State Roles in Defining Essential Health Benefits (EHB)

Summary
The Patient Protection and Affordable Care Act (ACA) requires the establishment of an “essential health benefits (EHB) package” to define benefits covered in ACA-specified plans. The ACA requires EHB to be included in all “qualified health plans” and will apply to the ACA-established Medicaid expansion population, Basic Health Plans (ACA-created options for state-run programs for adults between 133%-200% of the federal poverty level (FPL)), enrollees in Medicaid benchmark and benchmark-equivalent plans, as well as non-grandfathered plans in the individual and small group markets sold both inside and outside exchanges.

On December 16, 2011, the Centers for Medicare and Medicaid Services (CMS) released an Essential Health Benefits Bulletin, announcing its intention to allow states to define their own EHB. This was a significant and noted change from the expectation that the federal government would define 1 national EHB package.

While we await the promulgation of regulations to further define state roles in establishing EHB packages, this December 16 CMS bulletin provides some guidance to states in this process.

It is critical that AAP chapters take proactive steps to influence the EHB process at the state level, to ensure that children receive medically necessary services and that EHB packages are robust and will meet the needs of children and the profession of pediatrics.

This document provides further detail on the EHB issue, and offers advocacy recommendations to AAP chapters working to influence the EHB development process at the state level. Specific advocacy guidance can be found in the attached document, EHB Advocacy Guidance: State Roles in Defining EHB.

Background
The ACA includes a very important set of provisions to establish an “essential health benefits (EHB) package.” The language of the ACA statute directs the Secretary of the US Department of Health and Human Services (HHS) to define and update the EHB package, which must include items and services within the following 10 benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
• Preventive and wellness services and chronic disease management
• Pediatric services, including oral and vision care

December 16, 2011 CMS Bulletin
On December 16, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid Services (CMS) released an Essential Health Benefits Bulletin, providing information and seeking comment on CMS’s intended plans for defining EHB. This bulletin is of the highest significance because, for the first time, CMS announced its intention to turn the process of creating EHB over to the states before an evaluation of that approach in 2016.

On January 23, 2012 the AAP filed a written response to this bulletin, calling into question the authority of HHS to delegate the EHB determination process to states. The requirements set forth by the ACA clearly direct the Secretary of HHS to establish 1 national EHB standard, and the AAP believes the intent of Congress was to ensure that all medically necessary services for children are covered in 1 standardized EHB package.

The AAP’s comments to HHS on the December 16 bulletin reflect concerns that the process for EHB determination is being passed to states as well as concerns with substantive interpretations in the bulletin as to services required in EHB packages, which may lead to benefit packages that do not ensure children will receive needed services.

The Academy is currently awaiting regulations to further spell out the process for EHB determination at the state level. More information on this will be forthcoming from the Academy once released.

December 16, 2011 CMS Bulletin Details: State Decisions
The December 16 CMS bulletin spells out preliminary details of how states will establish EHB packages. The bulletin maintains that EHB packages must provide items and services in the same 10 categories spelled out in ACA statute. The bulletin does not address cost sharing or actuarial value, and HHS notes that it plans to issue further guidance on EHB in Medicaid in the future.

[Of note, on February 25, 2012 CCIIO did release an Actuarial Value and Cost Sharing Reductions Bulletin, outlining its regulatory intentions related to actuarial value and cost sharing. More on these issues will be provided in subsequent communications with AAP chapters.]

The December 16 CMS bulletin details the research HHS conducted in taking steps to meet the ACA requirement that the scope of EHB be equal to a “typical employer plan.” HHS notes that it studied large employer plans, small employer plans, and plans offered to public employees, finding that plans differ in terms of cost-sharing but infrequently in terms of services covered, noting certain exceptions for children across markets. These specific services include:

• Mental health and substance use disorder services
• Pediatric oral and vision care
• Habilitative services

The bulletin restates that the ACA requirement all state insurance benefit mandates in excess of the EHB must be paid for by states.

State Benchmark Plan Selection
CMS states in the December 16 bulletin that EHB will be defined by a benchmark plan selected by each state for 2014 and 2015. States may choose from any of the 4 following benchmarks:

1) The largest plan by enrollment in any of the 3 largest small group insurance products in the state’s small group market
2) Any of the 3 largest state employee health benefit plans by enrollment
3) Any of the 3 largest national Federal Employee Health Benefit Plan (FEHBP) plan options by enrollment; or
4) The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state

States are permitted to select a single benchmark to serve as the standard for qualified health plans offered both inside the exchange and in the individual and small group markets.
HHS further indicates it will assess the benchmark process beginning in 2016 and beyond, based on feedback and evaluation.

