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NHeLP Comments to Essential Health Benefits FAQ

1. Under the approach described in the Bulletin, would the Secretary permit the State to adopt different benchmark plans for its individual and small group markets?

In our comments to the Department of Health and Human Services' (HHS) Essential Health Benefits (EHB) Bulletin (attached) we outlined why we consider a state-based benchmarking approach as contrary to the legal authority of the ACA, a harmful policy for consumers, and very difficult for HHS to regulate. If HHS does proceed with a benchmarking approach, we appreciate the clarification that HHS will not permit multiple EHB standards. We consider it extremely important that HHS maintain this requirement to promote some uniformity at the state level.

As we stated in our response to the EHB Bulletin, we strongly oppose allowing issuers to substitute benefits, and we are disappointed to see this problematic policy reiterated in the FAQ. The ACA did not authorize HHS to delegate this role to states or insurers. Such a policy will lead to insurers abusing their authority to design benefits packages that disfavor vulnerable and underserved populations and will act as a proxy for medical underwriting, which is explicitly prohibited by the ACA. This flexibility conflicts with the objectives of the ACA, including the effort to develop uniform benefits that consumers will understand.

2. When a State chooses an EHB benchmark plan, would the benefits be frozen in time, or as the benchmark plan updates benefits each year, would the benchmark plan reflect these updates?

We support HHS' decision to maintain constant benefits in the first two plan years, although we urge HHS to reserve the right to add additional benefit requirements if the EHB standard proves insufficient or insurers abuse it and limit access to important health care coverage.

We previously explained the importance of developing an effective process for reviewing and updating EHB benefits. For example, benefits packages should be regularly reviewed through a transparent and publicly-reported process, modeled after the new § 1115 public process regulation, which includes meaningful consumer participation. Such a process will help ensure that the EHB defined benefits do not adversely affect certain populations or specific diseases or conditions. We believe the FAQ or future regulations or guidance should clarify that states must conduct such a review when updating or renewing any plan.

3. Would States be required to defray the cost of any State-mandated benefit?

The FAQ reiterates the EHB Bulletin policy that states must defray the cost of state mandates not included in the EHB benchmark. We previously recommended that HHS reject this approach because it may result in exclusion of critical state mandated benefits (which often protect

underserved populations) and encourage states to select small group plans as their benchmarks (which will lead to inferior benefits packages).

We urge HHS to adopt a policy to protect important state mandates and promote selection of benchmarks offering broader coverage (not small group plan coverage). The two-year grace period, while potentially helpful to states in the short-term, only delays the inevitable conflict and does not change the fact that fiscally challenged states will have little choice but to drop mandates in two years. Mandates play a critical role in helping states address gender, racial, and disease-based disparities. An EHB standard which ignores state efforts to improve insurance coverage will undermine those efforts and put states and insurers in an untenable financial situation.

The FAQ also reiterates HHS' intent to use the largest small group plan as the default EHB benchmark plan when a state does not select a benchmark. We believe that setting the default as a small group plan risks providing consumers with an inferior benefits package. We recommend that the default be any one of the first three Medicaid benchmark options listed in § 1937 (i.e., FEHBP-equivalent, State employee, and largest HMO coverage). This policy would reduce harm to consumers resulting from inferior small group coverage and could create important uniformity of benefits between the Medicaid expansion and Exchange populations (and potentially Basic Health Plan populations). Our recommendation does not include Secretary-approved coverage because the insurance market should not depend on politics and what any given Presidentially-appointed Secretary is willing to approve. Insurers, Exchanges, and insured individuals need clear and dependable options.

4. Could a State add State-mandated benefits to the State-selected EHB benchmark plan today without having to defray the costs of those mandated benefits?

We recognize that HHS may need to set some outer limit on the ability of states to freely add to the EHB with limitless state mandates. However, we recommend that any such policy contain an exception process whereby the state mandate can be added to the EHB if the state can demonstrate that the mandate already exists in a plurality of states, is supported by evidence-based practice or the recommendations of a relevant academic or medical association, or is in keeping with medical standards of care.

5. How must a State supplement a benchmark plan if it is missing coverage in one or more of the ten statutory categories?

We previously explained why the policy of filling-in benchmark gaps by reliance on other benchmark plans is likely to result in inadequate coverage for consumers, and is counter to the ACA requirement to provide coverage in the 10 statutory categories. The FAQ, however, reiterates this policy, which we urge HHS to reconsider. First, the policy does not recognize a clear distinction between offering *no* coverage and offering *insufficient* coverage; HHS does not specify that states would have to fill-in for insufficient coverage. Second, reliance on another benchmark, which may itself be insufficient or subject to the same historical disparities in health coverage, is a poor method to fill-in benchmark coverage gaps. This offers a flawed solution if

the primary benchmark offers *no coverage*, and HHS' answer offers no solution if the primary or supplementary benchmark offers *poor coverage*.

