

BREAST TREATMENT TASK FORCE



AVON WEBINAR

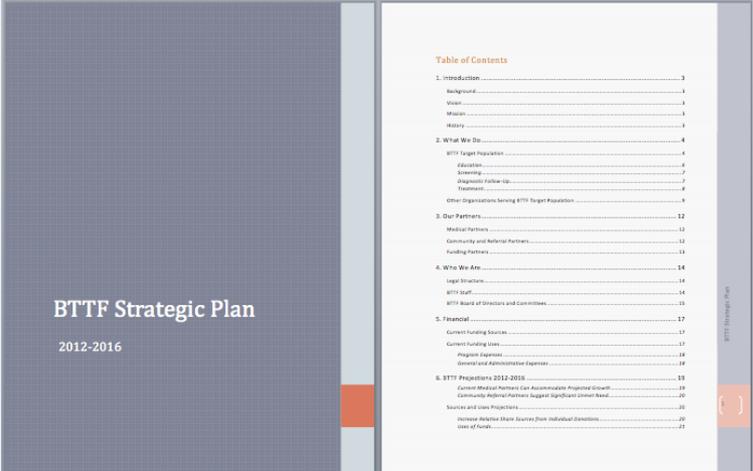
BREAST TREATMENT TASK FORCE &
YOUNG INVINCIBLES PRESENT

Assisting Breast Cancer Patients Now and in 2014

Strategic Planning for 2014

After conducting months of research, with the help of Harvard Business School Community Partners, Breast Treatment Task Force (BTTF) completed its five-year strategic plan in 2012.

The strategic process revealed that **the population BTTF serves, those individuals earning \$28,000-\$50,000 annually (living at 250-450% of the Federal Poverty Line (FPL))** will continue to need BTTF Diagnostic Programs in 2014 and beyond.



The image shows the cover and table of contents of the BTTF Strategic Plan 2012-2016. The cover is dark grey with the title 'BTTF Strategic Plan' and the years '2012-2016' in white. The table of contents is on the right page, listing sections 1 through 6 with their respective page numbers. A vertical page number '1' is visible on the far right edge of the table of contents page.

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"Across all three groups of states, the basic conclusion is, **with the exception of those at 201% to 400% of poverty [22-45K] with very high out-of-pocket costs,** virtually all income groups and the vast majority of families will find health insurance affordable."



Jonathan Gruber, Economist
Editor, Journal of Public Economics

What We're Doing Now BTTF Working Program Model

At the AVON Breast Cancer Forum in March 2012 a discussion emerged about providing mammograms for patients under 40, and diagnostic follow-up and treatment for uninsured patients of all ages.

BTTF's program model is simple and can be established in any state.

About Breast Treatment Task Force (BTTF)

MISSION

BTTF facilitates free screening, diagnostic, treatment and education for patients that cannot afford health insurance in NYC.

WHY WE HELP

Costs of diagnostic follow-up services and treatments are extensive, preventing low-income patients from obtaining treatment, or leaving them struggling with debt or bankruptcy.

HEALTH REFORM in 2014

DID YOU KNOW...?

New Yorker earning \$17,000 per year will pay \$57 per month for health insurance;

New Yorker earning \$35,000 will pay \$275 per month?*

<http://healthreform.kff.org/SubsidyCalculator.aspx>. **Estimates based on purchase of a silver plan; can buy lower-cost bronze plan.*

BTTF Diagnostic Follow-up Program: 2012

Referrals to the BTTF diagnostic follow-up program occur when community organizations screen uninsured patients, but do not have means to provide further examination(s).

Almost all patients with abnormal mammograms need sonograms; 30% of patients need biopsies or MRIS.

80% of BTTF patients are under 40; women under 40 are ineligible to receive New York State Cancer Services Programs.

BTTF M.O.U. with Medical Partners

BTTF has Memorandum's of Understanding (M.O.U.) with each of its five medical partner facilities with a reimbursement agreement as follows:

Procedure	BTTF Reduced Price/ Reimbursement Rate
Unilateral Sonogram	\$100
Diagnostic Mammogram	\$100
Ultrasound	\$100
Fine Needle Aspiration	\$400
MRI	\$500
Core Biopsy	\$650
Stereotactic Biopsy	\$750
Clinic Visit Charge	\$0-150

BTTF Partnership with Private Imaging Centers

A key factor to the success of BTTF's Diagnostic Program has been the utilization of private imaging centers for sonograms.

