ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244–8010

Submitted via EssentialHealthBenefits@cms.hhs.gov

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

Dear Secretary Sebelius:

Consumers Union, the advocacy and policy division of *Consumer Reports*, submits these comments regarding the Essential Health Benefits Bulletin ("Bulletin") dated December 16, 2011, issued by the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight (HHS).

Defining Essential Health Benefits (EHBs), a cornerstone of federal health reform, is a critical component of our new health care law, the Patient Protection and Affordable Care Act (ACA). After all, coverage for the medical services consumers need, at a price they can afford, is where the rubber meets the road for consumers.

To realize the full promise of health reform, and for the reasons set forth below, we strongly urge revision of some of the proposed approaches included in the Bulletin, particularly proposals to delegate benefits flexibility to insurers.

The Patient Protection and Affordable Care Act requires the Secretary to define the essential health benefits.[1] The law states that it is the Secretary's responsibility to "ensure that the scope of essential health benefits… is equal to the scope of benefits provided under a typical employer plan."[2] The intent of this provision is to promote health and well-being by establishing standards for coverage across the individual and small group insurance markets.

HHS Must Provide Additional Guidance to Ensure that ACA Requirements are Met

A central tenet in the Bulletin is a proposal to delegate to each state the authority to identify a benchmark plan, using federally established parameters. To ensure that the benchmark plan in each state complies with the requirements of the ACA, HHS must go beyond the initial proposed criteria for selecting a benchmark plan.

HHS must precisely define the scope and services within each of the 10 benefit categories required by the ACA. Traditional plans do not categorize their services within the same benefit categories or use the same terminology as the ACA uses. In the absence of further

[1] Affordable Care Act, Section 1302 (b)(1).
[2] Affordable Care Act, Section 1302(b)(2)(A)

guidance from HHS, it is unclear how the essential health benefit package could be compared to potential benchmark plans to ensure that it complies with the ACA. 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' standards. Any ambiguity with respect to what constitutes coverage of the 10 benefit categories may be exploited by insures, will lead to consumer confusion and tie up resources in an effort to establish where legal compliance begins and ends.

HHS recognizes that the benchmark plan selected is likely to require adding in benefits in order to incorporate benefits required by the ACA but often missing from benchmark plan options, like habilitative services or pediatric dental. The Bulletin contemplates a number of approaches whereby the state could essentially "borrow" the coverage approach from another benchmark plan. However, the Bulletin recognizes that even this may be insufficient if no benchmark option offers habilitative services, for example. In keeping with our request above, **HHS should provide a complete description of a coverage "safe harbor" for each of the 10 required benefit categories**. States would be deemed in compliance with the law if the benchmark package in their state includes coverage at that level. Stronger coverage designs could be included, using the benchmarking process described in the Bulletin, but not weaker coverage. This federal floor should provide a sufficiently robust level of coverage and should not inappropriately restrict the benefits needed by people with significant, specialized, or high-cost health care needs.

The State Process for Selecting A Benchmark Plan Must Require Timely Data and Allow for Public Input

If a state benchmarking process is to be used, a complete description of plan designs that qualify as benchmark plans must be made public on a timely basis, with an opportunity for public comment required.

Federal Review to Ensure that State Selections Conform to ACA and Regulatory Requirements

We recommend annual federal review to ensure that state benchmark plans comport with federal law. HHS should carefully consider comments made as part of the state's public review process. These comments and final federal decisions on the benchmark plans' validity must also be made public.

Insurer-Derived Benefits Variations Should Not be Part of the Rule

The other forms of flexibility proposed in the Bulletin are considerably more problematic.

The Bulletin considers two additional categories of benefit design flexibility. One is to allow health insurance issuers flexibility to adjust within benefit categories – including both the specific services covered and any quantitative limits – provided that such

substitutions are "actuarially equivalent" to the state benchmark and provide coverage for all 10 statutory EHB categories. (See discussion below on the weaknesses of "actuarial equivalency.") The second is to allow insurers to substitute across benefit categories.

