



A Passionate Voice for Compassionate Care

December 21, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G
Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-9980-P

RE: Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Ms. Tavenner:

The Catholic Health Association of the United States (CHA), the national leadership organization of the Catholic health ministry representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations, is pleased to provide comments on the referenced Notice of Proposed Rulemaking (NPRM) on Standards Related to Essential Health Benefits (EHB), Actuarial Value and Accreditation under the Patient Protection and Affordable Care Act (ACA).

CHA has long worked for policies to make health care affordable and accessible to everyone in a system that is patient centered and designed to address health needs at all stages of life. To achieve that goal, it is imperative that the ACA's essential health benefits requirement be implemented in a manner that balances comprehensiveness of benefit coverage with affordability. While we appreciate the difficulty of this task and the need to provide a degree of flexibility for both states and health plans, **we are concerned that the proposed EHB standards need to be improved in several areas to ensure that people will have access to the health care services they need in the most appropriate settings.** We also urge HHS undertake aggressive data collection, analysis and monitoring of issuer performance over the next two years in order to ensure that consumers are able to get meaningful, affordable coverage and to modify the EHB standards as necessary for the future.

Substitution of Benefits

Under the proposed rule, a state would select a base-benchmark plan from among four types of health plans: one of the three largest small group plans by enrollment; one of the three largest state employee health benefit plans by enrollment; one of the three largest national Federal Employees Health Benefits Program (FEHBP) plans by enrollment; or the HMO plan with the largest insured commercial non-Medicaid enrollment in the state.

If the selected plan failed to include coverage in any of the ten categories of benefits required by the ACA, the state must supplement the base benchmark plan to add in the missing coverage. The ten required coverage categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The NPRM proposes to allow issuers to substitute benefits within an essential health benefits category, so long as the substituted benefit is actuarially equivalent to the benefit that is being replaced (and is not a prescription drug benefit). Issuers must submit evidence of actuarial equivalence to the state. This certification must be conducted by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, and use a standardized population.

While we are pleased that substitutions are not allowed across benefit categories, **we are very concerned with the broad ability for issuers to vary their health plans from the benchmark limited only by cost.** Such variations could be confusing for consumers, especially in the initial years, as they will be faced with many different plans containing many different rules. For example, service limits could vary from plan to plan, as well as the coverage of certain services by service site (inpatient v. outpatient). Too much variation will undermine the goal of access to comprehensive and meaningful health care coverage. **CHA urges HHS to develop additional safeguards beyond actuarial equivalence to ensure consumers will have access to the care they need. We also urge HHS to monitor carefully the variation that occurs among plans.** Finally, in the preamble to the proposed rule HHS notes that states may further limit or prohibit substitution. This should be made clear in the text of the regulation.

Habilitative Services

The ACA requires that plans cover both rehabilitative and habilitative services. As few plans currently cover habilitative services, this is an area where the states most likely will have to supplement the benchmark plan. The NPRM proposes to allow the state to determine which services to include in this category. If a state fails to define habilitative services, then it is up to the issuers either to provide parity by covering habilitative services benefits similar in scope, amount and duration to covered rehabilitation services, or to determine how to cover habilitative

services and report on that coverage to HHS. This approach does not provide sufficient assurance that those in need of habilitative services will have access to coverage that provides them with the services they need. **HHS should revise the proposal to include safeguards for consumers in need of habilitative services and should, at the very least, provide a definition of what constitutes habilitative services.**

Prescription Drug Benefits

HHS had previously indicated that it might only require health plans to cover at least one drug in each category and class in which the benchmark plan covered at least one drug. The NPRM proposes a better standard that would require plans to cover the greater of (1) at least one drug in every United States Pharmacopeia category and class or (2) the same number of prescription drugs in each category and class as the benchmark plan. CHA supports this important improvement and urges HHS not to go below this standard in the final rule. However, we remain concerned that some patients may still find that medically necessary drugs are not covered by their health plan. While the proposed rule does require health plans to have procedures to allow enrollees to request access to drugs not covered by the plan, no specific standards or guidance are provided. **We urge HHS to take additional steps in the final rule to ensure that patients will have access to the prescription drugs they need.**

Non Discrimination

The proposal includes a provision prohibiting discrimination in benefits or benefit design based on age, length of life, health conditions or quality of life which simply restates the requirements of the ACA. Primary enforcement will be left to the states, with no further guidance on how this requirement should be applied or interpreted. The preamble notes that this approach is intended to allow states to monitor and identify discriminatory benefit design or implementation. CHA is concerned that given the degree of flexibility allowed to states and issuers elsewhere in the proposal, for example with respect to the substitution of benefits discussed above, there is a significant risk that consumers could be harmed by plan practices that are discriminatory in effect if not in intent. **CHA strongly recommends that the final rule provide standards for preventing plan discrimination and indicate how HHS intends to monitor both plan activity and state enforcement.**

Out of Network Services

The ACA limits the amount of out-of-pocket costs for deductibles and cost sharing that may be imposed upon consumers. The proposed rule implements this requirement but adds a restriction with respect to plans using a network of providers. A consumer enrolled in such a plan who receives non-emergency services from an out of network provider will not be allowed to apply out of pocket costs for those benefits to the deductible or cost sharing limits. We believe this proposal could significantly undermine consumers' access to affordable health care. It is not at all clear that the network adequacy standards already finalized in previous ACA rulemaking will

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be robust enough to ensure that consumers in network plans will always be able to get the care they need in-network, particularly where specialty care is required. The proposal would appear to apply to a case in which the plan itself refers the patient to an out of network provider, creating a possible incentive for plans to maintain less than adequate provider networks. **CHA believes the out of network cost-sharing proposal could undermine plan accountability and impose unmanageable costs on consumers, and urges HHS to drop it or significantly revise it to protect consumers.**

Coverage of Abortion Services

CHA strongly supports the inclusion of proposed Sections 156.115(c) and 156.120(b) in the final regulation. Section 1303(b)(1)(A)(i) of the Affordable Care Act provides that qualified health plans offered in the exchanges may not be required to include abortion services as part of the essential health benefits package. These two proposed sections, along with previously finalized 45 CFR 156.280(d) codifying the ACA provisions, implement that requirement by stating that exclusion by a health plan of abortion services (including prescription drugs) will not prevent the health plan from meeting the requirement to provide essential health benefits. **CHA equally supports the proposal to allow health insurance issuers of plans outside the exchanges to decide whether or not to include abortion services in their health plans without violating the essential health benefits standard.** This is consistent with the Weldon Amendment to the annual Labor, Education and Health and Human Services appropriations legislation, which protects health care entities from discrimination because they object to providing, paying for, providing coverage of, or referring for, abortions.

Thank you for the opportunity to share CHA's comments on the proposal essential health benefits regulation. We await future proposals on how EHBs will be applied in the context of the Medicaid program and its expansion, and we look forward to continuing to work with you on implementing the ACA to ensure that everyone has affordable access to the care they need.

Sincerely,



Michael Rodgers
Senior Vice President
Public Policy and Advocacy