FamiliesUSA
The Voice for Health Care Consumers

January 31, 2012
The Honorable Secretary Kathleen Sebelius
Secretary of U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C., 20201

Re: Essential Health Benefits Bulletin

Dear Secretary Sebelius:

As an organization that has been fighting for health care justice for nearly 30 years, Families USA considers the availability of comprehensive coverage to be critical to our goal of achieving high-quality, affordable health care for all Americans. We therefore appreciate the opportunity to comment on the sub-regulatory Essential Health Benefits (EHB) Bulletin released by HHS on December 16th. We also applaud HHS for beginning implementation of a critical part of the Affordable Care Act; the Essential Health Benefits package will determine the scope of coverage that millions of American have access to. Thank you for considering our expressed concerns and comments.

Future guidance and regulations on the Essential Health Benefits package must:

1) Create a minimum coverage floor
2) Define comprehensive coverage for all ten required categories of services
3) Provide consumer protections
4) Restrict dangerous benefit design flexibility
5) Collect and disclose data on benchmark plans and their benefits in a timely and consumer-friendly manner, and provide opportunity for public comment
6) Address state benefit mandates
7) Develop a transparent and inclusive process for updating the Essential Health Benefits
8) Address how the Essential Health Benefits will be implemented into the Medicaid program and Basic Health Plan option

1. Create a Minimum Coverage Floor

The legislative intent of the EHB requirement was to standardize coverage and protect consumers against underinsurance. To do this, Section 1302 of the Affordable Care Act requires that "the Secretary shall define the essential health benefits" to include at least ten specific categories of services: 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; and pediatric services, including oral and vision care.[1]

Given the statutory language and intent of the law, we believe the Secretary is required to define a minimum coverage floor that states should use when implementing the EHB. This coverage floor would ensure that plans in all states subject to the EHB provision provide consumers with comprehensive coverage—no matter their health status. We recognize that it will take time to create detailed coverage

1 *Patient Protection and Affordable Care Act,* Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010,* Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1302 (b)(1).

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guidance. While using benchmarks may help as an interim measure, HHS should still define stronger minimum coverage requirements, particularly in areas that have been problematic for consumers.

The proposed Bulletin put forth by HHS would grant each state the authority to define its own EHB package from among ten different benchmark plans. States would be able to select from the three largest small group plans in the state, the three largest FEHBP plans, the three largest state employer plans, and the largest commercial non-Medicaid HMO in the state. All together, states and the District of Columbia would have 360 health insurance products that could serve as their defined EHB package. We are additionally concerned that, under the proposed Bulletin, insurers would have the flexibility to design plans that differ from the benchmark through the substitution of benefits within and across categories of services. We urge HHS to reduce this amount of flexibility and provide further guidance about a coverage floor.

We recommend that the Secretary define a minimum coverage floor for the EHB that details comprehensive benefits in all ten required categories of services. A state's chosen benchmark plan would have to provide at least the minimum coverage floor defined by the Secretary. Additionally, we recommend that the Secretary reduce the number of proposed benchmark options. The Bulletin indicates that it bases the proposed EHB benchmark approach off the approach established for the Children's Health Insurance Program (CHIP) and certain Medicaid populations. However, under CHIP and Medicaid benchmark plan options, states may only choose from three benchmark plans. We believe the Secretary must similarly limit the number of possible EHB benchmark plans to ensure that states are selecting from plans that will provide the best coverage and quality of care for all patients.

We are concerned that in states with few insurers or small insurance markets, the third largest small group plan may have very small enrollment and could provide inadequate coverage. Similarly, the prevalence and market penetration of HMOs vary greatly among states so that the largest HMO in a state may not provide coverage that is as comprehensive as a typical employer plan. For example, California has a total of 100 HMOs with over 15 million enrollees, while Alaska has a total of 16 HMOs in the state with 984 enrollees.[2] The benchmark options should be revised to only include a few benchmarks that have meaningful enrollment. For instance, the benchmarks could include the largest FEHBP plan and the largest group plan in a state subject to a state's benefit mandates, and, where enrollment reaches a threshold set by HHS, the largest commercial non-HMO plan in the state.

Further, guidance should require that benchmark plans meet standards about the quality and scope of coverage. For example, some state small group products include coverage exclusions that have the potential to severely restrict coverage across all ten required categories of services for certain populations. John Alden Life Insurance Company's Real Choices PPO, one of the top three small group products in Arkansas, Wyoming, and Montana, includes a broad exclusion of coverage for "any illness or injury caused by an act of war, felony, attempted suicide, or influence of an illegal substance." Such exclusion could limit coverage across a broad range of medical services for individuals with mental health and substance abuse treatment needs and should not be permitted.

As stated in the proposed EHB bulletin, HHS is proposing to reevaluate the benchmark approach in 2016. If the Secretary does not choose to create a minimum coverage floor for the transitional period of 2014 and 2015, we strongly recommend that, in 2016, the Secretary make such a revision. The Secretary should lay out a clear process for setting a national coverage floor, explaining who can participate and how, similar to the process described for Medicare national coverage determinations. However, we recommend that the determining entity—not the patients or providers requesting a revision in coverage—be responsible for collecting and evaluating medical evidence pursuant to the determination because, in the Medicare process,

2 Kaiser Family Foundation, *Number of HMOs, July 2010* (Washington: Kaiser Family Foundation, 2010) available online at http://www.statehealthfacts.org/comparemaptable.jsp?ind=347&cat=7.

it has proven difficult for patients and providers to meaningfully participate. States could play a role similar to that which local coverage determinations play in the Medicare arena: in areas where national coverage determinations have not been made, states could provide a transparent vehicle for updating and improving benefit requirements prior to issuance of a national determination.

Recommendations:

- The Secretary must define a uniform coverage floor for the EHB that details comprehensive benefits in all ten required categories of services. If the Secretary chooses to define the EHB package through a benchmark approach, a state's chosen benchmark plan would have to at least meet the established coverage floor.
- Under the CHIP and Medicaid benchmark plan options, states may only choose from three benchmark plans. We believe the Secretary must similarly limit the number of possible EHB benchmark plans to ensure that states are selecting from plans that will provide the best coverage and quality of care for all patients.
- The benchmark options should be revised to include only a few options that represent typical employer plans. For instance, they might include the largest FEHBP plan, the largest group plan in a state subject to a state's benefit mandates, and the largest commercial non-HMO plan in the state meeting certain enrollment thresholds.
- If not implemented in the 2014-2015 transitional period, the Secretary must define a standard coverage floor for the EHB when reviewing the benchmark approach in 2016. The process for defining a national floor should allow for meaningful participation from patients and providers as well as an evaluation of medical evidence. States could provide a vehicle for updating and improving benefit requirements prior to issuance of a national determination.

2. Define Comprehensive Coverage for All Ten Required Categories of Services

The Secretary should ensure that the EHB meets the health needs of all affected individuals and families. Vital services not included in benchmark plans will be unattainable for most low- and middle-income individuals and households that receive Medicaid benchmark benefits or premium and cost-sharing assistance through the Exchanges, or who purchase their coverage without financial assistance. This will lead patients to either forgo needed medical care or receive uncompensated care that will contribute to higher costs to the health care system. Coverage can be comprehensive to avoid these problems while remaining affordable. A recent research brief by the Office of the Assistant Secretary for Planning and Evaluation showed that narrowing benchmark benefits to exclude medical services like rehabilitative services, home health services, and medical equipment/supplies would have only a small impact on cost.[3] However, providing these necessary services at a marginal cost would greatly improve the health and well-being of many patients.

