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Benefit and Coverage Rules Under the ACA: California vs. Federal Provisions

California HealthCare Foundation

Since passage of the federal Affordable Care Act (ACA) in 2010, California has enacted implementing state legislation in key areas, including establishment of a state-administered exchange, health insurance premium rate review, benefit standards and cost-sharing limits, and detailed rules for the offering and sale of private coverage to individuals and small employer groups. These measures were taken in the context of pre-existing state laws and programs, requiring policymakers to analyze and reconcile state and federal standards.

This overview compares California law and the ACA regarding benefit and coverage rules **effective January 1, 2014**.

CALIFORNIA	FEDERAL
ESSENTIAL HEALTH BENEFITS	
Definition	
Health plans and health insurers (collectively "issuers")[1] of non-grandfathered[2] individual and small employer coverage issued, amended, or renewed on or after January 1, 2014, must, at a minimum, cover essential health benefits, which includes all 10 categories of health benefits outlined in the ACA as follows: ▪ Ambulatory patient services ▪ Emergency services ▪ Hospitalization ▪ Maternity and newborn care ▪ Mental health and substance use disorder services, including behavioral health treatment ▪ Prescription drugs ▪ Rehabilitative and habilitative services and devices ▪ Laboratory services ▪ Preventive and wellness services and chronic diseasemanagement ▪ Pediatric services, including oral and vision care Essential health benefits also include benefits and services of the selected benchmark plan for California, as below. Applies equally to issuers inside and outside of the exchange. Excepted benefits coverage is exempted from state essential health benefits requirements consistent with federal rules and requirements. ✚S [HSC §1367.005; CIC §10112.27]	Issuers offering non-grandfathered coverage in the individual and small group markets, both inside and outside of the exchange,[3] must offer a comprehensive package of items and services, at a minimum, known as essential health benefits (EHBs). EHB coverage must include at least the 10 benefit categories, as defined by the Secretary of Health and Human Services. The requirement to provide coverage for essential health benefits, and most of the ACA health insurance market reforms generally, do not apply to policies of "excepted benefits," as defined in federal law.[4] [ACA §1302(b); 42 USC §18022] (45 CFR §147.150)

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Abbreviations, page 9. [ ] Denotes statutory citations. ( ) Denotes regulatory citations.

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State Benchmark	
California implemented federal rules and selected as its benchmark plan the largest plan by enrollment offered in the state's small group market, the Kaiser Foundation Health Plan Small Group HMO 30, as it was offered during the first quarter of 2012 (EHB benchmark). The Kaiser plan selected is subject to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene, HSC §1340 et seq.) under the jurisdiction of the Department of Managed Health Care (DMHC). Issuers of non-grandfathered individual and small group coverage inside and outside of the exchange must provide coverage for essential health benefits as follows: ▪ The 10 categories of benefits outlined in the ACA. ▪ Medically necessary "basic health care services," as defined in state law,[5] a longstanding minimum requirement for health plans under DMHC. ▪ Benefits mandated by the state prior to December 31, 2011, that applied to the EHB benchmark, including those specifically referenced in the state EHB statute. ▪ "Other health benefits," as defined in the EHB benchmark, that are not otherwise mandated for all health plans (some examples include acupuncture for pain management, nonemergency transportation, durable medical equipment for home use, and limited skilled nursing services above the level of custodial or intermediate care). ▪ Pediatric vision care as per the federal Employees Dental and Vision Insurance Program for 2012. ▪ Pediatric oral care as provided in the Healthy Families Program[6] in 2011–12. ▪ Prescription drug benefits consistent with extensive statutory and regulatory requirements applicable to the drug coverage in the EHB benchmark.[7] + S [HSC §1367.005; CIC §10112.27] (28 CCR §1300.67.005; 10 CCR §2594–2594.7)[8]	States must define EHBs by selecting a benchmark reference plan, from among four employer plans offered in the state, outlined in federal rules. State-defined EHBs must reflect both the scope of services and any limits in the state's selected benchmark, and if any of the 10 categories of EHBs is missing from the state benchmark, the state must add that category of coverage. (45 CFR §156.100, §156.110)
The state requirement to cover EHBs must only be implemented to the extent essential health benefits are required pursuant to the ACA. [HSC §1367.005(k); CIC §10112.27(k)] Any EHB must only be covered to the extent federal law does not require the state to defray the costs of the benefit. [HSC §1367.005(l); CIC §10112.27(l)] No similar provisions in federal law. S	States may require issuers of exchange qualified health plans (QHPs) to offer benefits in addition to essential health benefits. Benefits required to be offered in the state prior to December 31, 2011, are not considered to be "in addition to EHBs." States must pay to defray the costs of any additional required benefits (such as the costs associated with federal premium tax credits for the incremental cost of any additional required benefits), as specified. [ACA §1311(d)(3); 42 USC §18031(d)(3)] (45 CFR §155.170) State exchanges may also make available QHPs "notwithstanding any provision of law requiring benefits other than the essential health benefits." [ACA §1311(d)(3); 42 USC §18031]

