



*Champions for Children's Health*

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January 31, 2012

Secretary Kathleen Sebelius  
U.S. Department of Health and Human Services  
200 Independence Avenue, Southwest  
Washington, DC 20201

Dear Secretary Sebelius:

On behalf of children's hospitals across the country, the Children's Hospital Association (formerly the National Association of Children's Hospitals) appreciates the opportunity to provide comments on the Dec. 16, 2011, Essential Health Benefits Bulletin. We have a number of concerns regarding the approach outlined in the bulletin, both with the general approach that delegates definition of the essential health benefits package to states, and with specific aspects of the approach, if implemented as proposed.

Children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. Though children's hospitals account for only 5 percent of hospitals in the United States, they care for 47 percent of all children admitted to a hospital. Children's hospitals also provide almost all of the care for children with cancer, cardiac conditions, cystic fibrosis and spina bifida. Children's hospitals are regional centers for children's health, providing care across large geographic areas and often serving children across state lines.

As advocates for children's health, we have strong concerns regarding the regulatory approach outlined in the Dec. 16 bulletin. As we have previously expressed, we believe that the language of the Affordable Care Act (ACA) requires HHS to define a benefits package that considers the unique health care needs of children. The Dec. 16 bulletin deviates significantly from this approach. The proposed approach outlined in the bulletin, if implemented by HHS, will result in an essential health benefit that does not adequately consider or represent children's health care needs; that is defined by states with no requirement for transparency or public feedback; and that may allow insurers to deviate to an inappropriate degree from what was intended to be a standard benefits package. These concerns are discussed in detail below.

### **Pediatric Services**

The ACA lists 10 benefits categories that must be addressed in the essential health benefits package, including "pediatric services, including oral and vision care." Congress listed pediatric services – which includes **but is not limited to** pediatric oral and vision services – in its own category to emphasize that children depend upon, and should have access to, services beyond those that may

fall into one of the other benefit categories. Children are in continuous stages of development, so their capabilities, physiology, judgment, and responses to interventions constantly change and must be continuously monitored. Additionally, a segment of children suffer from chronic conditions that affect their development and that require specific attention in order to generate, maintain, and restore age-appropriate functioning. To adequately address these unique needs, the essential health benefits package should provide children with access to all medically necessary services, similar to the standard used in Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

The Dec. 16 bulletin fails to define pediatric services, beyond addressing pediatric oral and vision services. Further, the proposed benchmark approach does not account for the unique health care needs of children as Congress intended. The commercial plans eligible for selection as benchmark plans were designed to address the health care needs of adults, with little to no consideration of the health care needs of children. Reliance on coverage offered through such plans to define the essential health benefits package will likely leave gaps in coverage for children, particularly those with chronic and complex conditions. For example, commercial plans routinely limit coverage for services such as therapies (physical, speech and occupational), home health care, durable medical equipment and personal care. Such services may be necessary for children to attain, improve, or maintain function.

In addition, as regional providers of children's health care, children's hospitals are concerned that the proposed benchmark approach will result in children's access to certain services being dependent on the state in which they live. For example, although 29 states currently require autism coverage, some states do not require autism treatment at all. Unless autism treatment is included in the federal definition of behavioral health services, children in states where there is no mandate for autism benefits (or those in states that choose a benchmark plan not subject to coverage mandates) will not be able to access those services through their qualified health plan. Further, coverage for children's mental health services can vary widely from state to state. This contrasts with the intent of the provisions of the ACA, which were clearly meant to provide protections and standardization to those accessing coverage through the state Exchanges.

We continue to urge the Secretary to define an essential health benefits package for children that includes comprehensive coverage based on medical necessity for children. However, if the current proposed approach is adopted through regulation, we respectfully suggest that HHS allow states to select their Children's Health Insurance Plan coverage to serve as a benchmark benefit plan for children. This would allow states to ensure that the benefits for children are adopted from a plan that was developed for the pediatric population. This approach is also supported by the requirement of § 10203(c)(2)(C) of the ACA, which states that HHS must certify by April 1, 2015, qualified health plans for which benefits and cost-sharing for children are at least comparable to those under state CHIP plans.

### **Benefits Not Typically Covered by Commercial Plans**

The bulletin addresses certain categories of benefits that are not typically covered by the commercial plans that may be considered as a benchmark plan. Those benefits – habilitation and pediatric oral and vision services – are particularly relevant to the pediatric population. Since coverage in these categories is likely to be lacking due to non-coverage in commercial plans, we suggest that HHS

define these benefits for children based on medical necessity, perhaps by allowing states to model their benchmark benefits on coverage through their Medicaid programs.

The bulletin specifically requests comment regarding the definition of “habilitation” and whether that definition should include “keeping” or “maintaining” function, since “this concept is virtually unknown in commercial insurance.” We assert that including maintenance of function in the definition of habilitative services is critical for children with severe disabilities, who may need such services to prevent them from regressing in function, such as during a plateau in treatment.

The bulletin also proposes an alternative approach to defining these benefits that would allow plans to determine what coverage to offer and to report on that coverage to HHS. We strongly oppose any approach that would allow the plans themselves to define the essential health benefits.

### **Oversight and Transparency**

We are also concerned that the proposed approach delegates a tremendous amount of authority to states to define the essential health benefits package, with no mention of how HHS will fulfill some of the oversight responsibilities required by the statute. Those responsibilities include ensuring that there is a balance among the benefit categories; that benefits are not designed in a way that discriminates based on age, disability, or expected length of life; and that benefits account for the health needs of diverse segments of the population. Congress clearly intended that HHS define and oversee an essential health benefits package that does not simply codify some of the discriminatory practices and gaps in coverage currently seen in commercial insurance products.

Further, the bulletin does not outline any process by which states will select or update an essential benefits package. Section 1302(b)(3) of the ACA requires the Secretary to provide notice and an opportunity for public comment when defining the essential health benefit. Clearly Congress intended definition of the essential health benefit package to be a transparent process that includes public input. Although HHS did solicit a great amount of public input in determining its approach to the essential health benefit, its proposed approach would allow states to define the benefits package by selecting a benchmark through a process that is not required to be transparent or to include solicitation of public feedback. If HHS implements its proposed approach, we strongly believe the statutory requirement of notice and an opportunity for public comment should be passed on to states through a process defined by HHS in the implementing regulation.

### **Plan Flexibility**

We are concerned that the bulletin proposes that qualified health plans must only be “substantially equal” in value to the benefits offered through the benchmark plan. Although “substantially equal” is not defined, it appears that insurers would have significant flexibility to vary benefits, both within and across benefits categories. Insurers may rely on this flexibility to avoid the difficult task of implementing coverage for benefits that they have not typically offered, such as habilitation and pediatric oral and vision services. This result would have a detrimental effect on children’s coverage, as discussed above. Further, this approach would erode a primary purpose of the essential health benefits requirement, which is to provide consumers with a standardized, comprehensive set of benefits. Those purchasing plans through the state Exchanges would lose the benefit of being able to “compare apples to apples” when choosing among plans based on benefits. Finally, this approach

may allow plans to avoid risk by varying benefits packages to attract desirable enrollees – a result that is clearly contrary to the intent of the ACA. We ask that HHS define “substantially equal” and create a process for assessing and enforcing this standard.

We appreciate the opportunity to provide feedback on this bulletin and would be happy to provide further information on the implications for the pediatric population.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Wietecha". The signature is written in a cursive style with a large, sweeping initial "M".

Mark Wietecha  
President and Chief Executive Officer