CCRF
California Coalition for Reproductive Freedom

a project of the Tides Center

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Peter V. Lee
Executive Director, California Health Benefits Exchange
1000 G Street, Suite 100
Sacramento, CA 95814

Dear Mr. Lee,

On behalf of the undersigned organizations, all members of the California Coalition for Reproductive Freedom, we are pleased to take this opportunity to provide you with our comments on the Essential Health Benefits (EHB), and to urge you to adopt clear standards for the Essential Health Benefits for all Californians. We strongly believe:

1. California should implement high standards for women's preventive services;
2. The EHB must ensure robust coverage of women's health services in addition to preventive services;
3. The EHB should include comprehensive reproductive health services for women, men and adolescents;
4. The EHB standard should minimize use of utilization management; and
5. The EHB should include all state insurance mandates.

The California Coalition for Reproductive Freedom (CCRF) is a statewide alliance of more than 40 sexual and reproductive health, rights and justice organizations. CCRF is a longstanding coalition that includes medical, legal, grassroots, faith-based, consumer advocacy, and community-based organizations from all parts of the state. For more than 30 years, CCRF member organizations have worked collectively to ensure that the diverse women, youth and communities of California have the right and access to quality, comprehensive reproductive health information and services.

The intent of the Affordable Care Act (ACA) is to promote health and well-being by expanding coverage to meet the needs of underserved individuals as well as to fill existing gaps in the private insurance market.[1] The ACA directs the Secretary of Health and Human Services to develop the scope of services that every qualified health plan sold in the Health Benefit Exchange must cover. That scope of services, known as the Essential Health Benefits (EHB), is tied to the scope of services available in a "typical employer plan" plus at least 10 specific categories of coverage.[2] The U.S. Department of Health and Human Services (HHS) has issued proposed guidance that would largely leave the responsibility for determining the EHBs to the states.

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[1] Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124

[2] ACA § 1302.

The EHB will apply to the Medicaid expansion populations (individuals below 133% of the Federal Poverty Level (FPL)), set the standard for the Basic Health Plan (BHP) if California chooses to adopt the BHP Option (which can only cover individuals below 200% FPL), apply to enrollees in Medicaid benchmark plans, and cover individuals in the Exchanges with incomes as low as 133% FPL.[3] Legal immigrants with incomes lower than 133% FPL may also be enrolled in the Exchange. These are extremely low-income populations that are more likely to be in worse health than their wealthier counterparts and unable to pay out of pocket for extra services.[4] Communities of color also tend to be disproportionately represented among very low-income populations.[5] Women have historically had to pay out of pocket for routine preventive services and contraception. Because women, particularly women of color, experience higher rates of poverty and lower wages than men, they are more likely to experience chronic health conditions associated with poverty and are less likely to overcome barriers to health care.[6] Generally, low-income women are the least likely to have the resources to obtain reliable methods of family planning and most likely to experience unintended pregnancies.[7] California has long been a model for providing comprehensive family planning services through the highly successful FamilyPACT program which has significantly reduced the number of unintended pregnancies among the population served.[8]

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[3] According to the ACA, individuals at or below 133% FPL will qualify for Medicaid under the new category of eligibility and those above 133% FPL will qualify for coverage in the Exchanges. However, application of new income rules using modified adjusted gross income rules as required by the ACA will result in income disregards bringing this income threshold to 138% FPL.

[4] AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL HEALTH DISPARITIES REPORT (2010), http://www.ahrq.gov/qual/nhdr10/nhdr10.pdf. Several health indicators demonstrate that low-income people continue to have worse results in several core health measures than those with higher incomes, such as: timeliness in receiving immediate care, hospital admissions for short-term complications of diabetes, and adults with major depressive episodes who received treatment within the last 12 months.