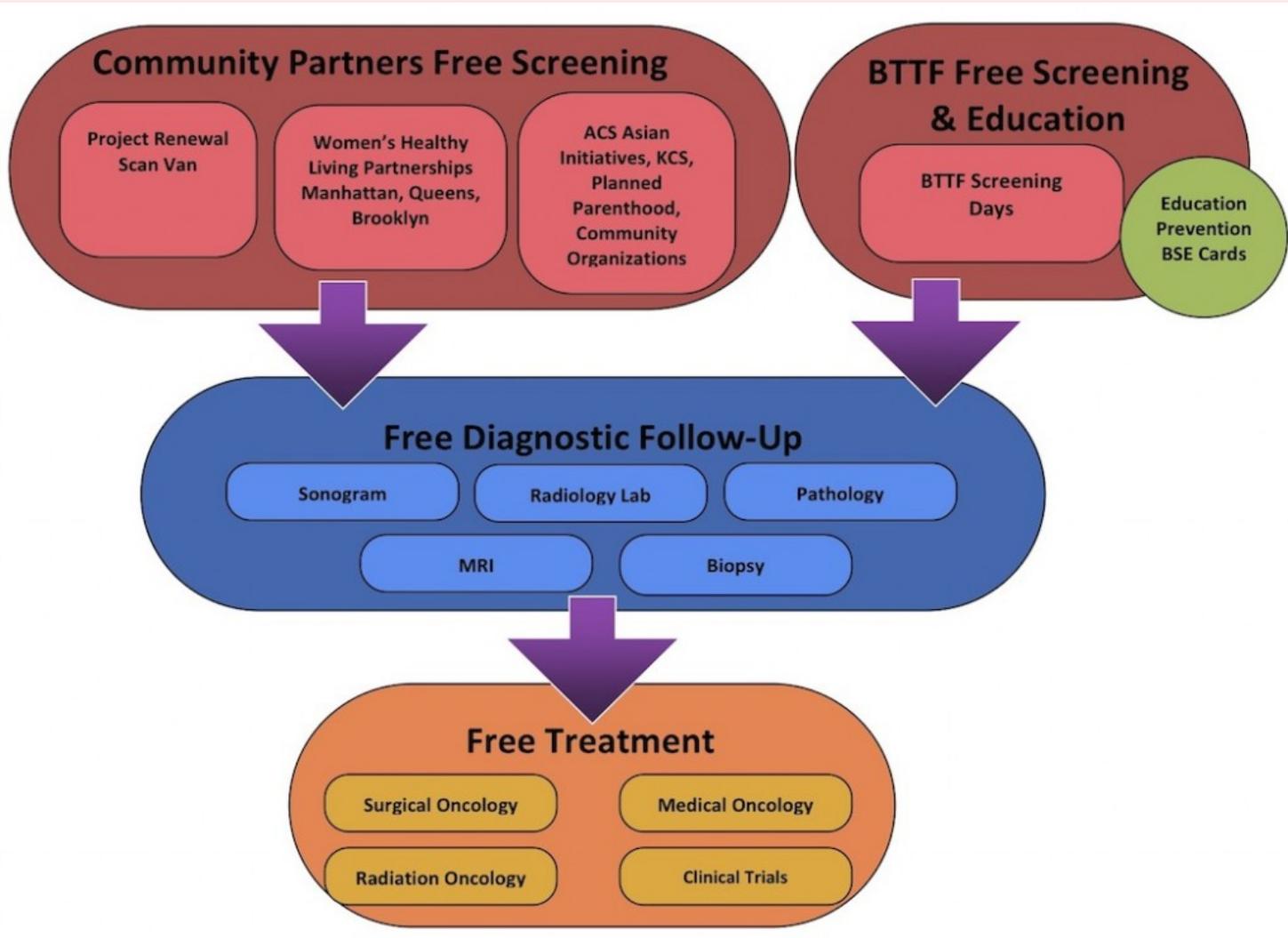
Private Imaging Centers:

- Accommodate high volume of patients
- Ensure fastest turnaround between abnormal mammogram and first diagnostic appointment (9 days or less)



Union Square Imaging

BTTF Programs Flow Chart



PART TWO

Young Invincibles Presents

A Deeper Look at PPACA and Provisions
Affecting Low-Income Populations

About Young Invincibles

Young Invincibles began in the summer of 2009, out of the recognition that young people's voices were not being heard in the debate over health care reform. We put up a one page website, asking young people to share their stories, believing in their generation's capacity to stand up and make itself heard.

In a little more than a year, 'YI' went from a group run out of a law school cafeteria to a national organization, representing the interests of 18 to 34 year-olds and making sure that our perspective is heard wherever decisions about our collective future are being made. We do this through cutting-edge policy research and analysis, sharing the stories of young Americans, campaigns designed to educate, inform and mobilize our generation and advocacy intended to change the status quo.



