

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-9965-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Data Collection to Support Standards Related to Essential Health Benefits proposed regulations [CMS-9965-P] RIN 0938-AR36

Dear Sir/Madam:

As an organization that has been fighting for health care justice for nearly 30 years, Families USA considers the availability of comprehensive coverage as critical to our goal of achieving high-quality, affordable health care for all Americans. We therefore appreciate the opportunity to comment on the proposed regulations on Data Collection to Support Standards Related to Essential Health Benefits. We want to thank the Department for issuing the Proposed Rule regarding Data Collection to Support Standards Related to Essential Health Benefits (EHB). As we have noted in previous comments and letters, robust data on the potential benchmark plans is vital to better understanding how the Department's intended approach to defining the Essential Health Benefits would impact the populations we represent. Robust data collection requirements for states and carriers will help HHS ensure it has the data needed to accurately assess the impact of the benchmark approach on consumers. This data will be necessary to meet the Secretary's statutory obligation to periodically review and update the essential health benefits to address any gaps in access to coverage or changes in medical evidence or scientific advancement. It will also be necessary to inform HHS's evaluation of the benchmark approach for the calendar year 2016 and to assess whether an alternative approach, such as a federally defined EHB, would better address access to care, consumer choice, risk selection, and the ACA's goal of establishing a minimum level of uniform benefits.

We are generally supportive of the proposed rule and believe the recommendations below will serve to strengthen it. We offer many comments and recommendations shared by colleagues at other consumer organizations. Five areas are of paramount concern to us:

1. Data collected on benefit limits should be used to prohibit discriminatory and overly restrictive benefit limits from being incorporated into the essential health benefits package.
2. HHS should collect data on rider policies included in potential benchmark plans.
3. A robust federal review process should ensure every state's essential health benefits package meets all statutory requirements.
4. Wellness incentive programs should not be incorporated into the essential health benefits package.
5. All data collected on the benefits of potential benchmark plans should be made publicly available.

Gathering Data on Limits on Potential Benchmark Plans:

We have previously expressed concerns about the lack of information available on limits in the potential benchmark plans and that limits could impede access to the essential health benefits. Information about quantitative and non-quantitative limits is not easily available and without it, consumers cannot be assured that all benchmarks will have reasonable, non-discriminatory limits that are truly within the scope of the typical employer plan and meet all applicable non-discrimination requirements established by the Affordable Care Act. We are glad to see that the information is being collected and hope it will be used to ensure consumers have access to the entire scope of essential health benefits.

While we believe the information is important to have, we want to make certain that its collection is not an indication that these limits will be incorporated wholesale into the essential health benefits. We reiterate our concern that arbitrary and unreasonable limits could be used to restrict needed care or steer consumers into or away from certain plans offered on the exchange and may be inconsistent with the ACA's clear intention to guarantee that at least the 10 benefit categories are covered.

In some instances, arbitrary service limits could seriously interfere with necessary care. For example, restrictive limits on the number of mental health service visits covered under a plan can not only seriously interfere with the treatment of a patient's mental health care needs, it can also have negative implications for the treatment of co-morbidities, including effective management of chronic conditions. Overly restrictive and arbitrary visit limits on rehabilitative services can seriously interfere with individuals receiving the care necessary to facilitate their successful recovery from surgery or other injury or illness, such as a stroke. **Under the statute, particular attention must be paid to limits that would result in discrimination against individuals based on their age, disability, or expected length of life. We believe that treatment limits that are clearly inadequate to address a condition would discriminate against people with that condition.**

For this reason, HHS should prohibit some limits or exclusions even if they are found in a proposed state benchmark plan.

We have some concerns specific to the request for information on non-quantitative limits, such as step-therapy and prior authorization. **It is important that the use of non-quantitative limits be restricted so that they do not prevent access to the essential health benefits. We have particular concern for non-quantitative limits that are not based on the best medical evidence or are being applied to situations outside the applicability of the medical evidence. For instance, any step therapy requirements should be based on evidence that they are appropriate for someone with a given condition and will not put a patient at risk. Plans should always have an exceptions process from step-therapy that allows a patient's physician to explain when step therapy is not appropriate due, for example, to complex medical conditions, co-morbidities, or because a patient had failed a lower step previously when covered by another plan. Without these protections, step therapy can pose a significant barrier to individuals accessing the prescription drugs best suited to address their personal health needs.** Restrictive step therapy requirements can create barriers to individuals with mental health needs accessing the medications best suited to treat their condition. Step therapy

requirements can also create barriers to accessing proper pain management medications for individuals suffering from chronic pain conditions.

