



January 31, 2012

VIA COURIER AND ELECTRONIC MAIL

Ms. Marilyn Tavenner
Acting Administrator/Chief Operating Officer
Centers for Medicare & Medicaid Services
Attention: CMS-9975-P
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Comments on CMS Essential Health Benefits Bulletin (December 16, 2011)

Dear Ms. Tavenner:

The Federation of American Hospitals (“FAH”) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, and provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment to the Department of Health & Human Services (“HHS”) on the Essential Health Benefits (“EHBs”) Bulletin issued by the Center for Consumer Information & Insurance Oversight on December 16, 2011 (“Bulletin”).

The FAH appreciates that HHS has sought public input on its current thinking on EHBs. As HHS recognizes, the Bulletin addresses only covered services and, thus, does not contain all necessary components to fully contemplate the implications of the EHB provisions of the Affordable Care Act (“ACA”). We look forward to HHS issuing soon additional guidance on the cost sharing and actuarial value components of EHB policy, and the opportunity to provide comments on those areas.

GENERAL COMMENTS

1. HHS Should Provide a Future Opportunity for Public Comment on All Components of EHB Policy at the Same Time

The FAH understands that the development of EHB policy is multifaceted and complex, and this has led CMS to issue proposed policy elements in parts. The Bulletin notes that HHS is soliciting “comments on the regulatory approach to define essential health benefits.” Thus, we anticipate that this

Bulletin will be followed by a notice of proposed rulemaking where the Agency takes formal proposed positions with respect to the overall regulation directed at EHBs, which we believe is appropriate given the level of detail and policy rationale that is left unaddressed in the Bulletin.

As noted above, the Bulletin also indicates that guidance will be forthcoming on cost sharing and actuarial value components of EHBs. Each of these components plays a very important role in an overall EHB regulatory framework. Thus, we look forward to commenting on that guidance when it is released. We strongly urge HHS to follow the comment period on the guidance document(s) with a formal rulemaking process on those important components. It is critical that CMS develop a clear rulemaking record on all aspects of the highly important EHB policy as an integrated whole.

Accordingly, the FAH requests that HHS address through rulemaking all issues relevant to EHB policy at the same time, as it is imperative that ultimately all proposed policies be available for review and public comment simultaneously. This approach is the only way stakeholders will be able to understand in detail the various components, how they fit together, and the overall integrated impact of the EHB program on the market, on potential enrollee subscribers, on insurance plans, and on those who will provide the needed health care services.

2. HHS Should Create a Minimum Federal Standard or Basic Requirements for EHB Packages To Which States Must Comply

HHS’s intended “regulatory approach utilizes a reference plan based on employer-sponsored coverage in the marketplace today, supplemented as necessary to ensure that plans cover each of the 10 statutory categories of EHB.” In reaching this approach, HHS sought to balance comprehensiveness, affordability, and state flexibility.

The FAH favors a regulatory approach to EHBs that would create a floor or basic standard, national EHB package, which would minimize variability of benefit packages in states and regions and create a consistent insurance product for consumers, health providers and practitioners. We understand why HHS would believe greater state flexibility is necessary for the new program to be implemented on the statutory timetable with greater state uptake and involvement. However, unbridled state discretion to set their EHBs packages seems fraught with peril, and in many states could present a “race to the bottom” scenario that harms consumers and providers, especially if employers decide to discontinue their coverage and send their employees into state exchanges. We also note the need for coverage does not stop at the state line. Thus, if there is no uniformity whatsoever in benefit approaches, inefficiency, delay, and frustration with the process will result.

The FAH strongly urges HHS to create policy that establishes a federal floor or minimum level standard of EHBs. While states may be deserving of some flexibility, we believe a minimum level of qualifying EHBs is essential to better protect consumers from benefit variability and to create consistency for consumers and providers across the nation without detracting from the ability of a state to vary benefits above that level. The federal minimum benefit level is especially important because nearly 20 million exchange enrollees will be receiving federally subsidized premium tax credits and cost sharing subsidies, at an annual cost that will exceed \$100 billion. We also urge HHS to address how, in a regulatory framework of state flexibility, this policy would be applied to insurance products that are offered in multiple states.

