BlueCross BlueShield
Association

An Association of Independent
Blue Cross and Blue Shield Plans

January 31, 2012

Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and
Insurance Oversight
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Submitted via email: essentialhealthbenefits@cms.hhs.gov

Re: Essential Health Benefits Bulletin

Dear Mr. Larsen:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to submit comments on Essential Health Benefits Bulletin (the "Bulletin"). We believe that the essential health benefit ("EHB") definition must balance the need to provide appropriate, high quality coverage with the need to ensure that such coverage is affordable for small employers and individuals purchasing health insurance. We look forward to working with the Department of Health and Human Services ("HHS") to implement the essential health benefits provisions of the Patient Protection and Affordable Care Act ("ACA") in a manner that will further these goals both in the short-term and longer term looking forward to 2016 and beyond.

BCBSA is a national federation of 38 independent, community-based, and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 99 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), and the Federal Employees Health Benefits Program.

BCBSA appreciates HHS' recognition that providing state flexibility is important in its transitional strategy for the implementation of EHBs, given all of the other reform elements that need to be put into place by late summer 2013 in order to have products available for exchanges for open enrollment in October 2013. We also believe this approach recognizes the variation that exists today across states and will ensure some people will not have to upgrade their benefits from what they have today.

However, we are concerned that HHS issued this guidance in the form of a Bulletin, and not as a proposed regulation. As we have remarked in earlier comment letters, it is critically important to finalize all of the regulations – following a proposed rulemaking process – in the first quarter of this year so states and payers can make all the significant business and information technology changes needed to be ready for the October 1, 2013 open enrollment. These

changes are interwoven and adequate time is essential so that these reforms are done right and consumers get the coverage and subsidies they deserve. States and health plans should not be expected to implement multi-million dollar changes based on informal guidance that can be subject to changes in a final rule.

To ensure coverage is affordable and individuals and small employers have a choice of all metal levels, including bronze, it is important to consider costs when defining and updating the EHBs. While we appreciate that HHS is striving to balance the competing goals of comprehensiveness of coverage and affordability, we offer three categories of recommendations that we urge the Department to adopt:

1. **Ensure EHBs are affordable and evidence-based.** The benefit package must be affordable to ensure individuals and small groups obtain coverage. Scientific evidence should also be a key consideration in determining which services should be included in EHBs to ensure consumers receive safe and effective care at the right time and in the right setting. Consistent with the Institute of Medicine's (IOM) recommendations, our key recommendations to ensure affordability and evidence-based coverage include:

    - Do not automatically include benefits in EHBs that are not evidence-based or that are problematic due to the benchmark process to ensure consumers receive safe, proven and cost-effective care
    - Permit the application of dollar limits on benefits in states that choose a benchmark plan that includes such limits so that coverage remains affordable for consumers
    - Do not require coverage of habilitative medical services for physical, occupational and speech therapy with a "keeping" or "maintaining" medical necessity standard
    - Define pediatric oral services to include only the preventative oral health services recommended by Bright Futures and the American Academy of Pediatrics
    - Define the pediatric vision benefit to include only vision screening as recommended by Bright Futures and the American Academy of Pediatrics
    - Permit large employers to employ limits on benefits if the chosen benchmark plan contains such limits during the 2014 – 2015 transition years
    - Remove references to Medicare Part D requirements and regulations and retain flexibility for health plans to design prescription drug benefits consistent with the flexibility available for other benefits; prohibit manufacturers from providing co-pay coupons to enrollees
    - Permit health plans to exclude adult dental services that are covered in the Federal Employee Health Benefit Plans if FEHBP is selected as the benchmark plan in a state so that premiums remain affordable
    - Consider affordability in the determination of EHB definitions for 2016 and beyond by evaluating benefits from both a cost and medical effectiveness perspective
    - Update EHBs for 2016 and beyond based on an evidence-based model that incorporates cost considerations to ensure access to effective, safe, appropriate and affordable care

2. **Provide more clarity on the EHB requirements and process for state implementation.** States, health plans and other key stakeholders do not yet have the definitive guidance and information they need to begin the lengthy process required for successful implementation.

To provide further clarity and to ensure that the practical implications and operational challenges are addressed, we recommend that HHS:

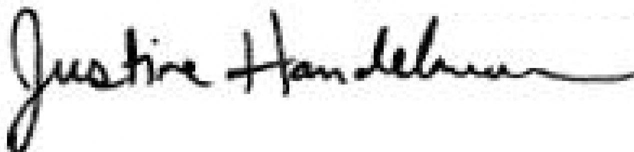
- Provide additional clarity on the benchmark approach so that health plans have sufficient time and information to develop compliant benefit packages
- Provide more detail on the process for supplementing a benchmark plan so that states provide health plans with enough time to develop compliant benefit packages
- Evaluate issues surrounding the stand-alone pediatric dental option and requirements related to dental coverage to address the logistical and operational issues surrounding the stand alone dental option and develop guidance that addresses these issues
- Require the State or the benchmark plan to provide a moderate level of specificity for their covered services to ensure that plans are offering all of the services within the EHB categories and to minimize the administrative burden of reporting such covered services

3. **Ensure EHBs do not lead to adverse selection that raises costs for individuals and small employers.** It is important that EHBs are not implemented in ways that would cause adverse selection. To ensure a level playing field and to protect against adverse selection, we recommend that HHS take the following steps:

   - Do not permit benefit substitutions within or across benefit categories to avoid adverse selection
   - Require OPM multi-state plans to offer a benefit design compliant with each state's benchmark plan to ensure a level playing field for both the multi-state plan and other plans offered in a state
   - Remove the "intent to reside" approach to exchange eligibility and instead follow section 1312(f)(1)(a)(ii) of the ACA, which requires that an individual enroll through an exchange where he or she actually resides

Attached are BCBSA's detailed comments and recommendations on the Bulletin. We appreciate your consideration of our comments. We look forward to continuing to work with HHS on implementation issues related to the Affordable Care Act. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,



Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association

cc: Sherry Glied, MD, Assistant Secretary for Planning and Evaluation, HHS

The following are BCBSA's detailed comments and recommendations on the Essential Health Benefits Bulletin:

