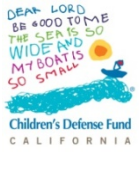
CH1LDREN NOW



December 21, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Comments on proposed Essential Health Benefits regulation CMS-9980-P

To Whom It May Concern:

Our undersigned organizations have previously shared with you our concerns and questions on how children would best be served by the proposed Essential Health Benefits (EHB) benchmark in our comments on the December 2011 Essential Health Benefits Bulletin. We nevertheless appreciate your consideration of the following comments on the Essential Health Benefits proposed rule (CMS-9980-P) published in the *Federal Register* on November 26, 2012.

Establish a comprehensive standard for "pediatric services"

By including pediatric services as a distinct EHB category, Congress expressed its intent that children receive an additional and customized set of benefits unique to children beyond that provided in the other nine categories. Those additional pediatric benefits include, *but are not limited t*o, oral and vision care. Guidance to date on the definition of pediatric services has been severely limited, but we strongly urge HHS to define pediatric services to include a full range of services from preventive and primary care to ancillary services utilized by children with special health care needs, such as physical, speech and occupational therapy, home health care, mental health care, habilitative services and devices, durable medical equipment, audiology services and devices, and personal care. As they develop, children also need preventive and supportive services to ensure they have the tools to maintain or improve their health well into adulthood. These services include, for example, regular developmental assessments and screenings, audiology screenings, education, behavioral health care, and other health services such as nutritional counseling, and treatment of pediatric obesity. Pediatric services should be explicitly defined to include such care.

Children have unique health needs that can help define the path they take for the rest of their lives; therefore, absent a federal definition, we are concerned that children may not receive the basic health benefits that they, as children, need. We are also concerned that state Exchanges will be reluctant to add appropriate pediatric services without assurances that federal subsidies will include a broad interpretation of pediatric services. Additionally, we remain unconvinced that the benchmark approach will ensure that children can access medically necessary services regardless of where they live or which health plan they are enrolled in. We recommend that HHS define pediatric services to explicitly include all medically necessary services for children and require benchmark plans to be supplemented when they do not cover all essential pediatric services.

Because Medicaid provides a robust package of pediatric services specifically designed to meet the unique developmental needs of for children through its Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, we recommend that the EHB pediatric services definition should be equivalent or similar to current Medicaid or CHIP benefits for children.

Additionally, the final EHB regulations should require the Exchanges to ensure that qualified health plans have developed and defined pediatric services, as well as the other services, in scope, duration, and amount in a manner that is tailored to children among other populations etc. We believe this is in line with paragraph b, subsection 4 of §1302 of the ACA, which establishes certain minimum standards for EHB-governed plans. Specifically, §1302 calls for the Secretary of HHS to "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their *age*, disability, or expected length of life […] and to take into account the health care needs of diverse segments of the population, including women, *children*, persons with disabilities, and other groups" when defining EHB.

Establish an age definition of pediatric services consistent with child-only plans and Medicaid

The preamble of the proposed rule states that pediatric services are for individuals under 19 years of age. We support the establishment of a defined age threshold for pediatric services, and we believe a federally-defined age will help reduce discrimination based on age. However, we believe the pediatric age limit should be codified in regulation with appropriate flexibility for states to increase the age. We strongly recommend that HHS define the minimum age limit to cover those up to age 21 in order to: 1) align with the age rating bands proposed for health insurance market rules (CMS-9972-P) and the enrollees in child-only plans, and 2) provide continuity with Medicaid, which provides EPSDT services to enrollees up to age of 21.

Define "habilitative" services

Rehabilitative and habilitative services and devices are important for children, especially for vulnerable children and children with special health care needs; therefore those services and devices should be clearly defined. The proposed rule allows states to define habilitative services when they are not present in the state's benchmark plan. However, if the state does not define habilitative services, then insurers have the ability to define the benefit. State flexibility may be appropriate; however, insurer flexibility has the potential to limit needed services. An approach that allows insurers, not the state, to define the habilitative benefit is not acceptable, because it would allow insurers the option to provide a minimal benefit that may be far less than comprehensive.

We recommend that HHS define "habilitative services and devices" to mean health care services *and devices* that are designed to assist individuals in acquiring, improving, or retaining, partially or fully, skills and functioning related to activities of daily living and instrumental activities of daily living in the most integrated setting appropriate to their individual needs. These services address the skills and abilities a child needs for optimal functioning in interaction with his or her environment, and include occupational, physical, and speech therapy as well as devices like hearing aids and wheelchairs, that may need frequent replacement as children grow and develop. Of note, the EHB benchmark plan selected in California (Kaiser Small Group) does not cover hearing aids. Given the habilitative value of hearing aids to a child with a hearing problem, we believe that HHS should clarify that such devices must be covered for children as part of the habilitative services benefit.

