CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

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Submitted electronically to: EssentialHealthBenefits@cms.hhs.gov

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

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide our comments on both overarching issues and specific responses to the questions outlined in the EHB Special Bulletin regarding the regulatory approach that the Department of Health and Human Services (HHS) proposed to define essential health benefits (EHB) under section 1302 of the Affordable Care Act.

Overarching Issues for Consideration in Defining Essential Health Benefits

Formal Rulemaking Must Be Undertaken Expeditiously: CHA urges HHS to move quickly in establishing formal regulations establishing the Essential Health Benefits. To date, HHS has sought extensive input from experts and stakeholders on this important topic. While we appreciate this outreach as well as the opportunity to comment on the special bulletin, formal rulemaking is needed to provide very specific guidance for states like California that are moving forward in implementation of its health benefits exchange. Further, it is imperative for HHS to respond to the comments received and provide clear guidance that directs states on how to proceed. The federal rule making process should not be subverted or rushed on a topic as important and critical to the successful implementation of the state health benefit exchanges.

The Medical Necessity of the Patient Should Determine Covered Services: CHA recognizes the delicate balance that is required to achieve affordability while developing a comprehensive and meaningful scope of covered benefits. It is critical that the EHB meet the health care needs of individuals that will be covered by Qualified Health Plans (QHP) within the Exchange. For example, older populations have different health care needs than younger populations. The medically necessary needs of the patient should determine the covered services that are available to them. Further, medical necessity must be driven by clinical standards stemming from proven best practices for delivering effective, safe, high-quality, efficient patient care. Insurance companies should not be determining the medically necessary needs of the patients rather, established and tested

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clinical best practices should be the foundation for medical decisions. The benefit design of the QHPs operating in the Exchange must have uniformity of benefits that are administered consistent with evidence based guidelines to prevent disparities among beneficiaries and QHPs. The goals of the benefits exchanges are diverse. While coverage is essential for access to care, the care provided must be medically appropriate, and administered at the right time and in the right setting.

Limitations in Coverage and Cost-Sharing Must be Understandable: The cost-sharing features of coverage offered by a QHP will determine the actuarial value – or precious metal level – of the health coverage product being offered in the Exchange. It is extremely important for purchasers to have a comprehensive understanding of the cost-sharing requirements inherent with health plan products. Individuals focused on monthly premium affordability may choose a product with high cost-sharing; finding themselves shouldering the burden of medical debt resulting from a major health event or unexpected illness. Insufficient coverage will only lead to high out-of-pocket costs that, if not reimbursed, will drive up the costs of coverage for everyone.

Consumers and other purchasers of health care coverage must have readily available and user-friendly information so that they comprehend any limitations in benefit coverage and cost-sharing responsibilities. Failing to make this information understandable and consumer friendly will be a disservice to consumers and may lead to a growth in the number of underinsured – which would be a critical failing in the implementation and the intent of the Affordable Care Act.

In addition, in reviewing the EHB bulletin and the proposed benchmark approach, CHA urges HHS to further clarify in formal regulation how the proposed method of allowing states flexibility to set the benchmark plans based on existing plans will or will not result in a potential "double hit" to cost sharing levels. For example, the benchmark plans in California include a number of cost sharing components and benefit limitations already embedded (e.g. limits on visits, site of service restrictions, specific drug formularies). Once the actuarial value assessment is performed, this is likely to result in an increased level of cost-sharing to the individual; which will significantly impact the affordability and the actual level of coverage the consumer will have.

Transparency in Approval and Ongoing Evaluation of EHB: CHA appreciates HHS efforts over the past year in taking public input throughout the process of establishing and implementing EHB. CHA also supports an ongoing mechanism for individual and stakeholder input to share concerns about EHB and the implications of affordability and access to coverage going forward. The mechanism should be in addition to but separate from the annual rulemaking process and should be ongoing through an approach such as a Technical Advisory Group. Stakeholder consultation is critical to an open and transparent process. Stakeholders should have access to all information and analysis available to the states.

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We believe a benchmark plan approach will help to achieve uniformity and consistency of benefits and coverage across the state. Any limitation in coverage, however, must be easily understandable by purchasers. It is important for the benchmark plan to provide coverage that meets the needs of the consumers covered by the plans within the Exchange. In California, the four benchmark plan types included in the guidelines seem to offer a similar set of products; however there are many variances that may not be clear to consumers. The most significant variances between the benchmark plans appear to be differences in the level of cost-sharing required by the purchaser and limitations in scope of services. The actuarial value determination must consider any embedded cost-sharing, service or site of service limitations. The needs of the population expected to be covered by QHPs in the Exchange should be the primary consideration in determining EHB.

In determining how to update EHB, we suggest that a medical needs assessment of the covered population be part of the periodic review process. This is consistent with the requirements for the QHPs to report on quality measures that will assess the health of the patient population served by the plans. The medical needs and general health of the population served should dictate the services covered and for many of the newly covered individuals, their needs may be unknown.

Flexibility to Adjust Benefits for Advancements in Medicine, Technology: CHA believes that flexibility in the design of the EHB is important when considering patients' needs should drive coverage. Further, the market should be able to respond quickly to continual improvements and refinements in clinical best practices for treatment and medical necessity. A broad range of new technologies and other advancements in medical practices will likely establish new treatment and drug therapies proven as new standards for treating patients. Flexibility in benefit design will be helpful in minimizing the cliffs or valleys in coverage between the annual review and update of EHB as required by the Affordable Care Act.

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<u>Specific Responses to Requested Input</u>

B. Similarities and Differences in Benefit Coverage Across Markets: Cost-sharing is not taken into account in determining EHB. However cost-sharing may be a key decision making issue for consumers – more so than the comprehensiveness of the EHB. As stated above, consumers and other purchasers of health care coverage must fully understand any limitations in benefit coverage or cost-sharing responsibilities. Failing to make this information clear and understandable will be a disservice to consumers and a flaw in the implementation of the intent of the Affordable Care Act. Consideration should be given to any cost-sharing elements and service limitations already embedded in benchmark plans. Failing to do so will result in unaffordable choices for individuals and other purchasers of health care coverage.

Mental Health and Substance Abuse Disorders: CHA supports consistency of coverage with the Mental Health Parity and Addiction Equity Act.

Habilitative Services: CHA recognizes the delicate balance that will be required to achieve affordability while developing a comprehensive and meaningful scope of covered benefits. The medically necessary needs of the patient should determine the covered services that should be available to them.

Pediatric Oral and Vision Care: CHA recognizes the delicate balance that will be required to achieve affordability while developing a comprehensive and meaningful scope of covered benefits. The medically necessary needs of the patient should determine the covered services that should be available to them.

C. Intended Regulatory Approach:

CHA generally supports the goals set forth in the special bulletin but have concerns regarding the challenges that this approach poses for HHS in providing appropriate oversight of 50 state benchmarks. Further there are significant areas that warrant further clarity. As noted above, CHA strongly urges HHS to pursue the formal rulemaking process to ensure that comments from all stakeholders are publically vetted and solidified so that states may continue to pursue their efforts of aggressive implementation in order to meet the timelines set out in the Affordable Care Act

Thank you for the opportunity to provide comments and other information. If you have any questions, please do not hesitate to contact me at (202) 488-4688 or akeefe@calhospital.org, or my colleague, Anne McLeod, senior vice president for health policy, at (916) 552-7536, amcleod@calhospital.org.

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