September 30, 2015

VIA ELECTRONIC SUBMISSION

Kevin Counihan
Director & Marketplace Chief Executive Officer
Centers for Medicare and Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue, SW
Washington, DC 20201

RE: Proposed 2017 Essential Health Benefits Benchmark Plans

Dear Director Counihan:

The National Health Law Program (NHeLP) appreciates the opportunity to provide comments in response to HHS' posting of the proposed 2017 Essential Health Benefits (EHB) benchmark plans. NHeLP advocates, litigates, and educates at the federal and state levels to protect and advance the health rights of low-income and underserved individuals.

Based on a preliminary review of the proposed 2017 EHB benchmark plans, below are general EHB comments followed by specific comments regarding issues with the proposed benchmarks.

General comments on EHBs

Benchmarking approach

Forty-six states and D.C. have a small group plan as their proposed 2017 EHB benchmark, either by state selection or assigned by default. As a result, most benchmarks do not cover certain services, and there is inadequate coverage of EHB statutory categories, including harmful treatment limitations and exclusions impacting access to care.

The benchmarking approach has also produced inconsistency in how EHBs are covered. For example, it appears that states are not supplementing EHB categories when needed. Also many of the proposed 2017 benchmark plans are not in compliance with existing EHB requirements (*e.g.*, preventive services). Since they are based on 2014 plans, the 2017 benchmarks are also not in compliance with new EHB standards that go into effect in 2016 and 2017 (*e.g.*, prescription drug requirements), making oversight and enforcement by the Department of Health and Human Services (HHS) critical.

NHeLP continues to oppose the use of a benchmarking approach to define the EHBs. There is a clear directive in the Affordable Care Act (ACA) *requiring the Secretary of HHS* to define the EHBs, and as a legal matter, HHS has no authority to delegate defining the EHBs to states or issuers. *See* 42 U.S.C. § 18022(b)(1). HHS must move towards compliance with the law and develop a strong federal standard to ensure covered populations can access comprehensive care that consistently meets their needs. We commend HHS for establishing a uniform definition of habilitative services, but this is not enough. We urge HHS to establish a minimum definition for the remaining EHB categories.

RECOMMENDATION:

We recommend that HHS only use the benchmarking approach to define the EHBs on a transitional basis while working towards establishing a federal minimum definition, which states can expand upon, for all EHB statutory categories by a set date.

Supplementing

While HHS continues using the benchmark approach to define EHBs, clearer "supplementing" guidelines are needed. In the Notice of Benefit and Payment Parameters for 2016 final rule (Final Rule 2016), HHS noted that states retain the ability to determine whether the EHB base-benchmark plan (BBP) covers an EHB category or whether supplementing is warranted.[1] But for the most part, it appears states are only supplementing when an EHB BBP does not cover *any* items or services in one of the ten EHB statutory categories. Therefore a plan with minimal or inadequate coverage in one of the 10 categories does not always get supplemented.

RECOMMENDATION:

HHS should clarify in written guidance to states that they may supplement when there is insufficient or inadequate coverage of an EHB category.

[1] HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, 10, 813 (Feb. 27, 2015) (to be codified at 45 C.F.R. pts 144, 147, 153, 154, 155, 156, and 158), *available at* http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

Substitution of Benefits

Unless prohibited by state law, issuers offering EHBs are permitted to substitute benefits that are 1) actuarially equivalent to benefits replaced and 2) within the same EHB category. As a result, issuers may substitute services that certain populations (*e.g.*, individuals with chronic conditions) need and replace them with actuarially equivalent services, which may be less costly and more likely to attract healthier populations.

Allowing issuers to substitute benefits within an EHB category makes it difficult for consumers to compare health coverage options, making plan selection challenging. In addition, without a standard set of EHBs that issuers must cover, it is unclear how state regulators are ensuring adequate coverage of EHBs. While states have the option to adopt more stringent standards that limit or prohibit this type of substitution, only a few states have prohibited benefit substitution.

RECOMMENDATION:

We urge HHS to eliminate any provision allowing issuer flexibility to substitute benefits.

