

December 26, 2012

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, CMS-9980-P

Dear Secretary Sebelius:

The Center for Public Policy Priorities (CPPP) respectfully submits the following comments to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) in response to the proposed regulations regarding Essential Health Benefits (EHB) released in the Federal Register on November 26, 2012.

CPPP is a nonpartisan, nonprofit 501(c)(3) policy institute established in 1985 and committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. Improving access to health care for Texans has been at the core of our mission and activities since our founding.

We believe that EHB are a critical component of health reform. They will benefit millions of Texans who have coverage today in the individual or small group markets where consumers have historically lacked access to comprehensive coverage and millions more who are uninsured today, but will gain coverage through the Affordable Care Act.

We support consumer protections that were strengthened in this rule relative to the initial EHB guidance, including the prohibition of benefit substitution across EHB categories, and the support of anti-discrimination and parity protections. We believe there are several ways the regulations could be improved to further support consumer access to high quality health care for Texans, and have focused our comments on these specific areas.

Monitoring, Oversight, and Data Collection
§156.100 - State selection of benchmark

As part of the state benchmark approach, HHS should require states to collect and report data (or HHS could collect the data directly from insurers) on EHB benchmark packages to determine variability in coverage and issues with access to health care services.

This information will be helpful as HHS re-evaluates its EHB approach for 2016. At a minimum, HHS should collect each issuer's definition of medical necessity; information on rider policies; and data elements related to network adequacy. Along with this information, HHS should collect, analyze, and publish data on consumers' use of covered

benefits and spending on non-covered health services. All of this information should be made available to consumers in an accessible and understandable way.

HHS should clearly articulate the process for state EHB benchmark evaluation over the next two years and what the EHB review process will look like in 2016. HHS should set standards for open and transparent state processes to review and select EHB benchmarks, including standards on criteria used to evaluate plans, data collection, transparency of plan information, and public input.

§156.110 State Selection of Benchmark Paragraph (b) Coverage in each benefit category

The proposed regulation lacks a detailed definition of the 10 categories of care. This makes it difficult for consumers and states to assess whether or not the responsibility to offer the category is fulfilled. Absent sufficient category definitions, it is difficult to assess balance across the categories and parity requirements. Since the proposed rule only calls for supplementation of a category when the base benchmark plan fails to offer “any coverage” in a category and allows for insurer substitution of benefits, in categories of care where coverage is highly variable (like habilitative care and pediatric benefits), it is possible that a category could be “covered” in the benchmark, but the coverage is inadequate and lacks important services. **We urge HHS to further define the 10 categories of care to ensure adequate coverage consistent with the goals of the ACA.**

It is especially important that HHS further define pediatric and habilitative benefits.

As children develop, they need preventive and supportive services to ensure they have the tools to maintain or improve their health well into adulthood. These services include, for example, developmental assessments and screenings, audiology screenings and hardware, education, counseling, and services such as anticipatory guidance, nutritional counseling, and treatment of pediatric obesity. Pediatric services should be interpreted to include these types of care, but we remain unconvinced that the benchmark approach will ensure that children can access medically necessary services regardless of where they live. HHS should define pediatric services to include all medically necessary services for children and require base benchmark plans to be supplemented when they do not cover all essential pediatric services.

Habilitative care is another area that requires a more substantial definition of care. This category impacts a diverse set of consumers from children to seniors, many with a range of medical needs. We ask that HHS claim the task of defining habilitative services rather than allowing insurers to determine such criteria. We recommend that the Medicaid program be used as a guide for determining the specific services included under habilitation. Regardless of the diagnosis that leads to a functional deficit in an individual, the coverage and medical necessity determinations for habilitative services and devices should be based on clinical judgments of the effectiveness of the therapy, service, or device to address the deficit. A transitional approach that allows insurers to define the habilitation benefit is not acceptable because it would allow insurers to provide a minimal benefit that does not fulfill the ACA’s requirement. HHS should adopt a federal standard to serve as a default when states do not define habilitative care.