Basics of the ACA

- Expands Medicaid (state-dependent).
- Requires that everyone has health insurance (but gives hardship exemption).
- Sets up state exchanges to get people affordable health insurance, providing tax credits for low-moderate income individuals/families.
- Requires certain preventive services are provided at no cost.
- Creates consumer protections like the 80/20 rule and baseline coverage requirements like “essential health benefits.”

Preventive Care Requirements

- All new plans must provide certain preventive care at no cost.

- This includes one baseline/preventative breast cancer mammogram every one to two years for women over 40:
 - ▣ Complaints that insurers are unfairly calling preventive mammograms diagnostic because of prior history
 - ▣ Those under 40 should be covered when it is medically necessary (reason for the procedures)

- States could increase the pre-deductible requirements for preventive care.



Federal Subsidies

- In general, if employer coverage is available, an individual will be ineligible for federal subsidies to purchase health insurance; otherwise they can get coverage through the exchanges.
- The amount of premium help (subsidies) each individual or family receives is based on the price of the second lowest-cost silver plan available.

Federal Subsidies (cont'd)

- The Kaiser Subsidy Calculator factors in age, family status, income, and regional cost factors to determine the subsidy an individual can receive. Subsidies are awarded from 133% up to 400% of the poverty line.

To determine higher and lower regional cost premiums, the calculator adjusts up and down by **20%**.

Estimated Costs of Bronze Plans

- Congressional Budget Office 2016 Estimates

- Single Policies: \$4,500 - \$5,000

- Family Policies: \$12,000 - \$12,500



- Out-of-pocket estimates range from \$2,750 (with 30% coinsurance) to \$6,350 (with 0% coinsurance)

- Premium subsidies are based on a silver plan (with an actuarial value of 70%).

- Enrollees can use this silver-level tax credit to buy down to a cheaper bronze plan.

Status of State Exchanges

STATE	ESTABLISHED EXCHANGE?	STATUS:
TEXAS	No	Will not be establishing an exchange; government will run theirs.
CALIFORNIA	Yes	Kaiser small group HMO established as benchmark plan
NEW YORK	Yes	Operational January 2013
COLORADO	Yes	Operational October 2013
NORTH CAROLINA	No	Has until January 2013 to submit exchange legislation
MASSACHUSETTS	Yes	Currently operational
ILLINOIS	No	Has until January 2013 to submit exchange legislation
WASHINGTON, D.C.	Yes	Awaiting decision whether exchange will be independent or in partnership with the federal exchange

Check out [this](#) link to see where your state is.

How Do I Enroll and Stay Enrolled?

- Individuals can enter exchanges during designated enrollment periods; generally, outside of those periods, individuals cannot get into exchanges.
- There are special enrollment periods for people who:
 - Get married and become eligible
 - Become a dependent
 - Lose minimum coverage for outside reasons beyond their control
 - Demonstrate another special circumstance
- People can apply for special enrollment periods and show exceptional circumstances; but many may be without coverage until they can reenroll.
- The special enrollment period lasts 60 days; but if you lose coverage for lack of timely payment of premiums must wait until the standard designated enrollment period opens up again.

What if I Pay My Premium Late?

- Insurers can terminate coverage for non-payment:
 - ▣ Must give enrollee 30-day notice before termination that explains reasoning
 - ▣ Must notify exchanges
- Those receiving subsidies have a three-month grace period for late payment:
 - ▣ Triggered when provider doesn't receive full payment for that month's premium
 - ▣ Health plan providers should pay claims the first month
 - ▣ Health plan providers can pend claims in second and third month & eventually deny claim if non-payment is continued



Fines for Being Uninsured

- In 2014: Higher of two amounts; capped at \$285
 - Flat rate (\$95/uninsured individual & \$47.50/dependent)
 - If household income > \$10,000 annually, 1% of income

- In 2015: Higher of two amounts; capped at \$975
 - Flat rate (\$325/uninsured individual & \$162.50/dependent)
 - If household income > \$10,000 annually, 2% of income

- In 2016: Higher of two amounts; capped at \$2,085
 - Flat rate (\$695/uninsured individual & \$347.50/dependent)
 - If household making > \$10,000 annually, 2.5% of income

- Beyond 2016, the fine will be indexed to include cost of living adjustments

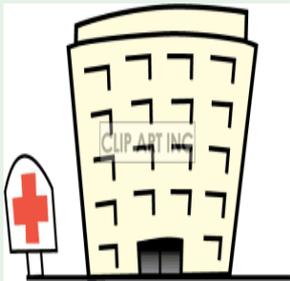
ACA & Undocumented Immigrants

- Aliens ‘lawfully present in the United States’:
 - ▣ Subject to health insurance mandate
 - ▣ Eligible (if qualified) to participate in the high-risk pools and exchanges
 - ▣ Eligible for premium credits and cost-sharing subsidies

- Unauthorized aliens:
 - ▣ Exempted from mandate
 - ▣ Barred from exchanges & high-risk pools
 - ▣ Ineligible for federal premium credits & cost-sharing subsidies

Good News Specific to Avon Grantees

- The ACA has significant available funding for health centers, which can increase their capacity by a significant number.