State Benefit Mandates

HHS' current policy on state benefit mandates has led to a freeze on new mandates. States requiring Qualified Health Plans (QHPs) to cover benefits in addition to those included in the EHB BBP must defray the cost of covering those benefits if the requirement was enacted on or after January 1, 2012. We urge HHS to create a process for states to address important market coverage gaps by allowing states to add new state-required benefits to the EHB without additional cost to the state. We recognize that HHS cannot allow states complete discretion to add mandates to the EHB standard given the state incentives and federal costs, but some public process should exist to add needed mandates. For example, most of the proposed 2017 EHB benchmark plans do not cover certain services, including acupuncture, bariatric surgery, hearing aids, routine foot care, weight loss programs, and infertility treatment. By continuing to use a benchmarking approach, HHS is passing on the responsibility to modernize and update benefit coverage to the plans that serve as benchmarks. Therefore it is important to allow states some way to improve benefit coverage to help meet the health goals of the state.

In addition, HHS should issue written guidance to states clarifying the policy on habilitative services mandates. In the Final Rule 2016, HHS noted that new state benefit mandates enacted in order to define habilitative services are part of the EHB, so states do not have to defray the cost for those mandated benefits. Twenty-six proposed EHB benchmark plans do not appear to cover hearing aids. Therefore, if states do not have to defray the cost for enacting a hearing aids mandate as part of the definition of habilitative services, that should be clear to states.

RECOMMENDATION:

HHS should issue written guidance to states clarifying, with examples, that state benefit mandates enacted in order to define habilitative services are part of the EHB and states do not have to defray the cost for those mandated benefits. For other state benefit mandates, HHS should develop a process for states to demonstrate the significance of including the benefit as an EHB without the state having to defray the cost of that benefit.

EHB Updating Process

HHS must create a transparent and inclusive standardized process for developing, updating and reviewing EHBs and set forth a framework for addressing barriers and gaps in access to care. The 30-day public review period of proposed 2017 EHB benchmark plans did not provide sufficient time for advocates and stakeholders to thoroughly review the benchmark plans and identify all issues that need to be addressed. In addition, while we appreciate that HHS included supporting plan documents for each proposed EHB benchmark plan, many times these documents refer to an additional document for coverage details, such as a benefits schedule, which was not included.

Also, we found that generally evidence of coverage or certificate of coverage documents were confusing or incomplete, and many times these documents included multiple amendments which made it difficult to determine covered benefits. The benefits and limits charts provided for each state along with plan documents were supposed to help with the review process, but the level of detail in the charts varies significantly from state to state, with most states simply indicating whether a benefit is covered. The charts should be amended to provide an accurate picture of covered benefits and, thus, include specificity about covered benefits and limits. This way everyone will understand exactly what benefits are included in the BBP and how they are covered. Also, with more detail, the charts could even become a helpful tool for state regulators to ensure coverage of EHBs by health plans and issuers.

HHS should also set-up a process for continued feedback from advocates and stakeholders regarding the EHB benchmarks to help with monitoring and enforcement of the EHB requirements.

RECOMMENDATION:

We recommend that HHS create a transparent and inclusive standardized process for developing, updating and reviewing EHBs and set forth a framework for addressing barriers and gaps in access to care.

To promote clarity and plan compliance with the EHB standard, the benefits and limits charts should also be updated to include some of the coverage details in the plan

documents. The charts should also include information regarding all covered benefits in the benchmark plan instead of just categories of benefits (*e.g*., hospitalization services, substance abuse disorder outpatient services, etc.)

Specific comments on proposed 2017 EHB benchmark plans

Given the brief 30-day comment period, we did not thoroughly review all proposed EHB benchmark plans. Per our preliminary review of the benchmark plans, below are some trends that we identified.

Benefits not adequately covered, including benefits with limits or exclusions

Pediatric services

The health plans used as EHB benchmarks were developed for adults and without adequate consideration of children's health needs. A robust and comprehensive EHB is critically important for children; however, in many states the EHB benchmark approach has led to inadequate coverage of pediatric services.[2] We recommend that HHS establish a federal minimum definition for pediatric services based on either: 1) Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit standard, or 2) the Children's Health Insurance Program (CHIP) coverage. For children with special health care needs, the EPSDT benefit offers the appropriate benchmark coverage.

