ESSENTIAL HEALTH BENEFITS BULLETIN

Center for Consumer Information and Insurance Oversight

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ESSENTIAL HEALTH BENEFITS BULLETIN

Purpose

The purpose of this bulletin is to provide information and solicit comments on the regulatory approach that the Department of Health and Human Services (HHS) plans to propose to define essential health benefits (EHB) under section 1302 of the Affordable Care Act. This bulletin begins with an overview of the relevant statutory provisions and other background information, reviews research on health care services covered by employers today, and then describes the approach HHS plans to propose. This bulletin only relates to covered services. Plan cost sharing and the calculation of actuarial value are not addressed in this bulletin. We plan to release guidance on calculating actuarial value and the provision of minimum value by employer-sponsored coverage in the near future. In addition, we plan to issue future guidance on essential health benefit implementation in the Medicaid program.

The intended regulatory approach utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB. In developing this intended approach, HHS sought to balance comprehensiveness, affordability, and State flexibility and to reflect public input received to date.

Public input is welcome on this intended approach. Please send comments on the bulletin by January 31, 2012 to: EssentialHealthBenefits@cms.hhs.gov.

Defining Essential Health Benefits

A. Introduction and Background

Statutory Provisions

Section 1302(b) of the Affordable Care Act directs the Secretary of Health and Human Services (the Secretary) to define essential health benefits (EHB). Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014.[1] Section 1302(b)(1) provides that EHB include items and services within the following 10 benefit categories: (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) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

[1] Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

Section 1302(b)(2) of the Affordable Care Act instructs the Secretary that the scope of EHB shall equal the scope of benefits provided under a typical employer plan. In defining EHB, section 1302(b)(4) directs the Secretary to establish an appropriate balance among the benefit categories. Further, under this provision, the Secretary must not make coverage decisions, determine reimbursement rates, or establish incentive programs. Benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population. The Secretary must submit a report to the appropriate committees of Congress along with a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the scope of the EHB is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

In addition, section 1311(d)(3) of the Affordable Care Act requires States to defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB.

The statute distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features will determine the level of actuarial value of the plan, expressed as a "metal level" as specified in statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value.[2]

Public and Other Input

To inform the Department's understanding of the benefits provided by employer plans, HHS has considered a report on employer plans submitted by the Department of Labor (DOL), recommendations on the process for defining and updating EHB from the Institute of Medicine (IOM), and input from the public and other interested stakeholders during a series of public listening sessions detailed below.

Section 1302(b)(2)(A) requires the Secretary of Labor to inform the determination of EHB with a survey of employer-sponsored plans. On April 15, 2011, the DOL issued its report, in satisfaction of section 1302(b)(2)(A) of the Affordable Care Act, providing results on the scope of benefits offered under employer-sponsored insurance to HHS.[3] The DOL survey provided a broad overview of benefits available to employees enrolled in employer sponsored plans. The report drew on data from the 2008 and 2009 National Compensation Survey (which includes large and small employers), as well as DOL's supplemental review of health plan Summary Plan Documents, and provided information on the extent to which employees have coverage for approximately 25 services within the 10 categories of EHB outlined in the Affordable Care Act (e.g., a certain percentage of plan participants have coverage for a certain benefit).

In order to receive independent guidance, HHS also commissioned the IOM to recommend a process that would help HHS define the benefits that should be included in the EHB and update the benefits to take into account advances in science, gaps in access,

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[2] As noted, these will be the subject of forthcoming guidance.

[3] Available at http://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf

and the effect of any benefit changes on cost. The IOM submitted its consensus recommendations in a report entitled "Essential Health Benefits: Balancing Coverage and Cost" on October 7, 2011.[4] In order to balance the cost and comprehensiveness of EHB, the IOM recommended that EHB reflect plans in the small employer market and that the establishment of an EHB package should be guided by a national premium target. The IOM also recommended the development of a framework for updating EHB that would take into account new evidence about effective interventions and changes in provider and consumer preferences while ensuring that the cost of the revised package of benefits remains within predetermined limits as the benefit standards become more specific. The IOM recommended flexibility across States and suggested that States operating their own Exchanges be allowed to substitute a plan that is actuarially equivalent to the national EHB package. The IOM also recommended continued public input throughout the process.