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State Benchmark *(cont.)*	
California prohibited the benefit substitution in EHBs otherwise permitted in federal law. However, an issuer may substitute its prescription drug formulary for the EHB benchmark formulary, as below. ✚ S HSC §1367.005(c); CIC §10112.27(c)] (10 CCR §2594–2594.7)	Issuers must comply with EHBs and offer benefits "substantially equal" to the state benchmark but may, unless prohibited by state requirements, substitute benefits that are actuarially equivalent, as specified. (45 CFR §156.115)
Treatment limitations imposed on EHBs must be no greater than the limitations in the EHB benchmark. ☑ S [HSC §1367.005(b); CIC §10112.27(b)] (28 CCR §1300.67.005; 10 CCR §2594–2594.7)	Essential health benefits include limitations on coverage in the state benchmark, including amount, duration, and scope but are also subject to other applicable federal requirements. (45 CFR §156.115)
Preventive Services	
Issuers must comply with the requirements in federal law (by specific reference to 42 USC §300gg-13) related to coverage and cost sharing for preventive services. ☑ S [HSC §1367.002; CIC §10112.2]	Group health plans and issuers of non-grandfathered group or individual coverage must, at a minimum, cover in-network preventive services (with no [enrollee] cost sharing), including immunizations and screenings recommended by specified federal agencies and committees, such as the US Preventive Service Task Force.[9] [ACA §1001; PHSA §2713; 42 USC §300gg-13] 45 CFR §147.130)
Prescription Drugs	
Prescription drug coverage must comply with applicable federal rules, and in addition, California issuers must provide coverage for outpatient prescription drugs consistent with extensive state law and regulations applicable to health plans under the DMHC, including the EHB benchmark. Statutory and regulatory provisions are specifically referenced in the EHB statute and regulations. Issuers may substitute a drug formulary for the one in the EHB benchmark, providing the alternative formulary meets specified state and federal requirements. ✚ S [HSC §1367.005; CIC §10112.27] (28 CCR §1300.67.005; 10 CCR §2594–2594.7)	EHBs require a health plan issuer to cover at least the greater of: (1) one drug in every category and class, or (2) the same number of drugs in each category or class of the benchmark plan. Issuers must have procedures in place to allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. (45 CFR §156.122)
Habilitation	
Issuers must cover habilitative services as follows: (1) services included in the benchmark plan, (2) any coverage required by federal rules and guidance, (3) benefits consistent with a new state statutory definition of habilitative services,[10] and (4) under the same terms and conditions applied to rehabilitative services. ✚ S [HSC §1367.005(a)(3) and (p)(1); CIC §10112.27(a)(3) and (q)(1)] (28 CCR §1300.67.005; 10 CCR §2594–2594.7)	If a benchmark plan does not include coverage for habilitation services, (1) the state may determine which services are covered in that category, and (2) an issuer may meet the requirement either by providing parity with rehabilitative services in scope, amount, and duration of habilitative benefits or by determining what will be covered and reporting that determination to Department of Health and Human Services (DHHS).[11] (45 CFR §156.110, §156.115)