HHS should review and oversee that benchmark plans provide comprehensive coverage in all ten categories of services. As HHS acknowledged in the Bulletin, small group plans employ stricter benefit limits, especially in areas like mental health services. Congress explicitly intended these ten categories be considered essential benefits in order to ensure that consumers have access to comprehensive coverage—especially for conditions that are not covered, or that are covered inadequately in the individual and small group markets. Many of the categories, such as mental health and substance use disorders, rehabilitative and habilitative care, maternity and newborn care, and pediatric services were specifically included within Section 1302 of the Affordable Care Act to correct longstanding gaps in coverage that consumers face in the individual and small group markets. However, a large number of the top three state small group products that could now be used as benchmark plans do not provide comprehensive coverage for many of the categories of services listed above. For example, John Alden Life Insurance Company's REAL CHOICES PPO, a potential benchmark plan in three states, does not cover maternity care at all. In

3 Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, U.S. Department of Health and Human Services, *ASPE Research Brief: Actuarial Value and Employer-Sponsored Insurance,* (Washington: ASPE, November 2011) available online at http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.shtml.

addition, it only covers inpatient behavioral health and substance abuse services through 28 days and limits coverage for inpatient rehabilitation to 90 days. United Health Care's Choice Plus, which is among the three largest small group products in 15 states, restricts coverage of rehabilitation, mental health, and substance abuse treatment services. Choice Plus only covers outpatient rehabilitation, mental health, and substance abuse treatment services up to 20 visits each. Inpatient mental health and substance abuse treatment services are only covered up to 30 days and inpatient rehabilitation services are only covered up to 60 days. This level of coverage is simply inadequate for individuals recovering from serious injuries and individuals suffering with severe mental health and/or substance abuse disorders. In order for the EHB to properly correct these gaps in coverage that persist in the individual and small group markets today, the Secretary must define a minimum, standard scope of benefits that plans must cover under each of the ten required categories of services. The coverage floor for each of the ten categories should be based on medical evidence and guidelines but most importantly ensure that all consumers have access to a comprehensive level of care.

It will be especially important for the Secretary to define the scope of services that must be covered under each of the ten categories because traditional plans do not categorize their services within the same benefit categories or using the same terminology. It is unclear how the EHB package could be compared to potential benchmark plans to ensure that it complies with the Affordable Care Act. For example, "ambulatory patient services" is not a category that is commonly seen in commercial plans, and it is unclear what specifically would need to be covered to satisfy HHS's standards.

We also gathered examples from consumer assistance programs of services that people in private health plans have needed and been surprised to learn, after enrolling in a plan, were not covered. Many fall within categories of services that are "essential" under the Affordable Care Act and are now covered by Medicare. However, it is not clear whether they are covered by some of the benchmark plans, and one would have to delve into detailed plan documents and clinical bulletins to learn whether they are covered:

- Within the DME/Medical supplies category, plans may not cover insulin pumps, which can cost $6,000-$8,000 initially plus $250-$500/month to run. Similarly, they may not cover continuous glucose monitoring equipment. We could not determine if these were covered under the various benchmarks. Ostomy supplies are expressly excluded by many plans. One plan said that DME is only covered when needed for habilitation/rehabilitation, which excludes people with chronic illness.
- Enteral nutrition therapy is covered by Medicare for people who must be tube fed and cannot swallow. Private plans sometimes cover enteral nutrition only for people with specified illnesses or only if it is the sole source of nutrition.
- IV drugs may be covered by a policy, but clinical policy bulletins explain that IVIG is not covered for myasthenia gravis and is only covered for Common Variable Immune Deficiency (CVID) in a few narrow circumstances.
- Methadone treatment is excluded in some plans that say they cover treatment of chemical dependency.
- Weight loss surgery (gastric bypass/lap band) may be excluded even when medically indicated.

Other examples of uncovered services consumers have brought to the attention of consumer assistance programs include:

- Complications arising from excluded surgery (such as weight loss surgery) that the person paid for out-of-pocket.
- Mammogram for women under 40, even when there is a family history of breast cancer
- Specific types of organ transplant, such as lung

- Anesthesia for colonoscopies, a frequently encountered gap
- Maternity
- Infertility
- IVF
- Chiropractic care
- TMJ treatment

These examples point to the need for HHS to issue coverage determinations related to the EHB over time and to provide at least some minimum standards and comparison tools meanwhile.

The Bulletin proposes to cover the ten required categories of services by supplementing a state's chosen benchmark plan if it is missing any required category of service. Under the proposed method the chosen benchmark plan would be supplemented with benefits from another benchmark plan that currently offers coverage for the missing category of service. The Bulletin does not propose a mechanism for supplementing categories of services that a benchmark may offer but not comprehensively. For example, what if a state's chosen benchmark plan only covers two habilitative service benefits? Would HHS consider this sufficient?

The benchmark plan approach relies on what plans in the market currently offer as coverage. As discussed previously, commercial plans traditionally have not covered or sufficiently covered many of the ten required categories of services. Given these long-standing gaps in coverage, benchmark plans should not be taken as is or used to supplement each other. Instead, the Secretary must require and monitor that categories of services in a state's chosen benchmark plan are all supplemented until they meet the minimum scope of benefits for each category of service, as established by the Secretary. Having a stand-alone floor of what plans must provide under each category of service instead of relying on what the market currently offers will ensure that the EHB provides comprehensive access for all ten required and essential categories of services in the Affordable Care Act.

Recommendations:

- ❖ The Secretary must define a minimum scope of benefits that plans must cover under each of the ten required categories of services
- ❖ The Secretary must require and oversee that a state's chosen benchmark plan supplements all ten categories of services until they meet the established minimum scope of benefits.

The Bulletin also solicits comments on several of the ten categories of services. We would now like to provide specific comments for some of those categories.

Preventive Health Services:

Section 2713 of the Public Health and Service Act requires non-grandfathered individual and group health insurance plans to cover evidence-based preventive services at zero cost-sharing. This ensures that low-income individuals, women, children, and other vulnerable populations who might not otherwise be able to afford such vital services can access them. While preventive services is a required category under the EHB, HHS has not included Section 2713 as part of the EHB. This is of great concern to us because the Bulletin does not preclude grandfathered plans, which are not subject to Section 2713, from serving as a state's chose benchmark plan. Therefore, these services and cost-sharing protections may not be included in a state's EHB. While we have heard that plans subject to Section 2713 would still have to comply regardless of whether a state's benchmark is a grandfathered plan, future guidance and regulation must ensure that Section 2713 is not undermined. HHS must explicitly prohibit grandfathered plans from serving as state benchmarks.

A large population affected by the EHB will be low-income individuals and families enrolled in Medicaid benchmark plans and the Basic Health Plan in states. These populations are currently not covered by Section 2713 but are among the ones that may find it most difficult to afford services that are not covered by the EHB or require some form of cost-sharing. For example, in 2003 when Oregon's Medicaid program, Oregon Health Plan increased premiums and implemented copayments for adult beneficiaries, many left the program because they could not afford the premiums and/or the new copayments. The changes also led to decreased care utilization among the affected beneficiaries.[4] Including Section 2713 into the EHB requirement would ensure that low-income individuals and families can access essential preventive services at zero cost-sharing. This would also increase the continuity of coverage between Medicaid, Basic Health Plans, and plans offered in the Exchanges. This is especially important for households with incomes below 200 percent of the FPL who experience a high rate of income fluctuation.[5]

The preventive services provided under Section 2713 are scientifically reviewed by the U.S. Preventive Services Task Force and have a strong evidence base. Ensuring that these services are extended to all populations affected by the EHB will improve health outcomes and reduce the cost of care in the long term.