- The Prevention and Public Health Fund is authorized to spend up to \$15 billion through FY2020.
- Safety net programs are expected to be providers for those that need services, **but remain uninsured (one estimate is 23 million)**.
- Hospitals will still be required to treat people who need services, regardless of ability to pay.

Potential Concerns for Safety Net Programs

- May have to consider attracting clients different from their current client base (lower-income & non-English speakers).
- Potential diversion of funds to pay for insurance expansions, like Medicaid reimbursement:
 - ▣ **Safety net programs are worried there will be rate cuts in states trying to save money**
- Medicaid Disproportionate Share Hospital (DSH) Program, which gives money to states to subsidize certain hospitals for the unreimbursed costs of treating uninsured & Medicaid patients, will be phased out starting in 2014.

Potential Safety Net Concerns (cont'd)

- If not defined as 'essential community providers,' safety net program will not be able to contract with Quality Health Plan providers.
- Face payment reductions if certain standards aren't met:
 - ▣ E.g. financial penalties if patients are readmitted too often → implicates hospitals that serve the chronically or mentally ill

So, What Happens in 2014?

With the passing of the Affordable Care Act (ACA) the population BTF serves earning \$28,000-\$60,000 annually in a 1-2 person household could still use extra assistance from safety net providers.

These patients may face high out-of-pocket costs for diagnostic follow-up, or still need help if they remain uninsured.

The following information and three patient scenarios* reflect issues BTF patients could need help with in navigating healthcare and insurance. See appendix for five additional scenarios.

*All healthcare and insurance calculations used for projecting scenarios are based on the [Kaiser Family Foundation Health Reform Subsidy Calculator](#), which uses the silver plan as its standard. Bronze plans may slightly differ in cost.

Health Care Exchanges

- ACA will provide new health care exchanges with more affordable health care options for most Americans, due to tax credits for individuals making under \$44,000 & families making under \$88,000.
- Estimating costs of insurance for Exchanges in 2014 is difficult.
- Costs will vary by geographic region and “age rating” of 3:1 (younger pays less). One can choose comprehensive coverage, or catastrophic plans for those under 30 or for anyone for whose premiums exceed 8% of income.
- Generally, plans on the exchange will cap out-of-pocket expenses at \$5,950 for individuals and \$11,900 for a family. There will be no maximum as to how much a plan will pay.
- The following are *estimates* based on a Kaiser Family Foundation calculator.

Insurance costs in 2014 For 39 Year Old Individuals Earning \$30,000-\$50,000 (Including Premium Subsidies/Tax Credits*)

Annual Salary	Insurance Annual	Monthly Cost	Maximum Out-of-Pocket Cost**	Catastrophic Coverage Choice***	Maximum Total Cost
\$30,000	\$2,509	\$209	\$3,125	\$1,800	\$5,634
\$35,000	\$3,325	\$275	\$4,167	\$1,800	\$7,492
\$40,000	\$3,800	\$316	\$4,167	\$1,800	\$7,967
\$45,000	\$4,275	\$356	\$4,167	\$1,800	\$8,442
\$50,000****	\$5,243	\$437	\$6,250	\$1,800	\$11,493

*Plans will be cheaper for younger enrollees.

**Out-of-pocket cost based on use of tax credits for silver plan; tax credits can be used to buy cheaper bronze plan.

***Estimates of catastrophic coverage are based on YI analysis.

****This individual would be ineligible for any Federal subsidy.

Actuarial Values & Co-Insurance Costs

The following groups are eligible for further cost reductions via their plan's actuarial value (portion insurer covers):

Income Level	Actuarial Value
150% FPL	94%
150-200% FPL	87%
200-250% FPL	73%

While it is unlikely that the out-of-pocket maximums will be reduced further for groups living at 250-450% of the FPL, there is legislation in place that gives insurers the discretion to raise or lower co-insurance costs for these individuals.