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Mental Health and Substance Use Disorder Services	
EHB coverage for mental health and substance use disorder services must comply with the federal mental health parity law and any federal rules or guidance issued, by specific reference to the federal law. [HSC §1367.005(a)(2)(D); CIC §10112.27(a)(2)(D)] (28 CCR §1300.67.005; 10 CCR §2594–2594.7) Issuers remain subject to California's pre-existing mental health coverage requirements related to severe mental illness, including autism, and serious emotional disturbances of children and any related state regulations and provisions applicable to the EHB benchmark plan.[12] ✚ S	Coverage for mental health and substance use disorder services, including behavioral health treatment, must comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) and implementing federal rules. (45 CFR §156.115(a)(3))
Pediatric Dental Coverage	
California law includes pediatric oral services as one of the 10 essential health benefits that must be covered by all issuers both inside and outside of the exchange. Additional federal rules apply to the offering of pediatric dental through exchanges, including the California Health Benefit Exchange (Covered California).[13] ☑ D [HSC §1367.005(a)(1); CIC §10112.27(a)(1)]	Pediatric dental benefits are an essential health benefit for issuers inside and outside of the exchange. Additional federal rules apply to pediatric dental benefits in exchanges, including that exchanges must allow qualified health plan issuers to offer a health plan that does not cover pediatric dental and must allow issuers of stand-alone dental benefits to offer coverage in the exchange, separately or in conjunction with a qualified health plan, if the stand-alone dental plan otherwise meets applicable state and federal requirements. [ACA §1302, §1311; 42 USC §18031, §18022] (45 CFR §155.1065)
Emergency Services	
Issuers must provide emergency services as one of the 10 categories of essential health benefits. Issuers remain subject to provisions of state law affecting coverage of emergency services, which differ depending on whether the coverage is subject to the HSC or the CIC, particularly as to enrollee cost sharing for non-contracted emergency services. The HSC limits enrollee cost sharing for these services (a prohibition on what is known as "balance billing"), while the CIC does not.[14] ✚ S [HSC §1367.005(a)(1); CIC §10112.27(a)(1)] (28 CCR §1300.67.005; 10 CCR §2594–§2594.7)	Services provided in an emergency department must be provided without prior authorization or limits on out-of-network coverage and at cost-sharing rates for out-of-network emergency services that do not exceed in-network emergency services, consistent with other specified federal rules. (45 CFR §147.138)

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Prohibition on Discrimination	
Pre-existing provisions of California law that prohibit discrimination for specific individuals and health conditions continue to apply. In addition, ACA reforms to the individual market rules in California prohibit marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. ✚ S [HSC §1399.851; CIC §10965.5]	Issuers must not provide or implement an EHB benefit design that discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions; issuers may appropriately use reasonable medical management techniques. In addition, issuers may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. (45 CFR §156.125, §156.200) Issuers in the exchange may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. (45 CFR §156.225)
Contingencies for EHBs	
If there are conflicts or omissions in the EHB benchmark compared to requirements in the HSC prior to December 31, 2011, the HSC requirements apply. ✚ S [HSC §1367.005(a)(2)(B); CIC §10112.27(a)(2)(B)]	No similar provision
Annual Dollar Limits on Coverage	
Issuers must comply with the federal provision (by specific reference to Section 2711 of the federal Public Health Service Act) applicable to annual dollar limits. ☑ S [HSC §1367.001; CIC §10112.1]	A group health plan (defined in federal law to include insured and self-insured plans),[15] and health insurance issuers of group or non-grandfathered individual coverage, may not impose any annual dollar limits on coverage for EHBs. Permissible annual limits were gradually reduced starting in 2010 and are prohibited entirely as of January 1, 2014, except for grandfathered individual coverage. [ACA §1001; PHSA §2711; 42 USC §300gg-11] (45 CFR §147.126)
Lifetime Dollar Limits on Coverage	
Issuers must comply with the federal provision (by specific reference to Section 2711 of the federal Public Health Service Act) applicable to lifetime annual dollar limits. ☑ S [HSC §1367.001; CIC §10112.1]	Group health plans and issuers may not impose any lifetime dollar limits on coverage for EHBs (effective in 2010). [ACA §1001; PHSA §2711; 42 USC §300gg-11] (45 CFR §147.126)