[5] *See* RAKESH KOCHHAR, ET AL., PEW RESEARCH CENTER, WEALTH GAPS RISE TO RECORD HIGHS BETWEEN WHITES, BLACKS, AND HISPANICS 1, 5 (2011), http://www.pewsocialtrends.org/files/2011/07/SDT-Wealth-Report_7-26-11_FINAL.pdf. As a result of the declining housing market and the recession, the median net worth of Black households was $5,677 (assets minus debts) in 2009; the typical Hispanic household had $6,325 in wealth; and the typical white household had $113,149. The median Asian household net worth also declined to $78,066.

[6] Nat'l Women's Law Ctr, POVERTY AMONG WOMEN AND FAMILIES, 2000-2010: EXTREME POVERTY REACHES RECORD LEVELS AS CONGRESS FACES CRITICAL CHOICES (2011), http://www.nwlc.org/sites/default/files/pdfs/povertyamongwomenandfamiliesin2010.pdf (last visited Jan. 12, 2012).

[7] Lawrence B. Finer & Mia R. Zolna, Guttmacher Institute, *Unintended pregnancy in the United States: incidence and disparities, 2006* 8, 11-12 (2011), http://www.guttmacher.org/pubs/journals/j.contraception.2011.07.13.pdf .

[8] Bixby Center for Global Reproductive Health, *Is California's Family PACT Program a good investment? Findings from the 2007 Family PACT Cost-Benefit Analysis.*

Even where the scope of benefits is not limited, restrictive utilization management tools such as heightened cost-sharing requirements will also restrict access. Numerous studies have shown that even a small co-payment constitutes a barrier to care, especially for low-income individuals. One study showed that a $12 co-payment resulted in a significant reduction in access to breast cancer screening.[9] A 10% increase in copayments for certain drugs (statins) decreased medication adherence by more than 12% for patients living in an area with median household incomes of less than $30,000.[10]

The ACA was designed to ensure that people have access to care that they need. If the EHB package is defined or altered based significantly on considerations other than the health needs of the populations being served, such as up-front cost-sharing, it is likely to leave low-income and underserved individuals in worse health and lead to higher costs over the long term as individuals' conditions deteriorate and they require more expensive care.

1. California Should Implement High Standards for Women's Preventive Services.

The EHB package is specifically intended to remedy and close existing gaps in private health care coverage. For this reason, "preventive and wellness services and chronic disease management" were included in the list of ten categories of additional coverage in Section 1302 of the ACA.

Robust and comprehensive preventive benefits will lead to fewer unnecessary emergency room visits or unnecessary hospitalizations, fewer unplanned and high-risk pregnancies, and less costly management of chronic illness.

A) *Incorporate PHSA Section 2713 into the EHB without limitations*

One of the Essential Health Benefits is "Preventive and Wellness Services and Chronic Disease Management." Section 2713 of the ACA requires coverage of four categories of recommended preventive health services, all of which are evidence-based and critical for securing the health of women, children, low-income individuals, and other vulnerable populations.[11] In addition, § 2713 prohibits insurers from charging co-payment or deductibles for covered preventive services.[12]

These new requirements acknowledge that the scope of preventive services traditionally covered by the private group and individual markets do not meet women's complex preventive health needs. Through the implementation of section 2713(a)(4), HHS has acknowledged that women must have access to coverage which includes necessary preventive services such as: screenings for gestational diabetes, domestic violence, HIV

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[9] Amal Trivedi *et al.*, *Effect of Cost Sharing on Screening Mammography in Medicare Health Plans*, 358 New Eng. J. Med. 375 (2008). *See also* NATIONAL HEALTH LAW PROGRAM, COST SHARING STUDIES AND THE IMPACT ON MEDICAID BENEFICIARIES (2011).
[10] Michael Chernew *et al., Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care*, 23 J. Gen. Intern. Med. 1131 (2008).
[11] ACA § 2713(a).
[12] Id.

and other sexually transmitted diseases; lactation support and counseling by trained providers and the rental of breastfeeding and lactation equipment; well-woman visits; and the full spectrum of FDA-approved contraceptive options. On February 16, the Centers for Medicare & Medicaid Services (CMS) issued a bulletin explicitly confirming that the preventive services of section 2713 are incorporated into the EHB. CMS has not yet, however, addressed the important cost-sharing protections that are required in § 2713.[13]

As noted below, California should explicitly require all Qualified Health Plans to cover all FDA-approved contraceptive methods, drugs, devices and the attendant services including sterilization without medical management limits or actuarial substitutions to ensure that men and women have access to the method that is most appropriate for their lifestyle and medical needs.