In HHS' answer, it used the term "default" (in the 3rd sentence of paragraph 1). We believe HHS intended this as a term of art referring only to a situation where a state had not selected a benchmark and thus the largest small group plan applies. This sentence may be confusing to some readers who do not recognize this term of art and interpret "default" to mean the benchmark selected by the state. We recommend HHS clarifies the term.

The EHB Bulletin and FAQ state the benchmarking policy for habilitative and pediatric oral and vision services. As we previously recommended, services for children should utilize Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) standards, and habilitative services should meet the needs of the diverse populations who will rely on the coverage (and should not be at the discretion of insurers or tied to rehabilitative services, which serve an entirely different purpose).

NHeLP also recommends that HHS should make clear that any benchmark tied to a FEHBP must allow abortion coverage in accordance with ACA § 1303. Federal funding restrictions such as the Hyde Amendment should not apply to or otherwise limit EHB benchmark standards used for private coverage.

6. One of the currently intended benchmark plans is the largest plan by enrollment in any of the three largest products in the small group market. What is the difference between a plan and a product?

While we understand the difficulty raised by the distinction between a product and plan as HHS defined them, we are concerned that the proposed policy could result in problematic limitations on care. If a health plan provides minimal coverage, but offers several riders to supplement care, HHS should consider the most popular riders as part of the benefits covered by the plan, if such a plan is selected as a benchmark. Failure to include these riders would limit the EHB and result in a smaller benefits package than the meaningful coverage individuals on that plan actually rely on. For example, if a certain rider is elected by 90% of the insured population, it should be included in the EHB standard because it is effectively part of the product. While we appreciate that HHS may not want to include all riders, we recommend that HHS develop a standard to include riders in the EHB based on factors such as election rates (e.g., selected by more than 50% of applicable enrollees), clinical importance (e.g., riders which offer critical clinical services), reduction of disparities, cost-effectiveness, or evidence-based medicine and accepted clinical practice.

We appreciate your final sentence confirming that under no circumstances may rider status obviate the requirement to provide all ten statutory EHB categories. If one of the ten categories is only provided by a rider, the state must supplement that category of coverage.

7. What is the minimum set of benefits a plan must offer in a statutory category to be considered to offer coverage within the category consistent with the benchmark plan?

While we commend HHS for reiterating that all benefit substitutions must at least be actuarially equivalent, we believe that the allowance of benefit substitution flexibility is a seriously flawed policy that HHS should abandon. As we previously discussed, benefit substitution would allow health plans to configure benefits to avoid undesired populations. This authority completely undermines the letter and intent of the ACA to ensure coverage in the 10 statutory categories and adequate overall coverage. We recommend the FAQ or future regulations or guidance require all EHB packages to include substantial coverage in all ten statutory categories. This coverage should be determined by the Secretary and defined as the amount needed to meet the needs of the covered population.

8. Can scope and duration limitations be included in the EHB?

We commend the policy that any scope or duration limit in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. We consider this critical to ensure that the EHB does not propagate the health disparities which persistently harm underserved populations. We believe HHS should develop a process for monitoring benefit design and to ensure discrimination does not occur.

We interpret HHS' use of the term "substantially equal" as a reference to a plan's ability to engage in benefit substitution, including altering scope of benefits and limits. As we previously stated in comments and in our answer to Question 1 above, benefit substitution will likely be used to create targeted barriers to care. Limitations, such as visit limits, are precisely the type of arbitrary and non-clinical methods that plans currently use to reduce costs, at the expense of consumer health. The most frequent victims of this practice are individuals who suffer from chronic conditions and other vulnerable individuals who cannot afford to pay out-of-pocket for care. For example, insurance plans often limit the number of mental health visits per year without any clinical justification. The limit is patently harmful for an individual with a chronic mental illness who needs regular visits which exceed an artificial limit.

We are gravely concerned that HHS' answer highlights a path for insurers to evade the ACA's important and historic limitations on annual and lifetime dollar limits. The answer implies that a plan can achieve through visit limits what it cannot achieve through dollar limits. This undermines the intent of the ACA and eviscerates one of its core and most popular protections.

9. State-mandated benefits sometimes have dollar limits. How does the intended EHB policy interact with the annual and lifetime dollar limit provisions of the Affordable Care Act?

We commend HHS' prohibition against benchmark plan dollar limits applying in the EHB context. We believe this policy matches the unmistakable intent of the ACA.

