American Cancer Society ☙ Children's Defense Fund/New York ☙ Community Service Society of New York ☙
Make The Road New York ☙Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices ☙
Schuyler Center for Analysis and Advocacy

January 31, 2012

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, Southwest
Washington, DC 20201

Dear Secretary Sebelius:

Health Care for All New York (HCFANY) submits these comments on the Essential Health Benefits Bulletin. HCFANY is a statewide coalition of 120 organizations which seek to achieve affordable, quality health care for all New Yorkers. We thank you for the opportunity to provide our comments on this fundamental provision of the ACA.

Overall, we believe that the proposed approach will benefit New Yorkers. New York has a strong history of consumer protections. The benchmark approach will allow the State to select an EHB benchmark plan that preserves New York's existing mandates and standards. However, we recognize that some states with weaker consumer protections could take advantage of the benchmark approach to select a plan with unacceptably low benefit standards. We urge HHS to maintain state flexibility to select more robust benchmark plans, while establishing a clear and uniform minimum standard to serve as a floor for benefits overall.

We support the Bulletin's approach, but have some suggestions to make this guidance stronger.

Ensure most vulnerable populations' needs are taken into account

HHS should ensure that this approach takes into account the needs of all consumers, including children, seniors, women, communities of color, low-income consumers, and consumers with chronic illness and disabilities. The benchmark plans are all employer-sponsored coverage,

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responding to the ACA's instruction that the EHB equal the scope of benefits provided under a typical employer plan. However, the benefits offered in an employer-sponsored plan, and particularly in the small group or HMO products offered in the State, might not take into account the needs of vulnerable populations. These plans are designed to meet the needs of working age adults, and may not cover benefits that are important to children, seniors, people with disabilities, and women.

Any benchmark plan selected by the state should include the full scope of pediatric services outlined in the American Academy of Pediatrics' Bright Futures guidelines and maternity care, as recommended by the Guidelines for Perinatal Care issued jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. A health benefit package that is "essential" should include all preventive, diagnostic, and treatment services that are medically necessary for children, including those who have a chronic conditions, functional impairment, or significant or multiple health risks. Unlike the employer-sponsored plans identified in the Bulletin, Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) standard was developed specifically for children with their developmental needs in mind. Therefore, the children's Medicaid benefit should be available to states as a benchmark option.

We strongly recommend that HHS provide a clear definition of maternity care that describes the scope of services necessary for quality care throughout the prenatal, intrapartum, postpartum and newborn periods. The definition should ensure women have access to comprehensive maternity care that is evidence-based and allows for individualized and culturally sensitive care.

The Bulletin should also take into account the differing levels of regulation that different benchmark plans are subject to. For example, while ACA consumer protections like Section 2713's preventive care coverage without copayments mandate will apply to all new private plans, some plans may be exempted by virtue of being granted grandfathered status. We are concerned that nothing in the Bulletin explicitly prohibits a state from selecting a plan with grandfathered status as the standard for its state EHB package, which would make it possible for the benchmark plan to be exempt from the Section 2713 requirements. This could result in a benchmark plan that does not cover comprehensive contraceptive care. And small group plans in New York are not subject to the federal mental health parity law, which is much stronger than New York's mental health parity law. If New York were to choose one of the small group plans, it would most likely have less comprehensive benefits for consumers who need mental health services. And New York's mandate for coverage of autism benefits has a financial cap that only applies to small groups.

To ensure that the most vulnerable consumers receive access to the coverage they need, HHS should require states to make complete information publicly available about the benefits provided by all of the possible benchmark plans, so that consumers, small businesses, advocates and

other stakeholders can meaningfully review the differences and weigh in on which plan should be chosen as the benchmark.

Ensure that New York's Autism Mandate is included in the Benchmark Plan

HHS should clarify that the benefits of the benchmark plan can include any state legislation enacted prior to issuance of HHS's December 16th Essential Health Benefits Bulletin. For example, New York adopted an autism mandate in November 2011, which will go into effect in November 2012. This benefit was enshrined in state law prior to the issuance of the Bulletin, and accordingly should be permitted to be included as a component of the State's benchmark plan. In the case of New York's autism mandate, the guidance indicates that only plans that were actually in effect as of the first quarter (which did not yet adopt the autism provisions) would be benchmark plans. HHS should clarify that state mandates enacted before the Bulletin was issued can be adopted.

Ensure Adequate Prescription Drug Coverage

HHS should adopt a definition for prescription drug coverage that ensures individuals have access to necessary medical care and ensures that vulnerable populations receive the specific drugs they need. The Bulletin proposes a lower plan requirement for prescription drug coverage than for benefits in the other ten categories under the EHB provision. We are concerned that the Bulletin's treatment of prescription drugs could be extremely problematic for a number of drugs used by women, and especially for contraceptives.

Rather than requiring plans to provide benefits equal to the benefit provided by the selected benchmark, the Bulletin proposes a one drug per category or class coverage requirement. This is inadequate. For example, standard anti-retroviral treatment for HIV, critical to the health of the growing number of HIV positive women living in this country, requires at least three anti-retroviral drugs and some of the medications may be from the same class. If the standard is to cover only one drug per category or class, medically necessary medications will not be covered for many patients with chronic conditions.