Recommendations:

- The Secretary should incorporate Section 2713 into the EHB requirement.
- HHS must prohibit grandfathered plans from serving as benchmark plans.

Mental Health and Substance Use Disorder Services, Including Behavior Health Treatment:
We applaud HHS for indicating in the Bulletin that they intend to propose that parity applies in the context of the EHB. The Mental Health Parity and Addiction Equity Act (MHPAEA) requires applicable plans that cover mental health and substance use disorder benefits to do so at parity with medical and surgical benefits. Parity will be a crucial tool to establishing comprehensive mental health, behavior health, and substance use disorder services under the EHB.

Section 1302 states that the Secretary must "take into account the health care needs of diverse segments of the population, including women, children and persons with disabilities, and other groups." Furthermore, Section 1557 of the Affordable Care Act additionally prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in health programs or activities that receive federal financial assistance, are administered by an executive agency, or were established by Title I of the Affordable Care Act. Given the nondiscrimination provisions of the law and that HHS intends on applying parity, we believe the Secretary must review and oversee that discriminatory restrictions and limits on mental health, behavioral health, and substance use disorder benefits are removed. For example, the REAL CHOICES product offered by John Alden Life Insurance Company, which is a proposed benchmark option, does not cover injury or illness resulting from an attempted suicide or use of an illegal substance. Discriminatory restrictions such as these must be removed.

Also, while parity will be extremely important to removing discriminatory benefit limits and restrictions, it does not require a state's chosen benchmark plan to offer vital benefits under this category of services that the plan currently does not cover. Mental health, behavioral health, and substance use disorder services have historically been excluded from plans in the small group and individual market and do not provide comprehensive coverage. But state employee and FEDVIP plans may not provide comprehensive coverage

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4 Common Wealth Fund, *Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Beneficiaries from an Ongoing Study of the Oregon health Plan* (Washington: Commonwealth Fund, July 2005) available online at http://mobile.commonwealthfund.org/Publications/Fund-Reports/2005/Jul/Impact-of-Changes-to-Premiums--Cost-Sharing--and-Benefits-on-Adult-Medicaid-Beneficiaries--Results-f.aspx.

5 Benjamin D. Sommers and Sara Rosenbaum, "Issues In Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and the Insurance Exchanges," *Health Affairs* no. 2 (2011): 228-236, available online at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_EBFA3F95-5056-9D20-3D269234D11B4BD7.pdf.

for this category of services either. As the Bulletin indicated, many small group plans in states cover behavioral health services that state employee and FEHBP plans do not. Specifically, over half of states have mandates requiring the diagnosis and treatment of autism for children, and in some cases adults, as well. [6] Behavior health services covered under these state mandates include applied behavioral analysis (ABA) therapy.

The benchmark plans will have to be revised to ensure that they provide comprehensive coverage for this essential category of services. To do this, the Secretary must define a specific coverage floor for mental health, behavioral health, and substance use disorder services that all plans subject to the EHB must offer.

Recommendations:

- We applaud HHS for requiring that mental health, behavioral health, and substance use disorder services be offered at parity with medical and surgical benefits and recommend that this requirement be included in the final regulation on the EHB.
- The Secretary must define a coverage floor for mental health, behavioral health, and substance use disorder services that would ensure comprehensive coverage and that all plans subject to the EHB must offer.
- In accordance with the nondiscrimination provisions in Section 1302 and 1557, HHS must ensure that plan exclusions and limits that prevent all enrollees from accessing mental health, behavioral health, and substance abuse services are removed.

Habilitative Services:

The Bulletin requests specific comments on defining habilitation. It is important that "maintenance of function" and "attainment of age appropriate function" be included in the definition of habilitative services. There are many instances in which a patient requires habilitative services in order to prevent a decline in function. Failure to cover these services under the EHB will result in many patients receiving habilitative services only to reach a level of function that they are unable to maintain because of a lack of access to continued service.

More broadly, the Secretary should develop a standardized definition of medical necessity that includes services that improve, maintain, or prevent deterioration of a patient's capacity to function. This would be in keeping the statutory provision to provide habilitative services. A clear and uniform definition of medical necessity at the federal level will lead to greater consistency of care, transparency for consumers and providers, and improved procedures for grievances and appeals. The Secretary should require states and insurers to use this federal definition of medical necessity.

As for covering habilitative services, the Bulletin proposes two approaches: habilitative services can be offered at parity with rehabilitative services, or plans can decide what habilitative services to cover and then report to HHS. HHS would evaluate what plans decide to cover and further define habilitative services in the future. Plans should not be allowed to decide what habilitative services to cover. Private insurance plans traditionally have not adequately provided habilitation services, if at all. And if allowed to design their own benefits, some insurers could structure benefits in such a way that they are discriminatory towards people with disabilities.

We agree with HHS that habilitative service should be covered at parity with rehabilitative services. However, we would like further clarification on two issues. First, as NHeLP noted in their comments, the scope and intent of the two categories vary greatly in that rehabilitation is meant to regain and maintain function while habilitation is meant for attaining and maintaining new function and skills that a patient did not have previously. Second, parity does not require vital habilitative services that are not included in a

6 American Speech-Language-Hearing Association, State Insurance Mandates for Autism Spectrum Disorder (Washington: American Speech-Language-Hearing Association, 2012) available online at http://www.asha.org/Advocacy/state/States-Specific-Autism-Mandates/.

state's benchmark plan to be covered. Given our concerns and the fact that habilitation will be a fairly new category of service that many plans will have to now provide, we recommend that the Secretary define a coverage floor for habilitative services.

Recommendations:

- "Maintenance of function" and "attainment of age appropriate function" must be included in the definition of habilitative services.
- The Secretary should develop a standardized definition of medical necessity that includes services that improve, maintain, or prevent deterioration of a patient's capacity to function.
- The Secretary must ensure habilitative services cover the needs of all patients, especially those with disabilities. Therefore, the Secretary must define the coverage floor for habilitative service under the EHB.

Ensure the Essential Health Benefits Include Comprehensive Pediatric Services, Including Oral And Vision Care:

Under Section 1302, "pediatric services, including oral and vision care" is one of the ten required categories of services. Section 1302 additionally specifies that coverage decisions must not discriminate based on age and children's health care needs should be taken into account. The approach outlined in the Bulletin does not guarantee that these standards will be met. For one, the Bulletin defines pediatric services as only oral and vision care. Secondly, the benchmark plan options may not provide adequate benefits for children. Nine of the ten potential benchmark plans are plans defined by their availability to employees, and the tenth—the largest HMO option—is also likely to be mostly employer-based. Because of their rapid physical and cognitive growth, children are a vulnerable health population with needs that often vary greatly from adults. The Secretary must define pediatric services to include all essential services that children need, including those that extend beyond oral and vision care.

