



December 23, 2012

Gary Cohen
Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

RE: (CMS-9980-P) ACA Standards Related to Essential Health Benefits, Actuarial Value and Accreditation of Qualified Health Plans

Dear Director Cohen:

The undersigned members of the Consortium for Citizens with Disabilities (CCD) appreciate the opportunity to comment on the proposed rule *ACA Standards Related to Essential Health Benefits, Actuarial Value and Accreditation of Qualified Health Plans*. For healthcare reform to work for individuals with disabilities, the Affordable Care Act's (ACA) mandated benefit categories and non-discrimination provisions must be the foundation of the essential health benefits (EHB) packages that Americans in the individual and small group markets will depend upon starting in 2014.

CCD believes strongly that the federal government must play a significant role in establishing and enforcing the ACA's nondiscrimination standards. The ACA provides an unprecedented opportunity to create a consistent and fair national insurance market, a particularly important opportunity for those Americans with disabilities and chronic conditions who have faced discrimination and variance in historically fragmented healthcare marketplaces. The rise of state insurance mandates themselves provides an example of an imperfect fix to a complicated problem that results in unequal care for Americans based upon their health conditions and geographical location.

CCD understands that the Department of Health and Human Services (HHS) is working to expand insurance coverage to the uninsured as quickly as possible under the ACA implementation timeline. Given the urgency of that important goal, CCD proposes in this letter alterations and additions to the proposed regulation which are consistent with the overall benchmark structure which HHS proposes and which can be fairly easily adopted into a final regulation. Our recommendations will also help to ensure that the marketplace runs smoothly upon starting operations in 2014.

In addition, given the significance of the reforms for all Americans accessing healthcare in this country over the next century, we strongly urge HHS to continue developing a national infrastructure for the review and enhancement of the EHB packages in the future. This infrastructure should provide national leadership for the development, growth and enforcement of nondiscrimination standards in the healthcare insurance marketplace for the future, as envisioned by the ACA.

Standards For and Approval of EHB-Benchmark Plans

Once a state selects a base-benchmark plan, HHS and states will evaluate the plans in 2013 to determine if any changes are necessary to meet the standards for an EHB-benchmark plan. All EHB-benchmark plans must cover the 10 mandated categories of benefits listed in the ACA. As noted in the proposed rule, the ACA also requires the Secretary to define EHB in a manner that (1) reflects appropriate balance among the 10 categories; (2) is not designed in such a way as to discriminate based on age, disability, or expected length of life; (3) takes into account the health care needs of diverse segments of the population; and (4) does not allow denials of EHB based on age, life expectancy, or disability. ACA, Sections 1302(b)(4)(A) through (D).

CCD recommends that HHS specify in the final rule that EHB base-benchmark plans must cover, at a minimum:

- Benefits routinely covered by the benchmark plan, regardless of whether those benefits are all listed in the data collection template used by states to report to HHS on their base-benchmark plan. For example, although kidney dialysis is not listed in the data collection template used by states to submit details of their base-benchmark plan, it is clear that the benefit is routinely covered by the benchmark plans and should be covered as an essential health benefit moving forward in 2014; and
- Cover all of the benefits within categories of care that list more than one benefit. For example, a plan should not be considered an EHB-benchmark plan unless it covers as three distinct benefits rehabilitative, habilitative and devices, as opposed to only covering rehabilitation or only covering devices.

CCD recommends that HHS specify in the final rule that appropriate balance standards require EHB benchmark plans to, at a minimum:

- Cover benefits explicitly listed within the 10 categories of benefits within the statute; and
- Cover EHB benefits across the continuum of care equally; that is, an ehb-benchmark plan cannot impose a financial requirement (such as copayments or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on one benefit category that is more restrictive than the predominant requirements or limitations that apply to other benefit categories.
- Cover all EHB benefits within the settings and by the specialists which provide the current standard of care for the benefit; and
- Prohibit substitution between categories of EHB; and

- Prohibit substitution between benefits explicitly listed by statute within a category of EHB; and
- Protect participant access to appropriate and medically necessary care when allowing substitution within benefits.

CCD recommends that HHS specify in the final rule non-discriminatory plan design standards require EHB-benchmark plans to, at a minimum:

- Prohibit more burdensome participant cost-sharing on some benefits than others; and
- Prohibit unreasonable and arbitrary visit and dollar limits on a specific category of benefits, so as to discourage participation by individuals with certain conditions or disabilities; and
- Prohibit the targeted use of utilization management techniques for some benefits, and not others; and
- Prohibit defining the benefits in such a way to exclude coverage for those services based upon age, disability or expected length of life.