Diagnostic Procedures: Essential Health Benefits vs. Preventative Care

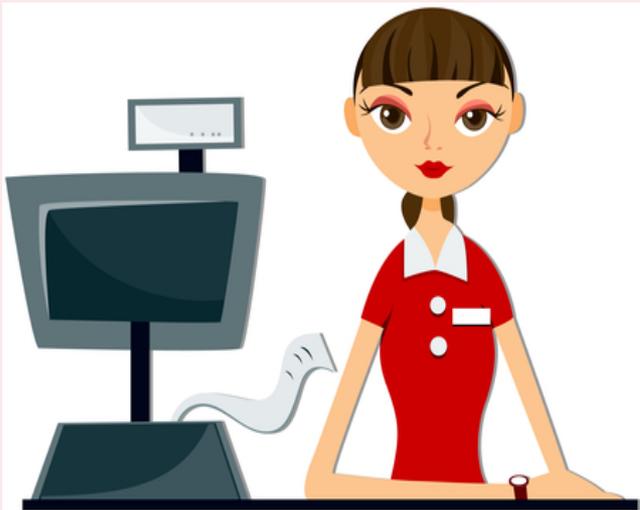
The disparities between mammography and diagnostic follow-up costs reflect themselves in the design of insurance plans.

The United Group explains their policy in their health reform video series (this is not a parody):



Diagnostic treatment, therefore, will likely continue to require copays, coinsurance costs, and deductibles.

1. Lana, 35



- Lana, 35 year old single female, cashier at local supermarket in Brooklyn. She earns \$17,000 annually (148% of Federal Poverty Level (FPL) before taxes, \$16,107 in take home pay).
- Although ineligible to enroll in Medicaid, Lana is thrilled that she is now able to afford health insurance at the price of \$54/month. Her maximum out-of-pocket costs: \$2,083. (Based on purchase of silver plan.)
- Lana received abnormal mammogram results and her Doctor orders an MRI.

The cost of an MRI is \$3500; Because Lana is living at 148% of the FPL, her plan ensures an actuarial value of 94%. She is therefore only responsible for a small copay of \$30.

Lana's total costs, including her premium, are \$678. (Based on silver plan.)

KNOW THE RULES

If Lana cannot pay insurance payments and loses coverage, she cannot rejoin the exchange until the following enrollment period – help keep her covered!

2. Susan, 34

- Susan, 34 year old single female, waitress in New York City. She earns \$40,000 (348% of FPL before taxes, \$32,246 in take home pay).
- Susan could qualify for the financial hardship exemption from the tax penalty; she could also purchase catastrophic coverage.
- She purchases health insurance for \$3,800 per year but struggles to pay rent and buy food.
- Susan received abnormal mammogram results; doctor suggests sonogram and MRI.



- Susan's procedures cost \$130/mammogram, \$500/sonogram, \$3,500/MRI, \$300/clinic charges = \$4,430. Under her plan, Susan is responsible for 20% of this amount or \$886.
- The combined cost of Susan's premium and out-of-pocket costs is \$4,686.
- Average monthly rent for studio in Harlem: \$1,432, \$150 is average cost of NYC utilities, and \$104 monthly for a Metro Card.
- Her high-out-of-pocket costs mean that she could use some help from safety net providers.

WORST CASE SCENARIO:

Susan's insurance company denies some of her procedures, saying they are not medically necessary.

This scenario is unlikely for standard breast cancer procedures, but service providers should be vigilant in helping the newly insured understand how to fight back against insurers in these cases.

3. Stacey, 42



- Stacey, 42, earns about \$40,000/year as substitute teacher in New York City. She does not receive full-time benefits.
- Stacey decided not to enroll in health insurance, filing for economic hardship tax exemption; premium would have exceeded 8% of her income (which means she won't get taxed for not enrolling).
- Through a local community non-profit organization, Stacey received a free mammogram, which returned abnormal results and requires a follow-up biopsy

- The program referred Stacey to a public medical facility where under a sliding-scale system, she had to pay \$2,000 for the biopsy.
- **The biopsy revealed that Stacey stage II breast cancer. Because Stacey did not sign up for insurance during the enrollment period, she cannot sign up until next year's enrollment period.**
- Stacey's situation is life-threatening. She must find financial relief from a community safety net or high-risk program.

WANT TO SEE MORE SCENARIOS?

Check out the BTTF appendix for five more patient scenarios.

WANT TO HELP EDUCATE YOUR PATIENTS?

2013 will be a critical time to ensure patients understand when they can and can't enroll in plans.

