American Hospital Association

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January 27, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CCIIO: Essential Health Benefits Bulletin December 16, 2011

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Center for Consumer Information and Insurance Oversight's (CCIIO) Essential Health Benefits (EHB) Bulletin released December 16 that outlines the proposed regulatory approach to define EHBs under the *Patient Protection and Affordable Care Act* (ACA).

The AHA is concerned that the efforts to date on defining EHBs may undermine one of the fundamental tenants of the ACA – that is, to extend meaningful *and* affordable coverage to millions of people who are currently uninsured or underinsured. The definition of EHBs is critical to determining whether the health coverage purchased is actually meaningful. The work of the Institute of Medicine (IOM) on this subject and the recent issuance of the CCIIO EHB Bulletin suggest that in the struggle to balance affordability with comprehensiveness of health benefits, the recommendations consistently tilt in favor of affordability.

The IOM recommended tying EHBs to the typical, small employer health plan, and the CCIIO EHB Bulletin looks to build on the IOM recommendation by allowing states to choose from four "benchmark" health plans that reflect the scope of services offered by a "typical employer plan" in that state. Those benchmarks already reflect limitations on services and significant deductibles, coinsurance and copayments. Further, yet-to-be published rules for how to determine the actuarial value of the bronze, silver, gold and platinum level plans are likely to further reduce coverage or increase cost sharing for those plans limited to coverage of EHBs.

What is missing in both the IOM and CCIIO recommendations is an approach that matches the individual's needs for a range of services grounded in evidence-based guidelines. The IOM, at the direction of the Department of Health and Human Services (HHS), sought public and stakeholder input on defining a process to determine the EHB package as stipulated in the ACA. The AHA participated in the IOM's deliberations regarding EHBs through testimony by Linda Fishman, AHA's senior vice president for public policy analysis and development, on January 14, 2011.

The AHA recommended a framework for defining EHBs, which we believe CCIIO should consider in its approach to define essential health services. That framework is:

> ***Basic Principle.*** *The essential benefits package should cover treatment that: encompasses a broad range of services, including medical, psychiatric, rehabilitative, dental, vision, preventive and hospice services, as well as pharmaceuticals; is driven by the needs of the individual; is generally available; and adheres to accepted professional guidelines.*
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> *From this basic principle, we suggest a three-pronged framework for assessing which benefits to include:*
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> - *Are the benefits responsive to individual needs?*
> - *Do the benefits take affordability into account?*
> - *Are the benefits easily understood and transparent?*

COMMENTS SPECIFIC TO THE EHB BULLETIN

The comments that follow apply this basic principle and framework to the recommendations in the EHB Bulletin. According to the EHB Bulletin, states can choose from four "benchmark" plan options, which include the largest small group plan in their state, largest state employee health plan, largest federal employee health plan and largest commercial health maintenance organization in their state. It is important to note that use of the "benchmark" approach raises concerns that benefits would be further limited by two factors:

- The scope of services that remain outside of the benchmark plan; and
- The embedded actuarial valuation and cost-sharing amounts within the benchmark plan.

<u>*Responsive to Individual Needs*</u>. The AHA believes that the essential benefits definition needs to be comprehensive enough to encompass the services that respond to an individual's health care needs, recognizing that a person's age and medical condition(s) will dictate what services are most important. The criteria should take into account diverse segments of the population and focus on the services that are widely accepted to improve health outcomes for those populations, which may necessitate supplemental or alternative benefits. The EHB Bulletin acknowledges that there are gaps in the benchmark approach, particularly as it relates to behavioral health, pediatric oral and vision, and habilitative services that are often not included in the typical small employer plan.

The AHA continues to believe that any limits placed on the services included in the essential benefits package should be grounded in clinical best practices and could include, for example, the number and frequency of diagnostic tests or procedures. Such limits should focus on services that are marginally effective and could change as underlying scientific evidence or comparative effectiveness research informs the creation of, or revisions to, clinical best practices. Particular types of services should not be eliminated wholesale – to do so would discriminate against individuals with medical conditions or disabilities that require those services. The essential benefit criteria also should consider the rapid pace of change in medical practice, as clinical, technological and pharmaceutical advances are made.

