Draft comments on Essential Health Benefits bulletin for submission by 1/31/2012

TO: EssentialHealthBenefits@cms.hhs.gov
CC: Region9ORD@hhs.gov
Subject: Essential Health Benefits for Children

To Whom It May Concern:

On behalf of California's children, the undersigned organizations appreciate the opportunity to comment on the *Essential Health Benefits Bulletin* released on December 16, 2011, which outlines the intended regulatory approach the Department of Health and Human Services (HHS) plans to use in defining Essential Health Benefits (EHB) in state Exchanges.

We appreciate that in the intended benchmarking approach, HHS seeks to offer states the flexibility to establish EHBs in a way that provides continuity and stability in access to health coverage for families. For instance, based on the flexibility described in the bulletin, California will have the opportunity to choose a known and existing EHB benchmark plan that would preserve important existing state standards and mandates. We note that while this is likely to serve California's children well, other states may not have comparable benefit requirements in place. For that reason, we sincerely hope that HHS, while not compromising state flexibility to identify more robust benchmark plans, will establish a clear and uniform minimum acceptable standard as the required foundation for benefits overall, and for comprehensive pediatric care in particular.

Children's health care needs are considerably different from adults; as such, children require a unique and tailored benefits package. We believe the Medicaid Early Periodic Screening, Diagnostic, and Treatment (EPSDT) standard, which has served children well for over 40 years in California, is a good model for the EHB package for children nationally. Furthermore, EPSDT or a comparable robust and comprehensive standard should serve as a core pediatric EHB standard federally required to be provided by qualified health plans in all Exchanges.

We acknowledge the special attention the bulletin gives to pediatric oral and vision care; however, we are concerned that the overall benchmarking approach and flexibility outlined in the bulletin may not serve children and families well in these areas. Therefore, we suggest that the benchmarking approach be improved in the following ways:

- **Define a core or "floor" EHB standard for children.** Although we are hopeful California can utilize the EHB flexibility suggested in the bulletin in a positive way, we understand that this may not be the case in all states. Therefore, we strongly urge HHS to identify a clear comprehensive core standard for children – one that includes vision, dental, habilitative, and behavioral health services. A prescriptive, uniform EHB "floor" would ensure that the millions of children across

the country that will enroll in coverage through Exchanges will receive a minimum level of coverage regardless of their state of residence. A benchmarking scheme could be applied for additional coverage on top of this standard core benefit that would allow states to tailor the choices and options presented to consumers.

The benchmark options identified in the bulletin were all designed for working-age adults, not for children. For instance, even though a small business plan provides family coverage, it is not a benchmark that is designed to serve children well. This is important because a robust pediatric standard will not have the same limits imposed on adults for certain services (e.g., durable medical equipment), and will cover services that adults do not need, such as anticipatory guidance for parents, developmental screenings, and certain counseling services. As stated above, we believe EPSDT should serve as the federal minimum and core pediatric EHB standard required for all qualified health plans in the Exchanges. At the very least, if EPSDT is not chosen as the federal minimum, it should be made an allowable benchmark option that states may select as the pediatric EHB standard. Furthermore, HHS should prohibit a state from benchmarking to grandfathered or outdated plans.

- **Evaluate additional options for pediatric vision coverage.** Appropriate vision care is crucial to a child's development and ability to learn. We are concerned that the bulletin only proposes one supplemental benchmarking option for pediatric vision services. That one option through the Federal Employee Dental/Vision Insurance Program (FEDVIP) was designed for working adults (i.e., federal employees) and may not be the most effective way to provide vision services to infants and children or screen for the early detection of eye disease and refractive problems in children. We strongly encourage HHS to consider the evidence-based recommendation for the essential pediatric vision benefit jointly developed by the American Academy of Ophthalmology, the American Academy of Pediatrics and the American Association for Pediatric Ophthalmology and Strabismus.

- **Provide more guidance and protections for pediatric dental coverage.** The oral health of children has a lasting impact on children's long-term health, educational achievement, and overall success. The EHB offers an important opportunity to ensure that children in qualified health plans have comprehensive dental coverage, yet more federal guidance is critically needed about supplemental pediatric dental plans to make this benefit most meaningful. Specifically, detailed guidance is needed on the methods Exchanges should use to determine the proportion of benefits that reflect an accurate cost of pediatric-only coverage. Despite the recent strides made in quality in California's CHIP dental plans, we are still eagerly awaiting CMS guidance on the CHIP dental benefit required by CHIPRA. Furthermore, we strongly believe that the EHB standard should incorporate the ACA consumer protections that exist in other health insurance into all stand-alone dental plans. These relevant and necessary consumer protections are important to establish parity among dental plans and

ensure that there are no cost-sharing or utilization management barriers to children's' access to oral health care services.