Following the release of the IOM's recommendations, HHS held a series of sessions with stakeholders, including consumers, providers, employers, plans, and State representatives, in both Washington, D.C. and around the nation to gather public input. Several key themes emerged. Consumer groups and some provider groups expressed concern at the IOM's emphasis on cost over the comprehensiveness of benefits. Some consumer groups expressed a belief that small group plans may not represent the typical employer plan envisioned by the statute, while employers and health insurance issuers generally supported the IOM conclusion that EHB should be based on small employer plans. Consumer and provider groups commented that specific benefits should be spelled out by the Secretary, while health insurance issuers and employers commented that they prefer more general guidance, allowing for greater flexibility. Both provider and consumer groups expressed concern about discrimination against individuals with particular conditions. Employers and health insurance issuers stressed concern about resources and urged the Secretary to adopt a more moderate benefit package. Consumers generally favored a uniform benefits package, and many consumers requested that State mandates be included in the benefits package. Some requested a uniform benefit package so that consumer choice of plan could focus on other plan features such as premium, provider network, and quality improvement. Some employer, health insurance issuer, and State representatives focused on the need for flexibility across the country to reflect local preferences and practices. States, health insurance issuers, and employers emphasized the need for timely guidance in preparing for implementation around EHB.

B. Summary of Research on Employer Sponsored Plan Benefits and State Benefit Mandates

While the Affordable Care Act directs the Secretary to define the scope of EHB as being equal to a typical employer plan, the statute does not provide a definition of "typical." Therefore, HHS gathered benefit information on large employer plans (which account for

[4] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx

the majority of employer plan enrollees), small employer products (which account for the majority of employer plans), and plans offered to public employees.5

There is not yet a national standard for plan reporting of benefits.6 While the DOL collects information on benefits offered by employer plans, no single data set includes comprehensive data on coverage of each of the 10 statutory essential health benefit categories. Consequently, to supplement information available from the DOL, Mercer,7 and Kaiser Family Foundation/Health Research & Educational Trust (KFF/HRET)8 surveys of employer plans, HHS gathered information on employer plan benefits from the IOM's survey of three small group issuers and supplemented this information with an internal analysis of publicly available information on State employee plans and Federal employee plans,[9] and information on benefits submitted to HealthCare.gov by small group health insurance issuers. To inform our understanding of the category of pediatric oral and vision care, HHS staff also analyzed dental and vision plans in the Federal Employees Dental/Vision Insurance Program (FEDVIP).[10] The FEDVIP program is a standalone vision and dental program where eligible Federal enrollees pay the full cost of their coverage.

Similarities and Differences in Benefit Coverage Across Markets

Generally, according to this analysis, products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover. They differ mainly in cost-sharing provisions, but cost-sharing is not taken into account in determining EHB. Similarly, these plans and products and the small group issuers surveyed by the IOM appear to generally cover health care services in virtually all of the 10 statutory categories.

For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and

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[5] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

[6] Section 2715 of the Public Health Service Act (PHS Act) requires group health plans and health insurance issuers in the group and individual markets to provide a Summary of Benefits and Coverage in a uniform format to consumers. HHS, DOL, and the Department of the Treasury issued proposed rules for PHS Act section 2715 at 76 FR 52442 (August 22, 2011). Further information is available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf and http://www.dol.gov/ebsa/faqs/faq-aca7.html.

[7] Available at http://www.mercer.com/survey-reports/2009-US-national-health-plan-survey

[8] Available at http://ehbs.kff.org

[9] HHS staff analyzed the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association Benefit plan booklets.

[10] Further information is available at https://www.benefeds.com/Portal/jsp/LoginPage.jsp

outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, prosthetics and orthotics, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. As noted in a previous HHS analysis, variation appears to be much greater for cost-sharing than for covered services.[11]

While the plans and products in all the markets studied appear to cover a similar general scope of services, there was some variation in coverage of a few specific services among markets and among plans and products within markets, although there is no systematic difference noted in the breadth of services among these markets. For example, the FEHBP BCBS Standard Option plan covers preventive and basic dental care, acupuncture, bariatric surgery, hearing aids, and smoking cessation programs and medications. These benefits are not all consistently covered by small employer health plans. Coverage of these benefits in State employee plans varies between States. However, in some cases, small group products cover some benefits that are not included in the FEHBP plans examined and may not be included in State employee plans, especially in States for which benefits such as in-vitro fertilization or applied behavior analysis (ABA) for children with autism are mandated by State law.[12] Finally, there is a subset of benefits including mental health and substance use disorder services, pediatric oral and vision services, and habilitative services – where there is variation in coverage among plans, products, and markets. These service categories are examined in more detail below.

