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BENEFIT NEWS BRIEFS

HHS Releases Proposal to Define Essential Health Benefits

The Department of Health and Human Services (HHS) recently issued a bulletin providing information and soliciting comments on defining "*essential health benefits*" (EHB) under Section 1302 of the *Affordable Care Act (ACA)*.

One goal of the *ACA* is to ensure Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), include a comprehensive package of items and services, known as "essential health benefits (EHBs)."

EHBs must include items and services within at least the following 10 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.

Under Section 1302(b) of the *ACA*, EHBs must be covered by:

- non-grandfathered plans in the individual and small group markets both inside and outside of the Health Insurance Exchanges,
- Medicaid benchmark and benchmark-equivalent, and
- Medicaid Basic Health Programs beginning in 2014.

However, the term "EHB" is not limited in applicability to the coverage required under Section 1302(b) and this is where any discussion of EHBs can get confusing. While the requirement to cover EHBs is limited to the above types of insured plans, the definition of EHB will have an indirect impact on other types of plans covered by the *ACA* such as self-insured group health plans (GHPs), including multiemployer plans.

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One reason for possible confusion is because the term EHB is also used in *ACA* Section 1001 in reference to changes to the rules prohibiting lifetime limits and setting rules on annual limits. The *ERISA* implementing regulation at Section 2590.715-2711 states in part:

> The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not *essential health benefits* to the extent that such limits are otherwise permitted under applicable Federal or State law. (emphasis added)

This *ERISA* regulation defines EHBs by referring to the EHBs under *ACA* Section 1302, as discussed above. Thus, the definition of EHB will be useful in applying "annual" limits on benefits that are not considered EHBs

The other area where there is a connection between the Section 1302 definition of EHBs and the *ACA* is the Section 1302 EHB requirements to cover "*preventative and wellness services and chronic disease management*" and the requirement of ACA Section 1001 requiring the coverage of "*preventative health services*" by NON-GRANDFATHERED GHPs only. The description of the two types of benefits may overlap in some places but the definition of this category of services is broader under the definition of EHB.

The *ERISA* implementing regulation at Section 2590.715–2713 states that only NON-GRANDFATHERED plans:

> "must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:
>
> (i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
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> (ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);
>
> (iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

> (iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

So, while this HHS bulletin will help non-affected plans better understand what an EHB is for the purposes of setting allowable annual limits, such plans are NOT required to cover EHBs, as explained above.

Contrary to expectations that HHS would set a uniform nationwide definition of EHBs, the bulletin proposes that HHS would allow each State to choose a "benchmark" health plan based on employer-sponsored coverage in the marketplace to define the parameters of each of the 10 statutory categories of EHBs. Public input is welcome on this intended approach with comments on the bulletin due by January 31, 2012 to: *EssentialHealthBenefits@cms.hhs.gov*.

The bulletin also did give some hints at what might be considered Habilitative Services and Pediatric Oral and Vision Care for the purposes of EHBs. What constitutes "essential" pediatric oral and dental vision care has been a topic of interest for many multiemployer GHPs attempting to maintain "good faith" compliance in setting annual limits on non-essential health benefits.

Habilitative Services
The bulletin noted there is no *generally accepted definition* of habilitative services among health plans. 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. An example of habilitative services is speech therapy for a child who is not talking at the expected age.

Pediatric Oral and Vision Care
As far as the scope of pediatric oral and vision care services, the bulletin noted that one possible benchmark plan, the FEDVIP vision plan, 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.

The HHS bulletin is available by *"clicking here."*

We will follow the development of this topic as it evolves.

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