I. Ensure EHBs are Affordable and Evidence-based

A. Do Not Automatically Include Benefits in Essential Health Beinefits that are Not Evidence-based or that are Problematic Due to the Benchmark Process

Issue: According to the IOM report on EHBs, many state mandates have been passed into law due to pressure from advocacy groups without sufficient scientific review of the evidence, imposing significant costs and making health insurance less affordable and less evidence-based.[1] In its recommendation to HHS, the IOM stressed the importance of the affordability of the EHB along with recommending that only state mandates that are evidence-based be included in EHBs. Additionally, the IOM stated that current state mandated benefit laws should not automatically be included in the EHBs, but should be reviewed in the same manner as other potential health benefits. To provide consumers with access to appropriate care at the right time and in the right setting, the processes, principles, or criteria used to define essential health benefits must be rigorously evidence based, free from political influence, and involve considerations of cost-effectiveness, quality and appropriateness. Without some constraint on the scope of EHBs, the premium prices faced by individuals seeking to obtain coverage both on and off exchanges in the individual and small group markets may be unaffordable when paired with actuarial value requirements, leading to reduced access to health insurance coverage.

Recommendation: States should be given the latitude to review their current benefit mandates and other covered services in the 2014 benchmark plan and elimainte any which are not evidenced-based or are problematic due to the benchmark process. Then for 2016, a process should be established to ensure that current state mandated benefit laws are not automatically included in the required benefits, but are reviewed for scientific evidence, in the same manner as other potential health benefits. Those state mandated benefits that don't pass this rigorous review should be excluded from EHBs in 2016 and beyond. In the event that a state wants to continue to apply mandates beyond EHBs, the state is required by law to either make payments to the qualified health plan enrollee or to the qualified health plan directly to defray the cost of these benefits. Finally, if a State has a legislative or insurance department approved benefit plan that is available without that state's mandates, typically called a "safety net" policy, that these be included as potential benchmark plans for 2014 and 2015.

Rationale: While BCBSA understands the reason for the transition period proposed by HHS for years 2014 and 2015, it is important that states have the ability to review their current benefit mandates and other covered services in the 2014 benchmark plan and eliminate any benefits which are not evidenced-based to increase affordability. This flexibility is particularly critical if HHS does not address the issue caused by benefits in the benchmark that currently have annual dollar limits, which is later addressed in more detail. For 2016 and beyond, EHBs should be updated to make them more affordable and evidence-based. As the IOM noted in their report on EHBs, state benefit mandates may be the result of political pressure from special interest groups, and the adoption process for such mandates may lack the rigorous level of evaluation of efficacy or evidence-based support from medical experts that should be required

[1] Institute of Medicine Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans. Report on essential health benefits: balancing coverage and costs. Washington, DC: National Academies Press, October 7, 2011.

in determining EHBs. As a result, EHBs should be updated in 2016 to incorporate cost considerations by evaluating state mandates from both a cost and medical effectiveness perspective. The Bulletin notes that updating the benchmark for 2016 will allow benefits to reflect the most up-to-date medical and market practices and it is important that HHS provide stakeholders with ample opportunity to evaluate and comment on the approach it will use starting in 2016. In the event that a state wants to continue to apply mandates beyond the EHB in 2016, such states should be held to the ACA requirement to either make payments to the qualified health plan enrollee or to the qualified health plan directly to defray the cost of these additional benefits. Finally, allowing a state to select a "safety net" plan that does not include mandates provides a state with a benchmark option that may be more affordable.

B. Permit the Application of Limits on Benefits in States that Choose Benchmark Plans with Such Limits

Issue: The Bulletin does not clearly address whether existing dollar limits on benefits, including dollar limits that are permitted as part of a state mandated benefit contained within benchmark plans would continue to be allowed. For example, the majority of states that require coverage of applied behavioral analysis (ABA), an intervention for autism, specify the annual dollar limit on coverage of this service that is required. Similarly, current dollar limits apply to certain benefits in the federal employer health plan are permitted, such as those currently in place for hearing aids.

The ACA delegates the authority to HHS to "define" the essential health benefits, but the 10 categories of coverage listed in the statute must be included as "essential." ACA § 1302(b)(1). The ACA also generally prohibits annual and lifetime dollar limits on essential health benefits, but the statute and implementing regulations clearly allow limits on benefits that are not considered essential health benefits to the extent that those limits are otherwise permissible under federal and state law. PHSA § 2711(b); 45 CFR § 147.126(b)(1). However, under the current benchmark approach, every service covered by a benchmark plan could be interpreted to be "essential," thereby requiring the provision of these services without annual dollar limits. This result could have significant cost ramifications for the benchmark plan's benefit package. Furthermore, prohibiting limits on such services derails efforts by States to ensure affordability in cases of mandates passed by state legislatures under the assumption of imposed dollar limits.

Recommendation: BCBSA recommends that HHS continue to permit the application of dollar limits on benefits, including state mandated benefits, in states that choose benchmark plans that already contain such limits. This could be accomplished by clarifying that at least until 2016, any benefit subject to a dollar limit that is included in the benchmark plan, and any state mandated benefit that may be permissibly subject to a dollar limit under state law, is not an "essential" benefit. As a result, these dollar limits would continue to be permissible under the ACA.

Rationale: Issuers have continued to offer certain benefits with annual or lifetime dollar limits that they did not consider to be EHBs. This includes certain state mandates. It appears that an unintended consequence of the transitional approach for EHBs where specific covered services were not defined as being an EHB could be that any service covered by the benchmark plan is considered an EHB. As a result, existing, permissible annual or lifetime benefits would no longer be allowed.

However, the benchmark plan proposal could be implemented to avoid this unintended consequence. It is clear that HHS intends to provide states with flexibility and substantive involvement in the design of the essential health benefits. In fact, at one point, the Bulletin suggests that any limit included in the benchmark plan may continue. Bulletin p. 8-9 ("As described below, health insurance issuers could adopt the scope of services *and limits* of the State benchmark, or vary it within the parameters described below.") (emphasis added). The benchmark proposal should be clarified to explicitly defer to states' judgments on applied limits on state mandated benefits.