Mental Health and Substance Use Disorder Services

In general, the plans and products studied appear to cover inpatient and outpatient mental health and substance use disorder services; however, coverage in the small group market often has limits. As discussed later in this document, coverage will have to be consistent with the Mental Health Parity and Addiction Equity Act (MHPAEA).[13]

The extent to which plans and products cover behavioral health treatment, a component of the mental health and substance use disorder EHB category, is unclear. In general, plans do not mention behavioral health treatment as a category of services in summary

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[11] ASPE Research Brief, "Actuarial Value and Employer Sponsored Insurance," November 2011. Available at: http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.pdf.

[12] In addition to mandated benefits, it appears that the small group issuers the IOM surveyed also generally cover residential treatment centers, which the FEHBP BCBS Standard Option plan excludes. However, as this analysis compares three small group issuers to one FEHBP plan, it is unclear if this finding can be generalized to other plans.

[13] See Affordable Care Act § 1311(j); see also PHS Act § 2726, ERISA § 712, Internal Revenue Code § 9812. See also interim final regulations at 75 FR 5410 (February 2, 2010) and guidance published on June 30, 2010 (http://www.dol.gov/ebsa/faqs/faq-mhpaea.html), December 22, 2010 (http://www.dol.gov/ebsa/faqs/faq-aca5.html), and November 17, 2011 (http://www.dol.gov/ebsa/faqs/faq-aca7.html).

plan documents. The exception is behavioral treatment for autism, which small group issuers in the IOM survey indicated is usually covered only when mandated by States.

Pediatric Oral and Vision Care

Coverage of dental and vision care services are provided through a mix of comprehensive health coverage plans and stand-alone coverage separate from the major medical coverage, which may be excepted benefits under PHS Act section 2722.[14] The FEDVIP vision plan with the highest enrollment in 2010 covers routine eye examinations with refraction, corrective lenses and contact lenses, and the FEDVIP dental plan covers preventive and basic dental services such as cleanings and fillings, as well as advanced dental services such as root canals, crowns and medically necessary orthodontia. In some cases, dental or vision services may be covered by a medical plan. For example, the FEHBP BCBS Standard Option plan covers basic and preventive dental services.

Habilitative Services

There is no generally accepted definition of habilitative services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services. However, many States, consumer groups, and other organizations have suggested definitions of habilitative services which focus on: learning new skills or functions – as distinguished from rehabilitation which focuses on relearning existing skills or functions, or defining "habilitative services" as the term is used in the Medicaid program.[15,16,17] An example of habilitative services is speech therapy for a child who is not talking at the expected age .

Two of the three small group issuers surveyed by the IOM indicated that they do not cover habilitative services. However, data submitted by small group issuers for display on HealthCare.gov indicates that about 70 percent of small group products offer at least limited coverage of habilitative services.[18] Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans, which often includes visit limits. All three issuers reporting to the IOM covered PT, OT, and ST, though one issuer did not cover these services for patients with an autism diagnosis. The FEHBP BCBS Standard Option plan also covers PT, OT, and ST. State employee plans examined appear to generally cover PT, OT, and ST.

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[14] When dental or vision coverage is provided in plan that is separate from or otherwise not an integral part of a major medical plan, that separate coverage is not subject to the insurance market reforms in title XXVII of the PHS Act. See PHS Act §§ 2722(c)(1), 2791(c)(2).

[15] For State definitions, see Md. Code Ins. § 15-835(a)(3); D.C. Code § 31-3271(3); 215 Ill. Comp. Stat. 5/356z.14(i).

[16] See 76 Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[17] For Medicaid definition, see Social Security Act, § 1915(c)(5)(A).

[18] Data submitted in October 2011.

Comparison to Other Employer Plan Surveys

These findings are generally consistent with other surveys of employer sponsored health coverage conducted by DOL, Mercer, and KFF/HRET. The Department of Labor survey found that employees had widespread coverage for medical services such as inpatient hospital services, hospital room and board, emergency room visits, ambulance service, maternity, durable medical equipment, and physical therapy. Similarly, Mercer found employers provided widespread coverage for medical services such as durable medical equipment, outpatient facility charges, and physical, occupational, and speech therapy. The KFF/HRET survey also found widespread coverage of prescription drugs among employees with employer-sponsored coverage.

