January 20, 2012

Peter Lee
Executive Director
California Health Benefit Exchange

Re: Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight, December 16, 2011

Dear Mr. Lee,

I write on behalf of the California Children‟s Hospital Association (CCHA) to provide our comments on the critical pediatric services to be provided under the essential benefits package of the health benefit exchange. CCHA advocates on behalf of the 8 non-profit Children‟s Hospitals in California, and the millions of children who access services at these hospitals. California‟s Children‟s Hospitals play an important role in their regional communities as major safety net institutions for children. They exist with a single-minded purpose: to protect and advance the health of all children locally, regionally and nationally. We are experts in the specialized health care needs of the sickest of young children and strongly advocate for their access to comprehensive health benefits and critical providers.

I will provide a brief snapshot of who the Children‟s Hospitals are in California. On average, we are more than 50 percent Medi-Cal and provide most of the care for children with complex medical conditions. We are important training centers for sub-specialists and other pediatric healthcare professionals, providing graduate medical training for more than 650 full-time residents, of whom more than 300 are in pediatric subspecialties. Children's Hospitals provide health care to children from all counties in the state and make available essential care and services such as trauma, burn, neonatal intensive care (NICU) and pediatric intensive care (PICU) services. Children‟s Hospitals provide the most intensive levels of pediatric care in the State -- over 57% of the state‟s Pediatric Intensive Care Unit (PICU) beds are in children‟s hospitals. Our emergency departments accommodate collectively more than 371,000 visits annually, an average of 43 visits per hour, for every hour, of every day of the year

In addition to the comments and concerns of the California Hospital Association, CCHA wishes to comment on matters that are most central to the care of children in California. In particular, we wish to address the following concerns:

- Variability in benefit design should be greatly limited to minimize adverse selection, inadequate treatment, and cost-shifting to patients and providers.
- Access to highest quality specialty care through essential Children‟s Hospitals should be explicitly guaranteed.
- Children are not little adults and require mandated benefits and limited cost-sharing that reflect their unique needs.
- Habilitation benefits are not commonly included in traditional benefit design that originated with adult populations and should be more explicitly defined to include attainment and maintenance of normal functions

HHS and the California Health Exchange Board should greatly limit variability in benefit design.

There is a profound effect on risk selection and risk-shifting to consumers and providers from variability of benefit design and cost-sharing. Under a rubric of „equivalent actuarial value" , much mischief occurs, some intended, some incidental, that continues the manipulation of insurance markets through benefit design; limitations on benefits; cost-sharing for certain services; provider networks and contracting practices.

A rationale for incorporating actuarial equivalence provisions into benefit package requirements is to allow some degree of plan flexibility and consumer choice when setting benefit package minimum standards. However, with flexibility and consumer choice come the potential for adverse selection between plans. In other words, even among technically actuarially equivalent plans, some plans may have features that appeal to high-risk individuals, and others may have features that appeal to low-risk individuals.

The more similar the plan design features are, the less concern there will be about adverse selection between plans. Further, very large differences in plan design features, for instance between a no- or low-deductible plan and a high-deductible plan, can cause more serious adverse selection concerns. Additionally, complex and variable benefit designs are impossible for providers to administer at the point of care, leading to significant financial losses from care provided that is not reimbursed. For these reasons, benefit design should reflect a robust set of mandated benefits that level the playing field.

Benefit limitations are inherently arbitrary and adversely impact sicker patients. Among the considerations in evaluating benefit limitations are:

- Impact on premium costs
- Impact of cost increases or benefits changes on enrollment
- Choice of and access to providers for enrollees under treatment
- Impact of benefit/program changes in unintended costs in other areas, such as increased hospital or emergency room use
- Network or provider impacts, including provider participation and financial impacts of cost-shifting

Providers and health plans could experience significant uncompensated care costs to the extent that they choose to continue providing services to children that reach annual limits on individual benefits. As well, increased copayments at the time of service can mean an effective reduction in provider payments if providers are unable to collect from low-income patients, potentially affecting provider willingness to participate in the program.

Similar to benefit standardization, provider access standards should be equalized in California and elsewhere. For example, current network adequacy standards allow PPOs regulated under the California Department of Insurance to have lower geographic access standards than PPOs regulated by the California Department of Managed Health Care, which requires that care be available within certain timeframes. This furthers adverse risk selection because sicker people have more allegiance to and dependence on their providers and are more sensitive to timely access concerns.

For example, certain plans have dramatically lowered payments and then, in response to provider pushback, terminated contracts with key categories of providers, such as physical therapists, that are currently serving sicker patients. This can force current patients (adverse selection) to have to pay out of network costs or to drop such coverage in favor of HMO coverage with higher scrutiny and access requirements.

Standards should be consistent for all PPOs, regardless of which California regulator the health plan chooses. These network standards should include both geographic access standards and timely access to care standards.

Access to highest quality specialty care through essential community Children's Hospitals and other providers that serve low-income and special needs children should be explicitly guaranteed.

We applaud HHS for recognizing the importance of essential community providers in meeting the needs of various communities throughout the country and, in particular, those individuals who are the most underserved.

