Affordable Care Act
Essential Health Benefits: Primer

Introduction

- The Affordable Care Act (ACA) ensures Americans have access to quality, affordable health insurance
- To achieve this goal, the law ensures health plans offered to individuals and small businesses, both inside and outside of Health Benefit Exchanges, offer a comprehensive package of items and services known as “essential health benefits”

The Basics

- Must include 10 ACA mandated categories of benefits
- Designed to provide comprehensive, affordable care that meets the needs of enrollees in Exchange plans and those seeking individual or small group coverage from non-grandfathered health plans outside the Exchange
- Serves as the basis of:
  - Non-grandfathered small group plans outside the Exchange;
  - Medicaid “benchmark” benefit package; and
  - Basic Health Program package (if offered by the state)

The 10 Mandated Essential Benefits

- Ambulatory Patient Services
- Emergency Services
- Inpatient Care
- Maternity and New Born Care
- Mental health and Substance Abuse Disorder Services, including behavioral health treatment
- Prescription drugs
- Rehabilitative
- Laboratory Services
- Preventive and Wellness Services and Chronic Disease Management
- Pediatric Services, including Oral and Vision Care

Benchmark Options for State*

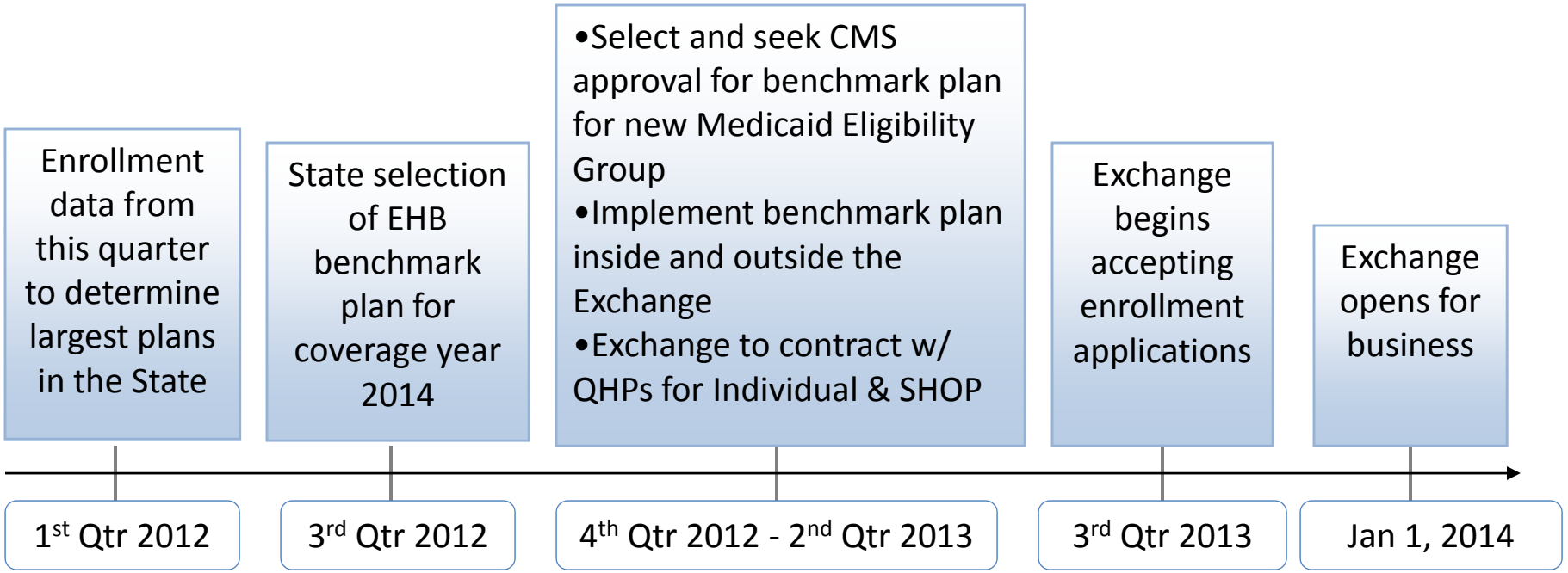
1. One of the three largest small group plans in the State by enrollment
2. One of the three largest State employee health plans by enrollment
3. One of the three largest federal employee health plan (FEHBP) options by enrollment
4. The largest HMO plan offered in the State's commercial market by enrollment

*December 16, 2011 CCIIO bulletin

Medicaid Benchmark Benefits

- EHB will be the base upon which Medicaid benchmark will be built
- Implications of selection:
  - Newly eligible Medicaid beneficiaries (e.g., In New York, childless adults, 100-138% FPL) are eligible for benchmark benefits at enhanced federal match
  - Other populations are eligible for benchmark benefits, but at lower federal match
- Key questions:
  - What core set of services should be included?
  - What are the fiscal implications?
  - How do we best ease administration (e.g., same benchmark for non-group, small group, and Medicaid)?

HHS Proposed Timeline*



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State Analysis

- Consultant assistance to study EHB and Medicaid Benchmark
- Determine 10 benchmark options:
  - Analyze Quarter 1 2012 data to determine largest small group, state employee, and HMO plans in the state
- Analyze detail within these options:
  - Compile detailed information on the benefits for these plan options (e.g., the products selected by consumers)
  - Analyze comparable data for FEHBP
  - Assess the implications of the different plan options:
    - For consumers
    - Fiscal implications for the State
    - Ease of administration

Terms

- **Health issuer** = licensed entity
- **Health plan** = standard offering of an issuer
- **Health product** = features selected by consumers (e.g., standard plan plus riders)