State Benefit Mandates

State laws regarding required coverage of benefits vary widely in number, scope, and topic, so that generalizing about mandates and their impact on typical employer plans is difficult. All States have adopted at least one health insurance mandate, and there are more than 1,600 specific service and provider coverage requirements across the 50 States and the District of Columbia.[19]

Almost all State mandated services are typically included in benefit packages in States without the mandate – such as immunizations and emergency services. In order to better understand the variation in State mandates, their impact on the benefits covered by plans, and their cost, HHS analyzed 150 categories of benefit and provider mandates across all 50 States and the District of Columbia. The FEHBP BCBS Standard and Basic Options are not subject to any State mandates, but our analysis indicates that they cover nearly all of the benefit and provider mandate categories required under State mandates. The FEHBP BCBS Standard Option is not subject to any State mandates, but our analysis indicates that it covers about 95 percent of the benefit and provider mandate categories required under State mandates. The primary exceptions are mandates requiring coverage of in-vitro fertilization and ABA therapy for autism, which are not covered by the FEHBP BCBS Standard Option plan but are required in 8 and 29 States, respectively.

These two mandates commonly permit annual dollar limits, annual lifetime or frequency limits, and/or age limits. Research by States with these two mandates indicates that the cost of covering in-vitro fertilization benefits raises average premiums by about one percent[20,21] and the cost of covering ABA therapy for autism raises average premiums by approximately 0.3 percent.[22] Approximately 10 percent of people covered by small

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[19] Of these 1,600 mandates, about 1,150 are benefit mandates and 450 are provider mandates.

[20] Maryland Health Care Commission. Study of Mandated Health Insurance Services: A Comparative Evaluation. January 1, 2008. Available at: http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf

[21] University of Connecticut Center for Public Health and Health Policy. Connecticut Mandated Health Insurance Benefit Reviews. January, 2011. Available at: http://www.ct.gov/cid/lib/cid/2010_CT_Mandated_Health_Insurance_Benefits_Reviews_-_General_Overview.pdf

[22] California Health Benefits Review Program. Analysis of Senate Bill TBD 1: Autism. March 20, 2011. Available at: http://www.chbrp.org/docs/index.php?action=read&bill_id=113&doc_type=3.

group policies live in a State requiring coverage of in-vitro fertilization, and approximately 50 percent live in a State requiring coverage of ABA.

The small group issuers surveyed by the IOM indicated they cover ABA only when required by State benefit mandates. The FEHBP BCBS Standard Option does not cover ABA. The extent to which these services are covered by State employee plans is unclear, as there is variation between States in whether benefit mandates apply (either by statute or voluntarily) to State employee plans.

C. Intended Regulatory Approach

As noted in the introduction, the Affordable Care Act authorizes the Secretary to define EHB. In response to the research and recommendations described above, as a general matter, our goal is to pursue an approach that will:

- Encompass the 10 categories of services identified in the statute;
- Reflect typical employer health benefit plans;
- Reflect balance among the categories;
- Account for diverse health needs across many populations;
- Ensure there are no incentives for coverage decisions, cost sharing or reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life;
- Ensure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Provide States a role in defining EHB; and
- Balance comprehensiveness and affordability for those purchasing coverage.

As recommended by the IOM, HHS aims to balance comprehensiveness, affordability, and State flexibility while taking into account public input throughout the process of establishing and implementing EHB.[23] Our intended approach to EHB incorporates plans typically offered by small employers and benefits that are covered across the current employer marketplace.

We intend to propose that EHB be defined by a benchmark plan selected by each State. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that State as required by section 1302(b)(2)(A) of the Affordable Care Act. This approach is based on the approach established by Congress for the Children's Health Insurance Program (CHIP), created in 1997, and for certain Medicaid populations.[24,25] A major advantage of the benchmark approach is that it recognizes that issuers make a holistic decision in constructing a package of benefits and adopt packages they believe balance consumers' needs for comprehensiveness and affordability. As described below, health insurance

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[23] Available at http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx.

[24] Balanced Budget Act of 1997; Public Law 105-33

[25] Section 42 CFR 457.410 and 457.420

issuers could adopt the scope of services and limits of the State benchmark, or vary it within the parameters described below.