Importantly, this would preserve the benefits to which consumers are entitled under state law—no consumers would be inadvertently deprived of benefits through the implementation of the Bulletin. Deferring to state law with respect to permissible limits on these benefits will also help to ensure that the essential health benefits remain "comprehensive" and "affordable" while also permitting significant state flexibility, as HHS intends. See Bulletin, p. 1.

Any prohibition on the continued use of such limits will impact the price and the actuarial value of healthcare coverage. To ensure products remain affordable, HHS needs to allow flexibility in applying benefit limitations including existing annual or lifetime dollar limits in a benchmark plan until at least 2016. This issue underscores the importance of continuing to provide issuers flexibility in applying appropriate treatment and benefit limitations in keeping coverage affordable for consumers

C. Do Not Require Coverage of Habilitative Medical Services for Physical, Occupational and Speech Therapy with a "Keeping" or "Maintenance" Medical Necessity Standard

Issue: The Bulletin notes that the definition of habilitation developed by the National Association of Insurance Commissioners (NAIC) and adopted by the Medicaid program includes the concept of "keeping" or "maintaining" function, a concept virtually unknown in commercial insurance, which focuses on creating skills and functions (in habilitation) or restoring skills and function (for rehabilitation).

HHS is considering two options for supplementing benchmark coverage if a benchmark plan does not include coverage for habilitative services:

1) Offering habilitative services at parity with rehabilitative services. For example, a plan covering physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for rehabilitation also would have to cover those services in similar scope, amount, and duration for habilitation; OR

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

Recommendation: BCBSA believes it is appropriate to offer non-maintenance habilitative medical services for physical, occupational and speech "rehabilitative" services. However, BCBSA does not support a change to the definition of habilitative services to a "maintenance" standard. This standard is very subjective and would result in a significant increase in the cost of these services. In addition, many plans currently cover medically necessary PT, ST, and OT benefits with limits regardless of whether the condition was present at birth. BCBSA recommends that plans continue to provide these services when they are medically necessary,

and are not custodial, vocational and/or educational in nature with the same visit limits on services rendered. For example, if the benefit limit for physical therapy is 30 visits per person per calendar year, this annual 30-visit limit should apply regardless of whether the services are provided for rehabilitative or habilitative purposes.

Rationale: Many Blue Cross Blue Shield plans do not distinguish between “habilitative” and “rehabilitative” today as it relates to physical, occupational and speech therapy. They do, however, apply the same medical policy and coverage limits that are applied to rehabilitative services – medically necessary, showing demonstrable improvement as a result of the therapy and making the services subject to the same visit limits as rehabilitative therapy. As long as the services are covered similarly, BCBSA does not have significant concerns about the cost impact of this requirement.

However, BCBSA is very concerned about an expansion of the definition to include “maintenance.” The criteria used to provide essential habilitative benefits should be based on valid, reliable and measurable observations. Because maintenance is a perceptual, conditional and subjective attribute, it should be excluded from the definition of habilitative services to prevent variation in care quality and cost. Furthermore, to ensure consumers receive safe, proven and effective care, plans should be able to continue to exclude certain types of care (e.g. vocational, educational, and custodial care) as this will also assure affordability and access for consumers.

In addition, it is unclear if parity would mean the maintenance standard would be applied to rehabilitative services. As noted above, BCBSA is concerned about the inclusion of “maintenance” in any definition of rehabilitative and habilitative services. Ensuring a measurable and assessable definition of habilitative and rehabilitative services will help ensure that the services are medically necessary and prevent potential abuse by providers if the measure is subjective.

D. Define Pediatric Oral Health Services to Include Only the Preventative Oral Health Services Recommended by Bright Futures and the American Academy of Pediatrics

Issue: BCBSA is concerned that the proposed options for supplementing benchmark plans that do not include pediatric oral services - the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment or the state’s separate CHIP program – both include very comprehensive benefits that will result in significantly higher prices that will result in fewer people enrolling, running counter to the intent of ACA in expanding coverage and improving overall health. In addition, HHS needs to provide direction regarding the age at which the pediatric dental benefit ends.

Recommendation: BCBSA believes that the ACA allows flexibility for pediatric oral services under EHBs to reflect only the preventive services related to pediatric oral care recommended by the Bright Future and American Academy of Pediatrics guidelines. These services include periodic oral health screenings, fluoride supplements if water is not fluoridated, and determination and/or referral to a dental home. The inclusion of dental benefits beyond these should be at the plan’s option. Should HHS desire to have a more expansive package, we suggest this package be limited to the coverage of an annual routine dental exam and cleaning. If HHS does not adopt one of BCBSA’s recommended alternatives, we suggest that the largest stand-alone dental plan offered in the small group market in a state be substituted for the FEDVIP dental plan. In addition, HHS should only require the pediatric dental benefit to be

offered through the age of 12, the age at which many children stop seeing a pediatrician. If HHS decides to extend the pediatric dental benefit to older ages, in no case should it be required past the age of 17.

Rationale: Comprehensive pediatric oral health services are not typically covered by employer plans as part of their medical plan today and many small employers do not offer the option of a stand-alone dental plan today. Adding an expansive pediatric dental plan will significantly increase the cost of coverage, which could lead to fewer small employers and individuals purchasing coverage. Providing dental screening, or at the most, an annual dental exam and cleaning, will reduce the increase in the cost of health benefits due to the implementation of the EHB, resulting in more persons purchasing coverage. To ensure this occurs, Congress stipulated that the EHB package "is equal to the scope of benefits provided under a typical employer plan."

If HHS requires a comprehensive dental benefit package, then the stand-alone dental plan with the largest enrollment in a state should be substituted for the FEDVIP dental plan, as this better reflects the level of dental benefits offered by a "typical employer" in the state as reflected in the language of the ACA.

Regarding the age through which the benefit is provided, BCBSA believes that the pediatric dental benefit should extend through age 12, the age by which most children have lost their "baby" teeth and when many children no longer see a pediatrician and have transitioned to a family practice doctor. In no case should the pediatric dental benefit extend beyond age 17, after which the insured is legally considered an adult.

