



Section 6

## BENEFITS

In addition to expanding access to affordable health coverage options, the Affordable Care Act (ACA) makes several changes to public and private health insurance benefits that will affect the populations served by Title V MCH and CYSHCN programs. This module gives an overview of the ACA's broad requirements for health insurance benefits and the ways these requirements affect MCH/CYSHCN populations.

### Preventive Services

The ACA requires most health plans to cover preventive services without charging patients any fees, known as copayments, co-insurance, or deductibles. The preventive services that plans must cover are all services given “A” or “B” ratings by the U.S. Preventive Services Task Force plus routine immunizations recommended by the Centers for Disease Control and Prevention. As these agencies update their recommendations, plans may have to cover additional preventive services and immunizations to match the recommendations.

In addition, the ACA requires plans to cover specific preventive services for women and children when delivered by an in-network provider:

- **Preventive services for women** – Plans must cover 22 preventive services for women without charging fees. That includes annual well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) testing; sexually transmitted infection (STI) counseling; contraception; HIV screening; domestic violence screening; and breastfeeding support, to name a few. These services are based on recommendations from the Institute of Medicine.
- **Preventive services for children** – Plans are required to cover specific preventive services and screenings for children and adolescents without charging fees. These recommendations include behavioral and developmental assessments, routine screening tests, and well-child care. The preventive services for children that plans must cover

are all services recommended by the Health Resources and Services Administration (HRSA)-supported Bright Futures initiative for children from birth to age 21.

### Exceptions

Some health plans are exempt from the ACA's requirements for preventive services. The main categories of plans exempt from this requirement are 1) self-funded plans, and 2) “grandfathered plans,” which are plans that existed before the ACA was signed on March 23, 2010 and that have not changed in a way that substantially changes benefits or increases costs for the consumer. In practice, this means that all Health Insurance Marketplace plans, known as Qualified Health Plans (QHPs), and many other private health insurance plans must cover nearly 50 specified preventive services free of charge to consumers. Group health plans for religious employers, non-profits, and closely held for-profit companies who have a religious objection to providing contraceptive coverage are exempt from the requirement to provide that preventive service for women.<sup>1</sup> However, women who are covered under these exempt plans are still offered access to contraceptives. CMS has issue guidance that, in the case of an organization's religious objection, its health plan issuer must provide or arrange separate payments for contraceptive services at no cost to the women or to the organization.

### Essential Health Benefits

The ACA requires all health plans sold inside the Health Insurance Marketplace and all new individual and small group plans sold outside of the Health Insurance Marketplace to offer a core package of services known as essential health benefits (EHB). EHB requirements also apply to Medicaid plans offered in states that have expanded Medicaid eligibility up to 133 percent of the federal poverty level for newly eligible adults. All of these plans must cover EHB in the following 10 categories:

<sup>1</sup> <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html>

1. Ambulatory (outpatient) 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
10. Pediatric services, including oral and vision care

While EHB rules set a baseline, there can still be great variation among health insurance plans related to the extent of covered services and cost sharing for those services. In 2012, every state selected an existing health insurance plan, known as a benchmark plan. The benchmark plan established the state's minimum definitions for the extent of covered services and cost-sharing limits within each EHB category. Most states selected the largest small group market plan in their state as their initial benchmark plan. In cases where the state-selected benchmark plan did not include a particular EHB category, states were required to supplement the benchmark benefits.

Generally, small group plans have coverage and cost-sharing policies for children that are less comprehensive than those available in Medicaid or CHIP programs. The differences in benefits between public and private coverage options may be particularly striking in habilitative and rehabilitative services, and pediatric oral, vision, and hearing services.<sup>ii</sup> These are benefit categories that are particularly important to MCH and CYSHCN populations. State EHB benchmark selections will remain in place through 2017.

## Exceptions

EHB requirements do not apply to traditional Medicaid, Children's Health Insurance Program (CHIP), large employer health plans, or "grandfathered" plans. In practice, this means that all QHPs sold on the Health Insurance Marketplace as well as new plans sold outside the Health Insurance Marketplace must provide EHB.

