

EXHIBIT A

Coverage for Essential Health Benefit (EHB) Categories, including:

- (1) Wellness and Preventative Care Services and Chronic Care Management;
 - (2) Pediatric Oral and Vision Care; and
 - (3) Habilitative Services
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Introduction

The Patient Protection and Affordable Care Act (ACA) directs that all qualified health plans (QHP) in the individual and small group markets -- sold on or off the Exchange -- must include the essential health benefits (EHB) package. The Act identifies ten categories of care that must be included in the EHB and indicates that coverage should be consistent with a “typical employer plan.”¹

The typical employer plan sold in Connecticut covers most of the ten categories of care. However, the benchmark plans currently being considered for Connecticut may not adequately cover three categories of care: habilitation services, pediatric oral care and pediatric vision care. In addition, the Advisory Committees are interested in receiving additional information regarding preventive and wellness services and chronic disease management.

I. Preventive and Wellness Services and Chronic Disease Management

In the February 2012 FAQ, released by the Center for Medicare and Medicaid Services (CMS), the federal government clarified that with respect to the EHB package, every QHP must include the preventive services described in section 2713 of the Public Health Services Act, as added by section 1001 of the Affordable Care Act. This will require any QHP to provide benefits for:

- 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 (USPSTF). For example, depression screening for children and adults, breast cancer screening, cholesterol screening, sexually transmitted infections screening for women. The full list of 45 recommendations that are relevant for the implementation of the ACA are available online.²
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and appearing on the Center’s Immunization Schedules. The CDC recommends

¹ [Section 1302\(b\)\(2\)](#) of ACA ([42 U.S.C. § 18022](#)) identifies ten benefit categories that must be included in every state’s Essential Health Benefits package. The ten categories are: (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.

² U.S. Preventive Services Task Force, *USPSTF A and B Recommendations* (August 2010). Internet: <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> (Accessed: July 1, 2012)

routine vaccination for 17 vaccine-preventable diseases that occur in infants, children adolescents, or adults.³

- With respect to infants, children, and adolescents, the evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).⁴

Furthermore, preventive services must be offered without patient cost sharing (for in-network providers) and must be covered outside of any annual deductible that may otherwise apply.

An analysis of the certificates of coverage for each benchmark plan option suggests that there are no meaningful differences across the plans with respect to their coverage of preventive and wellness benefits. Existing Connecticut benefit mandates also cover many of the services that are included in this category. These mandated benefits include: comprehensive coverage for the treatment of diabetes; colorectal cancer screening; mammogram screening; PSA tests; and direct access to obstetrician-gynecologists.

The chronic disease management programs, offered by each of the benchmark plans, differ. The programs range in variety and are often considered supplements to the covered services or benefits of the plan design options. Often these programs are not explicitly identified in the plan's certificate of coverage (as filed with the Connecticut Insurance Department), but are identified in the plan brochures, marketing material and website as value-added services for their members. The following examples illustrate the types of wellness or chronic disease management programs the Carriers may offer: Asthma programs, Vision Discount Programs, HeartCare Management program and Health Management Programs to mention a few.

Exhibit 1 provides a detailed summary of potential benefits that could fall under the “preventive and wellness services and chronic disease management” category.

II. Pediatric Oral and Vision Care

As noted in the December 2011 Bulletin regarding the EHB, issued by the Department of Health and Human Services, coverage of dental and vision care services are typically provided through a mix of comprehensive health coverage plans and stand-alone coverage that is separate from the carrier's major medical coverage.¹

In some cases, dental and/or vision services may be covered by the medical plan. For example, the FEHBP BCBS Standard Option plan covers basic and preventive dental services. And each of the small group plans provide coverage for annual vision tests for adults and children.

With respect to pediatric oral care, the February FAQ issued by the federal government provided some additional guidance. The FAQ indicated that states could—subject to a final rule—supplement the selected benchmark plan with benefits from either:

³ Center for Disease Control. *General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)* (January 28, 2011). Internet: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm> (Accessed: July 1, 2012)

⁴ The HRSA supports the comprehensive guidelines in the *Periodicity Schedule of the Bright Futures Recommendations* for Pediatric Preventive Health Care, and the *Recommended Uniform Screening Panel* of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

- The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or
- The State’s separate Children’s Health Insurance Program (CHIP).

Both Connecticut’s CHIP and the FEDVIP dental plans cover 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. There are no meaningful differences in coverage of benefits.

With respect to pediatric vision, the federal government is considering modeling coverage after the FEDVIP vision plan with the highest enrollment in 2010. Coverage includes routine eye examinations with refraction, corrective lenses and contact lenses. This level of coverage is more comprehensive than the benefits included in many of the stand-alone insurance plans sold by the carriers, with the exception of the vision care provided through the Anthem Blue Cross Blue Shield BlueCare HMO, which appears to be more comprehensive than the other benchmarks and in line with the FEDVIP plan.

Exhibit 2 provides detailed analysis comparing the benchmark plans’ coverage of vision and dental benefits; as well as the supplemental coverage arrangements identified by the federal government.

III. Habilitative Services

The December Bulletin acknowledges that 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. Suggested definitions of habilitative services include: defining habilitation as focusing on learning new skills/functions—as distinguished from rehabilitation which focuses on relearning existing skills/functions; or, defining “habilitative services” as it is used in the Medicaid program to include the concept of “keeping” or “maintaining” functions “for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.”

As a transitional approach for selecting the coverage for more general habilitative services, the Bulletin discusses two alternative options that the federal government is considering:

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. Plans would decide which habilitative services to cover, and would report that coverage to HHS.