We would like to underscore the importance of offering comprehensive pediatric services, coverage of habilitative services and devices that meet children's developmental needs, and access to a full range of pediatric oral and vision services.[3] The 2017 EHB benchmark plans do not identify separate pediatric services, therefore children receive the same coverage that adults do, with the exception of oral and vision care. Since HHS established a separate supplementing methodology to ensure coverage of pediatric oral and vision care we were able to review the proposed 2017 EHB benchmark plans for coverage of these two services.

Pediatric Oral Care

Children must have access to age-appropriate dental services, including regular dental check-ups, basic dental care, major dental care, and medically necessary orthodontia to

[2] *See* Wakely Consulting Grp., *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans* (July 2014), *available at* http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf.

[3] *See* comment letter on the proposed 2017 EHB benchmark plans submitted by the Children's Hospital Association on behalf of a number of organizations for additional observations and recommendations regarding coverage of pediatric services.

help assure their healthy growth and development. However, not all states are including an appropriate level of benefits in their benchmark plans. Specifically, not all states are supplementing their benchmark plans with either the Federal Employees Dental and Vision Program (FEDVIP) or their CHIP dental benefits. Both of these dental packages offer comprehensive services that meet children's dental needs.

Some states only cover basic preventive dental services, leaving families with no coverage for services such as fillings, orthodontics, or other important and routine procedures for children. In contrast, states that use FEDVIP or CHIP as the supplemental pediatric oral benchmark will automatically ensure that needed dental services for children are covered.

According to the proposed 2017 EHB benchmark plans twenty-one states will not supplement pediatric dental services. In several states there is no supplementing because the benchmark plan is based on a 2014 plan, which includes embedded dental benefits either based on FEDVIP or CHIP. Yet several states that are not supplementing dental benefits have plan documents that either do not offer a list of covered dental benefits or offer limited information on how they are covering dental services, which makes it difficult to analyze whether the benefit is adequately covered (*e.g.* DC, NH, NV, OK, VT, and WA.) This also raises questions and concerns about how the dental services EHB standard is set in states. For example, what is the benchmark for dental benefits in states that are not providing coverage details? In addition, it appears Iowa's EHB benchmark plan does not cover pediatric dental services, and the state is not supplementing with either FEDVIP or CHIP.

HHS should also carefully review all benchmark plans to ensure that lifetime and annual limits on EHBs, including dental services, are not part of the state's EHB standards. See for example, Mississippi, which appears to have both a $2000 limit per year for dental care, and a $5000 lifetime limit for certain services needed to treat Temporomandibular Joint Disorders (TMJ).

Also, HHS should review benchmarks and ensure states are not adopting unnecessary or outdated restrictions on benefits. For example, FEDVIP used to have a 12-month waiting period for medically necessary orthodontia treatment. That waiting period was eliminated from FEDVIP starting in 2014. The waiting period is a type of prior authorization requirement that should not have been part of the EHB benchmark to begin with, but it looks like states adopted it in their benchmark for 2014-2016. It also appears that some states selecting FEDVIP for the 2017 plan year are adopting this restriction when supplementing with FEDVIP, even though the restriction has been eliminated from that plan. See for example, PA's plan document or NC's benefits and limits chart that indicates there is a 12-month waiting period for medically necessary orthodontics. HHS should review benchmarks that have supplemented with FEDVIP or are proposing to supplement with FEDVIP and ensure this restriction on orthodontic care is eliminated.

RECOMMENDATION:

In order to ensure adequate coverage of pediatric dental services, HHS should require all states to include in their EHB benchmark, at a minimum, the dental coverage of either FEDVIP or the state's separate CHIP plan. HHS should also carefully review benchmarks to ensure there are no lifetime or annual limits on dental services, and that any unnecessary or outdated restrictions, like the 12-month waiting period on orthodontic care, are not included as part of the EHB standard.