This provision could also limit women's access to contraception. For example, a woman could be denied access to the method of contraception that she and her clinician have determined to be medically appropriate for her, if the coverage categorization lumps together all intrauterine devices (IUDs) and a health plan opts to cover the hormonal IUD but not the copper IUD. The EHB must provide comprehensive and robust prescription drug coverage so that women's full

prescription needs are met and every woman can access the particular method of family planning that is best suited to meet her health needs.

We urge HHS to clarify how its proposed plan for prescription drugs will not limit women's access to all FDA-approved contraceptive methods guaranteed under Section 2713. Furthermore, we urge HHS to adopt a definition for prescription drug coverage that ensures individuals have access to necessary medical care and ensures that vulnerable populations receive the specific drugs they need. To accomplish this, we recommend that HHS consider adopting policies like those in force in Medicare Part D that identify certain classes of drugs where restricted access would have significant clinical consequences.

Limit Insurer Flexibility

We urge HHS to reconsider the degree of flexibility afforded to insurance carriers as outlined in the Bulletin. In short, we urge HHS to rewrite the guidance in a way that States may be able to require adequate standardization in the market so that consumers can adequately compare products and make good choices for themselves and their families. Specifically, we are concerned that the Bulletin allows carriers to have the ability to substitute services within and across categories without state review. States must have the option to offer standardized benefits within the Exchange and to simplify the products for consumers. This will minimize consumer confusion when they compare and select coverage. Yet, the Bulletin appears to preclude this important governmental role.

We are concerned that the language in the Bulletin affords undue discretion and offers undue flexibility to the carriers offered through the Exchange. The discretion to deviate benefits or limit a State's benchmark plan is an important regulatory function which should be reserved to State government and not abdicated to commercial carriers. We urge HHS to amend this language to clarify that States have the regulatory authority to impose standardization and coherence amongst the insurance carrier offerings in the Exchange.

Similarly, we strongly recommend that HHS not allow insurer flexibility to substitute benefits within or across the 10 categories. The Bulletin proposes to allow insurers to substitute within and across the 10 required benefit package categories to promote insurer innovation and meet the needs of consumers. If insurers are allowed flexibility to substitute benefits, it will be more difficult for consumers to make "apples to apples" comparisons between plans. It will also increase the risk that insurers will use benefit design to steer consumers and segment risk.

If HHS allows insurers to substitute actuarially equivalent services within the 10 categories, there should also be a transparent process for monitoring these substitutions, enabling consumers to

understand how the substitutions impact their health coverage. If HHS decides to allow flexibility to substitute benefits within and across the 10 benefit categories, it must provide a detailed set of policies and procedures that protect consumers from harm and the market from adverse selection. Substituting benefits risks consumer health and market stability.

If HHS allows insurers flexibility to substitute benefits, HHS should identify particular types of covered services (e.g. visit limits, utilization reviews, etc.) and levels of variation from the benchmark benefits that would raise a red flag for HHS.

Clarify Anti-discrimination Protections

HHS should clarify what protections will be put in place at the state and federal levels to guarantee the EHB benchmark plans are subject to strong, enforceable standards to protect consumers from discrimination in every aspect of the plan, from scope to definition to benefit design, including cost sharing.

The ACA has specific provisions to protect consumers from discriminatory insurance practices. The EHB provision of the law prohibits the Secretary from discriminating against individuals because of their age, disability, or expected length of life in defining the essential health benefits. It is also directs the Secretary to "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups" in defining the EHB. These provisions bar discrimination and require special considerations for diverse populations with respect to the EHB package. The EHB provision is also subject to the general nondiscrimination protections established in Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age and disability. But the Bulletin makes no mention of Section 1557 or its requirements.

We urge HHS to clarify that the Secretary has a legal obligation to ensure compliance with the provisions of the ACA that protect women and all consumers from discrimination in the EHB.

Ensure Transparency of Benchmark Selection and Updating

We are concerned that the Bulletin does not outline a clear process by which States must select the benchmark plan. We believe that a clear, transparent process that allows for consumer and stakeholder input is essential. Consumers, employers, and advocates should be provided with complete data on the potential benchmark plans and allowed enough time to review this information and make recommendations to the State. HHS should also define a clear and transparent process for regularly reviewing and updating the essential health benefits package.

HHS should also outline the process that it will use to evaluate a State's benchmark plan. It should establish robust data collection requirements for states and insurers so that regulators and consumers have reliable data to use in reviewing and updating the EHB. Furthermore, HHS should clearly outline how it will evaluate a state's benchmark and where consumers will play a role in providing feedback.

Thank you for considering our comments. If you have any questions, please contact Elisabeth Benjamin at ebenjamin@cssny.org or at (212) 614-5461 or Carrie Tracy at ctracy@cssny.org or (212) 614-5401.

Sincerely,

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