- **Limit and closely scrutinize benefit design flexibility.** We have concerns about an approach that lets states or insurers define their own benefits, unless there are strong accountability and reporting requirements. While we recognize that some flexibility is needed, for example, to provide cost-effective risk-based pediatric dental benefits to children, future regulations should carefully provide incentives for interested dental plans to offer cost-effective risk-based pediatric dental care without creating a race to the bottom. We have serious concerns that overly broad flexibility authority (e.g., "substantially similar" or "actuarially equivalent") given to states or insurers could result in benefit designs that inadvertently or otherwise harm or discriminate against children and fail to secure the health of vulnerable populations. The ability of insurers to use benefit design as a proxy for health status would defeat the goals of the Affordable Care Act (ACA). If flexibility is allowed, we strongly encourage very close scrutiny by HHS of the design modifications and the related justifications, as well as an assessment of marketing practices and enrolled populations to ensure that any approved flexibility is used appropriately and that children are not negatively impacted. In addition, consumers are likely to have a large number of plan choices in the Exchange for themselves and their families, and additional flexibility could further confuse consumers when selecting a plan.

- **Place greater emphasis on the inclusion of preventive care**. A 2010 study in the *New England Journal of Medicine* found that children in private plans are twice as likely to be *under*insured as their counterparts in public programs, due in large part to the overall lack of emphasis on preventive care. We strongly encourage future EHB guidance to be more prescriptive and aggressive in setting out robust and comprehensive preventive care requirements that stretch beyond what has historically been provided in private market coverage, as is required under section 1302 of the ACA. In addition to a core pediatric standard based on EPSDT, one obvious step to achieve this is for HHS to explicitly reference and incorporate section 2713 of the Public Health Service Act into the core EHB requirements. Failure to provide the robust and comprehensive evidence-based preventive benefits children need will lead to unnecessary emergency room visits, unnecessary hospitalizations, costly mismanagement of chronic illness, poorer health, lower functional status, and exacerbation of existing health disparities among children.

- **Require that the EHB selection process is open and transparent.** The bulletin does not clearly outline the process states can or should undertake in selecting the EHB benchmark plan.. It is important that HHS set the expectation and requirement that states select their EHB standards in an open and transparent process that allows for input from consumers, advocates, and other stakeholders. A meaningful opportunity for public input is critical for the views of potential Exchange enrollees, providers, and health plans to be considered in

important decisions. Currently, it is unclear what state entity has the authority to designate an EHB. Yet since the EHB selection will have real implications for our state's existing insurance markets and consumers, Medicaid program, and potentially a Basic Health Plan, we recommend that the legislative process is the most appropriate and well-established mechanism for selecting the EHB, since it will allow elected officials, including the Insurance Commissioner, the appointed Exchange board, stakeholders, and members of the public to participate openly.

As we wait for final federal guidance from HHS, we will work with our state officials to explore a benchmark plan that best serves the needs of California's children and their families. We will want to ensure that EHBs are defined in a way in which children or others will not lose benefits by moving into the Exchange; clearly that would ultimately jeopardize the success of the California Health Benefit Exchange.

We believe it is important that HHS and state Exchanges monitor EHB packages for children immediately upon implementation and consider 2016 an opportunity to address how children are served by the definition of EHB adopted by the state. For example, during the intervening years, HHS could conduct an analysis of the impact of adopting the Medicaid EPSDT medical necessity definition for the children's EHB package and explore the potential benefits that could come from improved health outcomes for children and delivery system improvements across payor types.

We understand that the EHB must be developed within a delicate balance that ensures coverage of critically needed services while maintaining affordable access to health insurance, and we hope that the final guidance achieves these goals and better addresses the pediatric EHB standard for children as described above.

We thank you for the issuance of this timely bulletin and the opportunity to provide comment. Should you have any questions, please contact Mike Odeh at modeh@childrennow.org or 510-763-2444 x122.

Sincerely,

Children Now
California Coverage & Health Initiatives
Children's Defense Fund-California
PICO California
The Children's Partnership
United Ways of California