However, we believe that HHS' explicit allowance for plans to use a combination of benefit substitution and non-dollar limits to achieve the same result as the dollar limits violates the letter and intent of the ACA. Dollar limits prevent an enrollee from receiving needed health care

without any clinical justification whatsoever. Allowing plans to redefine dollar limits into benefit limits simply creates a different path to the same result.

10. How would the intended EHB policy affect self-insured group health plans, grandfathered group health plans, and the large group market health plans? How would employers sponsoring such plans determine which benefits are EHB when they offer coverage to employees residing in more than one State?

We appreciate HHS' clarification that self-insured, large group market, and grandfathered group plans must comply with the dollar limit prohibition for EHB services.

We do not understand why the EHB selection policy here does not mirror the policy used in Question 11 below (i.e., for small group plans the EHB is set to the employer's home state). We think the policy in Question 11 makes more sense since it affords states more control in setting minimum standards for businesses operating in the states.

We note, however, that this is the type of avoidable problem created by the failure to implement a strong *national* EHB standard, as we have previously recommended. Consumers and providers will continue to struggle to understand what is covered. Also, harmful interstate incentives (such as "race to the bottom") and misalignments will continue. More importantly, consumers will continue to face gaps in coverage due to excessive state (and insurer) flexibility.

Regardless of the method used to select the EHB for these plans, we do not understand why the Departments need to apply "enforcement discretion" for these plans. The EHB standard is readily available and these plans should have no more difficulty in evaluating their coverage than any other plan. We urge the Departments to vigorously enforce these requirements as may be necessary to change historical industry disparities.

11. In the case of a non-grandfathered insured small group market plan that offers coverage to employees residing in more than one State, which State-selected EHB benchmark plan would apply?

We believe that HHS has provided a reasonable policy answer to the question. However, this is another unnecessary problem created by the failure to implement a strong national EHB standard; see Question 10 above.

12. How do the requirements regarding coverage of certain preventive health services under section 2713 of the PHS Act interact with the intended EHB policy?

We commend and strongly support HHS' clarification that § 2713 of the PHSA will be included in EHB. This will help ensure that millions of people will have access to preventive care, and that women will be assured access to the full-range of health services to meet their needs. We thank HHS for this important policy and urge HHS to maintain it.

In addition, we strongly encourage HHS to require that all of the § 2713 preventive services be provided without cost-sharing. Given that the EHB applies to both Medicaid benchmark plans

and the Basic Health Program, the failure to prohibit cost-sharing for these services will create a barrier to care for these vulnerable populations and lead to the absurd result that higher income individuals enrolled in plans in the Exchange will have access to preventive services without cost-sharing, but lower income individuals may face cost-sharing for the same coverage.

13. Under the intended EHB approach, would the parity requirements in MHPAEA be required in EHB?

We commend and strongly support HHS' clarification that the parity requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) apply to the EHB standard. This policy will help reverse a historical bias towards covering only physical health conditions. We thank HHS and urge HHS to maintain this policy to improve health disparities and access to mental health services.

We note, however, that the flexibility provided by HHS to states, and the extreme "substitution" flexibility proposed for insurers, undercuts parity by allowing historical coverage gaps to persist and permitting the design of benefits packages which select against sicker individuals. This will exacerbate the serious problems that already exist enforcing parity laws. We urge HHS to support parity by setting strong national EHB standards and eliminating any insurer flexibility to alter benefits.

14. Could a State legislature require that issuers offer a unique set of "EHB" the way Medicaid and CHIP benchmarks have options for Secretary-approved benefits, or benchmark equivalent benefits, if the State benefits are actuarially equivalent to one of the choices that HHS defines to be EHB?

We agree with HHS' conclusion that states are not allowed to implement their own 'EHB benchmark equivalent' plans. This would be a harmful policy for health coverage standards and the ACA does not support this. We believe, however, that the flexibility provided to states and insurers to "substitute" benefits represents the same problem as allowing 'benchmark equivalent' plans and violates the ACA. For this reason, we oppose the substitution policy and urge HHS to reconsider it.

15. Would States need to identify the benchmark options themselves?

We appreciate HHS' commitment to helping states identify the three largest FEHBP and small group market plans to help them make accurate and informed decisions. We strongly recommend that HHS make this information publicly available in a descriptive format that provides consumers with enough information to meaningfully compare the plans, including posting on websites as soon as the information is available, so consumers can provide states with informed stakeholder input. We also urge HHS to consider the timeliness/accuracy of data on the "healthcare.gov" website, and how HHS will oversee state identification of benchmarks (for example, which are the three largest state employee plans).