Helping Patients in 2014 and Beyond

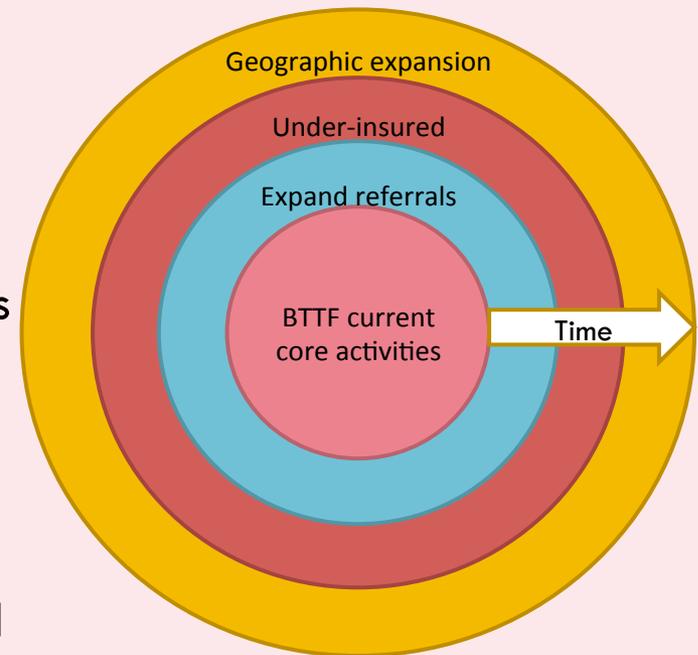
BTTF will closely monitor developments of the ACA implementation.

Education Strategy:

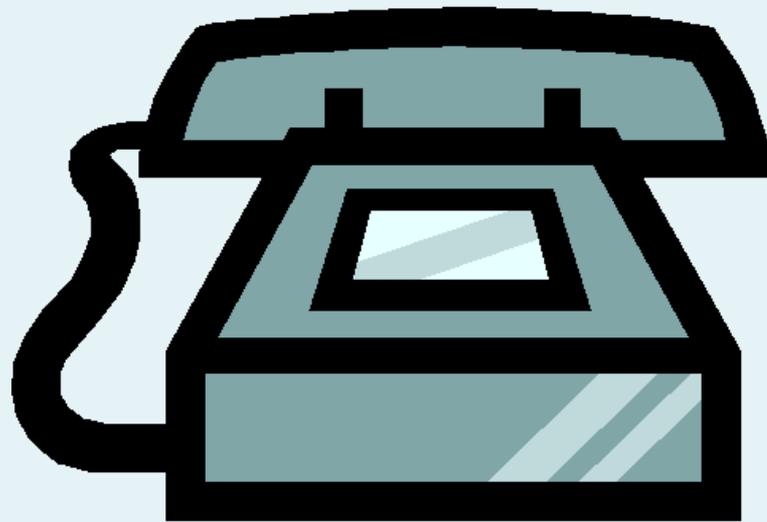
- Hold Health Reform workshops in addition to Breast Self-Exam Workshops
- BTTF welcomes partnerships with AVON grantees and others to disseminate health reform information

Program Strategy:

- Provide mammograms, diagnostic follow-up and treatment for patients who remain uninsured
- Potentially accept diagnostic referrals for *underinsured* patients



Q & A Session



Wait! I have more questions to ask!
That's okay, just email us.

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BTTF APPENDIX

Additional Materials & Patient Scenarios

Key ACA Terms

Actuarial Value: ----The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Cost-sharing — Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance and co-payments. Balance-billed charges from out-of-network physicians are not considered cost-sharing. **PPACA prohibits total cost-sharing exceed \$5,950 for an individual and \$11,900 for a family.** These amounts will be adjusted annually to reflect the growth of premiums.

Deductible — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small group policies to \$2,000 for policies that cover an individual, and \$4,000 for other policies. These amounts will be adjusted annually to reflect the growth of premiums.

Exchange — PPACA creates new “American Health Benefit Exchanges” in each state to assist individuals and small businesses in comparing and purchasing qualified health insurance plans. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them.

Economic Hardship Exemption— Individuals may be exempt from purchasing health insurance without penalty if the individual can demonstrate proof of: financial hardship, religious objection identify as American Indian, that you have been without health coverage for less than three months or **the lowest cost health plan available in your area exceeds 8% of your income**

4. Jennifer, 35



- Jennifer, 35 year old single mother of two, freelance graphic designer, earning \$60,000 annually (\$47,484.15 take home, 521% of FPL). They live in a two-apartment in Bay Ridge, Brooklyn.
- Jennifer purchased health insurance for \$4,937 (\$411 per month).
- Because she's under 40, Jennifer is ineligible for free mammogram coverage, so she pays \$300 out-of-pocket. She received abnormal results and now needs a biopsy.