Pediatric vision services

We urge HHS to review the vision coverage in the benchmark plans to ensure critical components of pediatric eye care are covered. Access to high-quality vision screening and high-quality and necessary optical, medical, and surgical eye care during childhood is a cost-effective strategy for ensuring long-term vision and eye health. Regular developmentally appropriate screening, vision care, referrals to tertiary medical/surgical eye care as needed, and treatment (*e.g.*, eyeglasses) all play an important part in ensuring children's ocular and visual health. Childhood vision deficits, if not detected early, may lead to lifelong uncorrectable vision conditions with the potential to affect all aspects of life and negatively impact a child's development, ability to learn, athletic performance, and self-esteem.

FEDVIP and CHIP provide comprehensive vision coverage that children need, but not all states are supplementing their benchmarks with these benefits. According to the proposed 2017 EHB benchmark plans thirty states will not supplement pediatric vision services. In several states there is no supplementing because the benchmark plan already includes the FEDVIP or CHIP benefits. But based on our review, there are many states that are still not adequately covering pediatric vision care. For example, some states like CO, NC, OH, and UT are either not covering eyeglasses or offering limited coverage.

In many states, it is unclear how pediatric vision services are covered because the plan documents do not provide a list of covered vision services or they provide the details in a separate document that is not included. For example, see CT, DC, MN, NV, and WA.

RECOMMENDATION:

In order to ensure adequate coverage of pediatric vision services, HHS should require all states to include in their EHB benchmark, at a minimum, the vision coverage of either FEDVIP or the state's separate CHIP plan.

Contraceptives

The ACA recognizes that contraception is essential preventive care. New group health plans and health insurance issuers are required to cover all Food and Drug

Administration (FDA)-approved contraceptive drugs and products, without cost-sharing, as provided for in guidelines supported by the Health Resources and Services Administration ("HRSA"). HHS acknowledges that the proposed benchmark plans may not be in compliance with new federal requirements, including the recent Frequently Asked Questions (FAQ) from May 2015 about the limited extent to which plans and issuers may utilize reasonable medical management. Moreover, many of the proposed benchmark plans are not in compliance with federal requirements that were in place in 2014.

At least two of the plans require co-pays when contraception prescriptions are filled for a 3-month supply (KY and WI). Additionally, some plans restrict access to contraceptives without cost-sharing by requiring prescriptions to be filled at a pharmacy (*e.g*., AK and CT). This creates a barrier for women who fill their prescriptions directly at provider's offices or community health clinics. The HRSA Guidelines are intended to ensure women's access to the full range of FDA-approved contraceptive methods, including coverage for over the counter contraceptives when prescribed by a provider, but proposed plans still excluded contraceptive devices, including IUDs (*e.g*., NE), and did not cover over-the-counter contraceptives (*e.g*., AK, DE, ID).

RECOMMENDATION:

HHS should require all benchmark plans to be in compliance with federal requirements at the time of their issuance. Where the benchmark plan is not in compliance, HHS should clearly identify the non-complying provisions in the benchmark plans to ensure that state insurance regulators and plans do not include these outdated provisions in new plans. HHS should put systems in place to ensure that new plans comply with all federal guidance, including providing access to all FDA-approved contraceptive methods without cost-sharing or unreasonable medical management measures.

Maternity and newborn care

HHS has not yet specified what must be covered under the category of maternity care and as a result coverage under benchmark plans varies both as to the extent of detail about coverage and specific benefits. Information in many benchmark plans was difficult to understand because it was buried in amendments, and documents that were referenced as providing more details regarding coverage were not attached or were blank. See examples, such as ID, LA, and NE. We recognize that these benchmark plans were issued before guidance from HHS requiring maternity coverage for dependents, but many of them will have to come into compliance with that guidance as they currently exclude dependents from comprehensive maternity benefits. See examples, such as SC, AL, and NC. Plans also included narrow benefits that do not provide comprehensive maternity coverage, for example the proposed benchmark plan for Michigan does not cover a birth out of the service area and the proposed benchmark plan for Arkansas limits routine prenatal care coverage to only one ultrasound.

Prenatal care must be covered without cost-sharing as a preventive service under Section 2713 of the ACA. From our plan review, it is unclear what services are being covered under prenatal care without cost-sharing and what services are being covered as maternity care where cost-sharing is permissible.