On January 25, 2012, CMS then published an illustrative list of the largest 3 small group products by state, to give states an idea of the plans that would meet benchmark requirements.

**Additional Benefits**
The ACA requires states to pay for state mandated benefits in excess of the EHB. CMS indicates that allowing states to select a benchmark plan for 2014 and 2015 will give states a transition period to coordinate benefit mandates and minimize the likelihood that a state will have to pay for such services.

States that choose a benchmark plan subject to state mandates will not have to pay for excess benefits as they will be included in the plan. Alternately a state may choose a benchmark that does not include such mandated benefits, and therefore be required to pay for the excess state mandated services. HHS further indicates that it is evaluating the benchmark approach for 2016 and will develop an approach that might exclude some state benefit mandates in a state EHB package.

**Impact of State Mandate Payment Requirement**: Some states have already begun looking at the impact the requirement that states pay for mandates in excess of EHB will have on existing mandates and on state spending. For example, California's Health Benefits Review Program released an issue brief in March 2012, examining the interplay between potential EHB packages and existing mandates. Moreover, Virginia commissioned a February 2012 study of existing state mandates and potential costs to the state. Moreover, New York held a March 22, 2012 stakeholder conference call to discuss the EHB requirement and state mandates. AAP chapters are encouraged to talk to state officials regarding similar studies in your states.

**Required 10 Benefit Categories**
As stated, the ACA requires all EHB packages to include all 10 categories of benefits required by statute. In the case of a benchmark benefit package with missing categories of services, the benchmark plan must then be supplemented by the largest plan in the benchmark type (e.g. small group plans or state employee plans or FEHBP) by enrollment that offer the benefit. If none of the benchmark options in that benchmark type offer the benefit, the benefit is then to be supplemented using the FEHBP plan with the largest enrollment.

With respect to habilitative services, pediatric oral and vision services, and mental health and substance use disorder services – those HHS noted are most often limited or missing from plan coverage – the bulletin spells out specific options for states to address plans where such services are not offered.

**Habilitation Services**
CMS cites a number of different definitions of habilitative services, including the National Association of Insurance Commissioner (NAIC) definition for purposes of the uniform summary of benefits and coverage and standardized definition requirements of the ACA, as well as Medicaid’s definition. CMS does not propose its own definition, but instead indicates that states have 2 options should they offer a benchmark plan that does not include habilitative services:

1) Habilitative services would be offered at parity with rehabilitation services, meaning that a plan covering such services as physical therapy or occupational therapy for rehabilitative purposes must also cover them in a similar amount, duration, and scope for habilitative purposes; or

2) As a transitional approach, plans would decide which habilitative services to cover and would report that coverage to HHS. HHS would then evaluate those decisions and further define habilitative services in the future.

**Pediatric Oral and Vision Services**
The December 16 CMS bulletin appears to limit the benefit category of “pediatric services” to pediatric oral and vision services only. The Academy has raised significant concerns with this interpretation to CMS, indicating that it is the Academy’s belief that Congress clearly intended for all children’s medically necessary services to be covered by this category.

That said, the December 16 bulletin includes 2 specific options for states to supplement benchmarks that do not include pediatric oral and vision services. States can supplement pediatric oral services with 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

CMS further indicates that it intends to propose that EHB would not include non-medically necessary orthodontic benefits.

Further, states can supplement pediatric vision services with the FEDVIP vision plan with the largest enrollment.

CMS indicates that, similarly to habilitative care, it is considering an approach that allows plans to define pediatric oral and vision services with reporting as a transition policy.

**Mental Health and Substance Use Disorder Services and Parity**

The December 16 bulletin reiterates the ACA requirement that mental health and substance use disorder benefits be offered as 1 of the 10 categories of services in an EHB package. Further, the ACA specifically extends the Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) to the individual market. As such, CMS is indicating that it intends to propose that all EHB plans include coverage for mental health and substance use disorder services, including behavioral health treatment, and that parity applies in the context of EHB.