In addition, the contraceptive requirements of section 2713(a)(4) only apply to women. California should ensure that these preventive services are available for men as appropriate. Reproductive health is integral to both women's and men's health, and men should also be able to gain access to annual counseling and screening for STIs and HIV/AIDS, as well as all FDA-approved contraceptive methods (e.g., condoms), sterilization procedures, and family planning education and counseling.

B) *Ensure robust coverage of contraceptives in the EHB*

The EHB policy must also require *comprehensive and robust* prescription coverage so that women's full contraception needs are met. A full range of prescription contraceptive drugs and devices must be offered by each plan so that each woman can access the particular method of family planning that is best suited to meet her health and life style needs and overcome potential barriers to use such as domestic violence, ease of pharmacy access and contraindications. The Institute of Medicine (IOM) report, *Clinical Preventive Services for Women: Closing the Gaps*, clearly found that women have different health and life needs and must have access to all FDA-approved drugs, devices, supplies and services.[14]

California should adopt the Family PACT Program model of comprehensive coverage of contraceptive methods. Family PACT provides a proven model for promotion of optimal reproductive health and reduction of unintended pregnancy. The Program emphasizes the need for coverage of appropriate contraceptive methods, counseling, and STD testing for female and male patients. As recommended by the IOM, Family PACT also covers the broad range of FDA-approved contraceptive methods. We strongly urge California to adopt a benchmark for the Essential Health Benefits that will include these and other important Family PACT services.

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[13] Centers for Medicare & Medicaid Services, Frequently Asked Questions on Essential Health Benefits Bulletin (Feb. 17, 2011) available at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

[14] INSTITUTE OF MEDICINE, CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS, Report Brief 1 (2011).

C*) Ensure Comprehensive Perinatal and Newborn Preventive Care*

Comprehensive perinatal services fall within two of the EHB's ten categories of required coverage: "Preventive and Wellness Services" and "Maternity and Newborn Care." In addition to prenatal medical visits and labor and delivery services, maternity benefits should include prenatal dental care, health education, nutrition counseling, prenatal vitamins, lactation consultation, manual as well as hospital-grade electric breast pumps, screening for intimate partner violence, substance abuse treatment, and other psychosocial services.

Each of these services for pregnant women is preventive in nature and would therefore help to halt escalating health care costs as well as to significantly reduce such costs over time. According to the U.S. Surgeon General, for example, there is a 32% higher risk of childhood obesity and a 64% higher risk of type 2 diabetes in children who are not breastfed.[15] Extensive research reviewed by the California Department of Public Health shows that breastfeeding reduces the mother's risk of breast and other cancers and benefits maternal health in other significant ways; it also protects a newborn's immune system, prevents respiratory illness and ear infections, reduces the risk of other serious diseases, and promotes a baby's growth, development and health in many other ways.[16] Researchers estimate that wider adoption of breastfeeding could save the U.S. health system billions of dollars a year.[17]

Preventive benefits for pregnant and post-partum women should also include exams, cleanings and other basic dental benefits to address oral health conditions in order to prevent premature labor and delivery; babies born too soon are at high risk of dangerously low birth weights. Preventive dental services are essential to avoid oral infections such as gum disease, which has been linked to preterm birth.[18] According to a

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[15] *The Surgeon General's Call to Action to Support Breastfeeding* (January 20, 2011), http://www.surgeongeneral.gov/topics/breastfeeding/calltoactiontosupportbreastfeeding.pdf; *see also,* USPSTF, Primary Care Interventions to Promote Breastfeeding: Recommendation Statement (October 2008) (Grade A and B for various breastfeeding interventions), http://www.uspreventiveservicestaskforce.org/uspstf08/breastfeeding/brfeedrs.htm.