The Bulletin proposes the option of allowing insurers to define the pediatric services under the EHB. We strongly believe that the Secretary should not allow insurers to determine the benefits. As of July 2011, only 33 states have at least one insurer that sells child-only plans.[7] A study in the *New England Journal of Medicine* also found that children in private plans are twice as likely to be *under*insured as their counterparts in public programs.[8] Given the fact that private plans have historically done an inadequate job covering pediatric services, they should be excluded from setting the pediatric benefits for the EHB. Instead, the Secretary should use Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) package as a baseline for defining benefits. Both Medicaid and CHIP have continually served low-income children throughout the years and should serve as the primary examples for modeling benefits. Medicaid EPSDT in particular covers screenings and treatments for physical and mental conditions as well as medical, dental, hearing, and vision services.[9]

Recommendations:

- The Secretary must define pediatric services to include all essential services that children need, including those that extend beyond oral and vision care.
- The Secretary should use Medicaid EPSDT as a baseline for setting pediatric services.
- The Secretary should not allow insurers to set their own pediatric services as proposed in the Bulletin.

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7 United States Senate, Committee on Health, Education, Labor and Pensions, *Ranking Member Report: Health Care Reform Law's Impact on Child-Only Health Insurance Policies*,(Washington: Committee on Health, Education, Labor and Pensions, August 2011, 112th Congress) available online at http://help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%202,%202011.pdf.

8 Michael D. Kogan et al., "Underinsurance among Children in the United States," *New Eng. J. Med no.845* (2010): 841-851.

9 Commonwealth Fund, *EPSDT: An Overview* (Washington: Commonwealth Fund, September 2005) available online at http://www.commonwealthfund.org/Publications/Data-Briefs/2005/Sep/EPSDT--An-Overview.aspx.

Addressing Pediatric Oral Care:

In the United States, millions of children suffer from painful and debilitating dental disease because they cannot obtain necessary preventive and routine care. In the year 2000, the report *Oral Health in America, A Report of the Surgeon General* stated: "Dental caries (tooth decay) is the single most common chronic childhood disease – 5 times more common than asthma and 7 times more common than hay fever." The report also highlighted that low-income American children are disproportionately affected by dental disease: "Poor children suffer twice as many dental caries as their more affluent peers, and their disease is more likely to be untreated."[10] Dental disease creates educational barriers (missed school days) and low self esteem for children, but it is also strongly linked to many health conditions, including heart disease, stroke, diabetes, and premature, low birth-weight babies.

Given the extent of dental disease among low-income children and the fact that millions of low-income Americans' health coverage will be defined by the EHB beginning in 2014, it is crucial that the EHB include comprehensive, affordable pediatric dental coverage that is tailored to the specific needs of children. The EHB Bulletin provides potential benchmarks for pediatric oral care. However, the outlined approach to providing adequate dental coverage needs to be more clearly defined.

The Bulletin proposes that states define pediatric oral care as one of three options: the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment, dental benefits from a state's CHIP program, or insurer-defined pediatric oral services. As stated in the previous section, private insurance plans have not traditionally offered oral services let alone pediatric oral benefits. Therefore we believe the Secretary should not allow insurers to define the pediatric oral services. We prefer that the Secretary define a strong federal floor for the pediatric dental benefits. We recognize the challenge of defining a high-quality, affordable pediatric dental benefit package, given that there are currently very few examples of child-only dental coverage in the insurance market. While CHIP does offer child-only dental coverage, CMS has yet to release regulations defining the CHIP dental benefit required by CHIPRA. Therefore, it is unclear what each state's CHIP dental benefit will be. Additionally, while FEDVIP dental plans, allow for the addition of dependents, they are not designed specifically with the oral needs of children in mind. Therefore, we ask that HHS provide further clarification in the form of detailed regulatory guidance as to what states must include in the pediatric dental component of the EHB.

It is crucial that the EHB provide the dental benefits that are medically necessary to promote oral health and prevent and treat disease in children, and that the EHB does not provide arbitrary coverage limits. If the EHB does provide a certain number of pediatric oral services or visits, there should be flexibility to accommodate children requiring more dental care than is typically provided. For more information about how such an approach could be cost-effective, please see the comments provided by the Children's Dental Health Project.

We recommend that, at a minimum, the pediatric dental component of the EHB include the following categories of services: diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, orthodontics, and emergency dental services. In addition, we strongly recommend that the EHB design allow for pediatric oral services to be provided by all types of providers allowed by state law. This may include mid-level dental providers and non-dentists (including hygienists and medical providers), who are often critical providers of oral health services for low-income children.

In addition, when determining the EHB package and in issuing further guidance about stand-alone dental plans, it is crucial that HHS ensure that children will have equal protections when using stand-alone dental plans offered through Exchanges. If pediatric dental coverage is offered through a QHP, the protections required of health insurance issuers in the Exchange—including the exclusion of annual and lifetime

10 U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000).

limits, preventive services at no cost, and other protections—will be applied to that dental coverage. However, if pediatric dental coverage is offered through a stand-alone dental plan, consumer protections may not apply, since stand-alone dental plans appear to be exempt under the Public Health Service Act.[11] In addition, it is unclear how children in stand-alone plans will be protected from excessive cost-sharing, and HHS should issue rules to protect them. In order to ensure that the dental benefits offered through Exchanges are affordable, regardless of the insurance issuer, HHS must require in future rules that if a child obtains dental benefits through a stand-alone dental plan, that child should receive the same overall protections from cost and the same consumer protections as a child receiving dental benefits through a QHP.

Recommendations:

- Given that there is a lot of variation in the pediatric dental benefits offered in the existing insurance market and the required CHIP dental benefit is yet to be defined by regulations, it is crucial that HHS provide detailed regulatory guidance specific to the design of the pediatric dental benefit.
- We recommend that the Secretary define a strong federal floor and not give insurers the authority to define pediatric oral or vision benefits without federal standards.
- The pediatric dental benefit should be tailored to the needs of children and not include arbitrary coverage limits.
- To ensure that low-income children can access care, we recommend that the EHB design allow for pediatric oral services to be provided by all types of providers allowed by state law, which may include mid-level dental providers and non-dentists (e.g., hygienists and medical providers).
- In order to ensure that consumers can afford high-quality pediatric dental benefits regardless of the insurance issuer, HHS must require in future rules that, if a child enrolls in a stand-alone dental plan through the Exchange, that child should receive the same overall protections from cost and the same consumer protections as a child receiving dental benefits through a QHP.

Prescription Drugs:

As proposed in the Bulletin, plans would not be required to provide the same level of prescription drug coverage as a state's chosen benchmark plan. Instead, they would only be required to cover at least one drug in a category or class that is offered by the benchmark and the specific drugs on the formulary may vary. The Bulletin references Medicare Part D in taking this approach to defining prescription drug coverage. However, Medicare Part D requires plans to offer at least two drugs per category or class and has the protected class policy to protect vulnerable individuals. The Bulletin's approach to defining prescription drug coverage for the EHB is not consistent with Medicare Part D or with the benchmark approach proposed for the other nine required categories of services. In general, the benchmark approach in the Bulletin requires plans to offer at least the same level of benefits as the state's chosen benchmark plan. However, requiring plans to only cover at least one drug per class or category would erode and actually lower prescription drug coverage. A study by Avalere Health LLC looking at drug coverage among the FEHBP BlueCross BlueShield Standard Option PPO and four small group plans in different states found that "for most of the classes in the study, plans covered at least 50 percent of both brand-name and generic products available in each class; in large classes, such as antidiabetic agents, small group plans cover more than 30 products."[12]

We recommend that the Secretary define a coverage floor that will ensure that all patients have access to comprehensive prescription drug coverage. If the Secretary does not do so, she must, at a minimum, require plans to provide prescription drug coverage at the same level as Medicare Part D.