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CONSUMER COST SHARING	
Annual Out-of-Pocket Maximum	
For 2014, issuers of non-grandfathered individual and group coverage must limit annual out-of-pocket expenses for covered essential health benefits (*except* for pediatric oral care) to $6,350 for an individual and $12,700 for family coverage. For specialized health insurance policies or health plan contracts[16] covering pediatric oral care, issuers must limit the annual maximum to $1,000 for one child and $2,000 for more than one child. Starting in 2015, issuers of non-grandfathered individual and group coverage must limit annual out-of-pocket expenses for covered essential health benefits (*including* pediatric oral care) to the federal annual limit for out-of-pocket expenses in health savings account (HSA) coverage for 2014, adjusted annually based on the average increase in health insurance premiums, pursuant to the ACA and pending federal rules.[18] Starting in 2014, issuers are prohibited from imposing separate annual maximums for mental health and substance use disorder benefits. Out-of-pocket limits apply to any copayment, coinsurance, deductible, or "any other form of cost sharing" for all covered services that meet the definition of essential health benefits. ✚ S [HSC §1367.006, §1367.0065; CIC §10112.28, §10112.285]	Cost sharing (deductibles, coinsurance, copayments, or similar charges)[17] in non-grandfathered individual and group health plans (small and large group, insured and self-insured) must not exceed the dollar limit for annual cost sharing allowed for coverage with a federal health savings account ($6,350 for an individual in 2014); annual adjustments apply in future years based on the formula in federal rules. Excludes cost sharing for out-of-network services. [ACA §1302(c)(1); 42 USC §18022] (45 CFR §156.130) In group coverage, for the 2014 plan year only, group plans that use more than one service provider (to administer or provide benefits) can satisfy the annual cost-sharing limit for EHBs if the limit applies to major medical coverage (excluding, for example, prescription drugs or pediatric dental) as long as the cost-sharing limit on other coverage (for example, a separate limit for drug or pediatric dental coverage) also does not exceed the HSA limit.[19]
Deductibles	
Same limits on deductible for small group coverage as in federal law, subject to annual adjustment by the "premium adjustment percentage" outlined in federal law and rules.[20] ☑ S [HSC §1367.007; CIC §10112.29]	For plan years beginning in 2014, the annual deductible for small group coverage must not exceed $2,000 for self-only coverage and $4,000 for family coverage. After 2014, the deductible must not exceed the 2014 deductible amount, adjusted annually for the average increase in health insurance premiums pursuant to the formula in federal rules. [ACA §1302(c)(2); 42 USC §18022] (45 CFR §156.130)

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LEVELS OF COVERAGE	
Coverage Levels Defined — Actuarial Values[21])	
Defines levels of coverage consistent with federal definitions and incorporates federal standards for determination of actuarial value (AV). Authorizes but does not require CDI and DMHC to use the federal AV calculator made available by DHHS. Requires CDI and DMHC, in consultation with the exchange, to consider whether to exercise state-level flexibility with respect to the calculator. ☑ S [HSC §1367.008, §1367.009; CIC §10112.295, §10112.297]	Levels of coverage defined in the ACA (sometimes referred to as "metal tiers" or "precious metals"): ▪ Bronze — AV of 60% ▪ Silver — AV of 70% ▪ Gold — AV of 80% ▪ Platinum — AV of 90% [ACA §1302(d); 42 USC §18022] (45 CFR §156.140) To calculate coverage levels, issuers must use the federal AV calculator. Starting in 2015, states may submit, and DHHS will implement, a state-specific data set for use in the AV calculator. (45 CFR §156.135) Plans may vary in value (within each level) only by a *de minimis* variation, +/- 2 percentage points. (45 CFR §156.145)
Catastrophic Plan	
Defines catastrophic plans in the individual market consistent with federal rules. Catastrophic plans may only be offered in the individual market. ☑ S [HSC §1367.008; CIC §10112.295]	A "catastrophic plan" that is not at one of the four levels is allowed *(in the individual market only)* if the plan covers EHBs but provides no benefits until the individual has incurred cost sharing equal to the annual cost-sharing limit, and the plan provides coverage for at least three primary care visits. The catastrophic plan may only be sold to individuals under age 30 or to individuals exempt from the individual mandate because of a hardship or an affordability exemption. [ACA §1302(e); 42 USC §18022] (45 CFR §156.155)

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Mandatory Offerings	
Effective January 1, 2014, issuers may only sell products in the five coverage levels, except that an issuer not participating in the exchange may only sell four levels of coverage because issuers not in the exchange may not sell catastrophic coverage. Issuers in the exchange must offer at least one product in all five levels of coverage in the exchange. If exchange issuers sell coverage outside of the exchange, they must offer and sell all of the exchange products to individuals and small groups outside of the exchange. If the exchange standardizes benefits, non-exchange issuers must offer at least one exchange-designated standardized product in each of the other four coverage levels. ✚ D [HSC §1366.6; CIC §10112.3]	Issuers wanting to participate in an exchange must offer at least one qualified health plan (QHP) at the silver level and one at the gold level in each exchange, as well as a child-only policy at each level the issuer offers in the exchange. [ACA §1301(a)(1), §1302; 42 USC §18021(a)(1), 18022] (45 CFR §156.200)
California's exchange may standardize benefits to be offered in the exchange and may require participating issuers to sell additional products within the coverage levels. (The California Health Benefit Exchange [Covered California] did adopt standard benefit designs.) ✚ D [GOV §100504(c)]	
Product Pricing	
Any charge imposed on QHPs to support exchange operations does not affect the federal requirement that issuers charge the same premium rate for a plan offered through the exchange or directly. ☑ S [GOV §100503]	An issuer must charge the same rate for a plan whether it is offered through the exchange or directly from the issuer or an agent (outside the exchange). (45 CFR §156.255)