HHS should also clarify that habilitative services for children include assistance that helps them acquire and improve skills and functioning related to childhood development and activities of daily living. In addition, habilitative services must be provided in coordination with other agencies to assist families in accessing other needed services for their children, such as respite, day care, recreation care, social services, and education services.

Assure mental health parity
The statute requires that all plans covering EHB must offer mental health and substance use disorder service benefits, including behavioral health treatment and services. We commend HHS for including language in the preamble of the proposed rule that coverage must provide parity in treatment limitations between medical and surgical benefits and the mental health and substance use disorder benefits required to be covered in both the individual and small group markets. We appreciate the requirement that EHBs must comply with federal mental health parity laws and urge HHS to work with states to ensure that benchmarks are compliant.

Because Medicaid provides a strong mental health benefit for children through its EPSDT benefit, we suggest that strong consideration be given for EHB mental health benefits to mirror Medicaid or CHIP coverage and standards.

Establish transparency in pricing of health and dental coverage
It is important for consumers to be able to easily understand the cost and value of their plan and any tax subsidies or cost-sharing responsibilities. Therefore, we strongly recommend that Exchanges be required to provide consumers with relevant information about the actuarial value, available tax credits, and all required cost-sharing responsibilities including premiums and out-of-pocket maximums for both integrated and stand-alone dental plans in an easily **understandable and comparable** format.

Reflect the cost of dental coverage in family cost-sharing limits
The EHB includes pediatric dental coverage, but allows for a qualified health plan to exclude the pediatric dental component if a qualified "stand-alone" dental plan is also sold through the Exchange. The proposed rule includes a separate "reasonable" cost-sharing limit for stand-alone dental plans. We strongly recommend that HHS define what is meant by "reasonable" cost-sharing limit.

Furthermore, the rule should ensure that the out-of-pocket costs for families be the same whether families purchase separate medical and pediatric dental plans or an integrated medical and dental plan of equal actuarial value. We understand the need to ensure that health insurance plans that do not include pediatric dental do not have an unfair price advantage over other health plans; however, the proposed rule creates an additional and burdensome out-of-pocket expense for families that will be determined by the state and difficult to track. Requiring families to pay an additional (and, as yet undefined) out-of-pocket expense may force families to opt out of pediatric dental insurance altogether, resulting in a reduced likelihood that children will receive needed dental care. We strongly recommend that the out-of-pocket maximum be applied to *all* costs associated with coverage for all EHBs, including costs associated with stand-alone dental plans. Further, we recommend that when in-network providers are not available to perform required dental procedures, payment for dental services provided by out-of-network providers should be counted as part of families' cost-sharing limits.

Protect family cost-sharing limits and include out-of-network services
Some children may have health needs that cannot be met by in-network providers, even if the health plan's network meets applicable network adequacy standards. Children who need complex subspecialty pediatric care are most likely to encounter this scenario. When medically necessary services are not available to a patient by an in-network provider, a family should still remain protected by the ACA's limits on cost-sharing as they seek the necessary care out-of-network. We therefore urge HHS to amend the final rule to contain an exception that keeps the

cost-sharing limit in place for all medically necessary out-of-network services that are not reasonably available in-network.

Develop a reasonable process for tracking out-of-pocket medical and dental expenses
Families should not be responsible for tracking their out-of-pocket expenses for the purpose of identifying when they meet their out-of-pocket maximums. Instead, the insurance companies and the Exchange systems should develop a process for tracking out-of-pocket expenses and informing families when they reach their out-of-pocket maximums, including out-of-pocket expenses that come from stand-alone dental coverage. The Exchanges should be responsible for letting families know when they have met out-of-pocket maximums, especially when many families will potentially have incurred costs from more than one coverage plan, such as stand-alone dental plans.

Simplify the actuarial value and tax credit calculations for dental plans
The proposed rule includes a high/low actuarial value standard for stand-alone dental plans, which complicates calculating the cost-sharing reductions for stand-alone dental plans for many families when making their purchasing decisions. In addition, families with incomes at or below 250 percent of Federal Poverty Level (FPL) will pay more for dental coverage through stand-alone dental plans because the law exempts stand-alone dental plans from the cost-sharing reduction. (In contrast, the cost-sharing reduction will be applied to dental coverage when the dental plan is integrated into a health plan). We recommend that this process be simplified and fashioned to ensure that consumers can easily understand cost-sharing reduction calculations.