Four Benchmark Plan Types

Our analysis of offerings that exist today suggests that the following four benchmark plan types for 2014 and 2015 best reflect the statutory standards for EHB in the Affordable Care Act:

(1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;[26]
(2) any of the largest three State employee health benefit plans by enrollment;
(3) any of the largest three national FEHBP plan options by enrollment; or
(4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

To reflect the State flexibility recommended by the IOM, under our intended approach, States are permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their State and plans offered in the individual and small group markets in their State. To determine enrollment in plans for specifying the benchmark options, we intend to propose to use enrollment data from the first quarter two years prior to the coverage year and that States select a benchmark in the third quarter two years prior to the coverage year. For example, enrollment data from HealthCare.gov for the first quarter of calendar year 2012 could be used to determine which plans would be potential benchmarks for State selection and the benchmark plan specified during the third quarter of 2012 for coverage year 2014. If a State does not exercise the option to select a benchmark health plan, we intend to propose that the default benchmark plan for that State would be the largest plan by enrollment in the largest product in the State's small group market.

Defraying the Cost of Additional Benefits

Section 1311(d)(3)(B) of the Affordable Care Act requires States to defray the costs of State-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market. Similar to other Exchange decisions, the State may select the benchmark plan. The approach for 2014 and 2015 would provide a transition period for States to coordinate their benefit mandates while minimizing the likelihood the State would be required to defray the costs of these mandates in excess of EHB. In the transitional years of 2014 and 2015, if a State chooses a benchmark subject to State mandates – such as a small group market plan – that benchmark would include those mandates in the State EHB package. Alternatively,

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[26] Nomenclature used in HealthCare.gov describes "products" as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A "plan" refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.

under our intended approach a State could also select a benchmark such as an FEHBP plan that may not include some or all of the State's benefit mandates, and therefore under Section 1311(d)(3)(B), the State would be required to cover the cost of those mandates outside the State EHB package. HHS intends to evaluate the benchmark approach for the calendar year 2016 and will develop an approach that may exclude some State benefit mandates from inclusion in the State EHB package.

Benchmark Plan Approach and the 10 Benefit Categories

One of the challenges with the described benchmark plan approach to defining EHB is meeting both the test of a "typical employer plan" and ensuring coverage of all 10 categories of services set forth in section 1302(b)(1) of the Affordable Care Act. Not every benchmark plan includes coverage of all 10 categories of benefits identified in the Affordable Care Act (e.g., some of the benchmark plans do not routinely cover habilitative services or pediatric oral or vision services). The Affordable Care Act requires all issuers subject to the EHB standard in section 1302(a) to cover each of the 10 benefit categories.[27] If a category is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer EHB. In selecting a benchmark plan, a State may need to supplement the benchmark plan to cover each of the 10 categories. We are considering policy options for how a State supplements its benchmark benefits if the selected benchmark is missing a category of benefits. The most commonly non-covered categories of benefits among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services.

Below, we discuss several specific options for habilitative services, pediatric oral care and pediatric vision care. Generally, we intend to propose that if a benchmark is missing other categories of benefits, the State must supplement the missing categories using the benefits from any other benchmark option. In a State with a default benchmark with missing categories, the benchmark plan would be supplemented using the largest plan in the benchmark type (e.g. small group plans or State employee plans or FEHBP) by enrollment offering the benefit. If none of the benchmark options in that benchmark type offer the benefit, the benefit will be supplemented using the FEHBP plan with the largest enrollment. For example, in a State where the default benchmark is in place but that default plan did not offer prescription drug benefits, the benchmark would be supplemented using the prescription drug benefits offered in the largest small group benchmark plan option with coverage for prescription drugs. If none of the three small group market benchmark options offer prescription drug benefits, that category would be based on the largest plan offering prescription drug benefits in FEHBP. We are continuing to consider options for supplementing missing categories such as habilitative care, pediatric oral care and pediatric vision care if States do not select one of the options discussed below.

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[27] A qualified health plan may choose to not offer coverage for pediatric oral services provided that a standalone dental benefit plan which covers pediatric oral services as defined by EHB is offered through the same Exchange.

Habilitation

Because habilitative services are a less well defined area of care, there is uncertainty on what is included in it. The NAIC has proposed a definition of habilitation in materials transmitted to the Department as required under Section 2715 of the PHSA, and Medicaid has also adopted a definition of habilitative services.[28,29] These definitions include the concept of "keeping" or "maintaining" function, but this concept is virtually unknown in commercial insurance, which focuses on creating skills and functions (in habilitation) or restoring skills and function (for rehabilitation). Private insurance and Medicare may use different definitions when relating to coverage of these services.[30] We seek comment on the advantages and disadvantages of including maintenance of function as part of the definition of habilitative services. We are considering two options if a benchmark plan does not include coverage for habilitative services:

1) Habilitative services would be offered at parity with rehabilitative services -- a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation; or
2) As a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habilitative services in the future.