Coverage for abortion services continues to be either not mentioned or confusing in most plans. Additionally, some benchmark plans restrict coverage beyond what is imposed by state law (*e.g.*, IA and NV).

RECOMMENDATION:

HHS should ensure that the proposed EHB benchmark plans provide coverage for comprehensive maternity care. HHS should also require that plans include all documents referenced as evidence of coverage and that they include easily accessible information about maternity and prenatal coverage benefits and accompanying cost-sharing obligations. In particular, HHS should require Idaho to submit supplemental documents as the state's proposed benchmark plan includes no evidence of maternity coverage.

Transgender health services

Forty-five proposed benchmark plans contain exclusions for transgender health services. Many exclude all care related to gender dysphoria or associated with gender transition. Examples include MI and NJ. Other plans, such as Oregon's proposed benchmark plan, exclude specific services that are necessary for comprehensive healthcare for transgender individuals, including counseling, hormone therapy, specific surgeries and complications from gender reassignment procedures.

RECOMMENDATION:

HHS should require that plans provide coverage for services related to gender dysphoria or associated with gender transition. The fact that plans excluded these services in the past should not justify excluding them in plans moving forward. On September 8th, HHS released a Notice of Proposed Rulemaking (NPRM) that took the groundbreaking step of prohibiting discrimination on the basis of gender identity and sex stereotyping.[4] Since the proposed regulation specifically applies to QHPs, HHS should ensure all QHPs comply with the regulation. These new proposed protections include:

- A prohibition on insurance plan exclusions that categorically exclude transgender individuals from coverage for health care services related to gender transition;
- A requirement that health care providers and insurance carriers must provide access to medically necessary services regardless of the individual's sex assigned at birth, gender identity, or legal gender marker (for example, a transgender man cannot be denied treatment for ovarian cancer);

[4] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172 (proposed Sept. 9, 2015) (to be codified at 45 C.F.R. 92.206).

- A requirement to treat transgender individuals in accordance with their gender identity, for example, in assigning hospital rooms; and
- A prohibition on discrimination related to sex stereotyping.[5]

Since the proposed regulation was based, in part, on prior HHS guidance, we expect the final rule will also include these protections and thus benchmark plans should not be allowed to exclude any services protected by Section 1557 of the ACA.

Rehabilitative and Habilitative Services and Devices

New federal requirements

HHS established a new uniform definition to serve as a minimum standard for covering habilitative services beginning in 2016. We commend HHS for evaluating plan coverage of habilitative services and addressing coverage gaps by establishing a minimum standard for plans and states to use.

However, because the proposed 2017 EHB benchmark plans are based on 2014 plans, they are not in compliance with new federal requirements. HHS must evaluate and ensure compliance with these new requirements because many of the proposed 2017 EHB benchmarks, for example, do not cover habilitative services in a manner that complies with the uniform definition.

In particular, several plans do not cover habilitative services unless improvement can be expected in an individual's condition. For example, New Hampshire's proposed benchmark plan excludes coverage of maintenance therapy treatment, which the plan defines as care that helps an individual keep their current level of function and prevent loss of that function but does not result in any change for the better. This exclusion is inconsistent with the uniform definition of habilitative services, which in part requires coverage of services and devices that help a person "keep" skills and functioning for daily living. Therapy that maintains, but does not improve, an individual's skills may also be necessary to prevent 1) deterioration of an individual's condition and/or 2) loss of critical skills. Maintenance therapy may also preserve the functioning needed for individuals to be independent enough to remain in their homes and avoid inappropriate and more costly institutionalization.

Also, for plan years beginning on or after January 1, 2017, issuers will be required to impose separate limits on habilitative and rehabilitative services, yet several proposed EHB benchmark plans combine visit limits for habilitative and rehabilitative services. Therefore HHS should carefully review proposed benchmarks to ensure that those limits do not become part of the 2017 EHB standard. For example, Georgia's proposed

[5] Sex stereotyping is defined as "stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics." *Id*. at 54177.

benchmark plan states that habilitative services apply toward the "Physical medicine and rehabilitative services" maximum number of visits specified in the "Schedule of Benefits." See also IN, NE, ND, and OH for examples of combined limits.