In addition to our concerns about the impact of non-quantitative limits, we are also concerned that it will not be possible to verify the actuarial equivalence of treatment limits, and particularly non-quantitative limits. This could result in some plans using non-quantitative limits to reduce access to benefits while still appearing to be actuarially equivalent to the benchmark plan. This is of particular concern in regard to non-dollar limits established in place of previously existing dollar limits. HHS's Frequently Asked Questions on Essential Health Benefits Bulletin allows dollar limits in state mandated benefits or other benefits to be converted to non-dollar limits that are at least actuarially equivalent to the dollar limits. But it is not clear that a determination of actuarial equivalence can be made for a specific benefit limit (as opposed to a package of benefits and cost-sharing). And even a limit that is actuarially equivalent when measured for a standard population could be grossly inadequate for many individual consumers. For instance, state mandated benefits for hearing aids or cochlear implants often require coverage up to a specified dollar amount. How to replace these limits with frequency limits or non-quantitative limits is unclear and could leave uncovered the hearing hardware that some individuals need. If there is no clear way to determine and verify the actuarial value of specific plan limits, then we do not see how they can be incorporated into the essential health benefits.

We recommend that the Department use the data collected to understand quantitative and non-quantitative limits and how they may be discriminatory and/or limit access to essential health benefits. We specifically encourage the Department to recognize any gaps in medical evidence that supposedly support non-quantitative limits and issue regulations that restrict the use of non-quantitative limits in essential health benefits.

Additionally, given the Secretary's obligation to ensure that the EHB package does not discriminate and to comply with the requirements in § 1302 and § 1557, we believe this data should be used to identify any quantitative or non-quantitative limits that might be discriminatory and ensure that they do not become part of the Essential Health Benefits.

Prescription Drug Data Should Help Direct a Robust Definition of Prescription Drug Coverage:

We are glad to see that detailed information will be requested on prescription drug coverage. Hopefully this data will help the Department issue regulations on the prescription drug category that ensures the essential health benefits include prescription drug coverage that is comparable to a typical employer plan. This means that the essential health benefits will require a broad range of drugs covered within each category or class. All of our concerns on the use of limits we discuss above apply to prescription drug coverage.

HHS Should Collect Data on Rider Policies:

The Department of Health and Human Services (HHS) has provided inconsistent guidance on the issue of whether rider policies will be considered as part of the benchmark for determining Essential Health Benefits (EHB). HHS stated in a Frequently Asked Questions (FAQ) document, "For purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product excluding all

riders. HHS intends to propose that if benefits in a statutory category are offered only through the purchase of riders in a benchmark plan, that required EHB category would need to be supplemented by reference to another benchmark.”^[1] Yet, a footnote in the HHS Bulletin states, “Nomenclature used in HealthCare.gov describes ‘products’ as the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A ‘plan’ refers to the specific benefits and cost-sharing provisions available to an enrolled consumer. For example, multiple plans with different cost-sharing structures and rider options may derive from a single product.”^[2] If a plan is, in fact, a product that is supplemented by optional rider policies as described in the HHS Bulletin, then it is very confusing for Centers for Medicare and Medicaid Services (CMS) to define a plan in its FAQ as a product without riders. Individual plans that emerge from a single product are, by definition, distinguished by the availability of rider policies.

As proposed, HHS intends to collect data from the issuers of the largest three products in each state based on the plan with the highest enrollment within the product. **We urge HHS to require the collection of data related to the rider policies made available by that plan. High enrollment in a plan can be attributed, at least in part, to the availability of rider policies and is therefore information that HHS must have in order to develop a policy that reflects the statute’s requirement that the scope of benefits reflect a “typical employer plan.”**^[3]

Further Clarification on Supplementing a Benchmark Plan, including the Alternate Approach mentioned in Appendix G: Benchmark Plan Data Requirements:

This appendix mentions an alternate approach that states may use when providing data on the selected benchmark plan. It notes that if the state chooses the alternate option, HHS will ensure coverage in all ten statutorily required categories. We assume that HHS will fill in the required categories in a robust way that ensures plan enrollees receive the comprehensive benefits intended by the ACA. However, as this alternate approach appears to be a new idea, we request further clarification on how HHS would supplement the ten categories to ensure access to all essential health benefits. The approach should use a transparent process when supplementing the ten categories under this approach with an opportunity for stakeholder input.