Pediatric Oral and Vision

For pediatric oral services, we are considering two options for supplementing benchmarks that do not include these categories. The State may select supplemental benefits from either:

1) The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
2) The State's separate CHIP program.[31]

We intend to propose the EHB definition would not include non-medically necessary orthodontic benefits.

For pediatric vision services we intend to propose the plan must supplement with the benefits covered by the FEDVIP vision plan with the largest enrollment. The rationale for a different treatment of this category is that CHIP does not require vision services. As with habilitative services, we also seek comment on an approach that lets plans define the pediatric oral and vision services with required reporting as a transition policy.

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[28] See 76Fed. Reg. 52,442 and 76 Fed. Reg. 52,475.

[29] For Medicaid definition, see Social Security Act, Section 1915(c)(5)(A).

[30] See section 220.2(c) and (d) in the Medicare Benefits Policy Manual available here: http://www.cms.gov/manuals/Downloads/bp102c15.pdf

[31] If a State does not have a separate CHIP program, it may establish a benchmark that is consistent with the applicable CHIP standards. http://www.cms.gov/SMDL/downloads/CHIPRA%20Dental%20SHO%20Final%20100709revised.pdf

Mental Health and Substance Use Disorder Services and Parity

The MHPAEA expanded on previous Federal parity legislation addressing the potential for discrimination in mental health and substance use disorder benefits to occur by generally requiring that the financial requirements or treatment limitations for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits. However, although parity was applied for covered mental health and substance use disorder benefits, there was no requirement to offer such a benefit in the first instance. Also, prior to the Affordable Care Act, MHPAEA parity requirements did not apply to the individual market or group health coverage sponsored by employers with 50 or fewer employees.

The Affordable Care Act identifies coverage of mental health and substance use disorder benefits as one of the 10 categories and therefore as an EHB in both the individual and small group markets. The Affordable Care Act also specifically extends MHPAEA to the individual market. Because the Affordable Care Act requires any issuer that must meet the coverage standard set in section 1302(a) to cover each of the 10 categories, all such plans must include coverage for mental health and substance use disorder services, including behavioral health treatment. Consistent with Congressional intent, we intend to propose that parity applies in the context of EHB.

Benefit Design Flexibility

To meet the EHB coverage standard, HHS intends to require that a health plan offer benefits that are "substantially equal" to the benefits of the benchmark plan selected by the State and modified as necessary to reflect the 10 coverage categories. This is the same equivalency standard that applies to plans under CHIP.[32] Similar to CHIP, we intend to propose that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories. Any flexibility provided would be subject to a baseline set of relevant benefits, reflected in the benchmark plan as modified. Permitting flexibility would provide greater choice to consumers, promoting plan innovation through coverage and design options, while ensuring that plans providing EHB offer a certain level of benefits. We are considering permitting substitutions that may occur only within each of the 10 categories specified by the Affordable Care Act. However, we are also considering whether to allow substitution across the benefit categories. If such flexibility is permitted, we seek input on whether substitution across categories should be subject to a higher level of scrutiny in order to mitigate the potential for eliminating important services or benefits in particular categories. In addition, we intend to require that the substitution be actuarially equivalent, using the same measures defined in CHIP.[33]

To ensure competition within pharmacy benefits, we intend to propose a standard that reflects the flexibility permitted in Medicare Part D in which plans must cover the

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[32] 42 CFR 457.420.

[33] 42 CFR 457.431

categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within categories and classes.[34] If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.

The Affordable Care Act also directs the Secretary to consider balance in defining benefits and to ensure that health insurance issuers do not discriminate against enrollees or applicants with health conditions. Providing guidelines for substitution will ensure that health insurance issuers meet these standards.

Updating Essential Health Benefits

Section 1302(b)(4)(G) and (H) direct the Secretary to periodically review and update EHB. As required by the Affordable Care Act, we will assess whether enrollees have difficulties with access for reasons of coverage or cost, changes in medical evidence or scientific advancement, market changes not reflected in the benchmarks and the affordability of coverage as it relates to EHB. We invite comment on approaches to gathering information and making this assessment. Under the benchmark framework, we note that the provision of a "substantially equal" standard would allow health insurance issuers to update their benefits on an annual basis and they would be expected on an ongoing basis to reflect improvements in the quality and practice of medicine. We also intend to propose a process to evaluate the benchmark approach.

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[34] Drug category and class lists would be provided by the U.S. Pharmacopoeia, AHMS, or through a similar standard. Note: we do not intend to adopt the protected class of drug policy in Part D.