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Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

RE: File Code CMS-9965-P, Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes.

Thank you for the opportunity to comment on the Proposed Rule on Data Collection to Support Standards Related to Essential Health Benefits. As we have noted in previous comments and letters on the Essential Health Benefits, the collection and dissemination of robust data on potential benchmark plans will be vital if state officials, lawmakers, advocates, and consumers are to truly understand how HHS' approach to defining the Essential Health Benefits (EHB) will affect those who will be purchasing health coverage in the individual and small group markets starting in 2014. The proposed rule outlines the data on enrollment and benefits information that issuers must submit for the products and their associated plans offered in a state's small group market. Additionally, the proposed rule outlines how data will be collected from stand-alone dental plans as well as the accreditation process for issuers of qualified health plans. Our comments are limited to the proposal for data collection.

The proposed rule includes provisions that should lead to a more open and transparent benchmark selection process. HHS proposes to collect very specific information on the benefits and their associated limits provided by certain potential benchmark plans, including plan-level data on prescription drug coverage. HHS also acknowledges the importance of making a state's benchmark selection and the associated coverage details public as soon as possible.

HHS should provide greater clarity on some sections of the proposed rule, either when a final rule on data collection is released or, in other instances, when a proposed rule on the essential health benefits is issued. For example, Appendix G, submitted for comment in accordance with the Paperwork Reduction Act, indicates that HHS is considering a third alternative process for states to construct their benchmark plans. To date, HHS has said states could either select their benchmark on their own, or default to a process prescribed by HHS. Appendix G proposes that a state could designate a small group plan as its benchmark and then allow HHS to fill in any missing categories

of benefits. More information is needed on how this approach would work and how it would differ materially from the default option for states that has already been developed.

We anticipate that under HHS' proposed approach to defining the EHB many states will choose a small group plan as their benchmark. Yet the proposed rule does not address the other plans available to be selected as benchmarks (state employee plans, national FEHBP plans, and commercial HMOs in the state). Limiting information to the small group plans will make it difficult for a broad cross-section of interested parties such as state officials, issuers, advocates, and the public to compare benefits and limits across the ten plans eligible to be chosen as a benchmark. To allow for a full evaluation of the options available to states and the feasibility of HHS' approach more generally, the data collection mechanisms for collecting plan information and transmitting it to the public should be expanded to include *all* the potential benchmark options in a state.

Collecting data from all the plans eligible to be chosen as a state's benchmark will help the Secretary meet her statutory obligation to periodically review and update the essential health benefits in order to address any gaps in access to coverage or changes in medical evidence or scientific advancement. It will also be critical as HHS evaluates the benchmark approach going forward and makes decisions such as whether an alternative approach, such as the Secretary specifically defining the EHB (as opposed to the current approach under which states can select a benchmark plan from 10 potential benchmarks), would better ensure access to care, more consumer choice, and less risk selection while fulfilling the ACA's goal of providing a comprehensive array of benefits in the individual and small group markets.

Thank you again for the opportunity to comment on this proposed rule. We provide more detailed comments below.

Sincerely,

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More Detail Needed Around New Alternative Approach to Selecting a State's Benchmark

Until now, it appeared that HHS envisioned two paths that a state could take when selecting an EHB benchmark: it could either choose a benchmark on its own and then fill in any missing benefit categories from other available benchmark plan options, or it could allow the default option, in which HHS designates the largest small group plan in the state as the benchmark and then fills in any missing benefit categories, to take effect. Appendix G of the Health Insurance Web Portal information collection suggests that HHS is developing a third path by which a state could designate one of the small group plans as its benchmark and then leave it to HHS to ensure coverage in all ten required EHB categories.

HHS should provide more information on how this new option will work in practice. The December 2011 EHB Bulletin and the February 2012 FAQs established a default benchmark selection process by which the largest small group plan would be the benchmark and missing categories would be filled in by looking first to the second largest small group plan, and then the third largest small group plan. Since a default process is already in place, HHS should provide more information on the need for this new approach. If it is because some states have expressed an interest in picking a reference plan but want HHS to fill in any missing benefit categories, then HHS should explain why this would help achieve the goals of the EHB requirement relative to the existing default approach.

HHS should also develop a rigorous process for verifying coverage in each of the ten benefit categories, no matter which of the three approaches a state selects. HHS should also provide more detail on how it will supplement any missing benefit categories during the default process in order to ensure access to all the essential health benefits. This should include a transparent process for identifying when a plan offers sufficient coverage in each of the category of benefits and how coverage will be supplemented when categories are found to offer insufficient coverage.