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11 Sections 2722 and 2791 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act, May 2010.

12 Avalere Health LLC, *Drug Coverage in Essential Health Benefits Benchmark Plans: Formulary Analysis* (Washington: Avalere Health LLC, January 2012) available online at http://www.avalerehealth.net/pdfs/Avalere_EHB_Formulary_Analysis.pdf.

Recommendations:

- ❖ We recommend that the Secretary define a coverage floor that will ensure that all patients have access to comprehensive prescription drug coverage.
- ❖ If the Secretary does not do so, she must, at a minimum, require plans to provide prescription drug coverage at the same level as Medicare Part D.

3. Provide Consumer Protections

Section 1302 spells out several critical requirements to ensure that the EHB provides comprehensive, balanced coverage and protects consumers from discrimination. It specifically requires the Secretary to "ensure that such essential health benefits reflect an appropriate balance among the categories;" "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;" and "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups." Section 1557 of the Affordable Care Act additionally prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in health programs or activities that receive federal financial assistance, are administered by an executive agency, or were established by Title I of the Affordable Care Act.

Because the Secretary has chosen to define the EHB through a benchmark approach, she must oversee that a state's benchmark plan complies with these nondiscrimination standards. The Bulletin does not explicitly address how the Secretary will do this. We recommend that the Secretary establish a transparent oversight and review process of state benchmark plans. In particular, because the Bulletin has indicated that limits in a state's benchmark plan would be imported into the EHB, the Secretary must review benefit limits and restrictions employed by a state's chosen benchmark. Arbitrary limits on the amount or duration of covered benefits pose a significant barrier to consumers in need of medical care. The Affordable Care Act prohibits plans from placing annual and lifetime dollar limits on EHB. However, plans can still limit the number of visits to a particular type of provider or the number of inpatient hospital days each year for example; the Secretary should therefore provide oversight to ensure that any limits are reasonable and that consumers will be able to access critical care. Benefit limits should be based on medical evidence and guidelines. The EHB standard should also require a clear and easy exceptions process that will be applied in an expedited manner if a consumer needs a prescribed treatment that exceeds a plan's benefit limits.

Restrictions on benefits that limit specific individuals from accessing the benefit should be considered discriminatory and removed. For example, consumer assistance programs report examples such as a plan that covers IV drugs but does not cover intravenous immunoglobulin (IVIG) for myasthenia gravis. Further, the plan may only cover an item or service if the patient first meets certain criteria. For example, a patient may need IVIG for Common Variable Immune Deficiency (CVID), but the plan may require the patient to show nonresponsiveness to other treatments first and also meet other criteria. HHS should remove any restrictions that are found to be discriminatory.

Lastly, we are concerned that the proposed benefit design flexibility in the Bulletin, which would allow plans to deviate from a state's chosen benchmark plan by substituting benefits within and across categories of services, could lead to discrimination against one of the protected populations listed in Section 1302 and 1557. Such flexibility would make federal review and oversight of plans extremely difficult. Furthermore, allowing plans to substitute out benefits could completely undermine the EHB intent of providing balanced coverage among all ten categories of required services. Insurers could build plans that favor specific categories of services and cherry-pick consumers. Therefore, to prevent benefit designs that could be discriminatory towards the protected populations under Section 1302 and 1557, the Secretary should not allow insurers the flexibility to substitute benefits in a state's chosen benchmark plan.

Recommendations:

- We recommend that the Secretary establish a transparent oversight and review process for state benchmark plans. Specifically, because the Bulletin has indicated that limits in a state's benchmark plan would be imported the Secretary must review benefit limits and restrictions employed by a state's chosen benchmark.
- Benefit limits and restrictions applied to the EHB must be evidence based. Benefit limits should be documented and publicly available to ensure that decisions are made based on medical evidence and guidance and are not discriminatory.
- The EHB standard should require a clear and easy exceptions process that will be applied in an expedited manner to determine access to prescribed patient's prescribed treatment if it exceeds a plan's benefit limits.
- If benefit design flexibility are allowed at all, to prevent benefit designs that could be discriminatory towards the protected populations under Section 1302 and 1557, the Secretary should review proposed substitutions in advance and determine if they are in keeping with EHB requirements. However, we recommend below that insurers not be allowed to substitute benefits.

4. Protect the Essential Health Benefits Against Detrimental Insurer Flexibility

We, like other consumer groups that have commented on the Bulletin, believe that permitting insurance carriers to deviate from the benchmark benefits chosen by the state, as HHS has proposed, would significantly weaken the Affordable Care Act's EHB provision. The EHB is intended to ensure a consistent, minimum level of benefits across all non-grandfathered, fully-insured plans in the individual and small group insurance markets so that consumers can make an apples-to-apples comparison of plan options. It is also intended protect against underinsurance and to prevent insurers from adopting benefit designs intended to attract healthier people and deter enrollment by those in poorer health. The proposal for "benefit design flexibility" would undermine these goals, regardless of whether variation is allowed within benefit categories or across benefit categories. Final guidance and regulations should prohibit such flexibility and require insurers to adhere to the chosen benchmark benefits in a given state.

HHS states that allowing insurers benefit design flexibility "would provide greater choice to consumers, promoting plan innovation through coverage and design options . . ." However, we question whether consumer will really have meaningful choices. Health insurance is a particularly difficult product for consumers to assess.[13] People usually do not know their health care and benefit needs until they become sick.

Secondly, allowing insurers to substitute benefits within and across the categories of services in a benchmark plan could result in benefit designs that lead to adverse selection. The proposed benefit design flexibility would give insurers' the authority to change benefits and self-regulate that such substitutions will not result in cherry-picking. While requiring insurers to provide benefits that meet a consistent actuarial value can be somewhat of a safeguard, it is not enough to prevent discriminatory benefit designs.

Benefit Design Flexibility: Lessons from Medicare Advantage on Harm from Too Much Flexibility

The proposal to allow insurers to deviate from a state's EHB standard is likely to be used by insurers to limit benefits in ways that would harm or shift costs to enrollees with high-cost or specialized health needs. Medicare Advantage (MA) provides a clear example of how too much flexibility can be harmful to consumers. MA offers private plans to seniors and people with disabilities as an alternative to traditional fee-for-service Medicare. Parts A and B of traditional Medicare (which cover inpatient and outpatient services, respectively) serve as a fairly detailed reference package for MA plans' inpatient and outpatient benefits.[14] While MA plans must cover at least the services covered by traditional Medicare in Parts A and B, an MA plan's benefit package can vary from that of the traditional program as long as the plan's overall

13 Lynn Quincy, "What's Behind The Door: Consumers' Difficulties Selecting Health Plans," (Washington: Consumers Union, January 2012)