We also request clarification on whether there will be any action taken by HHS to verify coverage of all ten categories when states DO NOT choose the alternate approach. As we stated in our earlier comments in response to the Essential Health Benefits Frequently Asked Questions, we support HHS’s proposal to collect benefit information for each state’s EHB package from states in a standardized format. Collecting information on states’ EHB packages in a standardized format will facilitate a coordinated and robust federal review process of EHB packages. **Once states submit their EHB package to HHS, HHS should review each state’s package to ensure: 1) the state-selected benchmark plan provides adequate coverage across all 10 statutory categories or has been supplemented with benefits to ensure adequate coverage across all 10 categories; and 2) the benefits and any duration and scope limitations included in the package meet all statutory requirements of EHB, including all nondiscrimination requirements and parity requirements applicable to EHB.**

^[1] <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>

^[2] http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf, page 4.

^[3] Section 1302(b)(2) of the Affordable Care Act

Question About Wellness Programs Mentioned in Appendix H-1: Medical Benefits Template for Individual Family Plan (IFP):

We were concerned to see that the Medical Benefits Template for Individual Family Plan included a question concerning Diabetes Wellness Plans. We want to ensure that wellness programs which are not actually benefits are not included in the EHB. We recognize that some Diabetes Wellness Plans are designed in consumer friendly manners and solely provide additional benefits to enrollees. These types of Diabetes Wellness Plans provide additional coverage for diabetes management programs and services universally to all enrollees who have or are at risk for diabetes. These programs do not place any conditions on obtaining coverage for these services or obtaining a certain level of cost-sharing for these services beyond an enrollee having or being at risk for diabetes.

However, wellness programs, that provide discounts on health care costs to enrollees who reach certain goals (such a specific blood glucose level, in the case of diabetes) or who participate in certain activities are not actually benefits and should not be taken into account in determining the Essential Health Benefits. Furthermore, we are very concerned that such wellness programs could be used as a way to circumvent other features of the Affordable Care Act, such as the end to discrimination based on health status and gender, and that wellness programs could be discriminatory towards women, low-income people, and minorities who may have more barriers to participating in these programs and are more likely to have chronic conditions or poor health to begin with. As such, it is critical that these types of wellness programs not be included in the Essential Health Benefits.

Additional Data:

This data is an important step in helping states make informed decisions when choosing a benchmark plan and will also provide important information about coverage available in insurance markets across states. In order for states and other parties working on state implementation to be fully informed, they need information on how limits actually work. We therefore recommend the following additions be added to the data request.

Exceptions and Numbers of People Reaching Limits

We recommend the final recommendation request, from each plan, data on how both quantitative and non-quantitative limits function including any exception process and the number s of people reaching each limit. Specifically, we suggest adding, for each limit:

- Is there an exception process for the limit? If yes: what is the exception? How many enrollees requested an exception in the last plan year? How many enrollees were granted an exception during the same period?
- How many people hit the limit in the last plan year? How many people hit the limit in each of the last two plan years?
- What proportion of users of that specific service hit the limit in the last plan year? What proportion of users of that specific service hit the limit in each of the last two plan years?
- What were the diagnoses/diseases of the people who hit the limit in the last plan year? What were the diagnoses/diseases of the people who hit the limit in the last two plan years?

Medical Necessity:

This information request provides an important opportunity to gather information on how plans will administer the essential health benefits. We therefore recommend the final recommendation request the definition of medical necessity used by each plan. This will allow the Department to have an understanding of how plans in various markets define medical necessity and should help the Department determine when certain definitions may be discriminatory and/or unreasonably limit access to the essential health benefits.

Collected Data Should Be Made Publicly Available:

Collecting this data is critical to helping states make informed decisions when choosing a benchmark plan. An essential component of the state process of selecting an essential health benefits benchmark plan should be engaging with diverse stakeholders, including consumers, and receiving their input on a state's benchmark plan options. **As such, we strongly recommend that this data collected by HHS be made publicly available as soon as possible, to ensure that consumers and stakeholders can effectively engage in the selection process in their state.**

Thank you for considering our comments. If you have any questions, please do not hesitate to contact Cheryl Fish-Parcham at CParcham@familiesusa.org or at 202-626-3030 or Lydia Mitts at lmitts@familiesusa.org or at 202-626-3030.

Sincerely,

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