

# AOA's Frequently Asked Questions on the Essential Health Benefit and Insurance Marketplaces

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## **What is the essential benefit package?**

The essential benefit package is a set of 10 benefits spelled out in the Affordable Care Act (ACA) which all health plans that sell in the new health insurance marketplaces (and non-grandfathered individual and small group plans outside of the exchange) must cover, at a minimum, in order to be compliant with the law. With the exception of the pediatric dental benefit, these benefits must be integrated within medical plan coverage.

## **What is the pediatric vision benefit?**

The pediatric vision benefit is one of the 10 essential benefits spelled out by the ACA that create a basic benefit package for all health plans sold in the new health insurance marketplaces (exchanges) and many plans outside of the marketplaces. Thanks to the advocacy of the AOA and state affiliates who fought back against insurance companies and ophthalmology who together pushed for a weaker benefit, the pediatric vision benefit will be a yearly eye exam with a materials benefit for every patient under the age of 19.

## **What is the benchmark?**

The benchmark is a health plan in the state whose benefit package was chosen to be the basis for all health plans that wish to sell in the state health insurance marketplace. States had a choice between the top three in each of these categories: small group plans, state employee plans and federal employee plans, or the largest HMO in the state. The selection in each state was only used to determine the minimum benefit package that must be offered (covered benefits); reimbursement and provider network makeup were not considered or examined in this process. The benchmark plan will not necessarily be one of the plans that consumers can actually purchase in the marketplaces.

## **Why is this a victory for optometry?**

After nearly a decade of determined advocacy by countless AOA member volunteers and staff, federal policymakers officially recognized last week what AOA members have known all along: that early and periodic comprehensive eye exams and follow-up care are “essential” to ensuring the overall health, development, and academic success for this nation’s children. Basically, coverage of eye health and vision care is now a medical benefit embedded within the health plans sold in the marketplaces and everyone who buys a plan in the marketplaces must, at a minimum, have this coverage. For the first time, the federal government is requiring private payers to cover eye exams and materials benefits for children and is linking medical eye care and vision care together under the same plan

### **Why is it an exam and not a screening?**

Several powerful and well-funded groups pushed very hard to try and diminish the pediatric vision benefit, including the ophthalmologists, the pediatricians, the insurance plans, and a range of business groups by perpetuating a myth that defining the kid's vision benefit as a comprehensive eye exam without having to first fail an undefined vision screening would be prohibitively expensive. Conversely, the AOA and state affiliates worked hard to show the minimal cost and maximum health benefits of early and periodic eye exams. In the end, HHS sided with the AOA and explained that under federal law, the essential benefit was supposed to mirror private insurance, which allows patients to directly access their vision benefits without having to first fail a vision screening.

### **Why is pediatric vision mandatory in the exchange and pediatric dental is not?**

Essentially, the pediatric vision benefit is mandated as an essential health benefit that must be included by health plans and dental is not. Under the ACA, pediatric vision is required to be integrated into the health plan like all other essential benefits; however, dental is treated differently because health plans do not have to include the pediatric dental benefit if there is a standalone plan selling dental benefits within the exchange. Also, under the law, an individual is not required to pay directly for essential benefits, but is required to purchase coverage through a health plan which meets acceptable coverage levels to satisfy the individual mandate. Because health plans operating within the exchanges may not necessarily include pediatric dental benefits, it is expected that many people will choose not to purchase the optional coverage and there currently is no requirement for them to do so. Additionally, there will be no refundable tax credit for somebody who purchases the standalone dental benefit because, under the law, the tax credit applies only to qualified health plans.

### **What is a "marketplace"?**

Health insurance marketplaces are the federal government's attempt to rebrand the exchange with a more consumer-friendly term. Many states that are running their own marketplace will likely rebrand the exchange with a local brand name. For example, in Massachusetts the exchange is called the Massachusetts Connector, and in California it will be called Connect California.

### **What is a private exchange?**

A private exchange is the private market version of a state marketplace and does not face the same regulatory requirements as the public marketplaces (exchanges). Private exchanges are being set up around the country and will compete directly against the government marketplace in many cases. Typically, these exchanges are run by insurance companies, large employers, employer coalitions, large benefits consulting firms, insurance industry entrepreneurs and other entities that have an interest in drawing customers out of the government marketplace. Health plans sold in these exchanges will have many of the same benefits as the marketplace plans but may not have a standardized benefit packages, and vision plans will be allowed to sell separately from health plans in these exchanges. Some private exchanges already exist. Examples include [ehealthinsurance.com](http://ehealthinsurance.com) and Bloom Health.

### **What is a QHP?**

A QHP is a qualified health plan or a health plan that has been certified by either the state or the federal government (depending on the type of marketplace the state has) that they are compliant with state law and the federal requirements of the ACA that must be met in order to sell in the marketplaces.

### **What is the “federal option”?**

The “federal option” refers to a federally-facilitated marketplace (or exchange) which is a result of a state not informing the federal government that it will be running its own health insurance marketplace or when a state forms a partnership with the federal government to operate a marketplace.

### **What does the federal option mean for my state?**

In essence the federal option marketplaces are basically websites that will sell health plans in states and the websites will be operated by the federal government. The website will be similar to travel websites (think Priceline or Hotwire) where users can enter their information and, depending on their income level, either be directed to the state’s Medicaid program or a selection of QHP products. The federal government will not actively manage the marketplaces aside from certifying QHP’s, which will be the job of state insurance commissioners.

### **Isn’t Davis Vision going to administer the pediatric vision benefit for all of the federally-facilitated exchanges being that they administer the FEDVIP plan?**

Davis Vision does administer the product that is sold to federal employees, but that does not mean that Davis Vision or any vision plan will be the default provider of the pediatric vision benefit in the federally-facilitated exchange. The benefit, regardless of which health plans sell in the marketplaces, will be sold by the QHP in a seamless, integrated manner because it is a required essential benefit. However, under the ACA, QHPs may decide to contract out their vision services to be administered by vision plans including Davis Vision, VSP or any other vision plan.