**Benefit Flexibility**

The Academy remains highly concerned with the December 16 bulletin’s intention to offer flexibility with respect to EHB benefit categories. In the bulletin, CMS indicates its intention to allow health insurance issuers to adjust benefits, including both the services covered as well as quantitative limits, provided that the plan continue to offer coverage for all 10 EHB categories.

CMS further states that it is considering flexibility for substitution of benefits both within categories and across categories. It remains the Academy’s strong position that benefits for children must not be compromised and that substitution of benefits counters the intention of Congress in the ACA to ensure that children receive all medically necessary services.

**Pharmacy Benefit Flexibility**

The December 16 bulletin indicates that CMS intends to propose a standard for pharmacy benefits that reflects the flexibility found in Medicare Part D coverage, in which plans are required to cover the categories and classes set forth in the benchmark, but may choose the specific drugs that are covered within those categories and classes. As such, advocacy will be required to ensure that drugs and biologics included in EHB are appropriate for children, especially children with special health care needs.

**February 17 FAQ Document**

On February 17, 2012, CMS released an EHB Frequently Asked Questions (FAQ) Document, addressing some initial questions raised by the December 16 bulletin. This FAQ document makes a number of clarifications with relation to CMS’ regulatory intentions, including:

- **One EHB benchmark permitted:** States will only be able to select 1 EHB package that will be applicable to both the individual and small group markets.

- **State benefits mandate specifics:** The February 17 FAQ document reiterates that states can avoid paying for the cost of state mandates in excess of the EHB if they choose a benchmark plan that offers state mandates. However if the mandates apply to only the individual market and therefore the mandated benefits do not apply to the small group market – states will have to either eliminate the mandate or cover the cost if the benefit is not covered by the selected benchmark. Benefit mandates applicable to the EHB in 2014 and 2015 are those enacted before December 31, 2011.

- **Clarification of riders with respect to benchmarks:** The February 17 FAQ document clarifies that a plan for purposes of an EHB benchmark excludes plan riders. This means that benefits covered by riders to the plan must then be supplemented to the benchmark.

- **Clarification on preventive services and mental health parity:** The February 17 FAQ document clarifies that preventive services required by the ACA (including Bright Futures preventive services, ACIP-recommended immunization services, and United States Preventive Services Task Force items and services recommendations with a rating of ‘A’ or ‘B’) must be included in the EHB.
• **Scope and duration limitations**: The February 17 FAQ document notes that while lifetime and annual dollar limits generally apply in full beginning in 2014, EHB packages may include scope and duration limitations pursuant to existing plan practices and in accord with relevant laws. This means that while benefit dollar limitations must abide by ACA requirements, plans may impose non-dollar limits that are actuarially equivalent to dollar limits. Moreover, while large group, self-insured, and grandfathered group plans do not need to offer EHB, they may not impose lifetime or annual limits on EHB (but may impose non-dollar limits). And finally, while some state insurance mandates do include dollar limits, such benefits must be incorporated into the EHB without such dollar limits.

• **EHB and Medicaid**: States may choose different EHB benchmark plans for Medicaid benchmark or “benchmark-equivalent” coverage, and must include the 10 statutory categories of EHB. States have the option of choosing from 3 of the 4 benchmarks for such coverage: the state’s largest non-Medicaid HMO, the state’s employee health plan, or the FEHBP Blue Cross/Blue Shield option.

**AAP Chapter State Advocacy**

The Academy continues to maintain that the ACA calls for 1 national EHB package, which includes all medically necessary services children are found to need. The AAP will continue to advocate that CMS build 1 national EHB package.

However, CMS is moving forward with its stated approach of allowing each state to choose an EHB. **It is therefore imperative that AAP chapters be active in state plans to determine your state’s EHB package, to ensure the needs of children and pediatrics are met.**

In particular, the Academy recommends that state AAP chapters:

• **Ensure a robust benefit package for children**, based on Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standard and the Academy Policy Statement, *Scope of Health Care Benefits from Birth Through Age 26*.

EPSDT should be the EHB gold standard sought by AAP chapters. However, it is possible that lawmakers in your state will not consider this option for private insurance plans. As such, chapters may need to investigate other benefit packages—such as that of the state’s Children’s Health Insurance Program (CHIP) plan— that may be suitable for children. Above all, AAP chapters are encouraged to review all EHB benchmark options, and absent an EPSDT standard, seek the most robust benefit package for children possible, including all the benefits outlined in the AAP Policy Statement, *Scope of Health Care Benefits from Birth Through Age 26* policy statement.