However, we are very concerned that the proposed rule does not require QHPs to contract with all essential community providers where available. Essential community providers, which include but are not limited to those entities specified in Section 340B, play a particularly important role in the care of low-income, critically or chronically ill, and disabled children. These children (as well as underserved and low-income adults) require a broad and diverse range of medical, habilitation and rehabilitation services throughout their lives. The role children‟s hospitals will play in their lives and in their communities is precisely the kind of provider the essential community provider provision in the ACA is intended to address.

To ensure that children have access to quality services when they need them, it is critical that HHS require QHPs to specifically contract with all essential community providers identified in Section 340B (a)(4) of the Public Health Service Act, including children‟s hospitals. To ensure that this blanket contracting requirement does not inhibit the use of network design to incentivize high quality care, HHS can require QHPs to collect and report on common quality measures, including pediatric measures. A common set of measures applicable to children that can be used across states would be a useful tool for Exchanges, states and HHS to assess pediatric quality in the QHPs. The initial core measures recommended under the Children‟s Health Insurance Program Reauthorization Act could be a starting point.

Children are not little adults and require mandated benefits and limited cost-sharing that reflect their unique needs.

A few key points:

- Comprehensive care for children is affordable. For example, the Medicaid program‟s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for children gives children covered by Medicaid access to all medically necessary treatments. Yet, children account for only 25 percent of Medicaid spending, despite the comprehensive nature of the EPSDT benefit and despite children numerically making up half of all Medicaid beneficiaries. EPSDT benefits should be part of all benefit designs.

- We thus endorse the notion that EPSDT benefits should be the floor for benchmark benefits for pediatrics. It is essential that the medical necessity definition for children mirror the EPSDT definition and include all diagnostic or treatment services to correct or ameliorate defects and physical and mental illness and conditions. Services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening, even if the condition cannot be prevented or cured. The determination that a service is medically necessary should lie primarily with the child's treating physician or other health care provider.

- We believe it is critical to maintain the California Children‟s Services (CCS) program separate from the exchange. This program serves the state‟s more seriously ill children and must maintain seamless access to specialty and other medically necessary care.

- We endorse the increased emphasis on preventive care but urge that children also receive coverage of treatments for conditions identified during routine screenings.

- Outpatient benefits, including those that support effective transitions between hospital to home, school and community, are essential for inclusion to change the locus of pediatric care from expensive hospital-based care to the home. Home health (including hospice), DME and supplies, physical and occupational therapy, and speech therapy are supportive to recovery following illness or surgery. Many of these benefits also allow children to stay in the home rather than enter an institution. Eliminating these benefits or making copayments excessive means that children could experience delayed recuperation, or short or long term disabilities from lack of follow-up therapies. There would also likely be a resulting increase in emergency and inpatient services resulting from decreased use of primary care physician and ancillary provider visits.

- The definition of „medical necessity‟ must take into account the special health needs of children, as addressed in the American Academy of Pediatrics Policy Statement on Model Contractual Language for Medical Necessity for Children. American Academy of Pediatrics, PEDIATRICS Vol. 116 No. 1 July 2005, pp. 261-262.

- In the statute, “pediatric services” stands alone as its own benefit category that includes, but is not limited to, vision and dental services. We believe that this category of pediatric services should be given full weight when balancing among benefits categories.

- Benefit limitations to only evidence-based treatment is important. In pediatric medicine, however, there has not been widespread comparative effectiveness research around pediatric treatments. This is reflective of the small population very sick children represent, rather than an indication that pediatric treatments lack an evidence base. We urge that HHS allows consideration of the best evidence available to support broad inclusion of pediatric benefits.

- Children may experience great difficulty accessing mental health services. Among the contributing factors is that there are few residential treatment facilities for children. Much of this care is delivered on an outpatient/home care basis, so it is important that those services are adequately covered.

- Habilitation benefits are not commonly included in traditional benefit design that originated with adult populations and should be more explicitly defined to include attainment and maintenance of normal functions.

A fundamental difference for children‟s health benefits is that insurance contracts frequently contain language limiting benefits to those that „restore‟ function. Many ill young children may not yet have attained a particular function (walking, speaking, manual dexterity, etc.); therefore, a focus of pediatric benefits needs to be on „attainment‟ and even maintenance of normal skills.

The essential health benefits package should incorporate benefits that not only increase quality of life for children, but that also may reduce overall health care spending long-term, whether by insurance, personal spending or government payer. Because of the short-term nature of insurance contracts, these long-term benefits may not otherwise be adequately incentivized in the private insurance market or reflected in employer plans.

By definition, these medically necessary health interventions are intended to promote normal growth and development and prevent, diagnose, treat or ameliorate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability. They should:

- Assist in achieving, maintaining or restoring health and functional capabilities, without discrimination to the nature of a congenital/developmental anomaly;
- Be appropriate for the age and developmental status of the child;
- Take into account the setting that is appropriate to the specific needs of the child and family
- Reflect current bioethical standards.

We appreciate the opportunity to provide input on the essential health benefits package and its importance for children. We would be happy to provide further information on the implications of defining an essential health benefit on the pediatric population.

Sincerely,

Lucinda A. Ehnes
President & CEO