Consumers Union Strongly Opposes Both Forms of Insurer-Derived Benefits Flexibility

Both forms of modification open the door for risk selection and consumer confusion. If the proposal in the Bulletin is promulgated as a regulation, insurers could use their flexibility to craft benefit packages that attract certain populations at the expense of others -- perpetuating the risk selection we see in the market today. Indeed, the benefits flexibility permitted to Medicare Advantage plans has been demonstrated to result in designs that attract favorable risk.[3] To illustrate, an insurer could put together a benefit package that substitutes physical therapy services that treat short-term sports injuries, for services that treat more chronic conditions, thus attracting a healthier population or denying necessary coverage for people with disabilities who have an ongoing need for regular physical therapy.

Permitting insurer-driven variations in covered services would undermine the promise of a uniform floor of medical service coverage and would create a "Tower of Babel" problem for consumers. That is, numerous, minor variations in coverage will make it extremely difficult for consumers to make valid, straightforward comparisons among the many products. It will make it far more difficult for exchanges to structure clear health plan comparisons, as envisioned by the ACA.

Moreover, issuer flexibility would make it extremely challenging for state regulators and the Secretary to assess the essential health benefits in each product and for the Secretary to accurately report to Congress about their adequacy and need for modifications and updates to meet the requirements of the ACA.[4]

More Consumer Choice Does Not Always Increase Consumer Welfare

HHS justifies the proposal to allow insurer-derived benefits flexibility by stating "[p]ermitting flexibility would provide greater choice to consumers, promoting plan innovation through coverage and design options…" Upon critical examination, neither of these justifications is persuasive.

Consumer behavioral research in general – and with respect to insurance choices specifically – shows that too much choice does *not* benefit consumers. It is cognitively impossible to meaningfully evaluate a large number of choices. In fact, consumer

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[3] 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.
[4] Affordable Care Act, Section 1302(b)(4)(G) and (H)

research has shown that having too many options reduces consumers' willingness to make a selection.[5]

This general principal is especially applicable to health insurance – a particularly difficult product for consumers to assess.[6] Extensive consumer testing in Massachusetts found that the ideal number of plan designs was 6-9. Further, the final designs differed only with respect to their cost-sharing provisions (with minor exceptions).[7] Significantly, consumers were *not* clamoring for additional variation in covered services to be added to their choices.

We are similarly challenged to come up with an example of how 40 years of insurer flexibility has resulted in product design innovations that benefit consumers in the non-group and small group markets. As demonstrated by consumer testing, consumers are completely befuddled by the products available today.[8] The record is even more disturbing in markets like Medicare Advantage where insurers are required to accept all applicants. Rather than a record of innovation benefiting consumers, we find that benefits flexibility was used to engage in risk selection to the benefit of insurers.[9]

The final rule on Essential Health Benefits should include a justification for any benefits flexibility that is included, but greater consumer choice and insurer innovation should not make the list. We strongly urge HHS to take a much more critical look at both of these claims.

Actuarial Equivalence Does Not Provide Adequate Protection for Consumers

In proposing insurer-driven benefits flexibility, the Bulletin proposes to protect consumers by requiring that any substitutions be actuarially equivalent. An actuarial equivalence test is not workable nor would it be sufficiently protective if it were workable.

Actuarial models are not well suited to the task of measuring fine gradations in service offerings. The primary task of actuarial models is to gauge the impact of plan cost-

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[5] We see this clearly in the Medicare Advantage program. A recent study found that Medicare beneficiaries were more likely to enroll in the program when their options were limited and less likely to opt for Medicare Advantage when their options became too numerous. J. Michael McWilliams, Christopher C. Afendulis, Thomas G. McGuire, and Bruce E. Landon. "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those With Impaired Decision Making," *Health Affairs*, August 18, 2011. http://content.healthaffairs.org/content/early/2011/08/16/hlthaff.2011.0132

[6] L. Quincy, *What's Behind The Door: Consumers' Difficulties Selecting Health Plans,* Consumers Union, January 2012.