3. The FAH Supports a General Approach to EHBs that Emphasizes a Proper Balance of Comprehensiveness and Affordability

The FAH supports HHS's plan to balance comprehensiveness and affordability in the development of EHB policy. Given the magnitude of the entire insurance reform aspects of the ACA, and the particular importance the EHB package plays in that structure, an approach that balances competing interests is prudent and reasonable. Because the Bulletin only addresses directly 2014 and 2015, it will be important for HHS to revisit periodically its EHB policy to evaluate whether an appropriate balance is being maintained with regard to existing benefit packages and current medical practice/standards that consumers should have a reasonable expectation of receiving through health plans that are subject to EHB requirements.

4. HHS Should Implement a Standard Definition of Medical Necessity

In the context of insurance reform, the FAH believes that a standard definition of medical necessity is appropriate, as that term will be used in the context of state exchange insurance products. Given that the proposed approach in the Bulletin is to provide states with flexibility on setting EHB packages, we believe a standard definition of medical necessity for plans is more important than ever, especially if CMS also permits health insurance issuers wide latitude to vary their EHBs on the basis of actuarial equivalence and define medical necessity (an approach with which we disagree, as explained below).

While a degree of flexibility at the state level may be a practical necessity, HHS should recognize that the simple notion of such flexibility is not without real downside risk to the ability to implement an EHB program consistent with the statutory goals. Too much state flexibility is likely to lead to a watered-down insurance product for consumers, with lesser than desired hospital benefits, thereby increasing the risks of economic turmoil that the current systems have fostered. To then allow insurance plans additional flexibility for both defining EHB benefits and determining what is medically necessary has the serious potential of eliminating the protections and the goals that Congress envisioned. This would be especially true (and a grave injustice) for consumers who currently have comprehensive coverage through employer-sponsored plans, but who must then shift to obtaining individual coverage through the state exchanges because their employers decide to drop their group health plans.

Thus, the FAH believes it is imperative for HHS to promulgate a standard definition of medical necessity that would apply to all state health plans that are subject to EHB requirements. This will help reduce administrative costs and make coverage decisions more consistent for consumers. We urge HHS to define medical necessity as follows:

“Health care services, supplies or products that a licensed healthcare professional would provide to or order for a patient for the purposes of preventing, diagnosing or treating a medical condition, illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice in the medical community in which the services are to be provided; and (b) clinically appropriate in terms of type, frequency, extent, and duration.”

SPECIFIC COMMENTS

1. HHS Should Not Permit Flexibility on EHB Design at the Insurance Plan Level

The Bulletin proposes to afford states the flexibility to select EHB benchmarks that reflect local market needs, creating variability in EHB packages across states. As noted above, the FAH understands that this flexibility may be necessary to facilitate state action towards successful state exchanges in the early years of this new program. Nevertheless, we remain deeply concerned that providing states with this flexibility would create the potential for variability across states on their EHB packages to the detriment of consumers, and would raise administrative costs.

Should HHS continue to pursue this approach of flexibility, the FAH believes that there should be no further variability in the design of EHB benefit packages at the plan level. This is true whether the variability would be within a particular benefit category or across benefit categories, even if heightened scrutiny would be required on the latter approach. As outlined below, allowing insurance plans to substitute benefits within or across benefit categories, at best, would result in needless confusion for consumers and, at worst, could lead to discriminatory plan benefit design and adverse selection with the erosion of the ACA’s guarantee of meaningful coverage in each of the 10 EHB categories.

a. Current Market Structure

In a December 2011 research brief conducted by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), researchers concluded that “[i]n evaluating the scope of benefits of employer plans, we found that overall, it appears that small group products and State and Federal employee plans cover similar services.” Researchers further state that only coverage for a few specific services (such as preventive and basic dental care, acupuncture, bariatric surgery, and hearing aids) varies across markets.

The Bulletin further emphasizes this point, highlighting that “products in the small group market, State employee plans, and the Federal Health benefit Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover.” We interpret these findings as signaling that a standardized benefit design is acceptable to consumers and markets, and that insurers are responding with products that meet consumers’ needs.

Additionally, the Bulletin does not present a business imperative or suggest robust consumer demand for benefit-for-benefit design flexibility at the insurance plan level. Any minimal potential benefit due to “plan innovation through coverage and design options” as cited by the Bulletin, must therefore be weighed carefully against potential harm to consumers and the providers that serve them. As detailed below, the risk of harm to consumers inherent in a marketplace with plan-level variability significantly outweighs any potential benefits and encourages the use of benefit designs to achieve favorable selection, and can lead to significantly watered-down insurance products available on the exchanges.

b. Standardization and Transparency

For consumers to have a meaningful choice of insurance plans, they must be able to compare product offerings. If plans are permitted to substitute benefits among and between the 10 benefit categories, it will be extremely difficult for individuals to make meaningful plan comparisons. While HHS indicates that plans will be required to offer benefits that are “substantially equal,” this term is not further defined at this time, and the process for assessing and enforcing this standard is similarly unclear. The American Academy of Actuaries in its May 2009 Bulletin on Actuarial Equivalence states clearly

that “[a]ctuarial equivalence comparisons are not particularly useful for helping consumer decide between different plan options.”