If HHS does not further define other EHB categories, it should grant states authority to determine that a benefit category in a base benchmark plan is inadequate. HHS has already taken this approach with respect to pediatric oral and vision coverage. Even though some base benchmark plans offer some minimal coverage for eye exams or dental check-ups, HHS determined that this coverage was not sufficient to fulfill the ACA's requirement for oral and vision care for children. Likewise, states should be able to determine that base benchmark coverage of a certain category is not sufficient. Consistent with the benchmark approach, a state that makes such a determination should have the authority to supplement the inadequate category with the benefits in that category from another allowable benchmark plan. If none of a state's benchmark plans provide adequate coverage of the category, the state should have authority to define the benefit, as the proposal allows for habilitation services.

As we noted in our comments on the initial EHB guidance, we believe that HHS should issue a clear and uniform definition of medical necessity at the federal level as part of establishing EHB. This will result in 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.** We ask that the Secretary develop a standardized definition of medical necessity that is broad enough to include services that improve, maintain, or prevent deterioration of a patient's capacity to function.

§156.115 Provision of EHB

We are pleased that §156.115 (a)(2) of the proposed regulations clearly state that the mental health and substance abuse category of the EHB must meet parity as defined by the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Although we support this clarification, we are concerned that the rules do not specify how these requirements apply and, therefore, request detailed guidance for states to ensure parity compliance within these plans. HHS should also provide information on the specific steps it will take to enforce parity in EHB plans when states do not.

We are concerned that benefit substitutions allowed under §156.115 (b)(1). Such "flexibility" will harm consumers by: 1) eliminating uniformity and adding complexity in benefit design, and 2) creating a back door-way for insurers to avoid risk and "cherry pick" healthier individuals. While some substitution to allow innovation in benefit design may be appropriate, strict limits on substitution are necessary to fulfill the goals of the ACA. The law establishes essential health benefits to provide a standardized floor for benefits in the individual and small group market. When comparing and purchasing plans, families must be confident that plans are truly comparable and will provide coverage for needed services.

We support the preamble's clarification that states may limit or prohibit benefit substitution and encourage HHS to codify this language. We further support the limit in paragraph (d) that prohibits issuers from including routine non-pediatric dental services, routine non-pediatric eye exam services, and long term/custodial nursing home care benefits as EHB. This prohibition will prevent issuers from including benefits like dental coverage or eye exams that may give them a marketing advantage over other plans while excluding other essential benefits.

We strongly suggest that HHS take additional steps to prevent issuer abuse of benefit substitution. **HHS should subject benefit substitutions to a high level of regulatory scrutiny to ensure substitutions are not used to limit important services or gain advantage in terms of risk selection or marketing appeal.** The proposed rule acknowledges this risk by establishing at (b)(1)(ii) that substitutions be made only within benefit categories. But without a definition of the categories, it cannot be determined whether a proposed substitution falls within the category. To limit this potential for abuse, HHS must first define each of the ten benefit categories. When an issuer proposes a benefit substitution, it can then be evaluated as to whether it fits into the category definition. Only substitutions that are actuarially equivalent AND consistent with the category definition should be allowed. HHS should further identify substitution limits, restrictions or prohibitions designed to protect populations with special needs and require issuers to clearly disclose substitutions so that differences can be easily grasped.

§156.120 Prescription drug benefits

Access to medically necessary prescription drugs is a critical aspect of health care. Access to a multiple drugs within the same class is particularly important for certain populations, including children, and for certain conditions, including mental illness. We support the proposed rule's revision of previous guidance to mirror the number of drugs available in the base benchmark plan as far superior to requiring only one drug per class. Nonetheless, there may still be medications that individual's require that are not available on their health plan's drug list. Therefore, we strongly support the provision at paragraph (c) that requires a procedure for requesting clinically appropriate drugs that are not on the plan's list. This provision should be expanded to clarify and codify that plan decisions on these requests are subject to expedited internal appeals as well as external appeals.

§156.125 Prohibition on discrimination

The proposed rule acknowledges the statutory provisions in the ACA that prohibit issuers from designing an EHB package that may discriminate against various populations on the basis of race, disability, or age, among other factors. The preamble proposes developing "the framework for analysis tools to facilitate testing for discriminatory plan benefits," and states that such framework will involve "allow[ing] states to monitor and identify discriminatory benefit designs, or the implementation thereof."