HHS Should Collect Data at the Plan Level

Under HHS' proposed approach to establishing the essential health benefits, states will choose a benchmark plan from among 10 options: the three largest plans by enrollment in the three largest small group products by enrollment in the state, the three largest state employee plans by enrollment, the three largest FEHBP plans by enrollment, and the largest HMO operating in the state. In order to identify each state's three small group options, HHS has indicated that it will first identify the three largest products in a state's small group market based on enrollment data from the first quarter of 2012, as submitted to healthcare.gov (which was just released this week). It will then be up to the issuers of those three products to submit data on the benefits and limits included in the largest plan by enrollment within those identified products.

We believe that enrollment data submitted to healthcare.gov should be the standard for determining the three largest products by enrollment in each state's small group market. As mentioned in the preamble to the proposed rule, enrollment data collected by states may differ from the data collected by healthcare.gov, which will likely lead to instances of discrepancies between what a state believes are its three small group options, and what healthcare.gov indicates those options are. In the interest of standardizing the benchmark selection process we believe states should not be able to use an alternative data source for determining a product's enrollment. There

should be one entity that determines enrollment information across states and healthcare.gov is the most appropriate entity to do that.

We believe it is essential that plan-level data for each of the potential benchmark options be submitted to HHS. While it is true that in some instances benefits will be the same across plans within a product, if states are to make an informed choice when selecting a benchmark they will need plan-level information on covered benefits.

Since it is likely that states will have to fill in benefit categories that are missing from their chosen benchmark, having plan-level data for *all* the benchmark options will be critical. Even though we expect most states to choose a small group plan as their benchmark, information about all potential benchmark plans should be collected and published in one venue. This will also be necessary because states will likely need to make subsequent rounds of decisions after selecting their reference plan in order to fill in missing benefit categories. We thus recommend that HHS collect and make public plan-level data for the small group, state employee, national federal employee (FEHBP), and the largest commercial HMO plans in each state in a way that facilitates the comparison of covered benefits and limits across plans. Only then can a cross-section of stakeholders truly evaluate the benchmark options available in states.

Information Needed on How Data on “Treatment” Limits Will Be Used

In the preamble to the proposed rule, HHS states that the definition of “treatment limitations” in §156.120(a) will have the meaning given to it in §146.136, in which both quantitative and non-quantitative limits are included. We support this definition and believe that collecting data on quantitative and non-quantitative limits can make the benchmark selection process more transparent by helping state officials and members of the public better understand in detail the coverage offered by potential benchmark plans.

Collecting this data can help allay one of our principal concerns with HHS’ proposed approach to implementing the essential health benefits: some of the plans eligible to be selected as a state’s benchmark may contain overly restrictive benefit limits that are likely to be problematic for certain patients, such as those with chronic illnesses and special health care needs. The information collected on limits should be employed to identify gaps in coverage where a plan does not offer sufficient coverage for a specific service included in the EHB. This in turn will help states and HHS make more informed decisions when they have to supplement benefits that are either missing or offered in an insufficient manner in the various benefit categories.

Since HHS is collecting data on non-quantitative limits, it should also take steps to ensure that these limits are not routinely incorporated into a state’s benchmark in a way that would likely reduce individuals’ access to needed services. That is because non-quantitative limits — such as step therapy or requiring prior authorization for certain procedures — are not able to be taken into account in actuarial value calculations (which we expect could be used under HHS’ proposed approach to determine whether a given insurance plan’s covered benefits are substantially equal to a state’s EHB). However, such limits could have a considerable effect in reducing the relative generosity of a benchmark plan (which in turn would affect the generosity of other plans offered in the individual and small group markets). For this reason, we believe that these types of limits should not be incorporated into a state’s benchmark.

Given the Secretary's obligation to ensure that the EHB package does not discriminate and to comply with the requirements in sections 1302 (which provides for the essential health benefits) and 1557 (which bars discrimination) of the ACA, we believe HHS should use this data 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.

HHS Should Collect Data on Riders

In its February 2012 Frequently Asked Questions (FAQs) CMS stated, "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." If HHS decides to define a plan as the benefits covered by a product excluding riders, issuers of the highest enrolled products should still be required to submit data on the riders attached to those plans. That is because high enrollment in a plan can be attributed, at least in part, to the availability of rider policies. In order to allow state officials and the public to truly evaluate the elements that went into making a plan attractive to consumers, data on all the benefits that comprise that plan should be submitted to HHS as part of the data collection. Data on riders should be a part of this data collection, even though the services they cover will need to be supplemented from other benchmark options.