[16] *Breastfeeding: Investing in California's Future,* California Department of Public Health (January 2007), http://www.cdph.ca.gov/programs/breastfeeding/Documents/MO-BreastfeedingFullDocument.pdf

[17] http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/04/05/MNUS1CPND0.DTL (April 5, 2010).

[18] *See, e.g.*: Yalcin F., Basegmez C., Isik G., Berber L., Eskinazi E., Soydinc M., Issever H., and Onan U. The Effects of Periodontal Therapy on Intracrevicular Prostaglandin E_2 Concentrations and Clinical Parameters in Pregnancy. *Journal of Periodontology*, 2002;73:173-177 (circulating levels of progesterone increase during pregnancy, stimulating production of prostaglandins, and these possibly result in pregnancy gingivitis (gum disease)).
Jeffcoat, M., et al., Current Evidence Regarding Periodontal Disease as a Risk Factor in Preterm Birth, *Annals of Periodontology*. 2001; 6:183-188 (examples of bacterial infections causing spontaneous abortion, preterm delivery, and low birth weight infants; bacteria that cause periodontal infection can enter the bloodstream and can reach the placenta; bacteria also stimulate an immune response associated with preterm labor).

2001 study, gum disease is as big a risk factor as smoking or alcohol use for having a low birth weight baby.[19]

Neonatal intensive care for a premature newborn typically runs into the hundreds of thousands of dollars; such costs can be avoided in many cases, for net savings in overall program costs, by the relatively low cost of basic oral health care for the mother during pregnancy. Such net program savings were a major reason why California, for example, added basic preventive dental benefits during pregnancy and those services were retained even after most other adult Denti-Cal benefits were eliminated in 2009.

2. The EHB must ensure robust coverage of women's health services in addition to preventive services.

Women have specific and critical – indeed, *essential* – health needs that are unique and less likely to be covered by insurers in the absence of explicit coverage requirements. To be substantial and comprehensive, coverage must consider and address the health needs of women.

A*) Require Comprehensive Coverage of All Ten Statutory Categories of Services*

The ACA defines the EHB package as the coverage offered by a typical employer plan plus ten additional categories of coverage ("Ten Categories"). California should require all EHB packages to include *substantial* coverage in *all* Ten Categories; substantial coverage should be established as the amount needed to meet the needs of the covered population.

In defining the EHB, the ACA reads:[20]

> Subject to [a requirement to cover services in equal scope as provided under typical employer coverage], the Secretary shall define the essential health

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Guthmiller J. M., Hassebroek-Johnson J.R., Weenig D.R., Georgia, Johnson K., Lester Kirchner H., Kohout F.J., and Hunter S.K., Periodontal Disease in Pregnancy Complicated by Type I Diabetes*, Journal of Periodontology*. 2001; 72 (11):1485-1490 (periodontal inflammation and destruction are increased in pregnant diabetics as compared to non-diabetic pregnant patients).
Offenbacher S., Lieffi S., Jared H., Madianosi P.N., Champagnei C., Murtha A., Boggess K.A., and Beck J.D., Maternal Periodontitis Impairs Fetal Growth, *Annals of Periodontology*. 2001; 6:164-174 (mothers who suffer from gum disease are significantly more likely to deliver their babies prematurely than women without gum disease).
López N.J., Patricio C. Smith P.C., and Gutierrez J., Periodontal Therapy May Reduce the Risk of Preterm Low Birth Weight in Women With Periodontal Disease: A Randomized Controlled Trial. *Journal of Periodontology*. August 2002; 73:911-924 (periodontal disease appears to be an independent risk factor for preterm low birth weight; periodontal therapy significantly reduced the rates of preterm low birth weight in the study population).