In the final rule HHS should provide a clear standard for evaluating discrimination, both in the base benchmark plan and in plans that contain benefit substitutions. The absence of a definition of discrimination in the rule is a fundamental problem that will inevitably lead to uneven enforcement of anti-discrimination provisions. We agree with other advocates that the definition of discriminatory benefit design should not vary across states. **HHS must develop and promulgate a standard definition that will allow states and, when necessary, HHS to evaluate plans uniformly.**

Beyond defining discrimination, the final rule should set out the process for enforcement of violations of the non-discrimination provisions. While the preamble contemplates shared authority for enforcement between states and the federal government, the final rule needs more clarity on when and how federal enforcement authority will be used. The

rule should also indicate procedures for reporting potentially discriminatory EHB, appealing decisions, and remedying any violations identified.

156.130 Cost-sharing requirements

Paragraph (c) Special rule for network plans

Some individuals have health needs that cannot be served adequately by any in-network provider, and in some cases this is true even if the network meets applicable network adequacy standards. When medically necessary services are not reasonably available in-network, a family should remain protected by the ACA's limits on cost-sharing. Therefore, the final rule should contain an exception that keeps the cost-sharing limit in place for medically necessary out-of-network services that are not reasonably available in-network, either in cases of emergency or when the service is not available within the network.

§156.140 Levels of coverage

Paragraph (c) De minimis variation

The +/- 2 percentage point standard for allowable variation could lead to plans in the same metal tier with significantly different cost-sharing amounts. Because the metal tiers are intended to allow consumers to compare plans easily, widely different cost-sharing amounts could lead to consumer confusion and potential adverse selection. HHS should examine the effects of this allowable variation and reduce the allowable amount for a metal tier if it results in plans with deductibles that differ by more than \$500. For instance, HHS could allow only +/- 1 percentage point variation for bronze plans, +/- 1.5 percentage points for silver plans, and +/- 2 percentage points for other plans.

We also urge HHS to prohibit bronze plans with actuarial values under 60 percent to protect consumers from inadequate coverage. Finally, plans' actuarial values should be transparent to consumers so they can be aware of any deviation from the target for their metal tier.

§156.150 Application to stand-alone dental plans inside the Exchange

Paragraph (a) Annual limitation on cost-sharing

The cost-sharing limits established in section 156.130 are a critical benefit of the Affordable Care Act for American families. Congress established these limits in the context of the other provisions of the ACA to ensure that families covered in the individual and small group markets have affordable access to essential health benefits. Congress, in turn, identified pediatric dental coverage as an essential health benefit. Therefore, Congressional intent is clear that spending on pediatric dental services should be subject to the same overall limit as other cost-sharing.

Paragraph (a) allows for a separate, reasonable cost-sharing limit for benefits under stand-alone pediatric dental plans. This means that families that approach the cost-sharing limit under their QHP may exceed the limit if their children have dental needs. Because the ACA intends to limit cost-sharing for essential health benefits, this is an unacceptable result that will penalize families who purchasing separate dental coverage. No family should be subject to out-of-pocket expenses for essential health benefits in excess of the law's clearly established affordability provisions.

One cost-sharing limit should apply to all EHBs. HHS should require that health plans and stand-alone dental plans track cost-sharing paid by their common members so that they can recognize when the cost-sharing limits of 156.130 are reached. Once they are, the limit should go into effect for all subsequent services, dental and otherwise. Insurers have the capability to coordinate benefits among primary and secondary payers for common members and can use similar systems to track cost-sharing.

Thank you for consideration of our comments on this important rule. We believe that essential health benefits will help ensure millions of Texans have access to good coverage and encourage you to strengthen the rule to provide additional transparency and protections for consumers. If you have any questions regarding these comments, please contact Stacey Pogue, senior policy analyst with the Center for Public Policy Priorities at pogue@cphp.org or (512) 320-0222 x 117.

Sincerely,

A handwritten signature in black ink that reads "Stacey Pogue". The signature is written in a cursive, flowing style.

Stacey Pogue
Senior Policy Analyst