

## **Summary of provisions of the federal health care reform law (HR 3590 and HR 4872) related to benefits and covered services**

**Sec. 2711. NO LIFETIME OR ANNUAL LIMITS.** Prohibits all plans from establishing lifetime or unreasonable annual limits on the dollar value of benefits.

**Sec. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.** Requires all plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, and certain child preventive services recommended by the Health Resources and Services Administration, without any cost-sharing.

**Sec. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.** Requires health insurance issuers in the small group and individual markets to include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all health plans to comply with limitations on allowable cost-sharing.

**Sec. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.** Defines an essential health benefits package that covers essential health benefits, limits cost-sharing, and has a specified actuarial value (pays for a specified percentage of costs), as follows:

1. For the individual and small group markets, requires the Secretary to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.
2. For all plans in all markets, prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts. For the small group market, prohibits deductibles that are greater than \$2000 for individuals and \$4000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums.
3. For the individual and small group markets, requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs:

Bronze:	60 percent
Silver:	70 percent
Gold:	80 percent
Premium:	90 percent

In the individual market, a catastrophic plan may be offered to individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they have a hardship. A catastrophic plan must cover essential health benefits and at least 3 primary care visits, but must require cost-sharing up to the HSA out-of-pocket limits. Also, if an insurer offers a qualified health plan, it must offer a child-only plan at the same level coverage.

### **Sec. 1303. SPECIAL RULES.**

**Voluntary Choice of Coverage of Abortion Services.** Abortion cannot be a mandated benefit as part of a minimum benefits package. A qualified health plan would determine whether it will cover: no abortions, only those abortions allowed under Hyde (rape, incest and life endangerment), or abortions beyond those allowed by Hyde.

**Sec. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.** The standard out-of-pocket maximum limits (\$5950 for individuals and \$11900 for families) would be reduced to one-third for those between 100-200 percent of poverty, one-half for those between 200-300 percent of poverty, and to two-thirds for those between 300-400 percent of poverty. The plan's share of total allowed costs of benefits would be increased to 90 percent of those between 100-150 percent of poverty (i.e., the individual's liability is limited to 10 percent on average) and to 80 percent for those between 150-200 percent of poverty (i.e., the individual's liability is limited to 20 percent on average). The cost-sharing assistance does not take into account benefits mandated by States.

### **Sec. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.**

**Eligibility.** Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on January 1, 2011. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). Creates a new mandatory Medicaid eligibility category for all such "newly-eligible" individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment.

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**Sec. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.** (continued)

Benefits. Newly-eligible, non-elderly, non-pregnant individuals would receive benchmark or bench-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Benchmark and benchmark-equivalent coverage would be required to provide at least essential benefits (as defined for the Exchange) and prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence.

**Sec. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.** Requires coverage of services provided by free-standing birth centers in Medicaid.

**Sec. 2302. CONCURRENT CARE FOR CHILDREN.** Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

**Sec. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.** Adds a new optional categorically-needy eligibility group to Medicaid comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under Medicaid or CHIP, and (2) individuals eligible under the standards and processes of existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies, including related medical diagnostic and treatment services.

**Sec. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.** Beginning with drugs dispensed on January, 2014, smoking cessation drugs, barbiturates, and benzodiazepines would be removed from Medicaid's excludable drug list.

**Sec. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.** Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation models. Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

**Sec. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.** Prohibits Medicare Advantage plans from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee-for-service program. Requires plans that provide extra benefits to five priority to cost sharing reductions, wellness and preventive care, and then benefits not covered under Medicare.

**Sec. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.** Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. Such services would include a comprehensive health risk assessment. The personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five to ten year screening schedule; a list of identified risk factors and conditions and a strategy to address them; health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition.

**Sec. 4104. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.** This section would waive beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

**Sec. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.** This section would authorize the Secretary to modify the coverage of any currently covered preventive service in the Medicare program to the extent that the modification is consistent with U.S. Preventive Services Task Force recommendations and the services are not used for diagnosis or treatment. The Secretary will also conduct a provider and beneficiary outreach program regarding covered preventive services. This section also authorizes a Government Accountability Office (GAO) study of the utilization of and payment for Medicare covered preventive services, the use of health information technology in coordinating such services, and whether there are barriers to utilization of such services.

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**Sec. 4106.** IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID. The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased Federal medical assistance percentage (FMAP) of one percentage point for these services.

**Sec. 4107.** COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID. States would be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use. Such services would include diagnostic, therapy and counseling services, and prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration for cessation of tobacco use by pregnant women. This section would also prohibit cost-sharing for these services.

**Sec. 4108.** INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID. The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.