It is also unclear how insurance plans providing coverage through the Exchange will receive credit for achieving the required actuarial value with respect to dental coverage. The proposed rule seems to allow for the same metal tier value for plans whether or not they provide pediatric dental coverage. We recommend that HHS provide further clarification as to how the premium tax credit will be calculated with respect to stand-alone dental coverage.

Increase access to prescription drugs
Access to medically necessary prescription drugs is a critical aspect of health care for children. Access to a multiple drugs within the same class is particularly important for children since their health care providers may need to try different drugs as new diagnoses emerge and as children's conditions change or develop. Thus, we support the proposed rule's revision of previous guidance to mirror the number of drugs available in the base benchmark plan; this approach is far superior to requiring only one drug per class. Nonetheless, there may still be medications that children will need that will not be available on their health plan's drug list. Therefore, we strongly support the provision at paragraph (c) of §156.120 of the ACA that requires a procedure for requesting clinically appropriate drugs that are not on the plan's formulary. This provision should be expanded to clarify and codify that plan decisions on these requests are subject to expedited internal appeals as well as external appeals.

Further limit substitution of benefits
We believe that the substitution of benefits adds a layer of complexity and confusion for families with children who have unique health care needs that require a comprehensive benefit package of health care services and devices. The proposed rule allows issuers to make actuarially equivalent substitutions within the EHB categories. While some substitution may be appropriate to allow innovation in benefit design, we believe that strict limits on substitution are necessary to fulfill the goals of the ACA. The law establishes EHBs in order to provide a standardized floor for benefits in the individual and small group insurance markets. Allowing insurers to substitute the benefits in their plans will make it nearly impossible for families to compare health plan benefits

when purchasing coverage and increase the likelihood that a plan will not meet the needs of their child.

We strongly support the preamble's clarification that states may limit or prohibit benefit substitution, and we urge HHS to codify this language. We strongly suggest that HHS take additional steps to prevent issuer abuse of benefit substitution. For example, the proposed rule establishes that substitutions be made only within benefit categories. But without adequate definitions of each category, it is difficult to determine whether a proposed benefit substitution falls within the category. To limit this potential for abuse, HHS must, at a minimum, clearly define each of the ten benefit categories. This will be necessary to properly evaluate and allow only substitutions that are actuarially equivalent AND consistent with the category definition should be allowed.

Develop a clear standard for evaluating discrimination and a process for enforcement

The proposed rule acknowledges the provisions in the ACA that prohibit issuers from designing an EHB package that may discriminate against various populations on the basis of race, disability, or age, among other factors. The preamble proposes developing "the framework for analysis tools to facilitate testing for discriminatory plan benefits," and says that such framework will involve "allow[ing] states to monitor and identify discriminatory benefit designs, or the implementation thereof." In the final rule, HHS should provide a clear standard for evaluating discrimination. The lack of a definition of discrimination in the rule is a problem that will lead to uneven enforcement of anti-discrimination provisions. In addition, the definition of discriminatory benefit design should not vary across states. We urge HHS to develop and promulgate a standard definition that will allow states and, when necessary, HHS to evaluate plans uniformly.

Beyond defining discrimination, the final rule should set out the process for addressing violations of the non-discrimination provisions. While the preamble contemplates shared authority for enforcement between states and the federal government, the final rule needs more clarity on when and how federal enforcement authority will be used. The final rule should also indicate procedures for reporting potentially discriminatory benefit design or delivery, appealing decisions, and remedying any violations identified.

In addition, we urge HHS to carefully consider the potentially discriminatory effects of benefit designs. The preamble states, "we believe that it is unlikely that an EHB-benchmark plan will include discriminatory benefit offerings." However, the proposed EHB benchmark plan in Utah, for example, includes a limitation on pediatric dental services ("Periodic oral exam fees are allowed twice in a plan year age 3-18"), which clearly discriminates against children under 3 years old.

Establish a monitoring and data collection process

Strong requirements for states to collect and report data on their EHB benchmark packages are essential to understanding whether benchmark plans are serving the needs of maternal and child populations and what, if any, refinements may be necessary. We urge HHS to require each issuer to report its definition of medical necessity and to collect data elements related to network adequacy.

We recommend that HHS collect, analyze, and publish data on consumers' use of covered benefits and spending on non-covered health services. These data are necessary to properly evaluate the effects of the current EHB approach for 2014 and 2015 as Exchanges get underway and to inform the revised approach for 2016 and beyond. Any evidence of delayed access to care, worsening health outcomes, cost barriers to needed health services, or other

detrimental effects of benefit design on children and families should be considered and addressed as the new EHB approach is developed in 2016.

We appreciate your consideration of these comments.

Sincerely,

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