Moreover, the EHB package should include the entire schedule of visits outlined in the *Bright Futures periodicity schedule*, as is required by the ACA. The AAP/Bright Futures recommended periodicity schedule is the basis for Bright Futures.

• **Ensure use of an appropriate definition of “medical necessity” for children**, such as the Medicaid definition of medical necessity, informed by the Academy’s *Model Contract Language for Medical Necessity for Children*.

• **Ensure that states choose a benchmark package that includes existing state benefit mandates for children in the EHB package**. As states are required to cover the cost of benefit mandates in excess of the EHB package, states that choose a benchmark including state mandates will not have to pay for them. Inclusion will ensure that many important state benefit mandates for children are not lost, as states examine their options with regard to EHB.

• **Guarantee that benefits supplemented by other plans meet the needs of children**. Plans that do not cover all 10 of the required benefit categories must supplement them as described previously. AAP chapters must work to ensure that these supplemented benefits meet the needs of children and pediatrics.

• **Ensure that substitution of benefits within categories is limited and that benefits are appropriate for children**. As plans will be able to substitute benefits within categories (ie, exchanging occupational therapy visits for physical therapy visits), AAP chapters must work to ensure such substitutions are limited and appropriate for children.
• Stop plans from substituting benefits across categories. The bulletin and FAQ document indicate that plans may be allowed to substitute benefits across categories, meaning that some increased benefits in one service area might compensate for a lack of benefits in another. This is unacceptable for children and chapters should work to ensure all benefit categories for children are covered.

• Make specific recommendations on habilitative, oral and vision care. The bulletin spells out specific actions that insurance plans may take with respect to habilitation, oral and vision care. AAP chapters can make specific recommendations to ensure these services are appropriate for children. Recommendations in this regard are spelled out on the following pages.

• Prevent “scope and duration” benefit limits. The bulletin indicates that, while plans must abide by the ACA’s annual and lifetime dollar limits, they can invoke “scope and duration” benefit limitations. AAP chapters are encouraged to ensure such limitations are prevented wherever possible.

• Ensure that the state will have a strong monitoring mechanism in place to guarantee that plans provide appropriate benefits. CMS has signaled that monitoring of EHB will be left to states. While we await regulations that may spell such monitoring out in further detail, AAP chapters are encouraged to work with states to ensure they establish an effective monitoring program to guarantee all needed benefits for children. AAP chapters are also encouraged to learn more about the state’s internal and external appeals processes, as required by the ACA.

The corresponding document, Advocacy Guidance: State Roles in Defining EHB, contains advocacy recommendations related to specific components of EHB at the state level. As this is an evolving issue, this document will be updated to reflect new guidance as it becomes available and as CMS promulgates regulations related to EHB establishment at the state level.

AAP chapters with questions related to state implementation of the ACA or other state health reform issues should contact the AAP Division of State Government Affairs at 800/433-9016 ext 7799, or stgov@aap.org.

More state ACA implementation resources are available on the myAAP.org site for AAP members at: http://www.aap.org/en-us/my-aap/advocacy/state-government-affairs/Pages/Affordable-Care-Act-State-Implementation.aspx

The AAP also has federal ACA implementation resources available on the myAAP.org site for members at: http://www.aap.org/en-us/advocacy-and-policy/federal-advocacy/Pages/AAP-Resources-on-Federal-Health-Reform-Implementation.aspx

Additional EHB Resources


CCIIO Frequently Asked Questions on Essential Health Benefits, February 17, 2012. Available at:


Updated: April 17, 2012
## Advocacy Guidance: State Roles in Defining EHB

The following summarizes guidance to AAP chapters on specific facets of state EHB determination. AAP chapters are encouraged to remain actively engaged in this process at the state level.