Prescription Drug Coverage Data Should Be Used to Enhance a State's Benchmark

As articulated in our comments to the December 2011 EHB Bulletin, we are concerned that HHS' approach to the essential health benefits will lead to scenarios where a state's benchmark will have very limited prescription drug benefits, such as covering only one drug per category or class. Such limited coverage would be particularly problematic for patients with complex prescription drug coverage needs, such as those with HIV who require more than one drug per category or class, or people with a particular mental illness who may need to try several drugs in a single category or class before they find an effective treatment.

We are pleased that HHS proposes to collect plan-level data on prescription drug coverage from insurers. This information can be used to help identify plans that offer insufficient drug coverage (for example, plans that cover one drug per category or class) and ensure that if one of those plans is selected as a state's benchmark its drug coverage will be supplemented by more robust coverage from one of the other benchmark options in the state. HHS should also define the particular categories and classes of prescription drugs that at a minimum must be covered under each state's selected benchmark.

HHS should take steps to account for the fact that many small group plans only offer drug coverage through a rider. Since HHS has indicated riders will not be considered part of a plan during the benchmark selection process, there will be states where there will be no small group plans or a single small group plan that covers drugs in the absence of a rider. With such limited options available, it will be even more likely that the drug coverage a state selects for its benchmark will offer insufficient coverage. Earlier in these comments we urged HHS to collect data on riders even if they will not be incorporated into a state's benchmark plan selection. We reiterate our belief that data on

riders should be collected since the collection and analysis of such data may indicate a necessity for flexibility around including riders in a benchmark in order to ensure adequate drug coverage.

HHS Should First Clearly Define How Services Fit within the 10 EHB Categories before Collecting Data

In addition to collecting data on the benefits covered and limits associated with potential benchmark plans, HHS should define which services comprise each of the 10 EHB categories. In turn, HHS should amend the instructions for plans to submit data on benefits and limits found in Appendix G of the PRA by breaking out the data on covered benefits by EHB category. Submitting plan information in this way will make it easier for state officials and members of the public to identify plans that are missing a category of benefits or that offer insufficient coverage within that category.

Standardizing the benefits that comprise each category of benefits will clear up confusion that has appeared in states that are undertaking a benchmark selection process. Approximately 20 states are working on the selection of a benchmark plan by forming working groups, conducting analyses of their different benchmark plan options, and holding public comment periods. California, Oregon, and Washington are the furthest along in this process and each has designated a small group plan as their benchmark.

When analyzing different benchmark options, states have thus far had to use their own judgment about which services fit within a given category of benefits. Among states, a consensus has emerged around the benefit category under which *most* services fall (for example, states have classified x-rays as a laboratory service and ultrasounds as a maternity and newborn care service) but there is confusion around others, including some services that are frequently used and/or high-cost. For example, home health services have alternately been designated as ambulatory care, hospitalization, and habilitative and rehabilitative services, depending on the state. And care in a skilled nursing facility has been designated as a habilitative and rehabilitative service in some states and as hospitalization in others.

All of this suggests that if states are allowed to designate for themselves which services are included in each category of benefits, there will be tremendous variation across states in what services are included in each EHB category. This variation goes beyond what was originally anticipated when the EHB Guidance's approach for selecting a benchmark plan was first issued and provided to the states. In the end, HHS' job of ensuring compliance with the EHB and calculating the actuarial value of plans will become even more difficult.

Finally, in our comments to the December 2011 EHB Bulletin we argued that HHS should take steps to ensure that each state's benchmark covers an appropriate scope of services within each benefit category. It remains our concern that a state could adopt a benchmark that covers so few services within a benefit category that plans would not meet the needs of consumers, especially those with chronic illnesses and extensive health care needs. Defining the category in which each benefit will be placed, and then appropriately classifying benefits information into the right category when plan data is collected, will allow HHS, state officials, and the public to better evaluate how comprehensive a plan's coverage within each benefit category is.

Information about States' Benchmark Selection Should Be Made Publicly Available

The proposed rule states that HHS will make information on a state's final benchmark selection publicly available so issuers can use it for benefit design and rate setting. It is important that this is done not only for issuers, but also for state officials, advocates, and members of the public who become involved in the benchmark selection process in a state. HHS should ensure that in addition to simply identifying the selected benchmark plan for each state, it will also identify covered benefits, treatment limits, which plans were used to supplement missing benefit categories, and any other data that were relevant during the selection process. Healthcare.gov is the most appropriate place for this information to be posted.