

December 20, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-9980-P Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule (Vol. 77, No. 227, November 26, 2012)

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule implementing the *Patient Protection and Affordable Care Act's* (ACA) provisions relating to essential health benefits (EHB), actuarial value and accreditation.

The AHA actively participated in the public process leading up to the issuance of this proposed rule and recommended a framework for EHB that bears repeating. That framework is:

The essential benefits package should cover treatment that: encompasses a broad range of services, including medical, psychiatric, rehabilitative, dental, vision, preventive and hospice services, as well as pharmaceuticals; is driven by the needs of the individual; is generally available; and adheres to accepted clinical professional guidelines.

From this basic principle, we suggest a three-pronged framework for assessing which benefits to include:

- *Are the benefits responsive to individual needs?*
- *Do the benefits take affordability into account?*
- *Are the benefits easily understood and transparent?*



This framework looks to balance the availability of a comprehensive benefit package capable of meeting individual needs, with the need to keep the benefit package affordable by emphasizing broad coverage grounded in evidence-based clinical guidelines. We believe that this is the best way to ensure meaningful coverage at an affordable price rather than making health plans more affordable by excluding various services or the settings for furnishing such services. One of the challenges facing CMS as it implements the ACA EHB standards is to balance flexibility for state governments and health plans to design affordable health plans while making certain that plan choices include the required range of services to ensure a meaningful benefit for the consumer.

The AHA, however, is concerned that CMS's approach to establishing standards and requirements to implement the ACA's EHB provision may have granted states and health plans too much flexibility undermining the ACA's goal of extending meaningful and affordable coverage to the millions of people who are currently uninsured or underinsured. The definition of EHB is the cornerstone for determining whether the health coverage offered and purchased is truly meaningful – that is, ensuring the ability to respond to individuals' needs with coverage of services grounded in clinical, evidence-based guidelines. The proposed rule builds on the recommendations of the Institute of Medicine and CMS's *Essential Health Benefits Bulletin*, which grants state governments and health insurance plans considerable flexibility in applying the EHB standards. While the AHA supports appropriate flexibility, we remain concerned that too much emphasis is being placed on providing flexibility and affordability rather than ensuring that coverage is meaningful.

The following comments are based on our framework and focus on the issues related to benchmark standards, actuarial equivalence and benefit substitution, out-of-pocket limits and out-of-network services, network adequacy, and consumer protections against discrimination.

EHB BENCHMARK STANDARDS, ACTUARIAL EQUIVALENCE AND BENEFIT SUBSTITUTION – SECTIONS 156.110-156.115

The AHA believes that the definition of an EHB should be responsive to individuals' needs while being transparent and easily understood. The proposed rule fails this test because of the significant degree of flexibility granted to both state governments and health plans in three areas: 1) the state benchmark plan options; 2) the process for states' to modify the benchmark through supplementation to conform the benchmark to the ACA EHB requirements; and 3) the process to allow health plans to substitute services in a health plan as a means to comply with the EHB requirements. Significant modifications to the EHB could lead to important and numerous variations in benefits offered under individual plans, some of which might not be transparent to the individual, thus making it difficult for individuals to compare plans readily.

The proposed rule requires that each state select a benchmark plan from four options:

- One of the three largest small group plans in the state by enrollment;

- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment; or
- The largest HMO plan offered in the state's commercial market by enrollment.

The state then must compare the benchmark to each of the ACA's 10 EHB categories (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). If the chosen benchmark lacks any of the required ACA categories, the state must supplement the benchmark with any lacking benefit required by the ACA. In the absence of a state selection, the default plan is the small group plan with the largest enrollment in that state.

Supplementation of services is expected for pediatric oral and vision services and habilitative services, which are not typically covered by individual and small group plans. With regard to pediatric oral and vision services, the proposed rule gives states two options to guide how they supplement their benchmark plans: the pediatric oral and vision services provided by either the largest federal employee plan (the FEDVIP dental and vision plan) or the Children's Health Insurance Program (CHIP) plan. With regard to habilitative services, however, the proposed rules provide little guidance; states can define the habilitative benefit in any way they wish. While the proposed rule suggests that a state provide parity between the habilitative benefit and the rehabilitative benefit, the rule allows an alternative of any benefit determined by the health plan issuer and reported to the Department of Health and Human Services. **Health plans should be required to cover habilitative services, which help an individual attain, retain or improve skills and functioning. A clearly defined habilitative service is critically important for lifelong developmental and health care needs, particularly for children.**

Health plans are given wide latitude to substitute services within any benefit category as long as the substitution is actuarially equivalent. The effect of this provision is that plans are allowed to deviate from their state's EHB definition and the only real standard for the benefit is cost. Furthermore, those substitutions may not be readily apparent in the general benefit summaries that will be available, resulting in a lack of transparency for consumers about what is covered. For example, an individual's health plan may include rehabilitative services for injuries suffered, but the individual may not know that the rehabilitation benefit was substituted for a benefit that was actuarially equivalent and mostly comprised of outpatient rehabilitation rather than inpatient rehabilitation. In the case of a seriously injured individual requiring substantial inpatient and outpatient rehabilitation, he or she might not understand the limitations of the coverage until it is too late.