14 MA plans also cover prescription drugs under Part D of Medicare.

actuarial value is not less than that of traditional Medicare.[15] Some MA plans, therefore, have utilized the flexibility they have to impose high beneficiary cost-sharing for certain services, such as chemotherapy drugs, skilled nursing facility stays, and kidney dialysis. A variety of analyses documented the problem of MA beneficiaries who need hospital care, home health care, and other specialty services having to pay higher costs under MA plans than they would have paid under traditional Medicare.[16] For example, an AARP study found that, while the average MA beneficiary in 2008 would pay $823 in cost-sharing charges for a ten-day hospital stay (less than the $1,068 average under traditional Medicare), 12 percent of MA beneficiaries would incur cost-sharing of $2,000 or more.[17]

Over time, the CMS has adopted stronger cost-sharing rules in Medicare Advantage and increased its upfront scrutiny of plans so that problematic charges are reduced before plans are offered to beneficiaries. A provision in the Affordable Care Act required that cost-sharing charges for certain services to be no higher in Medicare Advantage than they are for the same benefit in traditional Medicare.[18] For purposes of health care reform, it is significant that the problems in Medicare Advantage Medicare Advantage occurred even with protective mechanisms such as an increasingly sophisticated risk adjustment system and a prohibition against discriminating against people based on health status. HHS should avoid from the outset the types of benefit design and adverse selection problems that arose when insurers were given too much flexibility in Medicare Advantage by prohibiting insurer variation from a state's benchmark benefit for the EHB.

Benefit Design Flexibility: CHIP Benchmark Rules Differ in Many Respects from the HHS Bulletin

In the guidance, HHS proposes using "the same measures defined in CHIP" (42 CFR 457.431) to ensure that any of the proposed benefit flexibility that is exercised by insurers meets actuarial equivalence tests. But the approach suggested by HHS is actually quite different from the framework in CHIP, and HHS should clarify exactly how its proposal for benefit design flexibility would be similar to CHIP. In particular, it is significant that a benchmark or benchmark-equivalent plan selected by a state for CHIP is *uniform across the state* and is provided by all CHIP plans in the state (after being approved by HHS). Individual insurers cannot deviate from this standard. In the case of the EHB, HHS is proposing multiple variations *within* a state, at the insurer's discretion. This should not be allowed.

Benefit Design Flexibility: HHS Should Add Protections if Insurers Can Vary from the Benchmark Benefits

HHS should protect consumers by allowing only one EHB benchmark per state. Insurers should not be allowed to vary benefits. However, if HHS decides, despite the problems that would occur, to permit insurers to offer benefits that vary from a state's essential health benefits benchmark, a number of additional provisions and protections would need to be adopted.

For example, states should be able to implement their EHB standards in a manner that is more protective of consumers. If a state wants to pick one benchmark plan and not permit insurers to deviate from it that should be allowed.

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15 Edwin Park, *Informing the Debate about Curbing Medicare Advantage Overpayments* (Washington: Center on Budget and Policy Priorities, May 13, 2008) available online at http://www.cbpp.org/files/5-13-08health.pdf.

16 See, for example, Medicare Rights Center, "Too Good to Be True: The Fine Print in Medicare Private Health Plan Benefits," April 2007; Brian Biles, Lauren Hersch Nicholas and Stuart Guterman, "Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?" The Commonwealth Fund, May 2006; Medicare Payment Advisory Commission, "Report to Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans," December 2004; and Government Accountability Office, "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Serve May Not Always Reduce Beneficiary Out-of-Pocket Costs," February 2008.

17 Government Accountability Office, *Medicare Advantage: Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status*, (Washington: GAO, April 2010); Marsha Gold and Maria Cupples Hudson, *Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It Provide, and Should Standards Apply?* (Washington: AARP Public Policy Institute, March 2009).

18 GAO, April 2010, op cit.

HHS should also establish specific policies and procedures to help ensure that people with rare, high-cost, or significant health care needs are protected if insurers are allowed to modify their benefits compared to the benchmark. For example, insurers could be prohibited from varying from the benchmark for certain services, akin to the recent improvements in Medicare Advantage. HHS could also identify particular types of limits, levels of limits, and levels of variation from the benchmark benefits that would be of particular concern and would trigger a higher level of scrutiny from regulators. HHS should also implement requirements to ensure transparency if insurers are allowed to deviate from a state's benchmark benefits. Such variation should be clearly communicated to consumers and be subject to an approval process by the state (including requiring insurers to justify the benefit design changes). In general, HHS should detail the specific process for oversight and enforcement (both in the approval process and on an ongoing basis) if flexibility is allowed in insurer-benefit design. We expect that both states and the federal government would need to play a significant role.

Benefit Design Flexibility: Actuarial Equivalence Tests are Unlikely to Provide Sufficient Consumer Protections

As discussed above, HHS proposes to allow a health insurance issuer flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided the issuer continues to offer coverage for all ten statutory EHB categories. HHS proposes to require any substitutions by an insurer to be "actuarially equivalent" to the state's benchmark benefit, to ensure that the EHB package is not weakened overall. Two types of flexibility are considered: within benefit categories and across benefit categories.

Requiring actuarial equivalence may seem protective of consumers but in actuality is unlikely to be adequate. It is not at all clear that actuarial models in use today can accurately measure fine differences in benefits, even though such differences could be significant in their impact on individual plan enrollees.

Benefit Design Flexibility: Considerations for Actuarial Equivalence

Actuarial estimates vary greatly depending on the software being used and the assumptions employed to make the estimate.[19] If HHS proceeds to use actuarial equivalence as a standard for insurer benefits that vary from the standard benchmark, rigorous rules must be developed to make the actuarial equivalence standard is usable and meaningful. For example, a standard methodology and model must be used to make the estimates or HHS must require that the methodology and model has been certified that is has the capacity to gauge the impact of the fine differences being measured. The claims distribution underlying the model must be sufficiently robust to yield meaningful estimates. Merely requiring the analysis to be conducted "in accordance with the principles and standards of the Actuarial Standards Board" is insufficient. HHS should also promulgate rules for the actuarial equivalence calculations with respect to such elements as the benchmarking of costs, the standard population used for the estimate, utilization assumptions and the specificity of benefit categories to be used. Clearly some of the categories in the ACA are too broad to use when it comes to modeling the impact of small substitutions. Sensitivity testing by a reputable actuary must be used to test and fine-tune the rules.

Recommendations:

- Final guidance and regulations should require insurers to adhere to the chosen benchmark benefits in a given state and explicitly prohibit insurer flexibility to alter benefits.
- If insurer flexibility from the benchmark is retained at the federal level, states should be able to implement their EHB standards in a manner that is more protective of consumers. If a state wants to pick one benchmark plan and not permit insurers to deviate from it that should be allowed.

19 Lynn Quincy, *Creating A Usable Measure of Actuarial Value* (Washington: Consumers Union, January 2012)

- ❖ HHS should also establish specific policies and procedures to help ensure that people with rare, high-cost, or significant health care needs are protected if insurers are allowed to modify their benefits compared to the benchmark.
- ❖ HHS should detail the specific process for oversight and enforcement, if flexibility is allowed in insurer-benefit design.
- ❖ If HHS proceeds to use actuarial equivalence as a standard for insurer benefits that vary from the standard benchmark, rigorous rules must be developed to make the actuarial equivalence standard usable and meaningful. For example, a standard methodology and model must be used to make the estimates or HHS must require that the methodology and model has been certified that is has the capacity to gauge the impact of the fine differences being measured.

