

February 16, 2016

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

John Dalrymple
Deputy Commissioner for Services & Enforcement
Internal Revenue Service
Department of the Treasury
Ben Franklin Station
P.O. Box 7604
Washington, DC 20044

RE: Hospital Outpatient Benefit Gaps for Some Individuals in Employer-Sponsored Health Plans

Dear Mr. Slavitt and Mr. Dalrymple:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) has been distressed to learn that some emerging employer-sponsored health plans do not cover outpatient surgeries, including those performed in hospital outpatient departments. **We urge the Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury (Treasury) to take swift and decisive action to protect consumers from these limited-benefit plans.**

Patients rely on the hospital outpatient setting for many frequently performed surgeries, including cataract surgery; tendon, muscle and small joint repairs; and gallbladder removals; among others. In 2013, two-thirds of all surgeries performed in hospitals were done on an outpatient basis. Health plans that do not cover such surgeries put enrollees' physical and financial health at risk; violate the Affordable Care Act's promise of comprehensive, affordable coverage; and hamper efforts to transform the delivery system.

This is not the first time that some employers have sought to limit coverage of critical benefits. In 2014 and 2015, some employers used the broad latitude provided to them in regulation to exclude inpatient hospital services from their plans. Specifically, the federal government originally required that employer-sponsored plans cover sufficient services to meet a 60 percent threshold of anticipated health care costs. However, this guidance did not identify which specific services must be covered, and some employer-sponsored plans attempted to meet the 60 percent threshold while excluding inpatient hospital services from their benefit structures. The AHA, along with other stakeholders, voiced serious concerns about the impact such exclusions would have on employee health and, as a result, CMS and Treasury took swift and appropriate action to deem these limited benefit structures as unacceptable. Indeed, beginning March 1, 2016, federal policy requires that large employer plans cover inpatient and physician benefits. **We are deeply**



concerned that some plans have interpreted the new policy to mean that they may exclude critical outpatient surgeries as long as they meet the 60 percent threshold.

We urge CMS and Treasury to again act to protect consumers from “skinny” health plans that put their physical and financial health at risk. As a temporary measure, we ask that CMS and Treasury immediately issue guidance mandating employer-sponsored coverage of hospital outpatient surgeries. We strongly recommend, however, that the agencies not stop there. We urge CMS to close any remaining loopholes by further defining “substantial coverage” for purposes of calculating the minimum value threshold of employer-sponsored health plans. Plans should be required to provide substantial coverage of a comprehensive range of benefits, including hospital outpatient surgery, among other critical services. CMS may look to the essential health benefits (EHBs) that apply to Marketplace plans as an example.

In addition, we strongly advise CMS to ensure that coverage is substantial within each category of benefits. Otherwise, plans may look comprehensive but actually be quite limited. CMS should consider establishing a benchmark for what services within each category must be covered to be considered substantial, as well as setting a separate minimum actuarial value as if the benefit category were stand-alone. For example, a plan under such a framework would need to meet the minimum value standard at 60 percent actuarial value overall, as well as within the ambulatory care category, which includes hospital outpatient surgery. Such a policy also would limit unreasonable and variable enrollee cost-sharing requirements across benefit categories.

These policy changes would help protect employees’ health and financial stability. As recently reported by [Kaiser Health News](#), individuals have had to make hard decisions about their coverage when faced with “skinny” employer-sponsored plans. In order to protect their families, some individuals have declined their employer’s coverage and instead paid full market price for a comprehensive plan. However, many do not have the financial resources to make the same choice. Instead, these individuals will be forced to choose to pay out of pocket for uncovered services, forego care or seek a similar service in the inpatient setting.

The AHA urges CMS to act immediately to protect individuals covered by employer-sponsored health plans from critical benefit exclusions. Thank you for your consideration of our concerns. If you have any questions, please contact me or Molly Smith, AHA senior associate director of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President