Recommendation: HHS should not require health plans to price dental benefits separately when offered as part of the health plans product offering.

Rationale: It would be administratively costly to break out one benefit and assign a dollar amount to it, adding costs to the system and thereby to consumers' bottom line. Requiring separate pricing for this benefit would add additional costs because this practice would create two independent pricing processes. In addition, embedded benefits are simpler for the consumer to purchase and simpler for the plan to administer. This simplicity enables embedded benefits to have lower administrative costs, resulting in an overall lower price for consumers. And, from a clinical perspective, having medical and dental benefits provided by a single carrier provides a better picture of a member's overall health than if the policies are provided from different carriers.

E. Define the Pediatric Vision Benefit to Include only the Vision Screening Recommended by Bright Futures and the American Academy of Pediatrics

Issue: Because pediatric vision benefits may not be included in the four categories of benchmark plans identified by HHS in the EHB Bulletin, HHS proposes that the benchmark plan chosen by the state be supplemented by the FEDVIP with the largest enrollment. In addition, HHS needs to provide direction regarding the age the pediatric vision benefit ends as well as with respect to the use of service and dollar limits.

Recommendations: BCBSA believes that the ACA allows flexibility for pediatric vision coverage to reflect only the vision screening recommended by Bright Futures and the American Academy of Pediatrics. This screening would provide for regular vision screenings to identify

any issues that need further care. Vision screenings also often occur in the school. If HHS desires to provide additional services, we recommend that this be a model reflecting a continuum of care as opposed to a model based on a stand-alone vision product primarily designed for adults. This model would include the routine periodic screening by the primary care physician for eye disease and refractive error that is already part of the preventive benefit. Then if the primary care physician identifies an issue, there would be a follow up comprehensive eye exam for those children who fail a vision screening or cannot complete a screening, as well as any medical/surgical eye care identified as being medically necessary.

Additionally, HHS should only require the pediatric vision benefit to be offered through age 12, the age at which many children stop seeing a pediatrician. If HHS decides to extend the pediatric dental benefit to older ages, in no case should it be required past age 17.

Finally, HHS should clarify that it is acceptable for issuers to use a combination of both benefit and dollar limits in covering an essential benefit – including the pediatric vision benefit – and that the combination of such limits will not be considered a *de facto* annual dollar limit which would not be permitted under the ACA

Rationale: Comprehensive pediatric vision services are not typically covered by employer plans as part of their medical plan today and many small employers do not offer the option of a stand-alone dental plan today. Supplementing the benchmark plans' coverage of pediatric vision benefits with FEDVIP benefits is not appropriate both because FEDVIP is designed as a benefit for adults and because it is explicitly designed as a supplemental, voluntary benefit. BCBSA is concerned that reliance on the FEDVIP plan with the largest national enrollment includes a very comprehensive benefit that will result in significantly higher prices that will result in fewer people enrolling, running counter to the intent of ACA in expanding coverage and improving overall health. In addition, the FEDVIP benefit is designed for adults and does not take into consideration the screenings provided to children on a regular basis to identify vision problems.

FEDVIP was created by a 2004 law that authorized OPM to make supplemental dental and vision benefits available to federal employees. The OPM website has a section of Questions and Answers about FEDVIP that address how FEDVIP differs from regular FEHB benefits. It says the following; "While some FEHB plans offer dental or vision benefits as part of their benefit package, only those carriers under contract to OPM are FEDVIP plans. FEDVIP plans offer comprehensive dental and vision benefits." [2]

By intent, then, FEDVIP plans offer a scope of coverage that is much broader than vision coverage found embedded in FEHB. In addition, pediatric vision is not typically covered by employer plans as part of their medical plan today and most small employers do not offer the option of a stand-alone vision plan today. Adding an expansive pediatric vision benefit will thus significantly increase the cost of coverage, which could lead to fewer small employers and individuals purchasing coverage. Providing for a pediatric vision benefit that is limited to screenings allows any problems to be identified, with additional care financed either by out-of-pocket spending or with flexible spending account (FSA) or health savings account (HSA) funds, the way most people in the individual and small group markets do today.

If HHS desires to provide additional services, we recommend that this be a model reflecting a continuum of care as opposed to a model based on a stand-alone vision product primarily designed for adults. This model would include the routine periodic screening for eye disease and refractive error that is already part of the preventive benefit. Then if the primary care

[2] http://www.opm.gov/insure/dental/faq/faq.asp#background

physician identifies an issue there would be a follow up comprehensive eye exam for those children who fail a vision screening or cannot complete a screening; then medical/surgical eye care if identified as being medically necessary.

With respect to benefit and dollar limits, even though FEDVIP is considered to be comprehensive vision coverage, it clearly includes both service and dollar limits in its coverage. For example, one FEDVIP plan, the FEP BlueVision plan, provides the following coverage:

- **Benefit limits:** One eye exam, one set of contact lenses and one set of eyeglass frames per year (only one set of frames per every 24 month is covered under the standard option plan).

- **Dollar limits:** The retail allowance for frames is $130-$150 plus 20% off all charges beyond that amount. The retail allowance for contact lenses is also $130-$150 plus 15% off all charges beyond that amount.[3]

In contrast, the standard and basic option Blue Cross Blue Shield FEHB plan limit their vision coverage to coverage of vision screenings for children; in addition, up to one pair of eyeglasses, replacement lenses or contact lenses per incident are covered only to correct an impairment caused by an accidental injury or intraocular surgery; more generally, coverage of eyeglasses, routine eye exams or vision testing for the prescribing or fitting of eyeglasses or contact lenses is excluded.

F. Permit Large Employers to Employ Limits on Benefits if the Chosen Benchmark Plan Contains Such Limits During the 2014 – 2015 Transition Years

Issue: The HHS Bulletin does not address whether and how the specific benefits and limits in the states' benchmark plans would serve as the standard for determining what benefits may and may not be subject to annual and/or lifetime dollar limits. While EHBs per se do not apply to large employers, the ACA prohibits all health plans from having annual and lifetime dollar limits on essential health benefits. The Interim Final Rule related to annual and lifetime limits issued in June 2010 permitted health plans to make a "good faith" effort in determining what are essential health benefits for purposes of annual and lifetime limits. It is unclear how the approach outlined in the Bulletin impacts the annual and lifetime limits and what EHB definition(s) a large multi-state employer would follow.