In addition, issuers required to provide EHBs may no longer impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices. HHS must determine how to evaluate this new requirement given that in many circumstances states are not clearly indicating whether the limit is for rehabilitative or for habilitative services.

RECOMMENDATION:

HHS should carefully review proposed state benchmark plans to ensure that at a minimum they cover habilitative services as defined in the uniform definition, that EHB benchmark plans do not combine rehabilitative and habilitative service limits, and that there are no limits on habilitative services and devices that are less favorable than those imposed on coverage of rehabilitative services and devices.

Discrimination in coverage of habilitative services

Several proposed benchmark plans arbitrarily limit coverage of specific habilitative services and devices to certain age groups or for individuals with certain medical conditions. For example, more than ten states only cover hearing aids for children, and several states, such as AK and DE, cover services to treat Autism Spectrum Disorder only for children.

RECOMMENDATION:

HHS should carefully review benchmark plans to ensure that plans' coverage of rehabilitative and habilitative services and devices does not discriminate against populations based on age, medical conditions or in any other manner prohibited under the ACA.

Durable Medical Equipment

The coverage of rehabilitative and habilitative *devices* must include coverage of durable medical equipment (DME). Yet several state benchmark plans either do not provide a complete list of covered DME or indicate there may be additional covered items in a "DME formulary" that is not included in the plan documents available for advocates and stakeholders to review. See examples from CA, NV, VA, and WI. Without a complete list, consumers cannot know before enrolling in a plan whether a particular item of DME is covered. For example, in its comments to HHS on the proposed 2017 EHB benchmark plans, the American Speech-Language-Hearing Association notes that, with some exceptions, it is unclear from plan documents posted online whether proposed state benchmark plans cover a speech-generating device. For conditions that may

compromise a person's ability to communicate, such as cancers of the head and neck, cerebral palsy or multiple sclerosis, a speech-generating device is essential to maintain communication abilities.

Also, EHBs are not permitted to have lifetime or annual dollar limits applied to them. Without access to a complete list of covered DME, consumers and advocates do not know which DME are EHBs and cannot have such limits.

RECOMMENDATION:

To ensure transparency in coverage of DME, HHS should require all states to provide all plan documents for their proposed benchmarks, including DME formularies and any other documents referenced in their evidence of coverage or certificate of coverage documents. HHS should also review benchmark plans to ensure that there are no lifetime or annual dollar limits applied to covered DME.

Mental Health and Substance Use Disorder Services (Including Behavioral Health Treatment Services)

Since the 2017 proposed EHB benchmarks are based on plans from the first quarter of 2014, they may not be in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) final regulation that generally applies to plans beginning on or after July 1, 2014. Yet health plans and issuers required to cover EHBs are expected to comply with all effective regulations, including the MHPAEA final rules.

RECOMMENDATION:

HHS should develop an oversight mechanism in order to ensure compliance with new MHPAEA requirements.

Prescription Drugs

The Final Rule 2016 significantly modified EHB prescription drug requirements. These requirements include the establishment of pharmacy and therapeutics (P&T) committees to work in conjunction with the current United States Pharmacopeia (USP) standard to help ensure the health plan's formulary drug lists cover a broad array of prescription drugs. The Final Rule 2016 also includes standards on P&T membership, meetings, and establishment and development of formulary drug lists.

In addition, there are new federal requirements regarding the exceptions process, online formularies, and mail order pharmacies that need to be incorporated into each state's EHB standard.

RECOMMENDATION:

HHS oversight of these new prescription drug requirements will be critical. HHS should establish a transparent process to monitor plan compliance with the new prescription drug requirements, issue written guidance to states on how they can ensure compliance, and engage stakeholders in implementing the new requirements and monitoring compliance.

Conclusion

Thank you for considering our comments and recommendations. If you have any questions, please contact Michelle Lilienfeld (lilienfeld@healthlaw.org) at the National Health Law Program.

Sincerely,

Elizabeth G. Taylor,
Executive Director