5. Collect and Disclose Data on Benchmark Plans and Their Benefits in a Timely and Consumer-Friendly Manner and Provide an Opportunity For Public Comment

Section 1302 of the Affordable Care Act requires the Secretary "provide notice and an opportunity for public comment" when defining and revising the EHB.[20] If a benchmark plan approach is pursued for 2014 and 2015, the Secretary must require HHS to collect and disclose data on benchmark plans and also require that states provide public opportunity to comment on how and what benchmark plan they'll choose. It is especially important that stakeholders also have information on the potential default plan in the state, and that they have an opportunity to comment on the plan's benefits and recommend any needed modifications should the state fail to select a plan.

The Bulletin proposes that benchmark plans be determined using "enrollment data from the first quarter two years prior to the coverage year and that States will select a benchmark in the third quarter two years prior to the coverage year." Under this guidance, benchmark plans for 2014 would be based on plan enrollment data from the first quarter of 2012 and a state would have to decide on their benchmark plan by the end of the 2012 year. Given this short timeline, we propose that HHS must collect data on benchmark plans according to the first quarter requirement and then publicly disclose information on benchmark plans within 45 days after they've finished collection or provided the most current data on benchmark plans until the newly collected data becomes available. HHS must collect the data on benchmark plans and cannot rely on states to collect and provide such information to the public. We have heard from many consumer advocates in states who contacted their state insurance departments for plan data but found that the department either did not the authority to collect the data or could not share it because such information was proprietary.

We are also recommending that all plan documents for potential benchmark plans discussing benefits, limits, and restrictions be disclosed. HHS must collect data on all of the proposed benchmark plan options a standardized format and provide an easy-to-read, consumer friendly comparison chart listing all the benchmark plans in a state. The chart should list the ten required categories of services and a comprehensive description of benefits under each category. The columns in the chart would list whether or not each specific benefit is covered under the different benchmark plans and include information on any benefit limits and restrictions. Benefits covered by a plan that do not clearly fall under any of the ten categories should also be included in the chart.

Additionally, information about plan benefits that is readily available may not be detailed enough to determine the specific services that are covered. For example, does adopting a particular benchmark plan also entail adoption of that plan's clinical policy bulletins? If so, will states review these bulletins prior to making a decision on benchmark plans – and do states have the capacity to provide meaningful reviews of this information? HHS must address this in future guidance.

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20 *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public Law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1302 (b)(3).

Lastly, while we understand that the state entity that will have the authority to select the benchmark may vary from state to state and is subject to state law, HHS must ensure that all states implement a transparent process for selecting a benchmark plan and include opportunity for public comment and stakeholder engagement. Consumers should have the ability to review proposed benchmarks and provide comments. States should be required to solicit comments through in-person events such as townhalls and hearings as well as through at least one electronic means like email or comment submissions through a web portal. All comments should be open to public viewing. Once a state has allowed for public comment and selected a benchmark plan, they must provide a written justification for why the specific benchmark plan was chosen.

Recommendations:

- HHS must collect data on benchmark plans according to the first quarter requirement and then publicly disclose the collected information on benchmark plans within 45 days after they've finished collection or provided the most current data on benchmark plans until the newly collected data becomes available.
- HHS must collect the data in a standardized format and provide an easy-to-read, consumer friendly comparison chart listing all the benchmark plans in a state and details about the benefits they cover, including limits and exclusions.
- The Secretary must require and ensure that states provide a public comment period every time they decide to choose a benchmark plan.
- A state should be required to solicit comments through in-person events such as townhalls and hearings as well as through at least one electronic means like email or comment submissions through a web portal. All comments should be open to public viewing.
- Once a state has allowed for public comment and selected a benchmark plan, they should be required to provide a written and clear justification for why the specific benchmark plan was chosen.

6. Address State Benefit Mandates

Section 1311(d)(3)(B) of the Affordable Care Act requires states to defray the cost of any state-mandated benefit that exceeds what is covered under the EHB package for the enrollees of a Qualified Health Plan (QHP).State advocates, disease, and chronic illness groups are concerned that this could lead to the repeal of important mandates that many residents rely on in order to receive care they need. The Bulletin proposes that a state could keep their mandates if they choose a benchmark plan subject to state benefit mandates. We are grateful that HHS has given consideration to state mandates, but HHS should still help states to consider all of the information they need to make wise decisions. For instance, states should not choose a benchmark plan solely on the fact that it will maintain their mandates without giving full consideration as to whether the benchmark plan also covers other important services. Vice versa, a state should not chooses a plan which is exempt from its state mandates without first weighing whether the plan covers vital services that consumers need and that have been protected by a mandate in the past.

First, states need to know how mandates are covered by all benchmark plan options so that they can make the best choice for their state. Because of the lack of available data on benchmark plans and concerns about state mandates, HHS must provide an analysis on state mandates when they release data on the benchmark plans. This analysis must answer 1) What scope of coverage do state mandates cover now? 2) To what degree to do the different benchmark plans cover state mandated services?

Secondly, states need guidance on what costs they would have to defray if they wish to retain a mandate but do not pick a benchmark plan for which those mandates apply. States need to know how the cost of additional mandates will be determined and HHS should specify that there is no additional cost for retaining a mandate that in the long-run reduces, rather than increases, health care costs.

Third, HHS should clarify that some types of mandates are not affected by Section 1311(d)(3)(B). For

example, state laws that require plans to reimburse nurses and other health professionals for performing services within their scope of practice ("provider mandates") are laws about how a service will be provided, not whether a benefit is covered, and we assume that these state laws still stand.

Another issue that HHS will have to address is state benefit mandates that that have yet to go effect in 2012 or 2013. Because as the Bulletin seems to suggest that benchmark plans are based on a point and time look at plans from the first quarter two years prior to the coverage year, mandates that are enacted in the later quarters of the year would not be included in the benchmark plans subject to state mandates. Since HHS is planning on reassessing how to define the EHB in 2016, this time lag for when new mandates go into effect and when the benchmark plans are locked in would mainly affect consumers in 2014. That's because new mandates that go into effect later this year or in 2013 would not be included in the benchmark plans for 2014. Would states have to defray the cost of these mandates for 2014? But would they not have to defray the cost of these additional mandates in 2015 because the mandates have become part of the benchmark plans states can choose from?

Benefit mandates cover a wide scope of services, and many were enacted in response to consumer concerns about coverage gaps. For instance, many states recently enacted autism coverage mandates, and state work on breast reconstruction mandates in the 1990s preceded federal legislation. Before 2016, the Secretary must study the benefits that states currently mandate and require the EHB to explicitly include mandates which occur with high frequency among states, as well as those grounded in strong medical evidence. This evaluative process should be transparent and include stakeholder input. She should carefully consider the consequences of omitting any state mandated service from the EHB package. This analysis should help the Secretary set requirements for 2016 if she puts forth a uniform EHB floor for all states, as we recommend. Even if a benchmark approach remains in 2016, the Secretary should mandate that the EHB standard include certain benefits.

Recommendations:

- HHS must provide an analysis on state mandates when they release data on the benchmark plans. This analysis must answer 1) What scope of coverage do state mandates cover now? 2) To what degree to do the different benchmark plans cover state mandated services?
- The Secretary should study the benefits that states currently mandate and require the EHB explicitly include mandates which occur with high frequency among states, as well as those grounded in strong medical evidence. This evaluative process should be transparent and include stakeholder input.