Recommendation: While the ACA limits employers' ability to impose annual limits on EHBs, interim guidance allows plans to retain these limits on benefits not considered essential. However, as previously noted, under the current benchmark approach, every service covered by a benchmark plan could be interpreted to be "essential" and as a result, it is unclear what existing annual or lifetime benefits would no longer be allowed. BCBSA recommends that to the extent that large employers currently employ dollar limits, that those limits – just like those in state benchmark packages – continue to apply during the 2014-2015 transition years.

Rationale: Under the current benchmark approach, every service covered by a benchmark plan could be interpreted to be "essential," making it unclear as to what benefits in the benchmark plan are considered "essential health benefits," creating difficulty for employers to implement the prohibition on lifetime and annual limits on any benefit. Allowing the provision of

[3] http://cvw1.davisvision.com/forms/StaticFiles/English/FEP2012BenefitSummary.pdf

these services without the benefit limits already in place at the time of the plan's designation as a benchmark plan would have significant cost ramifications and lead to financial uncertainty. In addition, it is uncertain which EHB benchmark or benchmarks a multi-state employer would follow. BCBSA supports flexibility and innovation in benefit design, including flexibility in applying appropriate treatment and benefit limitations to keep coverage affordable for consumers. Any prohibition on the continued use of such limits will increase the price – and thus the actuarial value and affordability – of the subsequent health plan products.

G. Remove References to Medicare Part D Requirements and Retain Flexibility for Health Plans to Design Prescription Drug Benefits, Similar to that Used for other Benefits; Prohibit Manufacturers from Providing Co-pay Coupons to Enrollees

Issue: The Bulletin indicates that HHS intends to reflect the flexibility of the Medicare Part D program with respect to a standard for prescription drug coverage by requiring plans to either adopt the drug classes used by the state-designated benchmark plan or offer at least one drug in each class. While we appreciate the Department's intent to provide flexibility in regards to prescription drug coverage, we are concerned that this approach not only removes the flexibility provided in the commercial market today, but restricts plans' ability to design and deliver innovative, broad and cost-effective prescription drug benefits. Since private sector innovation, including the use of pharmacy management programs, in prescription drug benefit design is largely responsible for the decline in the share of drug expenses paid for by consumers out of pocket while also preserving or enhancing the value of drug coverage and quality of care, we urge HHS to simply adopt the drug coverage provided in the benchmark plan. Furthermore, Medicare is a benefit structure designed for specific populations of elderly and disabled adults, which is a very different population from the population that obtains coverage through the individual and small group markets.

Another issue of concern is the practice of some Rx drug manufacturers of providing co-pay coupons to enrollees. A key tool health plans use to manage the cost of prescription drugs is to encourage enrollees to use lower-cost medications by charging higher cost-sharing for expensive brand name drugs. The coupons undermine these incentives by reducing, or in some cases, eliminating the price differential between these higher-cost drugs and more affordable drugs on a plan's formulary.

Recommendation: BCBSA recommends that HHS remove references to Medicare Part D requirements and regulations and allow plans to retain the flexibility to design prescription drug benefits, similar to that used for other benefits. In addition, we recommend that HHS prohibit manufacturers from providing co-pay coupons to enrollees.

Rationale: The ACA calls for references to typical employer plans in establishing the EHB. Therefore, the establishment of all of the EHB, including prescription drug coverage, should be based on existing private sector coverage without reference to Medicare. As noted above, Medicare is a benefit structure that applies to specific populations that are distinct from the commercial small group and individual markets and should not serve as a reference for prescription drugs or any other part of the EHB package. Furthermore, adopting a Medicare-like benefit restricts private sector innovation that is largely responsible for reducing the average

beneficiary cost-sharing from approximately 56% in 1990 to 21% on 2009.[4]

In addition, BCBSA strongly recommends that HHS prohibit drug manufacturers from providing co-pay coupons to individuals. The use of these coupons undermines health plan ability to manage the cost of prescription drugs by encouraging enrollees to use lower-cost medications, e.g., by charging higher cost-sharing for expensive brand name drugs. The coupons reduce, or in some cases, eliminate the price differential between these higher-cost drugs and more affordable drugs on a plan's formulary – completely undermining the plans' ability to steer its members to lower-cost alternatives. Such a prohibition also would be consistent with current policy banning drug companies from offering co-payment assistance for patients in federal programs like Medicare and state programs like Medicaid because such offers are considered an inducement to use a drug and thus are a violation of anti-kickback laws.

H. Permit Plans to Exclude Adult Dental Services that are Covered in Federal Employee Health Benefit Plans when Selected as the Benchmark Plan

Issue: The Federal Employee Health Benefit Plans (FEHBP) is identified as one of the four possible benchmark plans, but it includes adult dental services which do not fall within the 10 categories of EHBs required by the ACA. This adult dental service is costly, making the FEHBP benchmark plan a less attractive option to a state.

Recommendation: To make the FEHBP option more attractive to states, BCBSA recommends that adult dental services offered by a FEHBP be excluded from that benchmark plan since these benefits are outside of the 10 required EHB categories.

Rationale: The FEHBP provides coverage of adult dental services, which are beyond the scope of the 10 required categories. Including adult dental services in addition to EHB-required benefits, results in the FEHBP plan being a less attractive option to states than it would be otherwise. We recommend that benchmark plans based on FEHBP exclude adult dental coverage. This is similar to the approach HHS has taken with removing orthodontic care from the FEDVIP dental option for the proposed pediatric dental benefit.

I. Consider Affordability in the Determination of EHB Definitions for 2016 and Beyond

Issue: The Bulletin leaves unanswered the question of affordability as a consideration for the establishment of EHBs. In particular, the transitional approach taken by HHS may include costly benefits, including state mandates that have little basis in scientific evidence. If cost is not taken into account, and EHBs are defined too expansively with the inclusion of benefits not subject to rigorous evidence-based reviews or cost analyses, then it will be difficult for small employers and individuals to purchase lower cost products. The result of this will be diminished access to health insurance coverage. Additionally, a broad and comprehensive definition may make it difficult for plans to design bronze-level coverage due to the statutory limit on out-of-pocket maximums since the actuarial value of a health plan is measured based on the cost of coverage of the EHBs.