16. When would States be required to select a benchmark plan?

We support the implementation of a uniform policy in 2014 and 2015; the more stable the EHB benefit, the more likely consumers will understand their health care. We understand the need to adopt EHB standards early in the process to allow for system planning. However, we make two recommendations. First, regardless of the official time frame, HHS should not approve any EHB standard until the state has completed a robust consumer stakeholder public input process, modeled after the new § 1115 public process regulation, including notice and comment process (no less than 60 days). HHS' ambition for a tight timeline should not limit the voice of consumers. Second, HHS should reserve some process to require the addition of services to EHB standards which are determined to be inadequate based on unintended/unexpected outcomes or problems.

17. How would a State officially designate and communicate its choice of benchmark plan and the corresponding benefits to HHS?

We strongly recommend that the state must, as part of its EHB selection process, include a robust consumer stakeholder process, modeled after the new § 1115 public process regulation, with an adequate notice and comment period (no less than 60 days).

We recommend a standardized reporting format that allows easy comparison between states, and requires sufficient details to fully evaluate the proposed EHB standard. We also believe that if HHS allows insurers to self-modify benefits (which we oppose and would violate the ACA), HHS should require the insurer to report their modifications using the same format, to allow easy comparison of the state EHB and the various modifications.

18. How can my State find benefit information with respect to the default benchmark plan?

We commend HHS for helping states identify default benchmark plans (although we oppose the use of small group plans as a default). We strongly recommend that the process for states to identify their default plans include a simultaneous process for public reporting of the default plan, including posting on a website an analysis of the plan benefits in a simple and standardized format.

19. By empowering the State to select an EHB benchmark plan, does HHS intend that the State executive branch (i.e., State Insurance Department) or the legislative branch must make the selection?

We commend HHS' clarification that the state Medicaid Agency is ultimately responsible for implementation of Medicaid standards. We strongly recommend that HHS not accept a state EHB selection process without a robust consumer stakeholder process, modeled after the new § 1115 public process regulation, including a notice and comment period (of no less than 60 days).

We understand that HHS may intend the default benchmark to address situations where a state process fails to identify a benchmark (for example, if a state has a state law requiring the EHB to be identified by legislation and the state fails to pass the EHB legislation). We recommend that

HHS change the default process as per our suggestion in response to Question 3. Setting the Medicaid benchmark as the default EHB benchmark would protect consumers from harm where a state failed to identify the benchmark and would promote uniformity.

20. How would EHB be defined for Medicaid benchmark or benchmark-equivalent plans?

We commend HHS for its broad policy of distinguishing between Medicaid § 1937 benchmark authority and the EHB standard. We believe HHS has correctly determined that states must primarily implement one of the § 1937 benchmarks for Medicaid, and then separately fill-in any gaps in the Medicaid benchmark based on the EHB standard. This distinction has been confusing for many states and stakeholders, and HHS' clarification is helpful.

We commend HHS for its decision not to apply a default benchmark in the Medicaid context.

We also commend HHS for restating the requirement for mental health parity compliance.

We interpret the FAQ to imply that the Medicaid benchmark would ultimately meet the ten statutory categories in the same way as the corresponding EHB benchmark (i.e., by reference to other EHB benchmark plans if the selected EHB benchmark lacks coverage in any of the ten categories). If this was not HHS' intent, we recommend HHS clarify the intended policy. Assuming this was HHS' intent, we reiterate our concern (raised in our previous comments and also above) that this policy is flawed, and the negative impact would be even more harmful for the Medicaid expansion population in at least the two ways described in our answer to Question 5. Considering the significant health risks of the Medicaid expansion population, HHS should fill-in any gaps in the ten statutory categories as intended by the ACA with a prescriptive requirement to offer enough coverage to meet the needs of the population.

21. Could a State select a different EHB benchmark reference plan for its Medicaid section 1937 benchmark and benchmark equivalent plans than the EHB reference plan it selects for the individual and small group market?

We commend HHS for the clarification that states can adopt differing Medicaid and Exchange benchmarks. While we have generally recommended that optimal policy would be to base EHB benchmarking on the Medicaid benchmark options to support uniformity, we believe that the framework HHS has developed necessarily requires that states could have differing benchmarks.

While we recognize that HHS may allow a state to operate multiple Medicaid benchmark plans, we do believe that HHS should consider whether states may abuse the authority to use multiple plans (i.e., without Medicaid comparability protections), and how HHS could curb this abuse.

22. Could a State select its regular Medicaid benefit plan as its Section 1937 benchmark coverage package?

We appreciate HHS' clarification that states can expand their Medicaid benchmark plans to include all Medicaid state plan services. We recommend that HHS work with states to promote this option since it will help ensure comprehensive coverage for the Medicaid expansion population.

We also commend HHS' reiteration of the requirement that the Medicaid benchmark plan cover the ten statutory EHB categories.