Specifically with regard to habilitation services, the AHA believes that restoring or maintaining function should be part of habilitative services and would agree with the option in the EHB Bulletin that says habilitative services should be offered at parity with rehabilitative services. The AHA also supports the position in the EHB Bulletin that behavioral health treatment should be included as mental health and substance use disorder services, consistent with congressional intent on mental health parity. And, with respect to pediatric oral and vision services, the AHA recommends that CCIIO take into account the clinical best practices research regarding the long-term benefit of such services for the pediatric population whose growth and development leads to productive adulthood.

Benefits that Address Affordability. The ACA requires that four levels of qualified health plans – bronze, silver, gold and platinum – be offered through the health insurance exchanges. These plans vary by the level of individual cost sharing. The AHA believes that the affordability of the EHBs could be governed by the cost sharing amounts among the four levels of qualified health plans. Under this approach, the benefits covered would not vary; rather what would vary is the cost sharing for which the individual would be responsible. This would establish a universal baseline of benefits and prevent insurers from picking and choosing the benefits that are covered, for example, excluding psychiatric or inpatient rehabilitation services.

The EHB Bulletin does not address issues of plan actuarial value nor does it specifically address the cost-sharing amounts specified in the ACA metal-level plans, choosing instead to defer discussion on those implementation issues to later guidance. However, one significant concern with the benchmark plan approach proposed by the EHB Bulletin is that embedded in this approach are actuarial value assessments and specified cost-sharing amounts for covered services. CCIIO needs to clarify that the use of the benchmark approach should not incorporate all the underlying decisions regarding actuarial value and cost-sharing in the various state, federal or commercial plans selected as the benchmark. The use of the benchmark should be limited to the range of covered services only and not include the actuarial or cost-sharing limits. If this benchmark approach does not explicitly clarify that such underlying limitations do not apply, it will implicitly incorporate significant limitations to needed services and undermine congressional intent of the use of the four metal-level plans to distinguish qualified health plans offered in the exchange.

Benefits that are Easily Understood and Transparent. The EHB package, as defined, should be easily understood so that individuals know what their health plan policy does and does not cover. Insurers make coverage and treatment decisions by determining what is "medically necessary," and defining that term is left largely to the insurers. No consistent federal or state definitions exist. This lack of a consistent or recognized standard allows insurers to control not only coverage decisions, but also treatment decisions, sometimes overriding clinical standards and the patient's needs. When an insurer uses its definition of medical necessity to exclude costly care, enrollees often do not know what will and will not be covered. Similarly, enrollees and providers should be able to rely on a health plan's prior authorization decision for a procedure or admission; but even under the reforms recently enacted, insurers are allowed to retroactively deny services that they preauthorized. The rules and decision processes that govern EHBs, medical necessity and pre-authorization decisions made by qualified health plans should be transparent so that enrollees understand the limitations of their health coverage. There also should be a means by which a health plan's decisions can be reviewed by an objective third party to ensure that plans properly adhere to appropriate clinical practice guidelines.

The EHB Bulletin allows the state to determine not only the benchmark plan to be used but also the process for developing EHBs within the state. The EHB Bulletin also allows plans to modify such coverage within a benefit category, as long as the modifications do not reduce the value of coverage. The AHA believes that an open, transparent process regarding the establishment of EHBs should be part of the ACA implementation. The AHA recommends that the state consult with the public and stakeholder community prior to a final selection of the EHB benchmark plan and that HHS require public consultation as part of its overall approval of a state's EHB plan and exchange certification. The AHA also recommends that if a plan modifies coverage within a benefit category, that information about the change be made publicly available through the state and health insurance exchange information systems.

The AHA strongly believes that an open and transparent process should govern the establishment of EHBs as well as any future updating and change to EHBs. The issuance of the CCIIO's EHB Bulletin and further sub-regulatory guidance as the primary approach to implementation is disturbing. The AHA encourages HHS to make sure that the full regulatory process is followed to ensure that the public has ample opportunity to participate in this important debate.

Thank you for your consideration of our comments. We look forward to working with you and your staff on further implementation of the ACA. If you have any questions, please contact me, Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org, or Ellen Pryga, policy director, at (202) 626-2267 or epryga@aha.org.

Sincerely,

Rick Pollack
Executive Vice President