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[4] Kaiser Family Foundation, Prescription Drug Trends (May 2010), http://www.kff.org/rxdrugs/upload/3057-08.pdf. Accessed on January 15, 2012

Recommendation: EHBs should be updated for 2016 to incorporate cost considerations by evaluating benefits from both a cost and medical effectiveness perspective. Benefits lacking a rigorous level of efficacy or evidence-based support should not be included in EHBs.

Rationale: The principle intent of the ACA was to enable low- and moderate-income individuals and small employers to obtain affordable health care coverage on and off exchanges. To ensure this occurs, Congress stipulated that the EHB package be "equal to the scope of benefits provided under a typical employer plan." Additionally, the ACA includes a provision that makes clear that health insurance issuers must be able to offer bronze-level coverage. Given Congress' intent to make affordable bronze coverage available to consumers and given the statutory limits on out-of-pocket maximums, it is critical that EHBs be defined in a way that permits issuers to offer such coverage. A comprehensive definition of EHBs may make it difficult for plans to design bronze-level coverage as a result of the statutory limit on out-of-pocket maximums and its affect on the actuarial value of health plans, which is calculated based on the cost of coverage of EHBs. In addition, too expansive a definition of EHBs, and one that ignores the importance of a sound evidence base for each service within the general categories of essential benefits, will negatively impact affordability for consumers. As a result, the definition for EHBs should be updated in 2016 to incorporate affordability considerations by evaluating benefits from both a cost and medical effectiveness perspective.

J. Update EHBs for 2016 and Beyond Using an Evidence-based Model that Incorporates Cost Considerations

Issue: The benchmark/transitional approach used for 2014 and 2015 does not take cost into consideration; nor does it evaluate benefits included in the various state benchmark plans for medical effectiveness. Instead, covered services, including some state mandates, will be automatically included in a state's EHB because of their presence in the chosen benchmark plan. It is critical that benefits that are not cost-effective or based on sound medical evidence be no longer a part of states' EHBs in 2016 and beyond in order to help address affordability of EHBs.

Recommendation: As we look to 2016, HHS should evaluate the various covered services included in EHBs both on cost and medical effectiveness and no longer automatically include benefits that do not meet the criteria of being cost effective and/or being based on sound medical evidence.

Rationale: To ensure consumers receive safe and effective care at the right time and in the right setting, the process for updating EHBs should balance the need to provide reasonable, appropriate, high quality coverage with the need to ensure affordability and access for consumers. As previously noted, and as recommended by the IOM, HHS should update EHBs to make the required benefits more fully evidence-based and value-promoting, incorporating cost as a consideration in both the determination of initial EHBs and in subsequent updates to ensure that EHBs remain affordable and to preserve access to healthcare coverage. The importance of using evidence-based guidelines to update EHBs is critical, and BCBSA supports the IOM recommendation that only state mandates that are evidence-based should be included in future EHBs. Additionally, in updating the scope of EHBs, it is important to maintain affordability so that if additional services are added to the scope of EHBs, the incremental cost associated with the added service is offset by the elimination of other covered services.

II. Provide More Clarity on the EHB Requirements and Process for State Implementation

K. Provide Additional Clarity on the Benchmark Approach

Issue: HHS identified four benchmark plan types for 2014 and 2015 and allows states to select a single benchmark plan to serve as the standard for individual and small group coverage offered both inside and outside of exchanges. The four benchmark plans are:

1) The largest plan by enrollment in any of the three largest small group products in the state's small group market

2) Any of the three largest state employee health benefit plans by enrollment.

3) Any of the three largest national FEHBP plan options by enrollment.

4) The largest insured commercial non-Medicaid HMO operating in the state.

If a state does not select a benchmark plan, the default benchmark plan for the state will be the largest plan by enrollment in the largest product in the state's small group market. While BCBSA finds the approach of allowing flexibility for states to determine the essential health benefit benchmark plan acceptable in the short-term, the current Bulletin needs additional clarification regarding the selection of the benchmark plan and what aspects of the benchmark plan will become part of EHB requirements.

Recommendation: We recommend that HHS provide further guidance and details on the requirements and processes for states to select a benchmark plan and provide processes and timelines for how a federally selected benchmark plan would be designated. Specifically, we recommend that HHS:

1. **Identify a process for state selection of a benchmark plan.** BCBSA recommends that HHS define the process by which states indicate their selection of a benchmark plan and the timeframes in which that selection is made. The Bulletin proposes that states make an election by the end of the third quarter (of 2012), but does not specify what form that election must take – i.e., whether it requires state legislation, an executive order, or other state action. In addition, the Bulletin does not indicate when the fallback approach (i.e. the most popular small group plan in the state) would become effective if states do not act by the deadline. First, BCBSA believes that the deadline for state action should be earlier and suggests no later than the end of the second quarter of 2012 in order to give health plans more time to develop compliant benefit packages. If this is not possible due to timeframes of having enrollment information available for March 31, 2012, then we recommend that the benchmark plans be based on enrollment as of December 31, 2011. Second, if states do not act by the end of the second quarter of 2012, the default option should become effective as of the first day of the third quarter and the benefit package should be based on the benefits that were in effect as of March 31, 2012.

   Rationale: A specific process including the acceptable actions by which a state can select its benchmark plan and specific dates are needed to provide more certainty to health plans about the benefit requirements they will have to meet in 2014. This includes clarifying that the benefits offered by the benchmark plan on March 31, 2012 would be the benchmark benefits in case the plan later adds or removes benefits. Moving back

the deadline for a state to select the benchmark plan is needed to provide health plans with more time to develop compliant benefit packages as the initial enrollment period begins just one year from the current deadline.