While more guidance is anticipated and certainly necessary, the FAH anticipates that the proposed approach to flexibility nonetheless creates significant risk that consumers will be presented with “apples to oranges” plan comparisons, mainly due to the variability in benefit design, and will make it difficult to make informed plan choices. On the other hand, a standardized EHB package, even if it is standard just at a state level, will support and enhance consumer choice by ensuring consistency in insurance plan benefit design. In turn, this would allow individuals to better compare plans based on EHB design, in addition to network adequacy, quality and other key features.

c. Non-discrimination

ACA § 1302(b)(4)(D) requires that HHS shall “ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or the individuals’ present or predicted disability, degree of medical dependency, or quality of life.” Allowing plans to vary benefits either within or across EHB categories would expose consumers to the potential for discriminatory plan benefit design, and it would be difficult for states or HHS to provide sufficient oversight to mitigate against this risk across all markets. The American Academy of Actuaries speaks to this issue as well, noting the tradeoffs between flexibility and adverse selection: “. . . even among actuarial equivalent plans, some plans may have features that appeal to high risk individuals, and others may have features that appeal to low risk individuals.” The oversight responsibility required by the ACA would be more efficiently executed through the establishment of standardized, comprehensive benefits at the state level. Further, a standardized design at the state level would put far less pressure on the as-yet untested three-part risk mitigation that HHS is implementing.

d. Increased Administrative Costs

In addition to causing confusion for consumers and the providers that serve them, variability among benefit packages can lead to increased administrative costs. For example, plans offering multiple, varied products with differing benefit packages must provide support for multiple packages, and providers must keep track of varying benefit designs for different patients. As a result, managing these various products would lead to more administrative expense, at both the plan and provider level, and would unnecessarily add cost to the overall system.

We believe that the additional cost for managing materially different plans would be tantamount to reducing or removing funding available for benefits for consumers. Conversely, a standardized EHB package would minimize confusion among consumers and help to streamline administrative expenses regarding benefit eligibility in a way that benefits consumers and providers and does not detract from a state’s desired scope of benefits.

e. Is CHIP a Proper Model For Developing EHB Policy?

HHS proposes relying on CHIP as a model for developing EHB policy, including for defining and implementing insurance plan flexibility. The FAH questions whether CHIP is an appropriate model for formulating the EHB infrastructure in the way that HHS has proposed. **Specifically, we do not believe that the separate state plan flexibility that applies under CHIP is relevant to the proposed insurance plan level flexibility (through a proposed test of actuarial equivalence). The market-based exchange is not intended to have similar levels of government purchasing powers or oversight functions as the state-run CHIP program.**

We believe that there are material differences in operating a public CHIP program and supporting a market-driven exchange. Thus, we have concerns with relying on CHIP as a model for allowing plan flexibility in benefit design.

For example, states operating separate CHIP programs may choose among four options when designing benefit packages, among them the choice of benchmark coverage or benchmark equivalent coverage. Under these options, the flexibility provided is focused primarily at the state level in order to give states options regarding benefit design. However, HHS cites this structure as a model for plan-level benefit flexibility even though it is not intended to provide CHIP plans with latitude to vary CHIP benefit packages, and thus makes problematic a parallel possible construct with regard to EHBs.

Another key difference between the CHIP program and the exchanges is that the state is the purchaser of insurance in the CHIP program. In the CHIP program, as in the Medicaid program, states purchase health coverage on behalf of beneficiaries and thus provide robust oversight of plan design and administration. In the Exchange, individuals will purchase health coverage in a private market, and state oversight will not be as direct as it is in the CHIP program. These differences make the use of the CHIP program equivalency standards less likely to provide the consumer protections necessary to guarantee coverage of the 10 EHB categories.

* * * * *

The FAH appreciates the opportunity to comment on the Bulletin. If you have any questions about our comments or need further information, please contact me, Jeff Micklos, or Liz Ward of my staff at (202) 624-1500.

Sincerely,