CCD recommends that HHS specify in the final rule that EHB-benchmark plans take into account the health care needs of diverse segments of the population when the plans by:

- Establishing a process for participants to request and receive coverage for benefits not routinely covered by the plan; and
- Providing a process that allows an enrollee to request clinically appropriate benefits not covered by the health plan, as proposed for the prescription drug benefit; and
- Providing a process for participants to request and receive coverage for benefits beyond the limits set by the plan when medically necessary and appropriate; and
- Providing a process for participants to request and receive coverage of specialist care not routinely covered by the plan when medically necessary and appropriate.

Habilitation Standards for EHB-Benchmark Plans

HHS is proposing a transitional policy for coverage of habilitative services that would provide states with the opportunity to define these benefits if not included in the base-benchmark plan. Where habilitation is not covered by a base-benchmark plan, HHS will supplement with an alternative benchmark. When a benchmark is not available, states allow plans to define the benefit or give issuers the option to cover habilitation at parity or define the benefit for themselves.

CCD recommends that HHS state in its final rule that when a state chooses to define the habilitation benefit, states must:

- Define the habilitation benefit to be at least consistent with the HHS Summary of Benefits and Coverage regulation, which was developed by the National Association of Insurance Commissioners.¹ The Summary of Benefits and Coverage document provides plan participants with a basic explanation of what benefits are generally covered under a

plan. States must define habilitation consistent with this definition so as to provide appropriate access to necessary habilitative services to individuals with chronic and complex conditions, including children with special health care needs. In addition, states' compliance with this definition will ensure that consumers have accurate and consistent information on which to base their insurance coverage decisions.

CCD recommends that HHS state in its final rule that absent a benchmark for habilitation, EHB-benchmark plans:

- Cover habilitation at parity with rehabilitation by covering habilitation in the same settings and including the same types of providers and specialists as covered in the rehabilitation benefit, regardless of whether those services and devices are needed to acquire (habilitation) or restore (rehabilitation) functions or skills; With respect to the amount, duration and scope of the benefit covered by the plan, however, it is inappropriate and inadequate to limit habilitation to “parity” with rehabilitative services since individuals acquiring skills for the first time require a different amount of services than an individual regaining a skill which was impaired due to injury or disability.
- Cover habilitation consistent with the definition provided by the HHS Summary of Benefits and Coverage regulation.

CCD recommends that HHS state in its final rule that plan coverage of habilitation satisfies appropriate balance and non-discriminatory plan design requirements when the plan:

- Covers habilitation separate and distinct from rehabilitation. For example, the plan cannot substitute rehabilitation for habilitation or apply only a single visit limit to both benefits.ⁱⁱ Each benefit must have separate and distinct visit limits which are applied based upon medical necessity, not based upon an arbitrary cap;ⁱⁱⁱ
- Cover habilitation services which *maintain* an individual's functional status, as defined by the HHS Summary of Benefits and Coverage regulation;
- Does not impose financial requirements (such as copayments or coinsurance) or quantitative treatment limitations (such as a limit on the number of outpatient visits or inpatient days covered) on habilitative services and devices that are more restrictive than the predominant requirements or limitations that apply to all other benefit categories;
- Cover habilitative devices without arbitrary restrictions and caps that limit the effectiveness of the benefit;^{iv}
- Prohibits the exclusion of specific conditions or diagnosis from accessing the benefit;^v and
- Prohibits the use of cost-sharing requirements or utilization management tools which target the habilitation benefit and are not applied to other EHB benefits.

Mental Health Parity and EHB-Benchmark Plans

Mental health and substance use disorder services, including behavioral health treatment services, must be provided under EHB packages in a manner that complies with the federal parity standards detailed in the Mental Health Parity and Addiction Equity Act of 2008.

CCD is concerned that that unless the final rule provides necessary details regarding the application of parity to EHB, mental health and substance use coverage in these plans will not be at parity due to discriminatory and illegal practices, as well as well-intentioned practices that fall short because the state did not realize they were deficient.

CCD recommends that:

- HHS specify in the final rule standards for how states should evaluate their benchmark plans for meeting mental health parity requirements.

Preventive and Wellness Services and Chronic Disease Management

All non-grandfathered individual and group market plans (which are not exempt from the EHB coverage requirement) must offer certain preventive and wellness services without cost-sharing, however, the proposed rule does not fully address the ACA-mandated benefit of chronic disease management. This is a major new benefit that has significant implications on people with disabilities and chronic conditions, but without further guidance, the benefit may be highly restricted under the EHB packages.

CCD recommends that:

- HHS explicitly state in the final rule that it will collect data on chronic disease management services in order to evaluate the benefit in 2016.