2. **Clarify that health plans will continue to be able to apply their own medical policy guidelines.** The Bulletin does not address the issue of whether the benchmark plan approach continues to provide flexibility to health plans in the area of medical policy. BCBSA requests that HHS clarify that issuers can continue to apply their own medical policy guidelines, even if those guidelines differ from those employed by the benchmark plan other benchmark plan limits.

   Rationale: To ensure that consumers receive effective, quality care in the appropriate setting, the definition of EHBs should continue to allow health plans to condition coverage of any benefit on "medical necessity" or medical appropriateness for a specific patient. This approach is consistent with ACA § 1563, which preserves the right of group health plans and health insurance issuers to employ common utilization management techniques in the provision of covered benefits.

3. **Clarify that the benchmark approach applies only for purposes of defining the types of services that must be covered,** not for defining the way in which those services must be covered. In other words, the benchmark approach should only define covered services themselves, e.g., hospital and physician services, and not address other aspects of benefit design such as place of treatment, specific cost-sharing requirements or quantity/service limits.

   Rationale: EHBs were intended to define the types of services that are covered and not the way services are covered. If the rules related to EHBs are expanded to other aspects of benefit design beyond covered services, it will be particularly disruptive and detrimental to product innovation. For example, if a plan has contracted and developed a tiered network based on quality and cost, the proposed benchmark approach should not hinder a plan from implementing this type of innovation. Additionally, imposing requirements on the way benefits are provided may jeopardize the ability of plans to develop products that meet the metal requirements.

L. Provide More Detail on the Process for Supplementing a Benchmark Plan

Issue: While the Bulletin provides a high-level roadmap for supplementing the benchmark plan, it leaves many open questions about the process specifics. The Bulletin indicates that if a benchmark plan is missing any category of benefits that the state must supplement the missing categories using benefits from any other benchmark option; however, it does not provide the processes involved to determine whether supplementing the selected benchmark plan is necessary. The Bulletin also fails to describe who would be responsible for determining how and what benefits must be supplemented in the case of states that did not select the benchmark plan.

Recommendation: HHS should issue additional guidance with respect to supplementing the benchmark plan. This includes additional clarity on how many services must be covered in a particular EHB category (i.e., whether one covered service is sufficient) and in the case of habilitative services, further clarity what must be covered (i.e., if the plan covers non-

maintenance physical, occupational and/or speech therapy for all persons regardless of the reason the therapy is needed whether this means that there is coverage for the habilitative category). Additionally, BCBSA recommends that HHS should specify that in cases where states did not select a benchmark, they still retain the right to specify the supplemental benefits and if they do not, HHS should select a state-specific plan from which to supplement the needed benefits for the benchmark plan. Finally, HHS must specify that determinations about supplementing the benchmark plan must be made no later than the beginning of the third quarter of 2012, so that health plan issuers have sufficient time to design compliant plans.

In cases where a state does not act, HHS should choose a state-specific plan as opposed to having a national solution as this is consistent with the approach of states being able to define EHBs based on coverage offered in their state. Additionally, BCBSA believes that the deadline for state action on determining a final benchmark plan, including any required supplemented benefits should be completed by the end of the second quarter of 2012, in order to give health plans sufficient time to develop compliant benefit packages.

Rationale: BCBSA supports the flexibility of states to determine whether and how to supplement (if needed) the benchmark plan it selects. However, to ensure that states have the necessary information to supplement the benchmark plan and to ensure that health plans are given the time needed to develop a product based on the supplemented benchmark plan, it is critical for HHS to provide additional guidance on the process states should take to supplement the benchmark plan. Moreover, the guidance does not indicate who would be responsible for supplementing the benchmark plan in cases where states do not select a benchmark plan. In this situation, states should retain the option to designate the supplemental plan as some states will simply allow the default option to occur as opposed to passing legislation since their desired option is the largest plan in the largest product in the small group market in their state.

M. Evaluate Issues Surrounding the Stand-Alone Pediatric Dental Option and Requirements Related to Dental Coverage

Issue: The ACA has a provision allowing for stand-alone dental plans to be offered on the exchange to provide the pediatric oral services component of the EHB, and if a stand-alone dental plan is offered, other health plans do not have to include the pediatric dental benefit. This provision raises a number of logistical and operational issues that the Bulletin did not address. A few examples of these include:

- How will health plans know whether an exchange is going to have a stand-alone dental option far enough in advance to know whether they have to offer embedded pediatric dental services? For example, an issuer that does not have dental capabilities will have to seek out and contract with a dental vendor, which may take months and ultimately be unnecessary.

- Will expenses incurred in relation to the pediatric oral services EHB count towards the plan's out-of-pocket maximum? If so, this has significant logistical and systems implications as the health plan and stand-alone dental plan will have to share information in order to process claims correctly and answer customer questions.

- What are the specific requirements related to reduced cost sharing when the enrollee is enrolled in a health plan and a stand-alone dental product?

- What other rules apply to stand-alone pediatric dental products (e.g. rate review, prohibition on pre-existing condition waiting periods, guarantee issue, etc.)?

Recommendation: HHS, with assistance from health plans and stand-alone dental plans, needs to explore the logistical and operational issues surrounding the stand-alone dental option and develop guidance that addresses these issues.

Rationale: There are significant logistical and operational issues such as those noted above surrounding the offering of a stand-alone dental plan that need to be addressed far in advance so that health and dental plans develop products and implement any necessary systems changes.

N. Require the State or the Benchmark Plan to Provide a Moderate Level of Specificity for their Covered Services

Issue: The Bulletin does not address the level of specificity that plans need to provide to states regarding covered services in EHB categories.

Recommendation: To ensure that plans are offering all of the services within the EHB categories and to minimize the administrative burden of reporting such covered services, BCBSA recommends that the benchmark plan provide a state with a description in a moderate level of detail on the covered services in the benchmark plan. Furthermore, to ensure consistency, we also recommend that states, not individual health plans, retain the authority in making decisions around benefit determinations and the criteria to satisfy each category of EHBs.