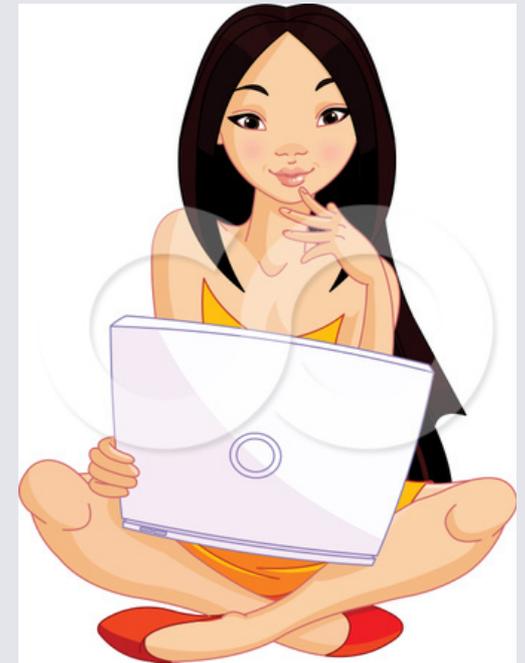
- Jennifer's biopsy/\$3,500, plus \$500/visits/clinic charges--or another \$4,000. Jennifer pays 30% co-insurance; \$1200.
- Jennifer's total costs are \$6,137 in medical bills.
- Average monthly rent for two-bedroom in Bay Ridge (one of least expensive Brooklyn neighborhoods); \$1,790 + \$150 in utilities.
- Jennifer could turn to safety net programs to help with required cost-sharing to ensure she receives adequate follow-up care.

UNKNOWN:

Will Jennifer receive any type of price break from insurance companies or state insurance exchanges as single mother?

5. Li, 26

- Li, 26 year old female graduate student at Hunter College.
- Li works part time towards her tuition, but owes \$20,000 in school loans. Li earns \$18,000 per year.
- Li is the first person in her family to have health insurance. With subsidies, her best option; \$64/month comprehensive exchange plan. (Silver level plan.)
- After finding a lump during breast self-examination, Li received a mammogram from a free screening program. Results were abnormal and ultrasound was strongly recommended.



- With cost-sharing subsidies and other protections for very low-income individuals, she does not pay anything out-of-pocket for the ultrasound.
- Doctors recommend Li return in six months for another ultrasound, which would have cost another \$500. It is again fully covered.
- If Li had enrolled in a catastrophic plan, she would have paid all expenses out-of-pocket, and may not have had enough to pay for these procedures. Educating Li on her better options will be key.

WHAT SHOULD LI DO?

Li may decide to enroll in her school's health insurance plan the following year.

Most of these plans will also be subject to ACA reforms.

6. Christine, 38



- ❑ Christine, 38, senior sales associate at Banana Republic earning \$35,000 (\$29,338.37 or 304% of FPL). Lives with boyfriend in Queens.
- ❑ Banana Republic has reduced her hours to 28 from 35, so she does not qualify for employer insurance as she's considered part-time.
- ❑ At high risk for breast cancer, she purchases health insurance for a \$3,325 premium (\$277 per month) through the NY health exchange. (Silver level policy.)
- ❑ Her biopsy revealed stage III breast cancer.

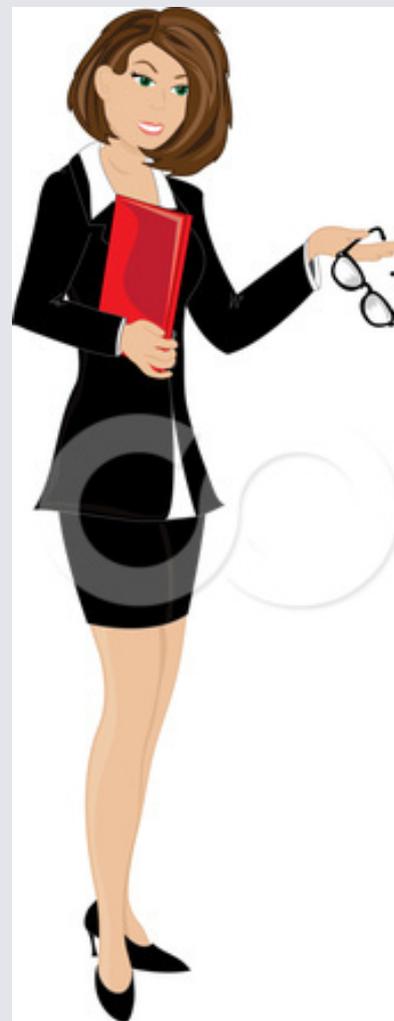
- In addition to \$3,325 premium for insurance, Christine must pay 30% co-insurance for her biopsy (30% of \$4,450 = \$1,365), a total of \$4,690.
- Average rent in Queens is \$1,190 and \$150 for utilities, which she splits with her boyfriend, plus a \$104 monthly metro card, for a total of \$774 per month.
- The ACA removes lifetime and annual caps on coverage by 2014. This means insurance cannot stop covering her treatment even at hundreds of thousands of dollars in costs.

DID YOU KNOW?

In calculating penalties for large companies (defined as 50+ employees) not offering health insurance under PPACA, part-time employees (30 hours or less) will not be considered.