Prescription Drug Benefit

People with disabilities or chronic conditions need access to a robust range of medications. In comments to HHS on the December 2011 EHB Bulletin, many health and disability advocacy organizations expressed support of Medicare Part D rules that set aside six therapeutic categories—antidepressants, antipsychotics, anticonvulsants, antineoplastics, immunosuppressants and antiretrovirals—and require plans to include “all or substantially all” of these drugs on their formularies. We recommend HHS include the Medicare Part D requirement to cover “all or substantially all” of the drugs in six protected classes of drugs in the final rules. Though positive changes were made related to prescription drugs, we strongly believe the proposed EHB rule continues to fall short on ensuring patients have access to a full range of medicines, including new therapies. The proposed standard emphasizes a minimum number of drugs in a class without regard to the type of covered drugs, thereby potentially excluding certain drugs that may provide important therapeutic benefits. The quality of medications must also be emphasized in plan formularies.

We support the requirement that health plans must have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan. Additionally, we recommend patients’ rights and safeguards, such as grievances and appeals processes, are incorporated into the final EHB rule.

HHS should adopt a more comprehensive standard for prescription drugs that will provide critical access to medically necessary medications. At a minimum, HHS must not go below the

proposed standard of “at least the greater of 1) one drug in every United States Pharmacopeia (USP) category or class; or 2) the same number of drugs in each category and class as the EHB benchmark plan. Additionally, HHS must work to ensure any future changes to the benchmark plans does not result in a reduction in scope of prescription coverage so that one drug in every category or class becomes the standard.

State Mandates

The ACA allows states to require coverage of benefits in excess of the EHB package, but states would be responsible for the costs of adding those benefits to the plan, not the federal government through premium subsidies. HHS proposes that state-required benefits (state coverage mandates) enacted on or before December 31, 2011 (even if not effective until a later date) may be considered EHB for at least plan years 2014 and 2015, which would include the costs of these state benefit mandates in the federal subsidies that flow to the exchanges. In addition, HHS proposes to allow exchanges to identify which state-required benefits, if any, are in excess of the EHB. HHS also proposes that the QHP issuer should conduct the calculation for the cost of additional benefits, because the QHP generates the necessary data regarding claims, utilization, trends, and other issuer-specific data typically used to calculate the cost of a benefit.

CCD strongly supports the proposal to include all state-required benefits within the EHB plan and the proposal to allow exchanges to determine whether additional mandates fall within the ten categories of essential health benefits.

Updating the EHB-benchmark plans

The ACA specifies that the HHS Secretary periodically review the EHB, report the findings of such review to Congress and the public, and update the EHB as needed to address any gaps in access to care or advances in the relevant evidence base. HHS proposes to review in 2016 the benchmark-plan process for establishing EHB.

CCD recommends that HHS specify that HHS will continue strong federal input and oversight of the EHB process and nondiscrimination standards, and specifically consider:

- Working with the National Association of Insurance Commissioners to formalize a committee designated to review and make recommendations on national health insurance nondiscrimination standards, including EHB standards, to CCIIO and HHS;
- Strengthening the Oversight office within CCIIO;
- Create or designate a department within the Office of Civil Rights to specifically address discrimination in the reformed insurance markets; and
- Formalize a process for stakeholders to regularly provide feedback on insurance market, EHB and non-discrimination standards and practices.

ⁱ “Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”

ⁱⁱ Numerous states appear to have benchmarks which apply the single, existing rehabilitation visit limit to both the rehabilitation and habilitation benefit. For the majority of states choosing this option, this has meant a 20 visit limit for PT and OT combined whether it is rehabilitation or habilitation. This so severely limits the availability of the therapies it and would discourage enrollment by anyone in need of these medical services.

ⁱⁱⁱ Setting distinct limits for habilitation is critical to patients attaining a functional ability for the first time. Coverage of habilitative services and devices without arbitrary limits is especially important for children who may suffer from a condition at birth (such as cerebral palsy, autism or spina bifida) or from an illness or injury, that prevents normal skills development and functioning. Receiving sufficient habilitative services that helps the child *acquire*, improve, or retain a skill or level of functioning that they did not previously possess can mean the difference between talking and not talking, walking and not walking, or needing special education and being able to join a regular classroom. Some children will need habilitative services only for a short time, while others will need them on an ongoing basis to ensure that hard-earned skills are not lost or, in the case of children with cerebral palsy, for example, so their muscles function as well as possible.

^{iv} As they grow, children will need frequent replacements of devices such as wheelchairs, glasses, orthotics and prosthetics, and as their skills develop, they may need new augmentative communications devices. For example, a child who gets a wheelchair or prosthetic limb at age 2 will need new devices as they grow.

^v For example, Tennessee appears to be limiting the rehabilitative and habilitative benefit to conditions resulting from an acute disease, injury, autism in children under age 12, or cleft palate. This suggests that individuals with other developmental disabilities such as intellectual disability or cerebral palsy would not be able to access rehabilitation or habilitation services.

Sincerely,