[19] Offenbacher S., Lieffi S., Jared H., Madianosi P.N., Champagnei C., Murtha A., Boggess K.A., and Beck J.D., Maternal Periodontitis Impairs Fetal Growth, *Annals of Periodontology*. 2001; 6:164-174.

[20] ACA § 1302(b)(1) (emphasis added).

benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.

Each of the Ten Categories is a non-redundant addition to supplement typical employer coverage. Furthermore, "plus ten" means that provisions including services like habilitative service now take on meaning. The "plus ten" reading matches the language of the law and is the only way to give meaning to all of the provisions. This interpretation is what statutory interpretation requires, as a matter of law.

Furthermore, "plus ten" is also the interpretation which best comports with legislative intent. One of the fundamental underlying principles in the ACA, reflected in countless ACA provisions, is that by investing in critical services we will transform health care coverage and reduce long term spending. It would make no sense for the ACA to, with regard to the EHB standard, list the critical services and then suggest they be covered only to the minimal extent already covered. It is no coincidence that the "plus ten" categories include critical gap services like preventive and wellness services and chronic disease management, maternity and newborn care, pediatric services, etc., and it is the ACA's intent to invest in these services beyond current minimum norms.

B) *Ensure comprehensive maternity benefits*

One of the EHB requirements is maternity care. To ensure a meaningful maternity benefit, it is not enough for plans to offer coverage of basic prenatal, labor and delivery care; California should require a prescriptive set of benefits that require plans to offer *comprehensive and robust* maternity care that specifically includes preconception care, pregnancy-related counseling, postpartum services including family planning services and supplies, screening for domestic violence, breastfeeding support, enhanced coverage for high-risk pregnancies, and services for other conditions which may complicate pregnancy.[21] California recognizes the importance of pregnancy-related services to maternal health and improved birth outcomes by including services such as prenatal

[21] *See* AMNESTY INTERNATIONAL, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE U.S.A., (2010), at http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf. African American women are nearly four times as likely to die from pregnancy-related complications than white women in the U.S. The authors describe solutions to address this public health emergency.

dental care in the Medi-Cal program. The Exchange should model the scope of maternity benefits after the services currently available to low income women.

C) *Ensure coverage of abortion services*

California's public and private insurance coverage currently includes abortion coverage. Abortion services are required in the Medi-Cal program, and the vast majority of private plans in California cover abortion services. These services must remain available and affordable.

In selecting among benchmark options listed in the HHS Bulletin, California must decide that the Federal Employees Health Benefits Program is unacceptable because it excludes coverage for virtually all abortion services, as noted below. This reflects a federal policy that conflicts with California's longstanding constitutional principles and health policies, and would have a serious adverse effect on the health of California women.

Congress has placed these restrictions in annual appropriations acts, most recently the Consolidated Appropriation Act of 2012:

> SEC. 613. No funds appropriated by this Act shall be available to pay for an abortion, or the administrative expenses in connection with any health plan under the Federal employees health benefits program which provides any benefits or coverage for abortions.
> SEC. 614. The provision of section 613 shall not apply where the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of an act of rape or incest.[22]

In California, the state may not weight a pregnant women's choice between abortion and childbirth by discriminatory funding of health care options.[23] Our public policy, codified in the Reproductive Privacy Act, states that "every woman has the fundamental right to choose to bear a child or to choose and to obtain an abortion."[24] Thus, California's public and private insurance programs currently include abortion coverage. Despite federal restrictions, our Medi-Cal system has provided benefits to indigent pregnant women for both childbirth and abortion for over 30 years. California must ensure that women do not lose coverage for services that are currently available.