[7] *Health Reform Toolkit Series: Resources from the Massachusetts Experience, Determining Health Benefits Designs to be offered on a State Health Insurance Exchange*, November 2011. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/MassachusettsExperienceBenefitDesignsToolkit.pdf.

[8] Quincy, op cit.

[9] Biles, op cit.

sharing provisions across a defined set of medical services. As proposed in the Bulletin, the equivalency calculation would not be measuring differences in cost-sharing, but differences in the medical services and the impact of inside limits. It is not at all certain that models in use today can usefully measure the differences that we are likely to see.

Benefits substitutions that have a minor impact on the plan's actuarial value still have a large impact on consumers – including their access to needed services, their ability to meaningfully compare plans, and the downsides of an insurance market driven by insurers' risk selection strategies[10], instead of competition based on price and value. An actuarial equivalence test does not help consumers with these potential pitfalls.

Furthermore, any coverage differences being measured by actuarial estimation would be washed out by the differences inherent in the estimation approaches of different actuarial models. Actuarial estimates vary greatly depending on the software being used and the assumptions employed to make the estimate.[11] As an example, the claims distribution underlying the model has a profound impact on the estimate, particularly for minor differences such as variations in visit limits or visit limits tied to diagnosis codes. In addition, the assumptions used in the estimation—such as how costs were benchmarked or the strength of the utilization effect—affect the estimates. Unless these sources of variation are controlled by robust federal rules, actuarial equivalence may be a meaningless test.

Strong Standards Are Needed if Actuarial Equivalence is Used

We strongly recommend against insurer-derived benefits substitution. We believe that actuarial equivalence is neither workable nor sufficiently protective of consumers. However, if HHS is to rely on actuarial equivalency, the agency must adopt rigorous rules to ensure usable, meaningful results.

We recommend:

- A central model must be used to make all actuarial estimates
- Alternatively, HHS must require that outside models have been certified to have the capacity to gauge the impact of the fine differences being measured. Under this alternative, HHS must promulgate rules with respect to the benchmarking of costs, definition of the standard population used for the estimate, utilization assumptions and the specificity of benefit categories to be used. Clearly "outpatient services" is too broad a category when it comes to modeling fine substitutions. Sensitivity testing by a reputable independent actuary must be used to test and fine-tune these rules.

[10] The American Academy of Actuaries reinforces the point that actuarial equivalence does not protect against risk selection in this brief: *Actuarial Equivalence*, May 2009. http://www.actuary.org/pdf/health/equivalence_may09.pdf
[11] L. Quincy. *Creating A Usable Measure of Actuarial Value*, Consumers Union. January 2012.

- Whether a central model or a certification process, standards will have to be newly developed to ensure meaningful results. An example of what is included would be a claims distribution that is sufficiently robust to yield meaningful estimates, including visit limits that are dependent upon diagnosis codes. Requiring the analysis be conducted "in accordance with the principles and standards of the Actuarial Standards Board" is welcome, but insufficient.

Anti-discrimination Provisions are Important, but Insufficient

The proposed benchmark plans must also adhere to nondiscrimination standards in benefit design. While this is an important protection for consumers, it is not a workable remedy for preventing discriminatory effects and practices before they happen.

Under Section 1302, the Secretary is prohibited from discriminating against individuals because of their age, disability, or expected length of life in defining essential health benefits.[12] 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 ACA.

The Bulletin does not suggest how HHS will evaluate benchmark plans to ensure these non-discrimination requirements are met. We look forward to rigorous guidelines and a workable method of identifying and enforcing violations of the non-discrimination requirements, but we note that such rules should be augmented by strong rules prohibiting specific discriminatory practices with respect to benefit design.