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Application of ACA Benefit and Coverage Rules by Market Segment and Effective Date				
Requirement	**Individual**	**Small Group Insured***	**Large Group Insured**	**Self-Insured Plans**
Essential health benefits	2014 (non-grandfathered)	2014 (non-grandfathered)	—	—
Prohibited annual dollar limit on EHB coverage (phased in starting in 2011)	2014 (non-grandfathered)	2014 (non-grandfathered)	2014	2014
Prohibited lifetime dollar limit on EHB coverage	2010	2010	2010	2014
Annual out-of-pocket maximum	2014 (non-grandfathered)	2014 (non-grandfathered)	2014 (non-grandfathered)	2014 (non-grandfathered)
Deductibles at $2,000 for individual and $4,000 for family, adjusted annually	—	2014	—	—
Coverage levels ("metal tiers")	2014 (non-grandfathered)	2014 (non-grandfathered)	—**	—**

**Insured coverage is purchased from a health insurance issuer. In California, a health plan under DMHC or health insurer under CDI.*

***To avoid a financial penalty when employer coverage requirements go into effect, employers with 50 or more full-time employees must provide health coverage to workers that meets federal definitions of "affordable" (self-only employee coverage does not exceed 9.5% of income) and "minimum value" (covers at least 60% of the total costs of benefits, as in a bronze coverage plan).*

Abbreviations

ACA – Affordable Care Act

CCR – California Code of Regulations

CDI – California Department of Insurance

CFR – Code of Federal Regulations

CIC – California Insurance Code

EHB – Essential Health Benefits

GOV – California Government Code

HSC – California Health and Safety Code

PHSA – Public Health Service Act

QHP – Qualified Health Plan

USC – United States Code

Endnotes

1. In California law, health care service plans (generally, HMO plans and some PPO plans) are under the jurisdiction of the Department of Managed Health Care (DMHC) subject to provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) in the Health and Safety Code. Health insurers (PPO plans not under DMHC) are under the jurisdiction of the California Department of Insurance (CDI) and subject to provisions of the California Insurance Code. The term "issuer" as used in federal law is typically not used in California law. California law does use the term "carrier" as an umbrella term for both health plans and health insurers (for example, relating to small employer coverage).

2. Grandfathered plans are contracts or policies sold to individuals or small groups that were in effect as of March 23, 2010, and continue to meet specific federal requirements limiting benefit and coverage changes. Under the ACA, grandfathered plans are exempt from many of the ACA reforms generally applicable to individual and small group coverage.

3. States expanding their Medicaid programs under the ACA must also provide EHB coverage to people newly eligible for Medicaid. See the Centers for Medicare & Medicaid Services, State Medicaid Director Letter (SMDL 312-003, ACA #21), *Essential Health Benefits in the Medicaid Program* (November 20, 2012), www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.

4. There are several types of excepted benefits. The US Department of Labor summarizes the types of excepted benefits as follows: (1) certain benefits are always treated as excepted benefits because they are not considered health coverage, such as accident only, disability income insurance, and workers' compensation; (2) other benefits are treated as excepted benefits if they are offered separately or are not an integral part of a plan, including limited-scope dental or vision and long term care benefits; (3) other benefits are treated as excepted benefits if they are offered separately and not coordinated with benefits under another group health plan, including coverage for a specific disease, hospital indemnity, or other fixed indemnity; and (4) other benefits are treated as excepted benefits if they are offered as a separate insurance policy and supplemental to Medicare, Armed Forces health care coverage, or (in very limited circumstances) group health plan coverage. As of this writing, federal rules related to excepted benefits and the ACA are pending as proposed by the Departments of Labor, Treasury, and Health and Human Services.

5. Medically necessary "basic health care services" are physician services, hospital impatient and outpatient services, diagnostic laboratory and diagnostic and therapeutic radiological services (x-ray), home health care, preventive care services, emergency services, and hospice care (HSC §1345 and CCR Title 28 §1300.67).