3. The EHB Standard Should Minimize Use of Utilization Management.

Utilization management techniques are not all inherently problematic. For example, a medication management review to evaluate prescription contraindications can be helpful. However, the reality is that the majority of utilization management conducted by insurers today is used to drive down utilization, not to improve care, much to the detriment of consumers. For vulnerable individuals who lack the extra money to pay out-of-pocket for

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[22] P.L. 112-74, 2011 HR [HR 2055] (Approved December 2, 2011).
[23] Committee to Defend Reproductive Rights v. Myers, 29 Cal. 3d 252 (1981).
[24] Health & Safety Code Section 123462.

needed care, the result is predictable: they go without care. Some forms of utilization management, such as copays, may in fact never serve any valid clinical purpose.

Utilization management strategies applied to the EHB should be limited to evidence based criteria with the sole objective of allowing health providers to improve the quality of services offered to their patients. Utilization management criteria should be documented and publicly available, to ensure that decisions are made based on sound clinical practice. The standards should be based on medical criteria (such as guidelines of the major relevant professional academies or provider associations, for example, the American Academy of Pediatrics, American Congress of Obstetrics and Gynecologists, etc.). Ultimately, a coverage limit should only be allowed if it is based on medical evidence and is not detrimental to the health care needs of enrollees.

In those circumstances where a health provider's clinical treatment plan is denied or limited due to utilization management criteria, the EHB standard should require a clear and easy exceptions process that will be applied in an expedited manner to determine access to the prescribed treatment. For example, if an EHB plan is allowed to impose increased cost-sharing for non-preferred drugs, there are likely to be instances where a prescribing provider determines that a preferred drug is not as effective for the individual or would have adverse effects (or both). In this case, the provider should be permitted to protect the patient's health by prescribing the non-preferred drug without additional cost or delay to the individual.[25] This position is currently reflected in the Medicaid Act's policies and should also be applied to EHBs.

4. The EHB Should Include All State Insurance Coverage Mandates.

The IOM recognized that state mandates are market interventions aimed at meeting critical health policy goals recognized by a state legislature. The aim of state mandates is to improve population health while requiring that the risk of loss be shared within the insured community.[26] Mandates also play a critical role in helping states address gender, racial, and disease disparities. An EHB standard that ignores state efforts to improve insurance coverage will undermine those efforts and put states and insurers in an untenable financial situation.

Numerous populations that are often ignored by mainstream health insurance – such as children with autism or low-income women – depend upon state mandates to receive critical services. California has been a leader in ensuring that insurance products in the state meet the needs of the population and our EHB standard should reflect that commitment.

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[25] Deficit Reduction Act of 2005 § 6042, Pub. L. 109-171 (109th Cong. 2d Sess.) (Permits states to apply cost sharing levels for preferred drugs to non preferred drugs, "if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both." (citation omitted)).

[26] *See* IOM Report at 4-16.

Conclusion

The Essential Health Benefits are the foundation for the public and private health insurance that will cover millions of Californians. It is critical to the health of us all that the EHB is robust, comprehensive, and meets the health needs of women, their families, and their communities.

Thank you for consideration of these important issues. CCRF members around the state are available to discuss these issues further with you. Please feel free to contact us with any questions or more information: Susan Berke Fogel, National Health Law Program, at Fogel@healthlaw.org or 310-204-6010 ext. 113; or J. Parker Dockray, CCRF Executive Director, parker@reproductivefreedomca.org or 510-451-3381.

Sincerely,

ACCESS Women's Health Justice
ACT for Women and Girls
American Association of University Women, California
American Civil Liberties Union of California
American Congress of Obstetricians and Gynecologists, District IX
Asian Communities for Reproductive Justice
California Adolescent Health Collaborative
California Council of Churches IMPACT
California Family Health Council
California Latinas for Reproductive Justice
California Nurse-Midwives Association
California Primary Care Association
Law Students for Reproductive Justice
Maternal Child Health Access
NARAL Pro-Choice California
National Center for Youth Law
National Council of Jewish Women
National Health Law Program
Planned Parenthood Affiliates of California
Women's Health Specialists, Feminist Women's Health Centers of California

Cc: The Honorable Ed Hernandez, Chair, Senate Health Committee
The Honorable William M. Monning, Chair, Assembly Health Committee