Rationale: While the EHB Bulletin requires coverage for each of the 10 categories of benefits, the Bulletin does not state the level of specificity this detail needs to be reported to states. We understand that providing some detail on the scope of covered services to states is important for ensuring that all plans are providing the requisite services within each EHB category. We also acknowledge the importance of this information for non-benchmark plans in developing complete and compliant products. To provide adequate detail on the covered services while minimizing the associated administrative burden, we recommend that HHS use a "moderate level of detail approach." Furthermore, because benefits may fall into multiple EHB categories, and because plans may decide to use their own discretion to determine that a particular service may suffice as a covered EHB benefit, we recommend that states, not individual health plans, retain the authority in making decisions around covered services and the criteria needed to satisfy each category of the EHB. This will ensure that all benefits are provided, while ensuring a level playing field and minimizing administrative burden for all plans.

III. Ensure EHBs do not Lead to Adverse Selection that Raises Costs for Individuals and Small Employers

O. Do Not Permit Benefit Substitutions Within or Across Benefit Categories

Issue: The Bulletin indicates that HHS will provide some flexibility to issuers to adjust benefits, including both specific services covered and quantitative limits, so long as such flexibility is subject to the baseline set by the benchmark plan coverage. HHS would impose a standard

requiring health plans to 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 ACA coverage categories.

HHS is considering permitting benefit substitutions that may occur, not only within each of the 10 benefit categories, but also across benefit categories, so long as such substitutions are actuarially equivalent. The Bulletin asks for comments on whether substitutions across benefit categories, if permitted, should be subject to a higher level of scrutiny to mitigate the potential for eliminating important services or benefits in particular categories.

Recommendation: BCBSA believes that permitting substitutions with a category of coverage is not warranted, as plans will already have flexibility in designing their benefits. BCBSA is concerned that benefit substitutions may be used by some plans to “game the system” and use the benefit substitution flexibility to avoid providing coverage of benefits that may attract higher-risk enrollees (e.g., bone marrow transplants – or some other example) in favor of benefits that may attract healthier enrollees, such as coverage of certain alternative medicine services. To avoid adverse selection, we recommend that substitutions within or across coverage categories be prohibited.

HHS references the substitution method defined in the Children's Health Insurance Program (CHIP) program as an analogous method for substituting benefits. However, in the CHIP program, all benefit substitutions are decided and determined by the state, not individual health plans. If benefit substitutions are allowed to occur, the decisions about such substitutions should follow the CHIP program approach and occur at the state level, not the health plan level. In states that allow such substitutions, all health plans in those states then would be able to make such substitutions. Alternately, If HHS retains its proposed approach, it will be critical to clarify how the “substantially equal” standard will be applied and to apply a strong standard of review in order to avoid gaming and adverse selection.

Rationale: Due to the level of specificity that is required to define covered services under EHBs, BCBSA believes that permitting substitutions within a category of coverage is not necessary, as plans will already have flexibility in designing their benefits. Furthermore, substituting any of these categories could lead to concerns about access to care and discrimination. Should HHS permit benefit substitutions, then we recommend that substitutions replicate the suggested CHIP program and only be allowed at the state-level. State-level decisions will result in more uniformity of coverage, and thus be less confusing for consumers (who otherwise could face different benefits from every carrier), and eliminate the opportunities for “gaming” that would arise if decisions on benefit substitution happened at the health plan level. If HHS proceeds to allow benefit substitutions at the health plan level, BCBSA respectfully asks the Department to clarify how the “substantially equal” standards will be applied to avoid gaming. We believe an actuarial certification of equivalence will not be sufficient, because under that standard, issuers could potentially reduce coverage of benefits needed by higher-risk populations and increase coverage of benefits attractive to lower-risk individuals in order to attract healthier enrollees. A strong standard of review needs to be established by HHS to protect against adverse selection and discrimination where benefit substitutions are made.

P. Require OPM Multi-state Plans to Offer a Benefit Design Compliant with Each State’s Benchmark Plan

Issue: The Bulletin does not address whether multi-state plans have to offer the benchmark plan. The absence of such a requirement would potentially allow an unlevel playing field in some states in which a multi-state plan operates.

Recommendation: BCBSA supports requiring multi-state plans to offer a benefit design compliant with each states benchmark plan. This ensures a level playing field for both the multi-state plan and other plans offered in a particular state.

Rationale: Requiring multi-state plans to offer the required EHBs in each state is critical to ensuring a level playing field among QHP offerings within an exchange and to avoiding adverse selection against single state plans in some situations and multi-state plans in others. While the core benefit package is similar across the nation, state mandates can vary considerably even in adjacent states. Allowing plans operating on a state's exchange to offer different benefits will lead to adverse selection as persons seeking out a particular benefit gravitate either to the multi-state plan or other plans offering coverage on the exchange.

Q. Remove The "Intent To Reside" Approach and Instead Follow Section 1312(f)(1)(A)(ii) of the ACA which Requires that an Individual Enroll Through an Exchange Where He or She Resides

Issue: Because of the "intent to reside" residency standard included in the Exchange Establishment NPRM, some individuals may attempt to purchase coverage in a state where the EHB benchmark plan selected provides more generous coverage than the benchmark plan in their own state, creating adverse selection against exchanges in such states. While this provision is not a part of this Bulletin, we raise this issue here because of how it could interact with the transitional EHB approach proposed in the Bulletin.

Recommendation: BCBSA strongly recommends that HHS drop the "intent to reside" approach and instead follow Section 1312(f)(1)(A)(ii) of the ACA which requires that an individual enroll through an exchange where he or she resides.

Rationale: We articulated concerns with the "intent to reside" standard in our comments on the Exchange Establishment NPRM. The approach to EHBs in the Bulletin raises additional concerns since benchmark plans will vary from state to state. Under the "intent to reside" standard, a person seeking out coverage for a particular benefit not covered in their state would simply have to apply for jobs (or otherwise provide an "intent" to reside) in a state that offers the benefit they are seeking and they could then enroll in that coverage for the entire year. The resulting adverse selection would drive up costs even further for enrollees in states with mandates that are subject to anti-selection. The potential for providing coverage of the particular mandate to persons in other states was not contemplated when these state's legislatures passed a particular mandate. Instead of an "intent to reside" approach HHS should use a simple residency requirement coupled with a special enrollment period if someone moves to address situations where people need to switch coverage between exchanges outside of the annual open enrollment period.