Any Deviation from the State Benchmark Should be Decided by States in Accordance with Federal Criteria

If variation from the state-defined benchmark package is allowed, we recommend prohibiting insurer-derived benefits substitutions in favor of a state-level approach of defining acceptable benefit substitutions, subject to certain federal tests. These federal tests should ensure that permitted substitutions benefit consumers and do no harm. As an example, each permitted benefit substitution must:

- Remain above the federal benefits floor described above
- Have a demonstrated net benefit to consumers
- Substitutions must be understandable to consumers and a disclosure required so that the differences from the benchmark are easily grasped;
- Risk selection effects of the substitutions must be evaluated, including whether the risk adjustment mechanisms included in the ACA are sufficient to counter any concerns.

[12] Affordable Care Act, Section 1302(b)(4)(B)

States Must Be Allowed to Opt-Out of Benefits Flexibility by Insurers

In light of the potential issues for consumers emanating from insurer benefits substitution,[13] we strongly urge that states be permitted to opt out of such benefit design flexibility by insurers (if retained in the forthcoming federal rule). Additionally, if health insurance issuers are permitted to offer benefit packages that vary from the benchmark plan under the federal rule, states must be allowed to require state regulatory approval of the packages, using consumer tests such as those above.

Don't let Flexibility Affect the Plan's Metal Tier Designation

Consumers purchasing coverage in the individual and small group markets will rely on the "metal tiers" to navigate differences in the overall levels of cost-sharing in the health plan. It is the intent of the ACA that these estimates be made using a *fixed* set of medical services – the essential health benefits package. Within a state, benefit variation from the benchmark package must be ignored when calculating actuarial value for purposes of assigning a metal tier. For example, the provision of a gym membership—which is not an essential health benefit— should not be allowed to improve a plan's actuarial value score for purposes of establishing the plan's metal tier.

Rigorous, Ongoing Assessment of EHBs Over Time is Critical

The Secretary has a statutory obligation to periodically review and update the essential health benefits to address any gaps in access to coverage or changes in medical evidence or scientific advancement. We support HHS's intention to assess the benchmark process for 2016 and beyond in order to refine and adjust it based on feedback from the public. We strongly recommend that HHS 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. HHS should also allocate funding to directly survey consumers with respect to their satisfaction with their coverage choices and their ability to navigate the resulting benefits variation.[14] The forthcoming rule should incorporate specific evaluation criteria including, but not limited to, consumers to access to care, satisfaction of consumer preferences, consumers' ability to navigate choices and risk selection.

[13] A noted above, these downsides may include: reduced access to needed services, more difficulty comparing and selecting plans, and an insurance market driven by insurers' risk selection strategies.

[14] This could be modeled on the robust process used by Massachusetts which resulted in consumer-driven changes to the coverage packages over time. *Health Reform Toolkit Series: Resources from the Massachusetts Experience, Determining Health Benefits Designs to be offered on a State Health Insurance Exchange*, November 2011. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/MassachusettsExperienceBenefitDesignsToolkit.pdf.

Conclusion

In summary, CU urges establishment of a federal floor for the EHB package, specifying the minimum coverage required for compliance with the ACA.

If a state-based approach to defining a benchmark plan is considered for the proposed rule, the Secretary should commit to closely tracking the state benchmark selection process, ensuring maximum public input, and standing ready to refine and adjust it based on feedback over time. In addition, to ensure that state benchmark plan choices comport with federal law, we urge making explicit that HHS will review the states' proposed benchmark plans, provide an opportunity for public comment, and make public such comments and a final federal decision on the benchmark plans' validity.

We strongly urge against allowing insurers to make substitutions within benefit categories or across them. If, as stated in the Bulletin, the Secretary intends to allow insurer substitutions, any health insurance issuer variance from the benchmark plan should have to be approved by the relevant state regulator using federally defined criteria. Because actuarial estimation is not protective of consumers, we urge different explicit consumer protection safeguards be used. In addition to requiring approval of the state regulator, such substitutions should be limited to those defined by HHS. HHS should develop a list of such substitutions, subject to several tests that are protective of consumers.

We urge that states be permitted to opt out of such benefit design flexibility by insurers and be allowed to prohibit health insurance issuers from designing flexible benefit packages that vary from the benchmark plan, without state regulatory approval.

Sincerely,

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