As long as a health plan can deviate from its state's EHB definition by meeting the actuarially equivalent standard for service substitutions, the current practice of complex variations in health plan offerings will continue – moving us further away from the ACA's goals of ensuring more consistent and meaningful coverage. Substitution could make it harder for consumers to comparison shop among plans in the insurance exchanges. It also would allow plans to continue

to discriminate against providing care in specific settings (e.g., excluding inpatient psychiatric or inpatient rehabilitation services by substituting actuarially equivalent outpatient care). Similarly, while the proposed rule notes that EHB definitions must meet federal mental health parity requirements and nondiscrimination provisions, it offers little guidance to states in terms of how to implement the parity requirements and does not offer reassurance to consumers in terms of federal oversight against discrimination. **The AHA recommends that the ability to substitute benefits on the basis of actuarial equivalence be more narrowly constructed and closely monitored. We further recommend that the rule clarify that the statutory requirements for parity and nondiscrimination take precedence over the regulatory grant of authority to health plans to substitute services.**

OUT-OF-POCKET LIMITS AND OUT-OF-NETWORK SERVICES – SECTIONS 156.130, AND 156.135

The proposed rule implements the ACA's cap on out-of-pocket limits for deductibles and cost sharing borne by the consumer. Health plans, according to the rule, will be allowed to not count toward the ACA out-of-pocket limit any deductibles or cost sharing for out-of-network services other than emergency services, even though the ACA does not make that distinction. This policy would allow plans to hold plan costs down by simply shifting more costs to consumers in a way that nullifies the out-of-pocket limits. **The AHA objects to the adoption of this provision and recommends that it be deleted or significantly scaled back. If the rule were implemented as proposed, CMS would need to do three things: 1) include exceptions beyond emergency services; 2) substantially improve network adequacy standards; and 3) monitor enrollee access more closely.**

The proposed rule argues that this policy is already applicable to health savings accounts (HSAs) and that experience has shown that enrollees in network plans seldom go out-of-network for non-emergency services. On the first point, exchange plans should not be equated with HSAs and high-deductible plans. HSAs were developed as low-cost plans to provide primarily catastrophic coverage. Exchange plans were intended to provide comprehensive coverage to individuals and small groups using standardized out-of-pocket limits to make plan comparisons easier for consumers. Separate provisions are made for offering catastrophic coverage through the exchanges. The "metal" levels are intended to provide a standardized means of making plans available at different price points for the consumer. The proposed policy would confound this intended approach.

We also are concerned that the recent trend among plans to significantly narrow their provider networks, when combined with the weak network adequacy standards adopted in other ACA-related regulations, will result in an increasing number of enrollees going out-of-network to gain access to care on a timely basis, especially for critical specialty care. As we read it, the proposed rule does not address circumstances where a plan knowingly refers a patient to an out-of-network provider because the service is not available in-network when needed. Allowing health plans to not count out-of-pocket expenses when a consumer seeks out-of-network services does not hold health plans accountable for offering adequate provider networks and it could substantially increase consumers' out-of-pocket expenditures in unexpected ways. **The AHA believes this**

cost-sharing policy on out-of-network services fails the test that the EHB be responsive to individuals' needs and take enrollee affordability into account.

CONSUMER PROTECTIONS AGAINST DISCRIMINATION – SECTION 156.125

The proposed rule reiterates the ACA's prohibition against discrimination on the basis of age, disability or health condition, medical dependency, gender identity or sexual orientation. Enforcement is largely left to state governments with little guidance. For example, the proposed rule allows health plans to use utilization management techniques such as prior authorization but provides minimum guidance on how such a technique could be applied in a non-discriminatory fashion. Further, the ability of plans to make substitutions for EHB services by meeting an actuarial equivalent test leaves the door open for potential discriminatory abuse. In addition to our recommendation above regarding the need to ensure the precedence of the nondiscrimination and parity provisions over plan substitution flexibility, **the AHA urges CMS to more clearly articulate standards to guard against health plan discriminatory practices as well as guidelines for state government enforcement of those standards.**

Finally, the AHA supports the proposed rule's policy allowing state-mandated benefits enacted prior to Dec. 31, 2011, to be included in the state's EHB. The ACA requires states to pay for any mandated benefit that exceeds the EHB package. The proposed rule allows states to include the state-mandated benefits in their benchmark plan without having to defray the cost of the mandated state benefits.

Thank you for consideration of our comments. The AHA looks forward to future rulemaking that will articulate how the EHB policy will be applied to the Medicaid program and the ACA expansion populations. We also look forward to working with you and your staff on the further implementation of the ACA. If you have any questions, please feel free to contact me or Molly Collins Offner, director of policy development, at (202) 626-2326 or mcollins@aha.org, or Ellen Pryga, policy director, at (202) 626-2267 or epryga@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development