The 10 Essential Health Benefits of the ACA, and Why it Matters to Your Practice

In late November, the Department of Health and Human Services published its proposed rules that outline how the insurance market will operate starting in 2014. The rules mean consumers will have access to the information they need to make informed decisions about their health insurance purchases, and will be able to compare plans of similar coverage and price side by side in new federal and state run health insurance exchanges.

The proposed rules cover three areas: Actuarial Value, Accreditation Standards and Essential Health Benefits.

Actuarial value is a calculation of the percentage of the cost of covered benefits that an insurance plan covers. A plan with an actuarial value of 80% pays for roughly 80% of the total costs of covered treatment for the subscriber. Plans that meet certain guidelines will earn “medal” status: plans can be designated gold, silver, or bronze medal and so on based on premiums and actuarial value.

The accreditation standards lay out the process of becoming certified for the Health Insurance Exchanges (HIEs – **not** to be confused with Health Information Exchanges!), and a big part of meeting those standards will be providing coverage for the

ten benefits that are defined in the rules.

The ten **“Essential Health Benefits”** benefits are really more areas of coverage rather than specific individual services or procedures, but all plans inside and outside of the HIEs must provide coverage in these ten areas:

1. Ambulatory patient services

2. Emergency Services

3. Hospitalization

4. Maternity and newborn care

5. Mental health and substance use disorder services, including behavioral health treatment

6. Prescription drugs

7. Rehabilitative and habilitative services and devices

8. Laboratory services

9. Preventative and wellness services and chronic disease management

10. Pediatric services, including oral care and vision

Each state will have the leeway to define the minimum standards of coverage based on already available plans in the state market, but each state must provide some form of coverage in each of these ten areas.

So what does this mean for your practice?

First of all, these ten essential benefits could represent an expansion of covered care for many of your current patients. Providers know the feeling of advising a patient to seek

specialized care or other benefits that are non-covered under their current plans, only to realize that medical expenses have to be balanced against a real-world budget, job market and economy. With these ten essential benefits as part of a minimum insurance package, providers will know that these areas have at least some coverage for their patients, and this could mean long-advised suggestions for physical therapy, behavioral health, or expensive prescriptions could find a more receptive audience.

Your patients are probably already coming to you with questions about healthcare reform, insurance coverage and what it means, and giving them a better understanding of their essential health benefits under the law can help them to participate in their own care. These proposed rules also provide a great excuse for you to review which groups and specialists you refer to in the area: with benefit expansions, you can find new opportunities to connect with other providers for the benefit of your patients and your practice.

And finally, the shift from volume reimbursement to accountable care models means that more than ever, the bottom-line success of a practice is explicitly tied to the healthcare outcomes of their patients. This means that providers need to have all the wellness and treatment weapons in their arsenal that they can find.

What is your practice doing now to get ready for the changes coming to the insurance system in 2014?