<table>
<thead>
<tr>
<th>Policy Consideration</th>
<th>AAP Guidance</th>
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<tr>
<td>EHB benefit standards for children</td>
<td>AAP chapters should advocate strongly for the following:</td>
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<td>• The use of Medicaid's EPSDT benefit as the benefit benchmark for children in EHB packages, additionally ensuring that</td>
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<td>• All services outlined in the AAP Policy Statement, <em>Scope of Health Care Benefits from Birth Through Age 26</em>, are included in the EHB package.</td>
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<td>• The entire schedule of visits outlined in the <em>Bright Futures</em> periodicity schedule is included in the EHB package, as is required by the ACA. The AAP/Bright Futures recommended periodicity schedule is the basis for <em>Bright Futures</em>.</td>
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Medicaid's EPSDT guarantee ensures that all services children need are covered, and the AAP policy statement *Scope of Health Care Benefits from Birth Through Age 26* provides a concrete blueprint for benefits packages for children.

EPSDT should be the EHB gold standard sought by AAP chapters. However, it is possible that lawmakers in your state will not consider this option for insurance plans in the private market. As such, chapters may need to investigate other benefit packages – such as that of the state’s Children’s Health Insurance Program (CHIP), if appropriate – that may be suitable for children. Above all, AAP chapters are encouraged to review all EHB benchmark options, and absent an EPSDT standard, seek the most robust benefit package for children possible, including all the benefits outlined in the AAP Policy Statement, *Scope of Health Care Benefits from Birth Through Age 26*.

Chapter advocates will want to remind state decision makers that children with special health care needs have different clinical challenges and will require different benefits than adults in the average small group plan.

Finally, it is imperative that states not choose a grandfathered plan as an EHB benchmark. While the December 16 CMS bulletin indicates EHB packages must include *Bright Futures* and other ACA-required preventive services, grandfathered plans do not have to follow other ACA consumer protections.

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<tr>
<th>Medical Necessity</th>
<th>State Medicaid programs generally provide a comprehensive definition of medical necessity for children. AAP chapters are encouraged to ensure that:</th>
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<td>• A robust Medicaid definition of medical necessity, informed by the AAP’s <em>Model Contract Language for Medical Necessity for Children</em> is applied to state EHB packages, to ensure children receive all medically necessary services they need.</td>
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<th>Existing state benefit mandates</th>
<th>States are required to pay for state insurance mandates in excess of the EHB package. Therefore, AAP chapters are encouraged to advocate:</th>
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<td>• That states choose a benchmark package that contains all state mandates for children, as states will not then have to pay for them separately.</td>
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<tr>
<th>Supplementation of missing benefits with other benefits from other benchmarks</th>
<th>If a benchmark plan does not cover 1 of the 10 required categories of services, the plan must be supplemented by the largest plan in the benchmark type by enrollment (e.g., small group plans or state employee plans or FEHBP) that offers the benefit. Chapters are encouraged to advocate for:</th>
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<td></td>
<td>• Medicaid’s EPSDT benefit as the supplemental coverage for benefits not explicitly included in the EHB package. Doing so will ensure that all services children are found to need are maintained.</td>
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• Should states not utilize EPSDT, chapters are encouraged to monitor state plans for supplementation of existing benefits not provided in the EHB package, to ensure that all services children are found to need are included.