6. Healthy Families was California's implementation of the federal State Children's Health Insurance Program. Children enrolled in Healthy Families have been transitioned to the state Medicaid program (Medi-Cal).

7. Prior to 2014, health plans under the DMHC, including the EHB benchmark, were subject to extensive and detailed statutory and regulatory standards affecting coverage of prescription drugs, including the requirement to cover all medically necessary drugs, standards for developing and administering health plan drug formularies and drug substitutions, provisions affecting enrollee cost sharing, and permissible and prohibited limitations and exclusions. Through the enactment of EHBs for California, many of these requirements related to prescription drug coverage were for the first time applied to health insurance coverage under the CDI.

8. While the California implementing statutes for essential health benefits are substantively the same in both the HSC and CIC, the EHB implementation regulations adopted by the DMHC and the CDI are not identical. The differences are primarily in the level of detail included, either for provisions of federal and state law or for coverage details of California's EHB benchmark. This comparison chart does not include details on the differences between the two sets of California EHB implementing regulations.

9. The preventive services that must be provided without cost sharing fall into four different categories: services with an "A" or "B" recommendation from the US Preventive Services Task Force, vaccines recommended by the Centers for Disease Control and Prevention, the Bright Futures guidelines developed by the American Academy of Pediatrics with support from the Health Resources and Services Administration (HRSA), and certain women's services listed in HRSA guidelines (supplementing some of the USPSTF recommendations).

10. California enacted one of the first comprehensive definitions of habilitative services in the country. The California definition: "Habilitative services" means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract [policy]."

11. According to CMS comments in the regulation authorizing issuers to determine habilitative services, this is "a transitional policy, and HHS seeks to monitor available data" regarding this issue (78 Fed. Reg. 12834).

12. See HSC §1374.72–73 and CIC §10144.5 and §10144.51.

13. For a more detailed description of the interaction of federal and California law related to pediatric dental coverage in California's exchange, see *FAQs: Pediatric Dental Coverage in California Under the ACA,* Health Insurance Alignment Project (July 12, 2013), www.kelchpolicy.com/sites/default/files/insert/Alignment%20Project%20Dental%20FAQ%20-7-12-13.pdf.

14. The Knox-Keene prohibition on balance billing (providers billing enrollees for the difference between the charges they bill and the amount they are paid by the health plan) is contained in HSC §1371.4, 28 CCR §1300.71.39, and a series of related court cases and decisions. The ACA provides some protections for enrollees in need of emergency services but does not prohibit balance billing by out-of-network providers.

Endnotes (Continued)

15. In federal law, a "group health plan" generally refers to any plan administered by an employer or by an employee organization (e.g., a labor union) that provides medical care to employees or their dependents, whether through the purchase of insurance, reimbursement, or otherwise (42 USC §300gg-91). Group plans that do not contract for coverage with a health insurance issuer to fully assume the risk and manage the coverage are considered "self-insured," even if the group plan contracts with issuer companies or other entities to help administer the coverage and claims payments (administrative services organizations [issuer companies] or third-party administrators). The federal definition of group health plan, therefore, includes both insured plans (offering coverage through licensed health insurance issuers) or self-insured plans (where the employer or the group plan assumes the risk of reimbursing for the care provided to participants). Different state and federal rules apply to health insurance issuers offering group coverage and to self-insured group plans.
16. Specialized health plan contracts and insurance policies provide coverage in a single specialized area such as dental, vision, pharmacy, or mental health.
17. Cost sharing excludes premiums, balance billing amounts for non-network providers, or spending for non-covered services (ACA §1302; 42 USC §18022).
18. HHS has proposed a "premium adjustment percentage" for 2015 of 6%, which would increase the annual out-of-pocket maximum for an individual to $6,750 in 2015. The proposed rules are pending final revision and adoption as of this writing (78 Fed. Reg. 72321 [Dec. 2, 2013]).
19. "Affordable Care Act Implementation FAQs — Set 12," CMS, www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html.
20 Based on the proposed federal rules (78 Fed. Reg. 72321 [Dec. 2, 2013]), the small group deductibles would rise in 2015 to $2,150 for an individual and $4,300 for family coverage.
21. "Actuarial value" means the percentage paid by a health plan of the anticipated medical spending for covered EHBs, for a standard population, taking into account enrollee cost-sharing amounts (see 45 CFR §156.20 for the related federal definitions).

About the Author

This table was prepared by the Kelch Policy Group, which administers the CHCF-funded Health Insurance Alignment Project.

About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

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