7. Karen, 33

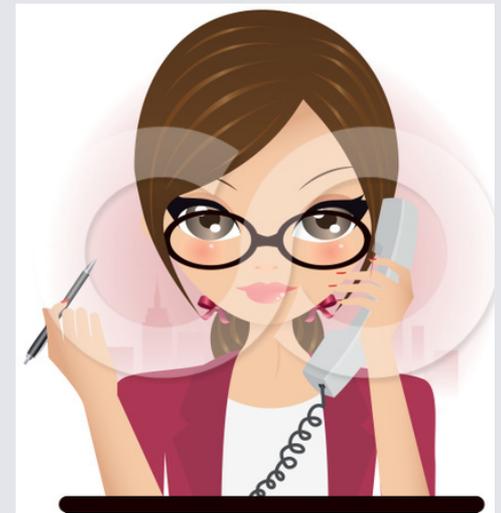
- Karen, freelance paralegal living in the Bronx. She earns \$48,000 (\$39,100 after taxes, or 417% of the FPL).
- Karen's salary is too high to qualify for any Federal tax credit, but was able to purchase an insurance plan for \$4,598 annually or \$383 per month. (Silver level plan.)
- Karen needed an MRI followed by a fine needle aspiration (FNA) after receiving abnormal mammogram.



- Karen must pay the full cost of a mammogram because of her age, \$300, as well as 30% co-insurance for her diagnostic procedures; FNA \$2,250, and MRI, \$3,500. Karen pays \$2,025.
- Karen's total insurance & medical costs are \$6,623.
- Karen could have chosen to enroll in a catastrophic plan for a much lower premium, but would then have to pay all out of pocket expenses until she hit the maximum of about \$5,950.

8. Maria, 32

- Maria, 32, therapist's assistant at a small non-profit child welfare organization in Harlem, earning about \$28,000 annually. Maria has been saving so that she can return to school for her Master's degree and earn more as a case-worker.
- Maria's mother was diagnosed with breast cancer at age 43; she therefore has a high-risk to develop breast cancer. Maria contacts several insurance companies, but is told she is not technically considered high risk because her mother was 11 years (the maximum difference is 10) older than Maria is now.



- Health insurance would cost Maria about \$2,189 annually, or 7.82% of her income. Maria ultimately decides to defer signing up for health insurance for two or three years, until she has saved enough for her tuition.

- **Because Maria's premiums are only 7.82% of her income, she is ineligible to apply for economic hardship exemption** (this is only available for individuals whose healthcare costs exceed 8% of their income).

- Maria will pay the full individual penalty of \$95 in 2014. Given that the penalty will increase (\$325 in 2015, and \$695 in 2016, or \$1,115 in total), and that her salary may change, she may rethink her choice to go uninsured over the next couple of years.

BTTF Board of Directors & Community Partners

BTTF Board of Directors

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Project Renewal Scan Van

Planned Parenthood NYC

Women's Health Living Partnerships

American Cancer Society Asian Initiatives

Korean Community Services



Young Invincibles Appendix

Additional Terms & Provisions

June 28, 2012 SCOTUS Ruling

- States have the option of accepting federal money to open Medicaid eligibility to all Americans within 133% of the poverty line under the ACA
- SCOTUS held that the federal government cannot revoke states' pre-ACA Medicaid funds if they refuse to take the post-ACA Medicaid expansion funds to expand their programs
- Some governors have already rejected the increase funding for the expansion on the grounds that it costs too much; however, the federal government will assume 93% of expansion costs from 2014-2022

What does 133% of the FPL look like in 2014?

\$14,404 for individuals

\$29,326 for a family of four



Timeline for Federal Certification of State Exchanges

DATE	REQUIREMENT
Nov. 16 2012	Deadline for states to notify HHS it plans to build its own healthcare exchange
Jan. 1 2013	Secretary of HHS will determine if state exchange will be 'fully operational' in time
Oct. 1 2013	Insurance providers must be ready for open enrollment thru the exchange
Jan. 1 2014	All state exchanges must be fully operational (e.g. operation of a toll-free hotline, maintenance of a website with current plan info, electronic cost calculators)
Mar. 31 2014	Initial open enrollment closes
Jan. 1 2015	Exchanges must be self-funded

Essential Health Benefits

Exchange plans and new non-exchange individual plans are required to include essential benefits in ten fields:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
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 and vision care

Essential Health Plans & Benchmark Plans

- How do we define what those 10 categories actually mean?
- States choose one of the following to be a “benchmark” plan that covers the 10 categories:
 - One of the three largest small group plans
 - One of the three largest state employee plans
 - One of the three largest federal employee plan options
 - The largest HMO plan offered in the state’s commercial markets
- If a state does not choose a benchmark plan, then the small group plan with the largest enrollment will be automatically considered the benchmark.
- State benchmark plans must be chosen by Sept. 30, 2012.