7. Develop Transparent and Inclusive Process for Updating the Essential Health Benefits Package

HHS proposes to require states to use enrollment data from the first quarter two years prior to the coverage year to determine benchmarks and to select a benchmark in the third quarter two years prior to the coverage year. This seems to suggest, but does not make clear that states will be required to actively designate an EHB package for each year, selected from the plans that would qualify as a benchmark based on plan enrollment. If this is the case, HHS should make clear states must make an annual choice (or use the default benchmark plan) and that once they make that choice, benefits cannot be reduced during the plan year. HHS should also require states to detail for consumers year-to-year changes in the EHB so consumers can easily identify how coverage will change under the EHB.

The Bulletin also states that "the provision of a 'substantially equal' standard would allow health insurance issuers to update their benefits on an annual basis and they would be expected on an ongoing basis to reflect improvements in the quality and practice of medicine." While insurers should be expected on an ongoing basis to reflect improvements in the quality and practice of medicine, the law requires the Secretary to update the EHB. Insurers should not be able to make changes to the benefits they offer under the EHB package without HHS approval. Changes and updates to the EHB, in general, must be made by the Secretary and driven by medical evidence and guidelines, not by the insurance market and insurers.

As the Institute of Medicine recommended in their report on Essential Health Benefits, we believe HHS should establish a benefit council that would make recommendations to the Secretary about changes to the EHB package. This council should work with expert researchers and medical professionals, as well as consumer advocates that can speak on the various coverage categories. It should consider advances in medical science and the experiences of consumers seeking to obtain needed care gathered through public comment and the appeals system. Additionally, the Secretary should have the authority to add new services, prescriptions, and devices to the package that are comparatively more effective and will provide substantial savings in the future, even if they are not fully cost-neutral at the time. Adding such new services would reduce health care costs in the long run.

In addition, HHS should establish robust data collection requirements for states and carriers to ensure it has the data needed to accurately assess the impact of the benchmark approach on consumers. This data will be necessary for two reasons. First, it will be necessary to meet the Secretary's statutory obligation to periodically review and update the EHB to address any gaps in access to coverage or changes in medical evidence or scientific advancement. It will also be necessary to inform HHS's evaluation of the benchmark approach for the calendar year 2016 and to assess whether defining a federal EHB coverage floor would better address access to care, consumer choice, risk selection, and the Affordable Care Act's goal of establishing a minimum level of benefits.

Recommendations:

- ❖ HHS should make clear that states must make an annual choice (or use the default benchmark plan) with benefits locked in for the plan year. HHS should also require states to detail for consumers year-to-year changes in the EHB so consumers can easily identify how coverage will change under the EHB.
- ❖ Changes and updates to the EHB must be made by the Secretary and driven by medical evidence and guidelines, not by the insurance market and insurers.
- ❖ HHS should establish a benefit council that would make recommendations to the Secretary about changes to the EHB package. This council should work with expert researchers and medical professionals, as well as consumer advocates that can speak on the various coverage categories. It should consider advances in medical science and the experiences of consumers seeking to obtain needed care gathered through public comment and the appeals system.
- ❖ HHS should establish robust data collection requirements for states and carriers to ensure it has the data needed to accurately assess the impact of the benchmark approach on consumers.

8. Address How the Essential Health Benefits Will Be Implemented into the Medicaid Program and Basic Health Plan Option

The EHB will affect low-income individuals and families covered through the Medicaid expansion, Medicaid benchmark plans, and through Basic Health programs that states may offer. The Bulletin notes that there will be future guidance on EHB implementation in the Medicaid program; however, there are some issues that we would like to note that are relevant to both Medicaid and Basic Health.

Release Guidance on EHB Implementation in Medicaid as Soon as Possible. First, it is essential that HHS share any additional information on the benchmark packages as soon as possible, including the upcoming guidance on EHB and Medicaid. States need more concrete information on benefit requirements in order to both prepare for the Medicaid expansion and determine whether to pursue the Basic Health option.

Design EHB to Promote Care Coordination Across Programs. Individuals will undoubtedly move between the Exchanges, Medicaid, CHIP, and Basic Health; some will transition between those programs frequently. The Secretary should encourage states to promote coordination with existing programs. Coordination between insurance options is a key to continuity of care, which is critical to improving

population health and, ultimately, lowering overall health care costs. Continuity in coverage is essential for continuity of care, particularly for lower-income individuals who do not have the option to pay for services if coverage is lost. Many of the comments made in the prior sections of this document are designed to not only ensure a comprehensive EHB package, but to ensure that EHB is a package that can be more easily coordinated across programs.

Creating a uniform coverage floor and defining comprehensive coverage for all ten categories for EHB, as recommended above, should help promote continuity of care as individuals move between programs as their financial circumstances change.

Offer Medicaid as a Benchmark Option for Pediatric Services. Regarding children, we urge that state Medicaid plan be available as a benchmark plan for pediatric services. "Pediatric services, including oral and vision care," were identified as one of the ten specific categories in the list of "Essential Health Benefits" in the statute. This indicates that Congress was aware of developing children's special health care needs. However, the Bulletin does not give adequate attention to the special needs of this population.

- EPSDT should be included in the children's EHB package. This will ensure that children have access to necessary diagnostic and screening services as they develop.
- Ensure that EHB recognizes that children may need services at a different frequency than adults. For example, as they grow, children who need wheelchairs or prosthetics require more frequent equipment changes than do adults with comparable needs.
- States should have the option of using the state Medicaid plan for pediatric services as the benchmark plan for children. This would include EPSDT, vision, and dental benefits that would ensure that children have access to services they need as they grow.

Ensuring that the EHB includes these changes, and that the Medicaid plan is available as a benchmark for pediatric care, will guarantee not only that children in the Exchanges have access to needed to care, but also that children continue to have access to critical services if they transition from one program to another.

In its guidance on EHB and Medicaid, the Secretary should make it clear that the requirements for EHB do not in any way change children's entitlement to EPSDT, dental, or any other pediatric services currently covered by the Medicaid program.

Incorporate Data Collection on Individuals Who Transition Between Programs. Data collection—specifically information on how individuals fare when they transition between traditional Medicaid, the expansion, CHIP, the Exchanges, and Basic Health—will be critical to ensuring that the EHB package is providing individuals with the needed access to care and that the Affordable Care Act is meeting its goals. This should include data collection on outcomes as well as consumer reported information. Information collected from consumers who transition across programs should include: continued access to services, particularly services that were being received at the time of transition between programs; ease of transition; availability of information and assistance during the transition process; continued access to providers; and, overall satisfaction with access and medical care.

Recommendations:

- ❖ Release guidance on EHB and Medicaid as soon as possible.
- ❖ Encourage states to promote coordination between programs.
- ❖ Include EPSDT in the EHB for children.
- ❖ Ensure that the EHB for pediatric services recognizes that children have special needs for services beyond vision and dental.
- ❖ Allow states to use Medicaid pediatric services as a benchmark plan for children; Include EPSDT in the children's package or give states the option to include it.

- ❖ In the forthcoming Medicaid/EHB guidance, clearly state that the requirements in EHB do not in any way alter states' requirement regarding pediatric services in Medicaid (e.g., EPSDT, dental, vision).
- ❖ Collect data to measure continuity of care for and satisfaction of individuals who transition between programs.

Thank you for considering our comments. If you have any questions, please do not hesitate to contact Cheryl Fish-Parcham at CParcham@familiesusa.org or at 202-628-3030.

Sincerely,

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