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<th>Substitution of benefits within benchmark categories</th>
<th>AAP chapters should work to:</th>
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<td></td>
<td>- <strong>Prevent substitution of benefits within benchmark categories</strong>. Should states choose EPSDT as the benefit standard for children, all services children are found to need will be included.</td>
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<td>- Should states choose to allow substitution of benefits within benchmark categories, AAP chapters should advocate for the strongest, most robust set of benefits possible.</td>
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<th>Substitution of benefits across benchmark categories</th>
<th>AAP chapters should work to:</th>
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<td></td>
<td>- <strong>Prevent substitution of benefits across benchmark categories</strong>. EHB categories are different and the addition of more or additional benefits in 1 category does not compensate for a lack of benefits in another category. Choosing EPSDT as the benchmark standard benefit for children will ensure that all services children need are covered.</td>
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<th>Specific coverage of habilitation services</th>
<th>The December 16 CMS bulletin includes specific options for plans chosen as a benchmark that do not include habilitation services. States may either (1) require that habilitation services be covered at parity with rehabilitation services, or (2) plans could decide which habilitation services to cover and report that coverage to HHS. AAP chapters should work to ensure that:</th>
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<td>- <strong>Habilitation services be offered at parity with rehabilitation services</strong> and that</td>
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<td>- A robust definition of “habilitation” be used.</td>
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<td>Often, the same types of treatments and services not covered by private plans for habilitation are covered for rehabilitation purposes, and therefore parity will justify coverage for the service. Further, using Medicaid as a guide is appropriate, as Medicaid programs have more experience with habilitation coverage.</td>
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<td>Further, the December 16 CMS bulletin does not define “habilitation,” but recognizes that a number of definitions exist, including a Medicaid definition (see Social Security Act, Section 1915(c)(5): <a href="https://www.ssa.gov/OP_Home/ssact/title19/1915.htm">https://www.ssa.gov/OP_Home/ssact/title19/1915.htm</a>) and the definition created by the National Association of Insurance Commissioners (NAIC) and promulgated by HHS in its Uniform Glossary of Health Coverage and Medical Terms. The Academy recommends that:</td>
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<td>- <strong>States define “habilitation” based on these NAIC/HHS Uniform Glossary definition</strong>, and should include a focus on:</td>
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<td>- Coverage for both habilitative services and devices</td>
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<td>- <em>Maintenance of function</em> in addition to the <em>attainment and improvement of skills</em></td>
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<td>- Reference to a medical necessity definition that defers to the physician or other provider actually treating the patient, in concert with the patient’s primary care physician and his/her family</td>
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<td>- Not limiting benefits or services except on the best available evidence, and deferring decisions on treatments to professionals with sufficient knowledge and expertise in the rehabilitative and habilitative fields.</td>
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<td>State decisions around habilitation should include pediatricians, and AAP chapters are encouraged to offer the specific expertise of chapter members to assist states in this regard.</td>
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| Specific coverage of pediatric oral health services | The December 16 CMS bulletin indicates that states can supplement pediatric oral services with 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. AAP chapters are encouraged to: |
| Specific coverage of pediatric vision services | The December 16 CMS bulletin indicates that states can supplement pediatric vision services with the FEDVIP vision plan with the largest enrollment. AAP chapters are encouraged to:

- **Ensure the state benchmark package for children is the most robust option for pediatric vision services.** For background on Academy comments to HHS on pediatric vision services in EHB, please see [this coalition letter](#), signed onto by the Academy. Please note this letter was written prior to the announcement that EHB would be a state decision. |

| Pediatric drug coverage | The December 16 bulletin indicates that the EHB pharmacy benefit may reflect flexibility found Medicare Part D coverage, where plans must cover categories and classes set forth in the benchmark, but then may choose specific drugs within those categories/classes to cover. AAP chapters are encouraged to:

- **Ensure that drugs and biologics for use by children – especially children with special health care needs – are covered without tiering or other limitations.** |

| Coverage of “spiritual care” benefits | Advocates of “spiritual care” have sought to include this benefit in insurance plans sold through exchanges, and are likely to seek similar coverage in state EHB benchmark packages. Spiritual care benefits are sought by those of various religious groups that seek to provide prayer benefits in place of evidence-based medical care. The Academy remains opposed to spiritual care replacing medical care for children, and is guided by the AAP policy statement, *Religious Objections to Medical Care*. AAP chapters are encouraged to:

- **Ensure EHB plans do not provide coverage for spiritual care services.** |

| Scope and duration benefit limitations | The February 17 CMS FAQ document indicates that while plans must continue to follow the ACA’s requirements on annual and lifetime dollar limits, plans may impose non-dollar limits that are actuarially equivalent to dollar limits. This effectively means that states and/or plans may create such scope and duration limitations that limit the services provided to children. AAP chapters are encouraged to:

- **Advocate for EPSDT as the benchmark standard of care for children**, which would ensure that all needed services are provided.
- **Should a state not choose EPSDT as the benchmark, AAP chapters are encouraged to work with states to restrict scope and duration benefit limitations**, which will directly impact the care children receive. |

| Monitoring/enforcement | AAP chapters are encouraged to work with states to:

- **Establish clear monitoring and enforcement mechanisms for EHB services**, to ensure that children receive all services spelled out in the EHB. Moreover chapters are encouraged to become familiar with internal and external appeals processes, as required by the ACA.
- **Help states compile instances of denied services for children, which will inform the process of reevaluation of EHB by HHS in 2016.** |

AAP chapters are encouraged to contact the AAP Division of State Government Affairs at 800/433-9016 ext 7799 or stgov@aap.org for more information or individual consultation on this or other ACA state implementation issues.