Non-grandfathered individual and small group coverage outside of the Exchange
- Persons newly eligible for Medicaid (133% of poverty and below)
- Persons enrolled in a Basic Health Option, if established by states

10 Benefit Categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Federal Essential Health Benefits Bulletin

Intended regulatory approach:

- Each state selects a benchmark plan
- Selected benchmark serves as a reference plan reflecting "both the scope of services and any limits offered by a typical employer plan"
- Plans chosen based on enrollment data first quarter two years prior to the coverage year (1st quarter 2012 for Jan 2014)
- Benchmark chosen in the third quarter of year two years prior (2012 for 2014)

Benchmark options (10 options)**:**

- **Small group** – largest plan by enrollment in the three largest small group products
- **State employee** – largest three state employee plans by enrollment
- **Federal employee** – any of the largest three national FEHBP plans by enrollment
- **Commercial HMO** – largest insured commercial non-Medicaid HMO in the state

Health Benefit Plan Design

1) Benefit design
   - Covered services
   - Cost-sharing
   - Terms and conditions of coverage
2) Delivery system design
   - Provider network
   - Medical Management
   - Payment and Reimbursement
3) Customer service and administrative services

Benefit Design Elements

(For illustration purposes)

1 Covered Services

- Covered benefits, drugs and devices and benefit definitions
- Quantitative limits or exclusions
- Key Terms affecting coverage
  - •Definition of medical service
  - •Medical necessity
  - •Experimental, investigational
  - •Cosmetic

2 Cost-sharing

- Deductibles, co-payments, co-insurance, out-of-pocket maximums
- Covered services with no cost sharing (e.g., prevention)
- How enrollee cost-sharing accrues to the out-of-pocket maximum and deductibles

3 Coverage Terms

- In-network / out-of-network provider
- Prior authorization or pre-service review
- Specified settings, sites or levels of care where service is covered
- Provider type or license
- Primary care coordination / specialty referral conditions

Next Steps

1) Comments on federal proposal from California and other stakeholders

2) Continue to get clarification from federal Department of Health and Human Services, including Medicaid-specific guidance

3) Verify the appropriate benchmarks in compliance with the federal choices

4) Compare the benefits and coverage terms

5) Ensure that the 10 categories in the Affordable Care Act are included

6) Understand and evaluate the implications of choosing each benchmark