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1. Ambulatory (outpatient) 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
10. Pediatric services, including oral and vision care

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<sup>ii</sup> [http://www.aap.org/en-us/about-the-aap/aap-press-room/Documents/AAP\\_EHB\\_Report\\_FinalPress.pdf](http://www.aap.org/en-us/about-the-aap/aap-press-room/Documents/AAP_EHB_Report_FinalPress.pdf)

## Pediatric Dental Benefits

Pediatric dental benefits are one of the 10 EHB, but dental benefits have traditionally been covered through dental insurance separate from medical insurance. In most states, insurers selling plans on the Health Insurance Marketplace have the option to continue offering stand-alone pediatric dental plans or to sell plans with embedded pediatric dental services. There is no federal requirement that families purchasing coverage on the Health Insurance Marketplace must also purchase stand-alone pediatric dental coverage for their child if it is not included in the selected medical plan.

Some parents may forgo dental coverage for their child due to affordability concerns. Tax credit subsidies are calculated based on the second-lowest cost silver plan in the Health Insurance Marketplace, which may or may not include pediatric dental benefits. For most families, this may mean that their tax credit subsidy amount might not be enough to cover the cost of a stand-alone pediatric dental plan. Stand-alone dental plans may also require cost-sharing beyond the out-of-pocket limits that apply to medical plans. Some states have taken action to ensure children receive pediatric dental benefits. For example, Kentucky, Nevada, and Washington have implemented state requirements that families purchasing medical coverage for a child must also purchase pediatric dental coverage. In 2015, California's and Connecticut's Health Insurance Marketplaces required that all QHPs embedded pediatric dental benefits within the plans.

## Habilitative Benefits

The EHB also include habilitative services, a set of benefits that were not traditionally covered by private health insurance plans. Habilitative services generally include occupational, physical, and speech therapy services. Unlike rehabilitative services, which help individuals recover lost skills, habilitative services help individuals attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. These benefits are particularly important for individuals with intellectual or physical disabilities, including CYSHCN. Since habilitative services were not traditionally covered in private insurance plans, many state benchmark plans do not recognize habilitative services as a distinct group of services. To fill the gap, HHS initially allowed states to define habilitative

services. If a state chose not to define habilitative services, health plan issuers can either provide habilitative services in parity with rehabilitative services or can provide a list of habilitative services they will cover, which the Centers for Medicare and Medicaid Services (CMS) must approve. In February 2015, CMS issued a final rule that defines habilitative services as health care services that help a person keep, learn or improve skills and functioning for daily living. This definition applies to habilitative services for all QHPs in all states and is effective for plan years beginning in 2016. The guidance also requires insurers to use separate visit limits for habilitative and rehabilitative services beginning with the 2017 plan year.<sup>iii</sup>

## Mental Health and Substance Use Parity

QHPs sold through the Health Insurance Marketplace and private health plans sold in the individual and small group markets must comply with the Mental Health Parity and Addiction Equity Act of 2008. Plans must include mental health and substance use disorder benefits. These benefits must be treated the same way as medical benefits with regard to cost sharing and limits on services.

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<sup>iii</sup><https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2016-PN-Fact-Sheet-final.pdf>

## Test your knowledge

1. Under the ACA, all qualified health plans (QHPs) must cover:
  - a. Preventive services recommended by the U.S. Preventive Services Task Force
  - b. Routine immunizations recommended by the Centers for Disease Control and Prevention
  - c. Preventive services for children recommended by HRSA's Bright Futures
  - d. Preventive services for women
  - e. All of the above
2. **True or False:** All plans offering EHB must cover benefits and services in 10 categories, which means that all EHB packages will look the same.
3. Which of the following is NOT true about stand-alone pediatric dental plans?
  - a. Stand-alone dental plans may require cost-sharing beyond the out-of-pocket limits that apply to medical plans.
  - b. Families will receive tax credit subsidies that are guaranteed to cover the entire cost of purchasing a stand-alone dental plan.
  - c. There is no federal requirement that families shopping on a Health Insurance Marketplace purchase stand-alone pediatric dental coverage for their child.



## Find Out in Your State

1. What EHB benchmark plan did your state select? Did your state supplement its benchmark plan? If so, how?
2. How are pediatric dental benefits being sold in your state's Health Insurance Marketplace—as stand-alone plans and/or embedded in medical plans? Has your state taken any policy or programmatic action to make pediatric dental coverage more affordable for children or to require purchase of pediatric dental benefits?

Test Your Knowledge Answers: 1. e  
2. False. There can still be great variation among EHB plans, particularly related to cost sharing and the extent of covered services  
3. b



This document, *The Affordable Care Act: A Working Guide for MCH Professionals*, is available in its entirety on the Web at <http://www.amchp.org/Transformation-Station/Pages/ACA-101.aspx>

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